Indian Health Service
Hospital and Surgery Billing

Introduction

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Objective:

To establish guidelines for processing, coding and billing Inpatient and Ambulatory Surgery Center services/visits according to CMS regulations.

Inpatient and ASC

Reimbursement for Medicare and other payers is based on either the medical severity-diagnosis related group (MS-DRG) payment amount for the inpatient stay or the ambulatory payment classification (APC) payment amount for outpatient encounters or services.

A patient is classified as an inpatient if ordered by the physician involves a stay greater than 24 hours and the medical record documentation supports medical necessity for inpatient reimbursement. It is also based on the how the patient's stay is coded according to the rules and regulations provided by Medicare, Medicaid and Private Insurance payers.

Medicare Part A Hospital Insurance

Medicare Part A helps pay for medically necessary care for the following:

- Inpatient hospital care.
- Extended care services in a SNF after a hospital inpatient stay.
- Home health care.
- Hospice care

The number of covered days used is maintained by CMS to track the beneficiary's eligible days in a benefit period. Part A coverage is renewed every time a beneficiary begins a new benefit period.

Medicare Part A Hospital Insurance

IHS providers are paid for covered inpatient services under the inpatient prospective payment system (IPPS) based upon diagnosis-related groups (DRGs). The IPPS Pricer recognizes that IHS providers are paid at a higher wage index than other acute care hospitals.

All charges are combined and reported under revenue code 0100 (all-inclusive room and board plus ancillary) on TOB 11X (hospital inpatient).

Inpatient services are billed from admission through discharge. In order to receive the appropriate payment under the IPPS, it is important that the applicable ICD-10-CM diagnosis codes as well as ICD-10-CM procedure codes are reported on the bill.

IPPS/DRG

IPPS was developed so the Medicare program would pay a predetermined rate for each type of hospital discharge in accordance with a federal payment schedule. These rates, depending on the DRG, represent payment in full to the hospital for routine inpatient operating costs. Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. The beneficiary's expense is limited to deductibles, coinsurance and non-covered items.

Under the DRG system, patients are classified according to:

- Patient diagnosis
- Patient age
- Treatment procedure
- Discharge status
- Gender

Inpatient Hospital Coverage Conditions

Medicare Part A will pay for inpatient hospital care if all the following conditions are met:

- Patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services.
- The hospital is participating in the Medicare program (in an emergency situation the patient may go to a non-participating hospital).
- The physician prescribes inpatient hospital care for the treatment of an injury or illness.
- The patient requires the kind of care that can only be provided in a hospital. The level of care the patient receives is medically necessary according to CMS regulations.

Three Day/One Day Payment Window

Medicare's policy for payment of outpatient services provided on either the date of a beneficiary's admission or during the three calendar days immediately preceding the date of a beneficiary's inpatient admission to a “subsection (d) hospital” subject to the IPPS (or during the one calendar day immediately preceding the date of a beneficiary's inpatient admission to a non-subsection (d) hospital). This policy is known as the three-day (or one-day) payment window. Under the payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the beneficiary during the three day (or one-day) payment window.

Medicare patients often receive outpatient services prior to being admitted as an inpatient. These outpatient services can be either diagnostic or non-diagnostic (therapeutic) in nature and must be reported according to the three-day or one-day payment window

Inpatient Admission Changed to Outpatient

When a patient is admitted as an inpatient, but during the course of the stay it is determined that the inpatient level of care does not meet admission criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (TOB 13X) with condition code 44 to report medically necessary Medicare Part B services that were furnished to the beneficiary only if all of the following conditions are met:

- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital.
- The hospital has not submitted a claim to Medicare for the inpatient admission.
- A physician concurs with the URC's decision.
- The physician's concurrence with the URC's decision is documented in the patient's medical record

When condition code 44 is appropriately used, the hospital reports the services that were ordered and provided to the patient for the entire patient encounter. Hospitals may not, however, report observation for services furnished prior to receiving a physician's order.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.

Inpatient Services Same Month as Repetitive Services

When a patient is hospitalized during the same month as outpatient therapy services, the outpatient claim that contains the repetitive services will need to be submitted with occurrence span code 74 and the dates of the inpatient stay.

Non-covered Inpatient Services Social Admissions

There may be situations when a beneficiary is admitted to an IHS facility for social reasons, such as the following:

• Patient is scheduled for outpatient surgery and the patient may live too far to come to the facility the morning of the scheduled surgery. The provider may place the patient in a room overnight for patient convenience. In this situation, the provider may only bill for the scheduled surgery.

• Patient was admitted as an inpatient. The patient is discharged. However, there may be situations where the family is unable to pick up the patient and the patient is placed in a room as a convenience.

These social admissions are for patient and family convenience and cannot be billable to Medicare on either an 11X or 12X TOB. The following represents CMS policy:

• When a 12X TOB from an IHS/tribal facility (including CAHs) covers the same time period as a 13X TOB received from another hospital or a 72X TOB received from a renal dialysis facility (RDF):

• The 12X TOB is presumed to represent a social admission and is disallowed.

• The 13X TOB/72X TOB will be paid.

• A social admission stay does not qualify for any payment for TOBs 11X or 12X. A social admission cannot be used to satisfy the three-day prior stay for SNFs.

Determining Covered/Non-covered Days and Charges

It is important to record a day or charge as covered or non-covered (except social admits) because of the following:

- Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care.

- Days denied as not medically necessary or as custodial care are not charged against a beneficiary's utilization record when the provider is determined to be liable. When the benefits days are exhausted, IHS providers are required to file a no-pay claim.

Billing Requirements for Non-covered Days

Form locator (FL) 35 (occurrence span code) – Include occurrence code M1 and the dates indicating the period of non-covered care.

- FL 39 (value code 80) – Report the total number of covered days.
- FL 40 (value code 81) – Report the total number of non-covered days.
- FL 41 (value code 31) – Report the total charges of the non-covered accommodations. These charges are also included as non-covered charges on the bill.
- FL 48 (non-covered charges) – These charges are also included as non- covered charges on the bill.

Inpatient No-pay Billing Instructions

A no-pay inpatient claim is submitted to track benefit periods. These claims are filed when:

- Inpatient benefit days are exhausted.
- Determination is made after the patient is dismissed that the inpatient stay was not medically necessary.
- The patient only has Part B entitlement but has a supplemental insurance policy that will consider payment of the inpatient claim; therefore, a denial from Medicare is needed

UB04 Population:

- FL 4 (type of bill) – Enter the bill type as 0110
- FL 35 (occurrence span code) – Enter occurrence code M1 and the same dates indicated in the “from” and “through” dates in FL 6 (statement covers period)
- FL 39 (non-covered days) – Indicate value code 81 and the number of non- covered days
- FL 40 (value code 31) – Report the total charges of the non-covered accommodations (this is patient liability)
- FL 47 (total charges) – Indicate the total charges for each line item
- FL 48 (non-covered charges) – Indicate the total non-covered charges for each line item

Once the inpatient “no-pay” inpatient claim has been submitted to Medicare and appears on a remittance advice, providers may then bill the ancillary Part B claim (121 TOB)

Ancillary Services

- The patient is not entitled to Medicare Part A.
- The admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made).
- The day(s) of the otherwise covered stay during which the services were provided was not reasonable and necessary (and no payment was made under waiver of liability).
- No Part A payment is made at all for the inpatient stay because the patient's benefits were exhausted before admission.

IHS facilities will submit an ancillary claim with a TOB 121, revenue code 0240, daily accommodation rate and total number of days based on the inpatient stay (indicated in the statement "from" and "through" dates).

Ancillary services cannot be submitted without first submitting an inpatient claim and receiving a denial based on one of the above reasons. The ancillary claim can be submitted after the denied inpatient claim has posted to a remittance notice.

Inpatient Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines

When vaccines are provided to an inpatient of a hospital, they are covered under the vaccine benefit. Hospitals bill the vaccine (administration, vaccine and A6 condition code) under TOB 12X using the discharge date of the hospital stay or the date benefits are exhausted. Payment for these vaccines is on a reasonable cost basis for hospitals

New Occurrence Code to Report Date of Death

Medicare systems will accept and process new occurrence code 55 used to report date of death. Occurrence code 55 and the date of death must be present when one of the following patient discharge status codes is present:

- 20 (expired)
- 40 (expired at home)
- 41 (expired in a medical facility)
- 42 (expired – place unknown)

Discharge

It is very important to select the correct discharge status code for all claims to be processed correctly.

Definition of a discharge:

The Medicare PPS considers a patient “discharged” when the patient is formally released from a hospital after receiving inpatient care.

Repeat Admissions

Hospitals should place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples could include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately. Institutional providers may not use the leave of absence billing procedure when the second admission is unexpected.

Placing a patient on a leave of absence will not generate two payments. Only one bill and one MS-DRG payment are made.

When a patient is discharged or transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to the prior stay's medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

Condition Code B4

When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stay's medical condition, hospitals shall place condition code B4 on the claim that contains an admission date equal to the prior admission's discharge date.

Leave of Absence

When billing for a leave of absence, report the following additional entries on the bill:

- FL 39a (non-covered days) – Indicate value code 81 and report the total non-covered days the patient is not occupying a bed.
- FL 42 (revenue code 018X to indicate the type of leave)

Same Day Transfers

Same-day transfers from participating hospital to participating hospital

If the beneficiary is transferred to a participating hospital or distinct part of a participating hospital, the day is counted if it is determined to be covered.

Same-day transfer billing procedures

- FL 6 (from and through dates) – The same day is entered.
- FLs 18–28 (condition code 40) – Same-day transfer.
- FL 39a (non-covered days) – Indicate value code 81 and report one day in the field.
- FL 47 (covered charges).

Note: Because the day is not counted against the patient's Medicare days (utilization days), the charges are covered and should be reported in the column in FL 47.

Ambulatory Surgery Center

The Medicare definition of covered ASC facility services for a covered surgical procedure includes services that would be covered if furnished on an inpatient or outpatient basis in connection with a covered surgical procedure. This includes operating and recovery rooms, patient preparation areas, waiting rooms and other areas used by the patient or offered for use to patients needing surgical procedures. It includes all services and procedures provided in connection with covered surgical procedures furnished by nurses, technical personnel and others involved in patient care. These do not include physician services or medical and other health services for which payment may be made under other Medicare provisions.

Covered ASC services are those surgical procedures that are identified by CMS on an annually updated ASC listing. Some surgical procedures covered by Medicare are not on the ASC list of covered surgical procedures. These may be billed by the rendering provider as Part B services but not as ASC services.

Payment Allowance

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- Cost of the physician's (surgeon) professional services for performing the procedure.
- Cost of services furnished by the facility where the procedure is performed (for example, surgical supplies, equipment and nursing services).

The professional fee is paid to the surgeon; the facility fee is paid to the ASC. Physician coding and ASC coding of the procedures performed should match. In addition to the surgeon's claim, a separate claim can be submitted for the anesthesiologist using anesthesia CPT codes.

The POS code for services rendered in an ASC is 24.

Anesthesia Services

Anesthesia is the administration of a drug or gas to induce partial or complete loss of consciousness. Services involving administration of anesthesia should be reported by the use of the CPT anesthesia five-digit procedure code plus modifier codes. Surgery codes are not appropriate unless the anesthesiologist or certified registered nurse anesthetist (CRNA) is performing the surgical procedure.

Every anesthesia procedure billed to Medicare must include one of the following anesthesia modifiers:

AA – Anesthesia services performed by anesthesiologist

QY – Medical direction of one CRNA by an anesthesiologist

QK – Medical direction of two, three or four concurrent anesthesia procedures

AD – Supervision, more than four procedures

CRNA Modifier:

QX – Anesthesia, CRNA medically directed

QZ – Anesthesia, CRNA not medically directed

Anesthesia Time

Anesthesia time begins when the anesthesiologist starts to prepare the patient for the procedure. Normally, this service takes place in the operating room, but in some cases, preparation may begin in another location (e.g., holding area). Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

Anesthesia time is reported in total minutes in Item 24G of the CMS-1500 claim form.

The allowance for anesthesia services is based on the following formula:

Time units + base units x conversion factor = allowance

The anesthesia conversion factor is used to compute allowable amounts for anesthesia services. Conversion factors (CF) are determined based on a formula consisting of work, practice and malpractice expense; therefore, each state or locality may have a different CF

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~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 8G ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: [illegible] [illegible]                              Claim: [illegible]
Mode of Export: 837P (HCFA) 5010
............................ (ANESTHESIA SERVICES) ...........................

     REVN                                                              TOTAL
     CODE          CPT - ANESTHESIA SERVICES                    MIN    CHARGE
     ---- ------------------------------------------------------ ---  --------

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//A


=============== ADD MODE - ANESTHESIA SERVICES ===============
Select Anesthesia (CPT Code): 00790    ANES IPER UPR ABD NOS
       ANESTHESIA FOR INTRAPERITONEAL PROCEDURES IN UPPER ABDOMEN INCLUDING
       LAPAROSCOPY; NOT OTHERWISE SPECIFIED

Select 1st MODIFIER: QZ        CRNA SVC W/O MED DIR BY MD

Select 2nd MODIFIER: AA        ANESTHESIA PERF BY ANESGST

Select 3rd MODIFIER:

                     DIAGNOSES
       Seq    ICD
       Num    Code                 Diagnosis Description
       ---  -------  --------------------------------------------
        1   N17.9    Acute kidney failure, unspecified

Enter Principle Corresponding DX: 1  N17.9   1
Enter Other Corresponding DX (carriage return when done):

   Anesthesia BASE CHARGE: 526.30 ENTER YOUR PRICE AS YOU CALCULATED
   Anesthesia PLACE OF SERVICE: 24//PLACE OF SERVICE ABMULATORY SURGICAL CENTER
   Anesthesia START DATE/TIME: DATE@TIM  (DATE@TIME)
   Anesthesia STOP DATE/TIME: DATE@TIME  (DATE@TIME)
Select SERVICE LINE PROVIDER: ADD PROVIDER

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 8G ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: [illegible] [illegible]                              Claim: [illegible]
Mode of Export: 837P (HCFA) 5010
............................ (ANESTHESIA SERVICES) ...........................

     REVN                                                              TOTAL
     CODE          CPT - ANESTHESIA SERVICES                    MIN    CHARGE
     ---- ------------------------------------------------------ ---  --------
[1]  **** 00790-QZ-AA ANESTHESIA FOR INTRAPERITONEAL            180    526.30
                PROCEDURES IN UPPER ABDOMEN
                INCLUDING LAPAROSCOPY; NOT
                OTHERWISE SPECIFIED
          Start Date/Time: DATE TIME
           Stop Date/Time: DATE TIME
                                                                    ----------
                                                                     $526.30
```

Rationale:

Per anesthesia guidelines in the CPT® code book under the subheading Time Reporting: Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia in either the operating room (or an equivalent area) and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. For example: Anesthesia start time (12:26) and the anesthesia end time (15:26) calculates as 3 hours or 180 minutes of total anesthesia time.

ANESTHESIA CALCULATION (gather data from PCC Display):

1. CPT CODE
2. MODIFIERS
3. START/STOP TIME
4. TOTAL ELAPSED TIME
5. PROVIDER

TOTAL TIME/15= #UNIT

#UNIT + BASE UNITS/RATE = TOTAL UNITS

TOTAL UNITS* CONVERSION FACTOR = TOTAL PRICE $$

EXAMPLE: System will process as:

Base Unit (BASEspreadsheet attached)	x	$27.70 (conversion factor)	= $193.90
Total lapsed time/divided by 15 mins 12	x	$27.70 (conversion factor)	= +$332.40

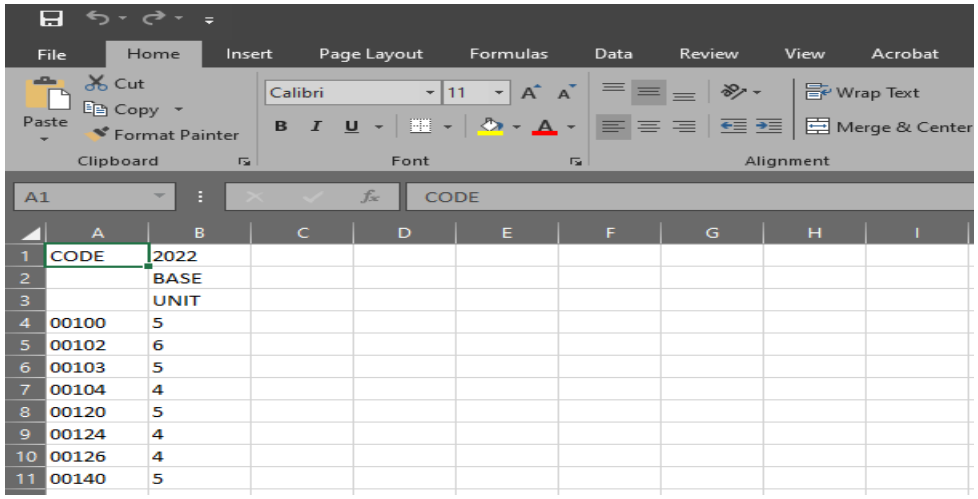
$526.30 TOTAL ANESTHESIA COST

Should have billed as

Date of Service	POS	ASA	Bill Amt.	Units
05/27/2015	06	00790	$526.30	12

MEDICARE	22.53
PRIVATE INSURNACE	22.53
MEDICAID (AZ)	27.70
MEDICAID (NM,MCOs)	18.43
VETERANS ADMIN	18.43

Base Units



	A	B	C	D	E	F	G	H	I
1	CODE	2022							
2		BASE							
3		UNIT							
4	00100	5							
5	00102	6							
6	00103	5							
7	00104	4							
8	00120	5							
9	00124	4							
10	00126	4							
11	00140	5							

CY_2022_Anesthesia_Base_Units_110921


thank you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