Perioperative Charge Process

There are eight components to the charge process for surgical services:

1. **Pre-op prep and care**
2. **Anesthesia**
3. **Operating room time charges**
4. **Equipment charges**
5. **Recovery / Post Anesthesia Care Unit**
6. **Supplies**
7. **Drugs**
8. **Post PACU Care**

Pre-op Prep and Care:

The pre-op care includes the starting of IV's, admin of drugs, scrubbing and shaving of the Patient. Pre-op antibiotic IV therapy is separately billable as a Nursing Service if there is medical justification and a Physician order. It is not appropriate to charge for pre-op care, the majority of hospitals have a cost center dedicated to this process; zero charges are used for the recording of workload.

Anesthesia:

There are six different types of anesthesia:

1. **Local**
2. **Block**
3. **Epidural**
4. **Conscious Sedation**
5. **Monitored Anesthesia Care**
6. **General**

Anesthesia services can be either charged individually for supplies, drugs and gases, more common is a time based charge for the type of anesthesia provided; some managed care contracts do not allow the combination of both an itemized anesthesia service with a time based charge.

CPT and CMS regulations (appendix G CPT and CCI edits) provide a schedule of procedures where the professional anesthesia service is not separately billable from the procedure.

Timing of anesthesia (CS, MAC and General) charges is based on the start / stop time recorded on the anesthesia record. The base time period is 30 minutes, with an add-on charge for each additional 15 minutes, add-on periods are charged after the first 5 minutes of usage within the period.

Anesthesia technical services are billed using revenue code 0370.

Operating Room Time Charges:

The operating room costs are classified into three different components, which are relieved by billing a time based level charge.

The components of the OR room costs are:

1. **Room set-up time**
2. **Staff surgical time charge (Nurses, Tech and First Assistant) charges**
3. **Rental / special equipment charges**

PARA recommends that the OR time charge be based on levels which are determined by the set-up, Staff and equipment charges.

The levels (1 – 5) are determined by the number of Staff in the surgery suite, plus a level "bump" for set-up time greater than 30 minutes, or special equipment rental or usage.

Set-up Time	OR Staff	Rental / Special Equip	OR Level	Base Time Period	Add-on Time Period
< 30 Minutes	**1**	**N**	**1**	**30 minutes**	**15 minutes**
< 30 Minutes	**2**	**N**	**2**	**1st hour**	**15 minutes**
< 30 Minutes	**3**	**Y**	**4**	**1st hour**	**15 minutes**
> 30 Minutes	**3**	**y**	**5**	**1st hour**	**15 minutes**
> 30 Minutes	**4**	**y**	**6**	**1st hour**	**15 minutes**

OR room time charges are based on the start / stop surgical time on the anesthesia record, add-on periods are charged after the first 5 minutes of usage within a period.

OR room charges are billed using revenue code 0360, the HCPCS codes are coded by HIM.

Equipment Charges:

Special and rental equipment are usually "packaged" into the OR room time charge by "bumping" a level, some Fiscal Intermediaries will allow the billing of equipment charges on a OR line on the UB04 claim form, rev code 0360.

Recovery / Post Anesthesia Care Unit:

The required time a Patient spends in the PACU is 1 hour for general anesthesia, with a Nurse to Patient ratio of 1:1. After the Patient is attended for the minimum period and the Nurse assessment determines the Patient requires a lower staffing ratio, a Nurse can attend to 2 Patients.

MAC anesthesia Patients are to be observed for a minimum of 30 minutes.

Children are usually 100% 1:1 Nurse staff ratio.

Charges for PACU should be set as follows:

1. **PACU - 1st hour 1:1 Nurse staff ratio**
2. **PACU - add 15 minutes 1:1 Nurse staff ratio**
3. **PACU - add 15 minutes 1:2 Nurse staff ratio**

Timing of the PACU charges are based on the PACU admit / discharge times recorded on the PACU record.

Medical Supplies:

There are seven types of supplies used in the OR, some of which should not be charged to the Patient. The supplies and their billing status is as follows:

1. **Routine items** – Low cost, bulk stock items, (band-aids, syringes, wipes, gowns, gloves, drapes and packs) are not to be charged, the cost is to be billed using the OR time charge.
2. **Sterile** – higher cost items, are to be charged, they are itemized on the charge form; multiple units are allowed, these items are to be billed with a "C" HCPCS code (if possible) and 0272 (sterile supply) rev code.
3. **DME exempt** – These are DME items which can be billed to the Medicare program, they include orthotics (splints, braces, collars and belts), these items are billed using an "L" series HCPCS code and a 0274 (orthotic) rev code.
4. **DME non-exempt** – Non-billable DME items (crutches, canes and walkers) are not to be billed to the Medicare program on a bill type UB04.
5. **Implants** – Hard items which remain in the Patient post procedure, these items may have a "C" HCPCS code and are to be billed using a 0278 (implant) rev code.
6. **IOL lenses** – Billed using a "C" (if possible) HCPCS code, and a 0276 (IOL) rev code. High cost lenses can be billed to the Patient (lens cost less the $150 Medicare allowance).
7. **Pacemakers** – Billed using a "C" (required) HCPCS code and a 0275 or 0278 rev code.

Drugs:

All drugs are to be charged, multiple units allowed, the Nursing service to administer the drugs is not billable.

Post PACU Care:

Routine care provided to a Patient post PACU and prior to discharge is not separately billable to the Medicare Program.

If a Patient is to be admitted to observation or inpatient status, a Interqual "type" of evaluation is required for admission.

Observation care is billed per hour, at 1/24th of the semi-private room rate, with a maximum of 48 hours, Medicare will not "pay" for observation the "day of or day after" a outpatient surgical or diagnostic procedure (APC Status T), a portion of the regulation is pasted below with a link to the complete billing regulation.

https://apps.para-hcfs.com/pde/documents/CMSObservationBillingRulesAfterJan1st2008.pdf

290.5.1 - Billing and Payment for Observation Services Beginning January 1, 2008

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

2. Additional Hospital Services

   a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:

      - A Type A or B emergency department visit (CPT codes 99284 or 99285 or HCPCS code G0384); or
      - A clinic visit (CPT code 99205 or 99215); or
      - Critical care (CPT code 99291); or
      - Direct *referral for* observation *care* reported with HCPCS code G0379 (APC 0604) must be reported on the same date of service as the date reported for observation services.

   b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.

Charge Process Worksheet:

Pre / Post PACU + Set-up Time - Minutes	Points	Operating Room Staff	Points	Extensive Equipment Use	Points
< 30	0	1	1	Yes	1
31 -> 90	1	2	2	No	0
91 -> 120	2	3	3		
		4	4		
		5	5		

OR Level Determination	# of Pts
Pre / Post / SU	
OR Staff	
Equipment	
Total	

OR Level Points	1st Hour time charge	Additional 1/4 time charge
1		
2		
3		
4		
5		
6		
7		

Anesthesia Type	Time Basis	1st Hour / Initial Procedure	Additional 1/4 Hours / Subsequent procedures
General	Elapsed time		
MAC	Elapsed time		
IV Sedation	Elapsed time		
Epidural	One time		N/A
Block	One time		N/A
Local	One time		N/A
Pain	Per Injection		

PACU - Nurse Patient Ratio	1st Hour time charge	Additional 1/4 time charge
1:1		
1:2		
ICU Holding		