Charge Process - Bedside Procedures

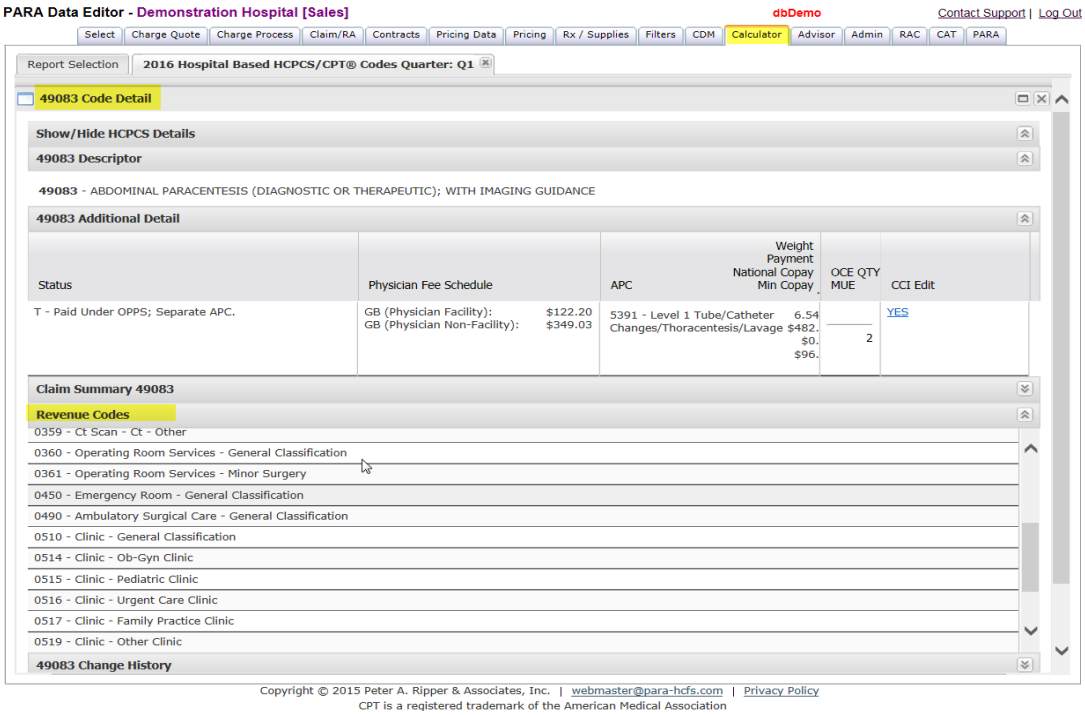
Bedside procedures may consume both supplies and extra resources from various departments, including unit staff, surgery and/or radiology, wound care, respiratory therapy, and PICC line team members. While these departments provide support to the care of the patient, it is not always possible to recognize that support with revenue generated by the service for the department providing the care.

Add-on charges for staff services assisting in bedside procedures must be carefully considered. For inpatients, the daily room and board charge represents the nursing support of staff regularly assigned to the hospital unit. No additional charge is appropriate if regularly assigned unit staff offer the support required by the physician in performing the bedside procedure.

However, bedside procedures are often performed using non-unit staff which travel on an as-needed basis throughout the hospital. In these cases, a separate charge for the assistance of the non-unit staff may be an appropriate representation of the non-unit resources. The difficulty is finding an appropriate revenue code and HCPCS to enable charges for travelling staff to be reported on both inpatient and outpatient claims.

On outpatient claims, charges for services are reported in revenue codes which require a valid HCPCS to accurately describe the service performed. For this reason**, PARA recommends billing both inpatient and outpatient bedside procedure only for services which may be accurately described by a valid CPT®/HCPCS code.** Services which do not meet this test should not generate charges above the basic evaluation and management charge for outpatients, or the daily room and board rate for inpatients.

The **PARA Data Editor** offers information on the acceptable revenue codes for each valid HCPCS on the Calculator HCPCS report.

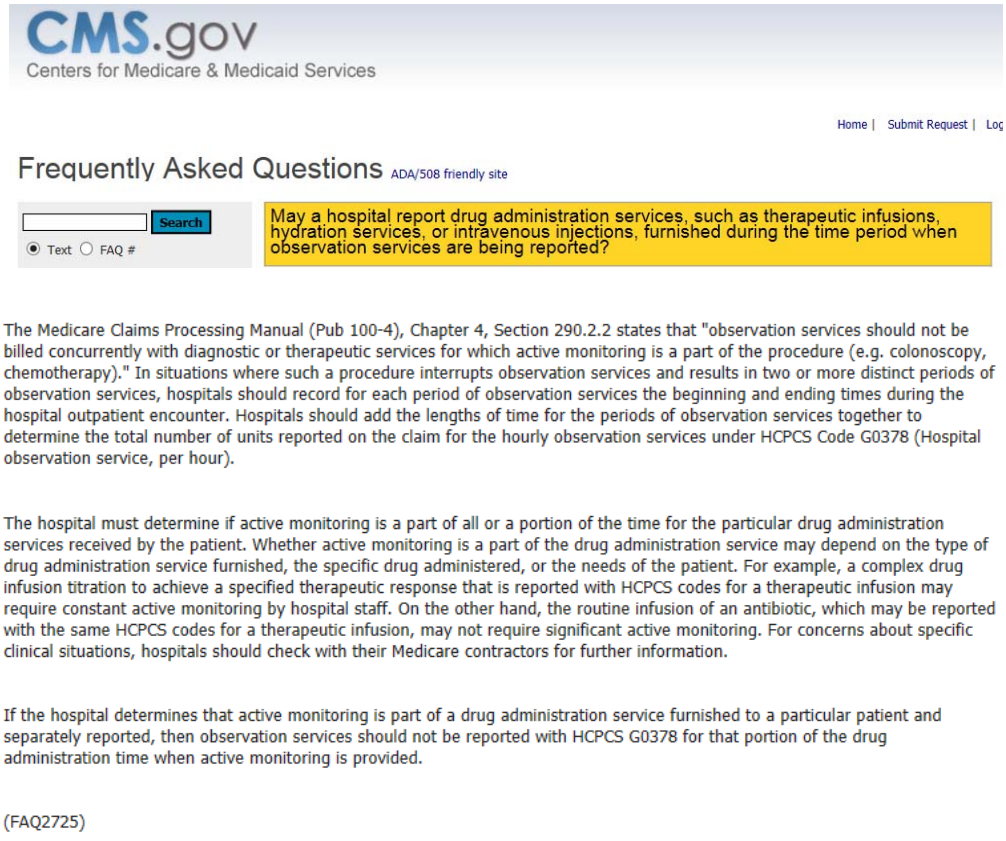


Inpatient claims do not report CPT®/HCPCS codes; charges under the revenue code for the department providing the service may be reported and no claims processing issues will result.

Observation status patients present unique bedside procedure charge challenges. The hourly charge for observation care (G0378) includes regular nursing care, evaluations, and monitoring. When performing another billable service for a patient in observation status, the hours reported as observation time must not accrue during a period when the patient is actively monitored for the other service(s). Time in patient care required to provide separately reimbursed services which include active monitoring should be carved out of the hours billed for observation care.

The following CMS FAQ provides guidance for hospitals in determining which procedures include "active monitoring":

https://questions.cms.gov/faq.php?id=5005&faqId=2725



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May a hospital report drug administration services, such as therapeutic infusions, hydration services, or intravenous injections, furnished during the time period when observation services are being reported?

The Medicare Claims Processing Manual (Pub 100-4), Chapter 4, Section 290.2.2 states that "observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g. colonoscopy, chemotherapy)." In situations where such a procedure interrupts observation services and results in two or more distinct periods of observation services, hospitals should record for each period of observation services the beginning and ending times during the hospital outpatient encounter. Hospitals should add the lengths of time for the periods of observation services together to determine the total number of units reported on the claim for the hourly observation services under HCPCS Code G0378 (Hospital observation service, per hour).

The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services received by the patient. Whether active monitoring is a part of the drug administration service may depend on the type of drug administration service furnished, the specific drug administered, or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring. For concerns about specific clinical situations, hospitals should check with their Medicare contractors for further information.

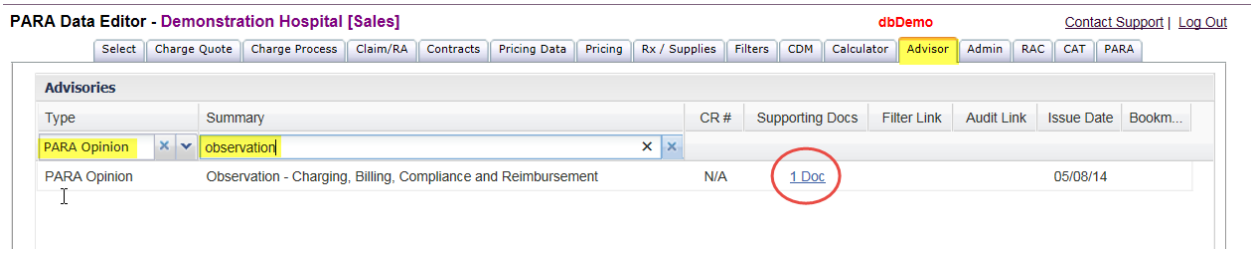
If the hospital determines that active monitoring is part of a drug administration service furnished to a particular patient and separately reported, then observation services should not be reported with HCPCS G0378 for that portion of the drug administration time when active monitoring is provided.

(FAQ2725)

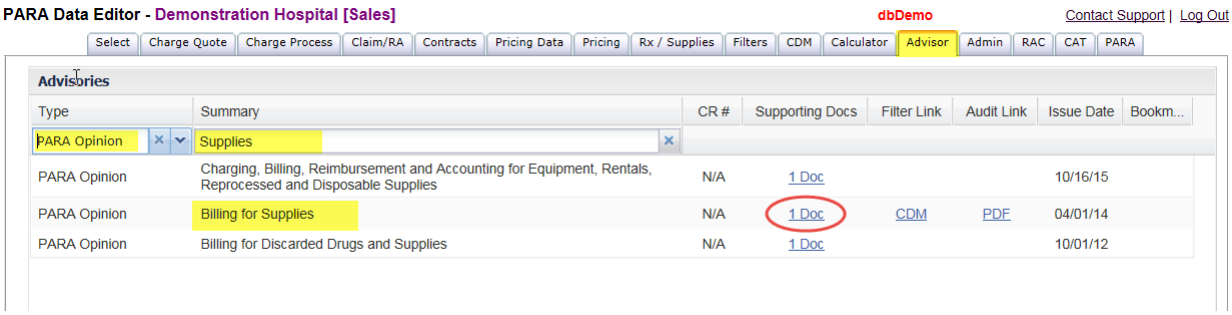
PARA offers a more thorough discussion on observation charging and billing at the following link:

https://apps.para-hcfs.com/pde/documents/Observation_Charge_Process.pdf

In addition, PARA papers are available in the "Advisor" repository on the PARA Data Editor:



PARA offers concise guidance on billing for supplies in the institutional setting; the **PARA Data Editor** Advisor tab may be queried for the term "Supplies" and a link to the resource is returned:



The link to the supplies paper is provided below:

https://apps.para-hcfs.com/pde/documents/Billing_For_Supplies_April_2014.pdf

Billing For Supplies

Hospitals need to be cautious when billing for supplies, as Medicare considers some supplies routine and not separately billable; some supply items are covered, billable and payable; and others are covered and billable, but are packaged and not separately paid.

To determine when to separately bill for supplies, Medicare states the following criteria should be met: *(Medicare Provider Reimbursement Manual, Section 2203.2)*

1. Directly identifiable to a specific patient
2. Furnished at the direction of a physician because of specific medical needs (this must be documented in the patient's medical record
3. Either not reusable or representing a cost for each preparation

Adminastar Federal, a Fiscal Intermediary, also created a checklist for providers to use when determining if a supply is billable or not. Adminastar Federal used the Medicare Reimbursement Manual, Section 2203.2 as a guide in creating this checklist:

1. Is the item medically necessary and furnished at the discretion of a physician? (not a personal convenience item such as slippers, powder, lotion, etc.)
2. Is the item used specifically for or on the patient? (not gowns, gloves, masks, used by staff or oxygen available but not specifically used by the patient)
3. Is the item not ordinarily used for or on most patients or was the volume or quantity used for on patient significantly greater than normally used for or on most patients in the billed setting? (not blood pressure cuffs, thermometers, patient gowns, soap)