HCPro, Inc., presents

Charging for Ancillary Bedside Procedures and Supplies in 2013: What You Need to Know

A 90-minute interactive audio conference

Monday, April 29, 2013

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Dear Program Participant,

Thank you for participating in our “Charging for Ancillary Bedside Procedures and Supplies in 2013: What You Need to Know” audio conference, featuring speakers Kimberly Anderwood Hoy, JD, CPC, and William L. Malm, ND, RN, CMAS, and moderated by Rebecca Hendren.

Our team is excited about the opportunity to interact with you directly. We encourage you to ask our experts your questions during the program. If you would like to submit a question before the audio conference, please send it to the producer, Rebecca Hendren, at rhendren@hcpro.com and provide the program date in the subject line. We cannot guarantee that your question will be answered during the program, but we will do our best to include a good cross section of questions.

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Thank you, again, for attending the HCPro program today. We hope you found it to be informative and helpful and that you will continue to rely on HCPro programs as an important resource for pertinent and timely information.

Sincerely,

Elizabeth Petersen
Senior Director, Education
HCPro, Inc.
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Please note: Continuing education credits are available for this program. For instructions on how to claim your credits, please visit the materials download page at www.hcpro.com/downloads/11090.
Agenda

I. What CMS really says about charging
   a. CMS guidance
   b. Defining routine and ancillary services
   c. Findings from Research Triangle Institute (RTI) and HCPro surveys

II. Strategies for charging inpatient bedside procedures
   a. Current industry practices
   b. Payer reaction
   c. Establish a charging practice

III. What you should do in 2013
   a. Charging for supplies
   b. Comparing inpatient and outpatient charges
   c. Accounting for costs

IV. Live Q&A
Speaker Profiles

Kimberly Anderwood Hoy, JD, CPC

Kimberly Anderwood Hoy is the director of Medicare and compliance for HCPro, Inc. She is a lead regulatory specialist for the HCPro Revenue Cycle Institute and is the lead instructor for HCPro’s Medicare Boot Camp®–Hospital Version and instructor for Medicare Boot Camp®–Critical Access Hospital Version. She is a former hospital compliance officer and in-house legal counsel, and developed and implemented corporate-wide hospital compliance programs. She has experience conducting billing, compliance audits, and internal investigations.

William L. Malm, ND, RN, CMAS

William L. Malm is a healthcare consultant for Craneware, based in Edinburgh, Scotland, with offices in Atlanta. He has more than 20 years’ experience in a combination of clinical and financial healthcare. He specializes in operations surrounding chargemasters, including education, audit, and post-implementation reviews. Additionally, Malm has served as a systems compliance officer for a large for-profit healthcare system and has conducted hundreds of pre-pay and post-pay audits. He is a nationally known author and speaker on topics such as compliance, chargemasters, and Recovery Auditors.
Exhibit A

Presentation by Kimberly Anderwood Hoy, JD, CPC, and William L. Malm, ND, RN, CMAS
Charging for Ancillary Bedside Procedures and Supplies in 2013: What You Need to Know

An HCPro audio conference presented on
April 29, 2013

Speakers

• Kimberly Anderwood Hoy, JD, CPC
  Director of Medicare and Compliance
  HCPro, Inc.
  Danvers, Mass.

• William L. Malm, ND, RN, CMAS
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Agenda

- What CMS really says about charging
  - CMS guidance
  - Defining routine and ancillary services
  - Findings from Research Triangle Institute (RTI) and HCPro surveys

Agenda

- Strategies for charging inpatient bedside procedures
  - Current industry practices
  - Payer reaction
  - Establish a charging practice

- What you should do in 2013
  - Charging for supplies
  - Comparing inpatient and outpatient charges
  - Accounting for costs
Inpatient Charging Practices

- CMS provides very little guidance on hospital inpatient charging practices
  - This creates a great deal of confusion among providers
  - Payers join the fray:
    - Saying with authority that something “can’t” be billed, even saying they are following Medicare
    - Denying items or services billed separately from the inpatient room rate, but then not allowing them to be added to the room rate

Inpatient Charging Practices

- What does CMS say in the Provider Reimbursement Manual, 2203 “Provider Charge Structure”?  

  “While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program.”

  To be allowed for apportioning, facilities should have:
  - Established charge structure
  - Applied uniformly to each patient
  - Reasonably and consistently related to the cost of the services
Inpatient Charging Practices

• What does CMS say about charges in the Provider Reimbursement Manual, 2203?
  – Hospitals which have subproviders and hospital-based SNFs must also maintain uniform charges across all payer categories, as well as like charges for like services across each provider setting, in order to properly apportion costs.

Inpatient Charging Practices

• What does CMS say about charges in the Provider Reimbursement Manual, 2202.4 “Charges”?
  – Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.
Inpatient Charging Practices

• What does CMS say in the FY 2009 IPPS Final Rule (attached)?

“If an item is not specifically enumerated as a routine item ... or an ancillary item or service ... then the rules in Section 2203 of the PRM-I apply. This section requires that the common or established practice of providers of the same class in the same State should be followed. If there is no common or established classification of an item or service as routine or ancillary among providers of the same class in the same State, a provider’s customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program.”

Inpatient Charging Practices

• How does CMS define routine services in 2202.6?

“Inpatient routine services in a hospital generally are those services included by [sic] the provider in a daily service charge—sometimes referred to as the “room and board” charge. ... Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.”
Inpatient Charging Practices

How does CMS define ancillary services in 2202.8?

Ancillary services in a hospital ... include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.

And CMS also hired some experts:

- Research Triangle Institute (RTI) analyzed ways to improve APC and DRG relative weights for CMS
  - RTI recommended increased use of patient-specific incremental charge codes over the baseline per diem charge
  - Would improve cost capture of nursing resources in establishing MS-DRG rates
Inpatient Charging Practices

So what can we take from all this?

• Hospitals must have an established charge structure with regular rates
  – They should follow the common or established charging practices of other hospitals in the same state, IF ONE EXISTS
  – They should follow a common charging practice across their provider settings, including outpatient, inpatient, and distinct part units or SNFs
  – They should follow a common charging practice among Medicare and non-Medicare patients
  – The charges should reasonably and consistently relate to the costs of the service

Example from FY 2009 IPPS Final Rule:

• Blood transfusions
  – Not specifically mentioned in list of routine services
  – Provider must consider the charging practices of hospitals in the same state
    • HCPro survey: 2013 – 57% charged separately; 2011 – 63% charged separately; 2009 – 58% charged separately
  – Providers should also consider charging practices in their other subunits/settings
    • Transfusions must be billed separately (because they are separately paid) in outpatient setting
    • Transfusion ancillary cost centers (e.g., operating room or ED) are generally billed separately
Inpatient Charging Practice

More on common charging practices

- In HCPro’s survey:
  - 56% of respondents separately charge for nursing bedside procedures (e.g., PICC line placement)
    - Up 9% from 2009 and 2011 survey
  - 29% of respondents separately charge for chemotherapy
    - 2011 – 33%; 2009 – 28%
  - Fewer respondents separately charge for therapeutic infusions (17%) or hydration (17%)
    - Therapeutic infusions down 4% from 2011, down 5% from 2009
    - Hydration consistent with 2011, down 1% from 2009

Inpatient Charging Practice

- In HCPro’s survey, most commonly mentioned separately charged nursing services stayed consistent with prior years and included:
  - Debridements
  - Cardioversions
  - Foley inserts
  - Thoracentesis
  - Paracentesis
  - PICC line insertion
  - Incision and drainage
  - Lumbar puncture
  - Central line
  - Bone marrow aspiration (new for 2013)
Inpatient Supplies

What about supplies?

- Often cited criteria
  - Directly identifiable to a patient
  - Not generally provided to most patients
  - Not reusable or represents a cost for each preparation or complex medical equipment

- Is actually specific only to SNFs – 2203.2 “Ancillary Services in SNFs”

Inpatient Supplies

- But doesn’t CMS say you can’t bill for routine or stock items?
  - Patient gowns, paper tissues, water pitchers, basins, bedpans, deodorants, mouthwashes
  - Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities (e.g., alcohol, applicators, cotton balls, Band-Aids, antacid, aspirin, suppositories, tongue depressors)

- You guessed it, also SNF only criteria – 2203.1 “Routine Services in SNFs”
Inpatient Supplies

- So should we throw out these distinctions/criteria?
- Probably not:
  - Identifiable to the patient allows auditing
  - Generally provided to most patients, easier to put in the room and board rate rather than bill separately
    - Stock and other items mentioned as routine fit here
  - Not reusable/represents a cost for each use allows charge to relate better to the costs of the care

Inpatient Supplies

- But understanding the rules and where they come from allows us to make better decisions
- There are individual exceptions that may/should be separately billed because they:
  - Can be audited (i.e., usage is documented separately)
  - Are easy to charge separately (i.e., usage is distinct to patient and documented)
  - Relate specifically to cost of care (i.e., used only for that particular patient)
Inpatient Charging Practices

So where does that leave us?

- The hospital must develop its own policy on charging practices
  - Multidisciplinary process including:
    - Revenue integrity
    - Chargemaster coordinator
    - Finance
    - Third-party contracting
    - Billing/coding departments
    - Affected clinical departments
  - Consider charging practices across subunits/settings, and of other providers in the region

WHAT YOU CAN DO IN 2013

An Operational Process
What Did RTI Say?

• Changes to the Medicare cost report and MedPAR files
  – Clarify the instructions given to providers to use all applicable standard lines in the cost report (i.e., avoid aggregating charges and costs across standard Medicare cost centers).
  – Consider adding new *standard* lines to the cost report to eliminate the need for any statistically disaggregated cost ratios. The most important of these include CT Scanning; MRI; Cardiac Catheterization; Devices; Infusion Drugs. While the markup differential for IV Solutions compared to other drugs is severe, the impact of this one item on inpatient or outpatient weights may not be big enough to merit a cost report change.

What Did RTI Say?

• Revise the charge categories summarized within the current MedPAR files by creating the following new groups:
  – Intermediate Care (revenue codes 0206 and 0214)
  – Devices (revenue codes 0274, 0275, 0276, and 0278)
  – IV Solutions (revenue code 0258)
  – CT Scanning (revenue codes 035x)
  – Nuclear Medicine (revenue codes 034x, possibly combined with 0404)
  – Therapeutic Radiology (revenue codes 033x)
Why Do We Want to Do This?

- As stated previously, this is not a reimbursement issue
- Will increase the adequacy of charge capture
- Knowing costs enhances the ability to perform contract negotiations
- From a cost accounting perspective, it gives better control to costs and resource allocation
- Ensures that all payers are charged the same
- Most of all it gives **STRUCTURE** to charge capture

Should Every Facility Do This?

- Before we begin, we need to reiterate that all facilities must comply with charging all payers equally
- However, we encourage facilities to review the presentation materials and make their own choice
- This is not a simple undertaking and will take years of ongoing commitment to ensure it is implemented and functioning accurately
What Do We Focus On?

- This presentation will focus on the operational challenges:
  - Differences between procedural charging (inpatient and outpatient)
  - Differences between supply/pharmaceutical charging (inpatient and outpatient)

Where Are We Today?

- Chargemaster generally charges all items on the outpatient side, but inpatients differ
- Outpatient is charged more separately (“a la carte”) while the inpatient room and board rate is more of a “buffet” concept
- The operational problem occurs with trying to match the inpatient charging methodology to the outpatient method
What Needs to Be Done?

- In order to ensure that there is adequacy of charging to work against the concept of “charge compression” as stated by RTI:
  - Will need to mirror the outpatient charging process with the inpatient
  - Will need to create a room and board charge that is devoid of the items charged separately on the outpatient
  - In other words, consider bedside charging for procedures, infusions, injections, and supplies

The Inherent Risks

- This is based on services rendered by nursing
- Nursing may be hard-pressed to document what they do now, but to be successful they will need to take on more documentation
  - Some documentation may be mitigated through templating and nursing order sets in EMR
  - EMR may be able to assign not only levels in ED and clinics, but also for inpatient charges
- Need to ensure that there is nursing buy-in before proceeding
Operational Approach – Supply/Procedure

• Rules to live by:
  – *This is not a reimbursement issue but one of accurate and complete charge capture*
  – *If you can charge it separately on the outpatient side, you can charge it on the inpatient side*
    • But do you want to?
  – *Review and know your payers*
    • *Is this something they are going to embrace?*

Capturing the Charge

• Every charge needs to be entered in order to activate the charge capture process
• Charging through a charge entry system will *assume all documentation and medical necessity is present*
  – Represents a significant potential compliance issue and audit issue if documentation is not present
  – *Once charged – forever forgotten*
• Supply or bedside procedure – in general this charge capture occurs within a nursing division
  – Who is going to capture this charge: RN, ward clerk, scribe???
Hardcoding/Softcoding

- The charge is always driven from the chargemaster whether inpatient and outpatient
- The difference is the nursing bedside procedures tend to be of a nature coded by HIM
  - PICC
  - Central line
  - Thoracentesis
  - Generally CPT codes 10,000–69,999 (softcoded)
- Ancillary procedures are hard-coded and within ranges of 70,xxx, 80,xxx, and some 90,xxx

Softcoded Procedures

- Procedures that are soft-coded by HIM still require a charge, whether it be a hard charge by CPT code or minute charge on the outpatient side
- Follow the same mechanism on the inpatient side
- Remember, PICC is something done by specially trained personnel and not a standard RN, so they tend to have their own charge structure on the outpatient side of the CDM – follow that structure
- Use state licensure as a guideline of which RN type can perform which procedures
  - Example: RN versus NP or CNS
  - Example: RN versus PA-C
Comparison

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Coded by HIM</td>
<td>- 10,000–69,999 coded by HIM</td>
</tr>
<tr>
<td>- Charged as room and board in the chargemaster</td>
<td>- 10,000–69,999 charged through CDM</td>
</tr>
<tr>
<td>- Supplies and pharmaceuticals to be charged and coded through the CDM</td>
<td>- 70,xxx – some 90,xxx coded and charged through chargemaster</td>
</tr>
<tr>
<td></td>
<td>- HCPCS codes for supplies and pharmaceuticals are coded and charged in the CDM</td>
</tr>
</tbody>
</table>

What Needs to Happen

- **Focus on the room and board**
- Make it comparable to outpatient “a la carte” charging
- Itemize each outpatient procedure performed as inpatient
- Use the HIM abstraction record for the past 12 months to compile the listing of procedures to be reconciled within the CDM
  - Remember, these may already be present in the CDM and not being utilized for inpatients
Step 1: Procedure Determination

- Begin by looking at what is in the chargemaster to identify procedures being performed as an outpatient
  - Remember, most of the ancillary tests such as echocardiograms, EKG, stress tests, radiology examinations (chest x-ray, MRI, CT, U/S) will be charged using the chargemaster and will come to the inpatient claim with the same price as outpatient but having only the revenue code
  - These are tests described in CPT 70,000–80,000 and some in the 90,xxx series

Step 1: Procedure Determination

- Inpatient procedures must have an accommodation revenue code and cannot use ancillary revenue code
- Revenue code 0230 Incremental Nursing Care is the selection for the bedside procedures
- Not all payers accept 0230; will need to know your contracts before embarking on the process – this is a key decision point
- Pushing back on the payer may be appropriate through contract amendments
  - i.e., change revenue code to meet payer requirements
  - Many payers will comply, but it unlikely Medicaid will change for the incremental nursing care 0230
Step 1: Procedure Determination

- Reconcile the abstraction report by location to the chargemaster
- For example:
  - Inpatient PICC ...... 230 .... No CPT .... $400
  - Outpatient PICC ..... 761 .... 36569 .... $400
- Since the outpatient PICC was set up, another CDM is not required; simply set up a proration rule to change the revenue code to 0230 (incremental nursing)

Step 1: Procedure Determination

- Proration is the act of changing a basic chargemaster to meet payer guidelines
  - Example: There is 761 and 12005 on the outpatient side in the chargemaster
  - With an inpatient procedure this will be charged through the chargemaster, but the revenue code requires changing to 0230 for Medicare inpatient financial class
  - Proration will recognize the financial class and take the 761 to 0230
  - Proration is key to inpatient charging
Step 2: Policy Is Required

- In order to change to have the outpatient and inpatient processes match, there must be a policy and procedure providing explicit guidance

- The room and board must only encompass resources that are not specified by the actual separately charged procedures

- Room and board will now more likely contain items such as nursing wages for nonspecifically stated procedures, linens, nutritional services, etc.

- Charges should represent resources utilized by the facility in provision of the room and board

Step 3: Education

- There is a host of misinformation regarding inpatient charging

- Staff will need very clear guidance on what procedures the facility plans on charging separately
  - Utilize nursing order sets
  - Nursing documentation–driven charging
  - Charge slips (paper or electronic)
  - Evaluate the obstacles to charging

- Documentation must exist PRIOR to charging
Step 4: Documentation

- Once the procedures are selected, create documentation templates that ensure all necessary documentation supportive of the charge(s) is present.
- Documentation should include only those elements clinically necessary and should not attempt to document to achieve a higher-level procedure.
- With the advent of EMR it is possible to create documentation templates to assist nursing. Once all elements are documented, the charge is rendered.

Step 5: Audit, Audit, Audit

- One of the key elements to consider is whether the charges are actually being documented and charged accurately.
- Once a “trial” period is undertaken, a random sampling of records should be audited in combination with the itemized claim and UB-04 to ensure that the charges are documented and represented correctly on the claim.
Supplies Charging

Charging Supplies – Inpatient

- Similar to procedures, inpatient supplies and outpatient supplies all represent a challenge to correct prior misunderstandings and operate under current and accurate guidance.
- CMS does not state how to charge supplies, but there are some concepts that allow for a commonsense approach.
Section 2203.2 Ancillary – SNF

• As previously stated, this is an often-cited criteria that confuses the picture!
  – Directly identifiable to a patient
  – Not generally provided to most patients
  – Not reusable or represents a cost for each preparation or complex medical equipment

• *Does provide a commonsense approach to charging and accounting for resources*

• Since there are so many chargeable supply items, it would represent a significant maintenance issue within the CDM

What About Gowns, Gloves...

• Inpatient or outpatient, there is confusion about surgery
• CMS does not have any prohibition on the separate charging of gowns, gloves, microscope covers, electrodes, etc.
• From a commonsense aspect they should be included into the procedure, as all procedures would use them and represent a risk of a lost charge if they had to be charged separately

• *Takeaway: More charge items create increased risk for charge capture loss*
Lower Dollar Threshold

- The “low dollar threshold” allows for supplies that represent a low cost to the facility to be “bundled” into the procedure
  - Example: Items costing less than $5 are bundled
  - Laceration repair would include:
    - Gauze (cost $0.10)
    - Band-Aid (cost $0.10)
    - Ace wrap (cost $3)
    - These would be bundled into the procedure charge, so the cost of the supplies would increase the cost of the procedure by $3.20, then apply the hospital markup policy

Lower Dollar Threshold

- Two choices for the claim:
  - Bundled (put into the price of the procedure charge):
    - Lac Repair 12001 (lower extremity) $103.20
  - Separately:
    - Lac Repair 12001 (lower extremity) $100
    - Rev Code 0270 – $3.20
Supplies: Step 1

• Every first step should start with the creation of a definitive policy and procedure
  – Items to define within the policy and procedure are:
    • Method of costing (LIFO, FIFO, acquisition cost, etc.)
    • Low dollar threshold
    • Concept of “routine to the procedure” (items that are used in every procedure of that type)
    • Management of carve-outs such as prosthetics/orthotics (revenue code 274), pacers (275), implants (278)

Step 2: Development of Supply Charge Capture

• In implementing supplies, focus on the facility risk areas:
  – Surgical Services
  – Cath Lab
  – Accident and Emergency
  – Room and Board
• One policy for the facility, but may need separate procedures for the areas defined above
Step 2: Development of Supply Charge Capture

- **Surgical Services:**
  - Identify those services that are “low dollar threshold” – automatically put these into the price of the OR minutes
  - Identify items always used in the level of surgery that is above low dollar
    - Is it a “carve-out”?
    - Is it a supply used on all cases, but above the threshold?
      - Policy will need to specify whether “bundled” or separately charged

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Step 2: Development of Supply Charge Capture

- **Surgical Services:**
  - Use the “Preference Card”
    - Isolate those supply items that are over “low dollar threshold”
    - Isolate those items that meet “carve-out”
    - Make sure these items are in the chargemaster if determined to be separately payable
    - Policy and procedure for charging is the same “by exclusion method” for inpatient, ambulatory surgery, or outpatient
Step 2: Development of Supply Charge Capture

- Example: CDM Surgery (Supply Charge Levels)
  - OR Level II – First 15 minutes $500.00
  - Supply Item Category: 0–50.00 $50.00
  - Supply Item Category: 151–200 $200.00
  - Implant (Revenue Code 0278) $1000.00

OR:
  - OR Level II – First 15 minutes $500.00
  - Suture Pack Ethilon 5 $15.00
  - Disposable Laparoscopy Supply $175.00
  - Lapband (Revenue Code 0278) $1000.00

Step 2: Development of Supply Charge Capture

- Accident and Emergency:
  - CDM and charge slips need to encompass
    - E/M
    - Procedure(s)
    - Separately billable supplies
    - Orthotics/prosthetics
  - Consider including into the E/M or procedure cost of routine supplies associated with the procedure, such as vacutainers, IV start kits, gauze, and tape, as most will be below the “low dollar threshold”
Step 2: Development of Supply Charge Capture

- Inpatient
  - Many supply items should be specified within the charge capture policy for the room and board rate
  - Consider using 2203 as a resource to list these types of items even though you are allowed to charge separately
    - Stock or routine supplies used on all patients (i.e., bulk items)
    - Low dollar threshold items on the “supply cart”
    - Admission kits, bedpans, urinals, etc.

Step 3: Education

- Education is required on both procedural bedside charging, outpatient procedural charging, as well as supply charging.
- Develop the policy and procedure, then consider competency testing to ensure that your message was received as it was delivered.
- Remember, for nursing it will need to be basic education—show how it will be easy to implement and make sure that during education you have “all ears open.” Failure to understand nursing obstacles can cripple the best made plan.
Step 4: Audit, Audit, Audit

- There are many “line item bill audit” tools on the market today
- Export an itemized claim for analysis
- Compare the UB to the itemized: Are they the same?
- Compare the UB to the remittance advice: Did the billing office manipulate anything?
- Look for orders on separately billed procedures and supplies, especially carve-outs
- Like any service, auditing is key

Dealing With Different Payers

- Remember, many payers have different requirements
- These requirements should be incorporated after the charge is rendered
  - For example:
    - Blue Cross does not want any 0636 pharmaceuticals on the claim on the same date of service as surgery 036x. Therefore, all pharmacy items must be prorated to 0250 if on the same date as surgery.
    - ABC insurance bundles all supplies (revenue code 0270) excluding implants (278) into the surgery charge. Therefore, all 0270 charges need to “roll” into the 0360 charges for the surgery.
Room and Board Policy

- XYZ Hospital includes within its room and board rate the following items:
  - Linens
  - Nutrition
  - Oxygen (if not billed as a supply)
  - Admission kits
  - All items that cost below $25 to acquire
  - Nursing services – routine, including vital signs, assessments, medication administration (not IV)
Room and Board Policy

• XYZ Hospital includes within its room and board rate the following items:
  – Fixed overhead
  – Variable overhead for utilities
  – Safety maintenance (needle disposal, etc.)
  – Housekeeping services
  – Equipment such as monitors, pulse oximetry, blood pressure cuffs

Room and Board Policy

• XYZ Hospital **does not include** within its room and board rate the following items:
  – Bedside surgical procedures such as thoracentesis, paracentesis
  – Intravenous blood administration
  – Chemotherapy administration (SQ, IM, IV)
  – Drug administration (IM, IV)
  – Cardiopulmonary resuscitation
  – Etc.
Room and Board Policy

- XYZ Hospital does not include within its room and board rate the following supplies:
  - Separately identifiable supplies that cost more than $25 to acquire based on invoice
    - Specialty implants such as temporary pacemaker wires
    - Specialty kits for arterial lines, thoracentesis, paracentesis, and PICCs
- It is the policy of XYZ Hospital to update this policy yearly on 12/31/xxxx under the direction of the CFO

Room and Board Policy

- Takeaway points:
  - Be specific
  - Include description of how you will determine the cost, such as by purchase order, invoice
  - Include who is responsible for updating the policy
  - Include the time frame in which the policy will be updated
  - Include a historical record of the room and board costs as the accountants and cost report personnel will require this
**SUMMATION**

Key Points

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**Summation**

- *Not a reimbursement issue*
- It ensures charge capture adequacy
- Allows for enhanced future contract negotiations
- Assists with cost accounting – knowing what it really costs to perform a procedure
- Bedside procedures using 0230 may not be accepted by all payers
- Supply charging is NOT dependent upon section 2203 – charge everything that represents a resource according to a scheme your facility feels appropriate (low dollar thresholds, bundling, etc.)
Summation

• The information afforded from this charge capture process can be utilized as the formation of bundled charges and ACOs begins

Questions?

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Exhibit B

Link to the RTI report


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