Starting in January, Illinois will post hospital prices on the Internet, joining other
states that are making charges public.

In June, 3 Milwaukee-area hospital systems were sued for allegedly overcharging
uninsured patients. The suits follow dozens of others around the country.

Congress has held hearings questioning how hospitals set their prices.
Lawmakers are probing hospitals’ overbilling of uninsured patients and aggressive
collection practices. They are also questioning why bills are so complex.

Once mainly the province of finance types, hospital chargemasters are increas-
ingly in the public eye. This attention, plus the need to manage more efficiently, are
causing hospitals to take a close look at their charges, including the chargemaster for
surgery. It’s not an easy task—an OR chargemaster can have 5,000 line items for sup-
plies alone.

“I think everyone makes chargemasters too complex. We need to simplify them,”
says Day Egusquiza, a consultant who serves on the Healthcare Financial
Management Association’s task force on patient-friendly billing.

“The public is demanding that we do a better job of being able to explain our
charges. We have made it so complex that our patients, business offices, and cus-
tomer service reps don’t understand what the charges are,” she says.

Why do we still need charges?

Why are charges even necessary when so much reimbursement is fixed? Often,
charges seem to bear little relationship to how a facility is actually paid.

But Egusquiza notes that many providers still are not paid on a fixed or contracted
basis. The majority of hospitals are in rural areas and under 200 beds, “and many are
not heavily contracted at all,” she says. Larger hospitals often are paid on a per-diem or
discounted basis, based at least in part on their charges.

With Medicare, “it’s even more important to submit charges because the govern-
ment determines inpatient and outpatient payment rates based on a cost-to-charge
ratio,” says Egusquiza, president of AR Systems, Inc, Twin Falls, Idaho. “If you’re
not submitting your charges, how will they know what your cost-to-charge ratio is?”

Probably the major reason to have charges, she says, “is that your payers need
accurate, consistent charge data so the database they use for contracting is accurate.”

We asked experts to respond to some common questions about OR room and
supply charges. (Interview participants are in the sidebar.)

Who should maintain the OR chargemaster?

Mitchell: I think it is best for a person in the finance or business office to have
ownership of the chargemaster. If one person manages it, they can minimize duplica-
tion and make sure markups are done according to hospital policy. If you leave it
up to individual departments, you have a mish-mash.

Polte: Usually, it is a middle manager in the finance department. In a large organ-
ization, that may be all that person does. In a smaller organization, the chargemaster
is maintained by the finance manager who also has other responsibilities.

Christman: Typically, the finance department maintains the pricing. But the
chargemaster needs to be reviewed at least annually by the OR to make sure it
reflects how the OR does business. For example, are there any inactive items that
should be removed? In a perfect world, a person from finance would meet regularly
with an OR representative to review the OR charges. It’s also a good idea for the
OR to have a relationship with the person who maintains the chargemaster so items
How do hospitals keep their chargemasters up to date?

Polte: The vast majority of hospitals apply a broad annual markup to their charges. There is a big caution about resetting the pricing (or charge value) for individual charge codes to bring the charge value more in line with the current cost of items: If 3 to 5 years have gone by, and you apply the markup schedule across all items that are chargeable, it can have a dramatic impact on gross revenue. The relationship between charge values and items’ actual costs can get wildly out of whack. It’s important to do revenue modeling to project what the impact will be. CFOs tend to be queasy about doing anything to the chargemaster. It may be a mess, but at least it’s predictable from one year to the next. They would love to clean it up, but they want to be able to predict what the impact is going to be.

Mitchell: This seems to be most successful when a person in the finance department is responsible for the chargemaster. There also should be a policy and procedure manual for establishing charges. This person makes sure policies are followed and the charges are updated.

The hospital should use a standard nomenclature for charges. That’s especially important for supplies. We suggest a naming system that starts with a generic “last name,” followed by the vendor and size, for example, plate, Zimmer, 4-10 holes, or suture, Ethicon, size (or size range). If you don’t follow a standard nomenclature, you can have a lot of confusion and duplication of charges.

Much of the worry about pricing and updating is taken care of if the hospital has information systems that talk to each other. Then pricing data from the materials management system can be passed into the surgical scheduling system to generate a pick list, and that information can carry over to the patient’s bill. But too often, the materials management database doesn’t match the hospital’s other databases, and a lot of manual work is needed to match them up.

What is the usual time increment used for OR charging?

Christman: Typically, our clients charge for an initial block of time, such as 15 minutes or 30 minutes. Then they charge for additional time on a per-minute basis.

The initial time block usually depends on the length of the cases. For example, say an OR has a tiered pricing system with 5 levels. The cases in Level 1, which are typically the shorter cases, will have an initial 15-minute charge. Cases in Levels 3 through 5, which are generally longer, will have an initial 30-minute charge. The OR then bills for additional time in 1-minute increments.

This method is most frequently used in organizations that have an OR information system that allows them to key in the case start and stop times, which allows for accurate time recording.

Egusquiza: We see hospitals moving to a per-minute charge instead of large 60-minute or 30-minute increments. We suggest moving to a per-minute charge because of Medicare’s so-called 8-minute rule.

Under the 8-minute rule, you are not allowed to bill for the next billable increment until at least half of that time has passed. In other words, you cannot bill for the next 15-minute increment until at least 8 minutes has passed. In the OR, you should not bill for the next 30 minutes until at least 16 minutes has passed.

You do not want to lose any minutes in the OR because of the enormous cost. By converting to a per-minute charge, you do not have a compliance problem, and you don’t lose revenue. Nurses chart the start and stop times anyway, so that can easily be converted to minutes.

We have also seen a front-loaded charge, say, of 30 minutes with a per-minute charge thereafter. The 30-minute charge is front loaded to cover the costs of the OR setup.

Mitchell: Typically, we create a per-minute charge because we believe it is the best reflection of the services given. If the patient has 61 minutes of surgery, the patient is charged for 61 minutes. We feel 30-minute increments are too long. Sometimes we do a 15-minute charge, but that is the maximum increment we would
Do most organizations charge by levels of procedures? If so, what criteria do they use for setting up levels?

Christman: Many use 5 levels, perhaps because that is what emergency departments have used. In setting the levels, organizations typically consider the number of staff assigned to procedures, capital equipment, and instrument trays. Some are adding a sixth level, which will eventually be used for robotic procedures because the equipment is so expensive.

If you assign levels, you need to match all of your procedures to a level and enter that into your OR information system. That enables the level to be assigned to cases automatically, which ensures consistency.

Egusquiza: We sometimes see levels that are hard to explain to patients. I have seen OR chargemasters that had 15 levels, including major and minor. Many of these levels have been around for so long that no one can explain what they are. How many people can explain what a Level 12 minor is?

We recommend that charges be specialty specific, such as eyes, orthopedics, neuro, and so forth. In orthopedics and cardiac surgery, you might still have minor and major levels.

We need to step back and say, “What is the easiest, quickest way to show what the charges are without making them so complex that it looks like we’re trying to hide something?” With specialties, it is simple—patients see exactly what they’ve had. It’s a compliance issue, and it’s a patient-friendly issue.

What is included in the OR time charge?

Egusquiza: Routine supplies are included in the time charge. These are supplies that are not separately billable and available for all patients. Examples are gowns, gloves, and capital equipment.

Medicare’s definition of routine supplies is vague. One way to define nonroutine supplies, which are billable, is to apply these 3 tests:
1. The supply is specific to the patient’s injury or illness.
2. The physician has to order it.
3. The supply is part of the documented care plan.

Suture and implants are usually separately billable because they are specific to the patient.

Are OR charges typically based on historical data or a cost analysis?

Christman: Typically, hospitals base their charges on history and increase them by a certain percentage each year. Lately, though, there’s been a push for hospitals to be able to articulate what is in their OR time charges. Frequently, hospitals can’t tell you that.

Mitchell: We have had a few clients who have done a cost analysis to set up charges. Some places use historical data. But if they haven’t been keeping up with price changes, they can either be charging too much or too little. In the OR, things change so quickly. If you rely on historical data, your charges may not be covering your costs. If the hospital has the resources, we prefer to go by a cost analysis. You don’t necessarily need a consultant to do that, but you do need someone who is dedicated to the project.
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