Draffin & Tucker, LLP
CERTIFIED PUBLIC ACCOUNTANTS

IT'S ALL ABOUT YOU! – PART 1

Departmental Responsibilities for Charge Capture

Let's start with a quick review of the revenue cycle process.

Physician order

You fell off your bike and hurt your arm. The doctor said you need to go to the hospital for an x-ray. So, he writes an order for you to take with you to the hospital.

Registration

You take the order to the outpatient registration desk. You are asked a lot of questions. Whatever for?

Charge Capture

You had your x-ray. Now a charge must be generated. Some hospitals may use a charge sheet. Some may have electronic systems to input charges.

RADIOLOGY REQUEST 1

Date: ✓ Date Ordered:

Diagnosis or Reason for Procedure:

Procedure:

Pregnancy Yes ( ) No ( ) ☐ OUTPATIENT ☐ WHEELCHAIR ☐ STRETCHER ☐ PORTABLE

Q	CODE	CPT	CHEST
	13012	71010	CHEST; SINGLE VIEW, FRONTAL
	13010	71020	CHEST; TWO VIEWS, FRONTAL AND LATERAL
	13201	71021	CHEST; 2-VIEWS, W/APICAL LORDOTIC PROCEDURE
	13011	71030	CHEST; COMPLETE, MIMIMUM OF FOUR VIEWS
	13013	71100	RIBS; UNILATERAL, TWO VIEWS
	14013	71101	RIBS, W/POSTEROANTERIOR CHEST-MIN 3 VIEWS
	13014	71110	RIBS, BILATERAL 3 VIEWS
	14014	71111	RIBS W/POSTEROANTERIOR CHEST, MIN 4 VIEWS
	13015	71120	STERNUM, MINIMUM OF 2 VIEWS
	14060	71130	STERNOCLAVICULAR JOINT MINIMUM 3 VIEWS
	CODE	CPT	ABDOMEN
	13040	74000	ABDOMEN; SINGLE ANTEROPOSTERIOR VIEW
	13047	74020	ABDOMEN; COMPLETE INCL DECUBIUS & ERECT
	13094	74022	COMP ABDOMEN SERIES W/UPRIGHT PA CHEST
	13200	76010	NOSE TO RECTUM, FOREIGN BODY, 1VW,CHILD
	13075	77075	OSSEOUS SURV. COMP. AXIA & APPENDICULAR
	13165	77076	OSSEOUS SURVEY INFANT
	CODE	CPT	HEAD AND NECK
	13155	70100	MANDIBLE; PARTIAL <4 VIEWS
	13004	70110	MANDIBLE COMPLETE, MINIMUM 4 VIEWS
	13001	70150	FACIAL BONES COMPLETE MINIMUM 3 VIEWS
	13003	70160	NASAL BONES COMPLETE, MINIMUM 3 VIEWS
	13005	70200	ORBITS COMPLETE, MINIMUM 4 VIEWS
	13156	70210	SINUSES, PARANASAL, < 3 VIEWS
	13006	70220	SINUSES, PARANASAL, COMPLETE MIN 3 VIEWS
	13157	70250	SKULL; <4 VIEWS
	13007	70260	SKULL COMPLETE 4 V
	13008	70330	TEMPOROMANDIBULAR, OPEN/CLOSED, BILATRAL
	13002	70360	NECK, SOFT TISSUE
	CODE	CPT	SPINE AND PELVIS
	14015	72020	SPINE, SINGLE VIEW SPECIFY LEVEL
	13158	72040	C SPINE 2 OR 3 VIEWS
	13016	72050	SPINE, CERVICAL, MINIMUM OF 4 VIEWS
	13017	72052	SPINE, CERVICAL, COMP INC OBLIQUE/FLEXION
	13151	72069	SCOLIOSIS, THORACOLUMBARCOLIOSIS
	13159	72070	SPINE; THORACIC, 2 VIEWS
	13020	72072	SPINE THORACIC THREE VIEWS
	13986	72100	LUMBER SPINE 2 OR 3 VIEWS
	13018	72110	LUMBAR SPINE MINIMUM OF FOUR VIEWS

Q	CODE	CPT	SPINE AND PELVIS (CONT)
	13019	72114	SPINE, LUMBOSACRAL; COMP INCL BEND VIEWS
	13021	72170	PELVIS; ONE OR TWO VIEWS
	13024	72202	SACROILIAC JOINTS; THREE OR MORE VIEWS
	13025	72220	SACRUM & COCCYX, MINIMUM OF TWO VIEWS
	13022	73510	HIP, COMPLETE, MINIMUM OF TWO VIEWS
	13023	73520	HIPS, BIL, MIN 2 VU, EA HIP INC PELVIS
	CODE	CPT	UPPER EXTREMITIES
	13026	73000	CLAVICLE, COMPLETE
	13029	73010	SCAPULA, COMPLETE
	14016	73020	SHOULDER; ONE VIEW
	13028	73030	SHOULDER; COMPLETE MINIMUM OF 2 VIEWS
	13027	73050	ACROMIOCLAVICULAR JOINTS, BILATERAL
	13092	73060	HUMERUS MINIMUM OF TWO VIEWS
	14017	73070	ELBOW, TWO VIEWS
	13031	73080	ELBOW; COMPLETE MINIMUM OF THREE VIEWS
	13032	73090	FOREARM, TWO VIEWS
	13160	73092	UPPER EXT. INFANT, MIN 2 VIEW
	13161	73100	WRIST; 2 VIEW
	13033	73110	WRIST COMPLETE 3 VIEW
	13162	73120	HAND 2 VIEWS
	13034	73130	HAND; MINIMUM OF THREE VIEWS
	13035	73140	FINGER(S), MINIMUM OF TWO VIEWS
	CODE	CPT	LOWER EXTREMITIES
	13036	73550	FEMUR, TWO VIEWS
	13985	73560	KNEE; 1 OR 2 VIEWS
	13037	73564	KNEE; COMPLETE, FOUR OR MORE VIEWS
	14061	73565	KNEE BOTH STANDING
	13038	73590	TIBIA AND FIBULA, TWO VIEWS
	14018	73592	TIBIA & FIB, LOWER EXT INFANT-MIN 2 VIEW
	13163	73600	ANKLE; 2 VIEWS
	13039	73610	ANKLE; COMPLETE MINIMUM OF THREE VIEWS
	13164	73620	FOOT; 2 VIEWS
	13040	73630	FOOT; COMPLETE MINIMUM OF THREE VIEWS
	13041	73650	CALCANEUS MINIMUM OF TWO VIEWS
	13042	73660	TOE(S); MINIMUM OF TWO VIEWS
	CODE	CPT	URINARY TRACT
	13066	74400	UROGRAPHY (PYELOGRAPHY), IV, W/WO KUB TOMO
	13061	74410	UROGRAPHY, INFUSION, DRIP OR BOLUS TECHN

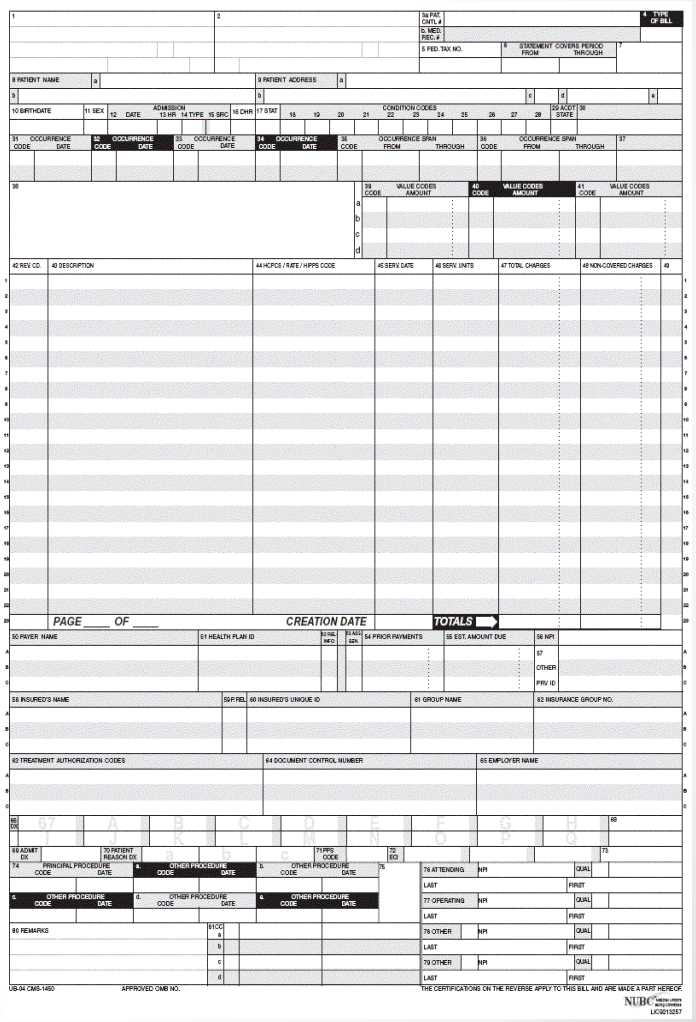
Coding

- Many charges that are billed to a patient must have a special code to let the payer know what was done. Our arm x-ray has this code which will be on the bill sent to the insurance company.

- **73060**
- **X-RAY OF HUMERUS**

Billing

- In order to get paid for the x-ray, a bill must be sent to the insurance company and patient. Hospitals use a bill format known as “UB-04”.

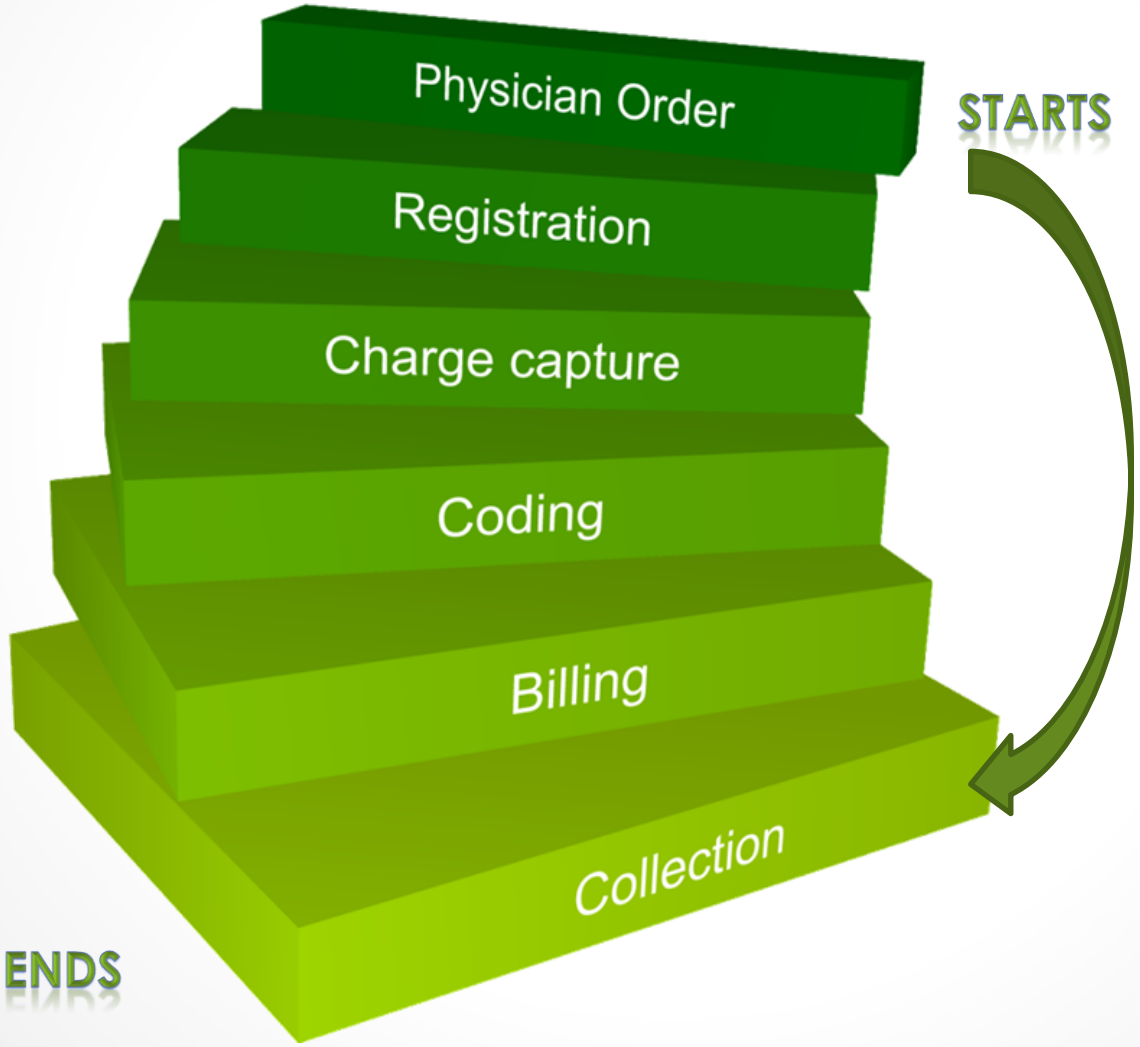


Collection

- Generally within 30 – 60 days the hospital will receive payment from either the insurance company or patient.

The revenue cycle is complete!

The Revenue Cycle



Charge Description Master File

Charge Capture

If it's not captured, it's not paid.

Charge capture is the most important step in the revenue cycle!

Why is charge capture so difficult?

Ancillary personnel were specifically trained on how to perform tests and procedures. They were not taught to capture charges.

If clinical staff cannot find an appropriate charge for the test or procedure, they may not charge or pick a charge that is close to what they are doing.

The billing staff are responsible for making sure bills go out. They rarely review for lost charges because they are thinking the ancillary staff are doing that.

Medical records staff are focusing on correct codes, not on whether or not an item was charged. And many codes are automatically assigned so coders ignore these charges.

And there are soooo many ways to capture charges in a hospital.

Charge sheets

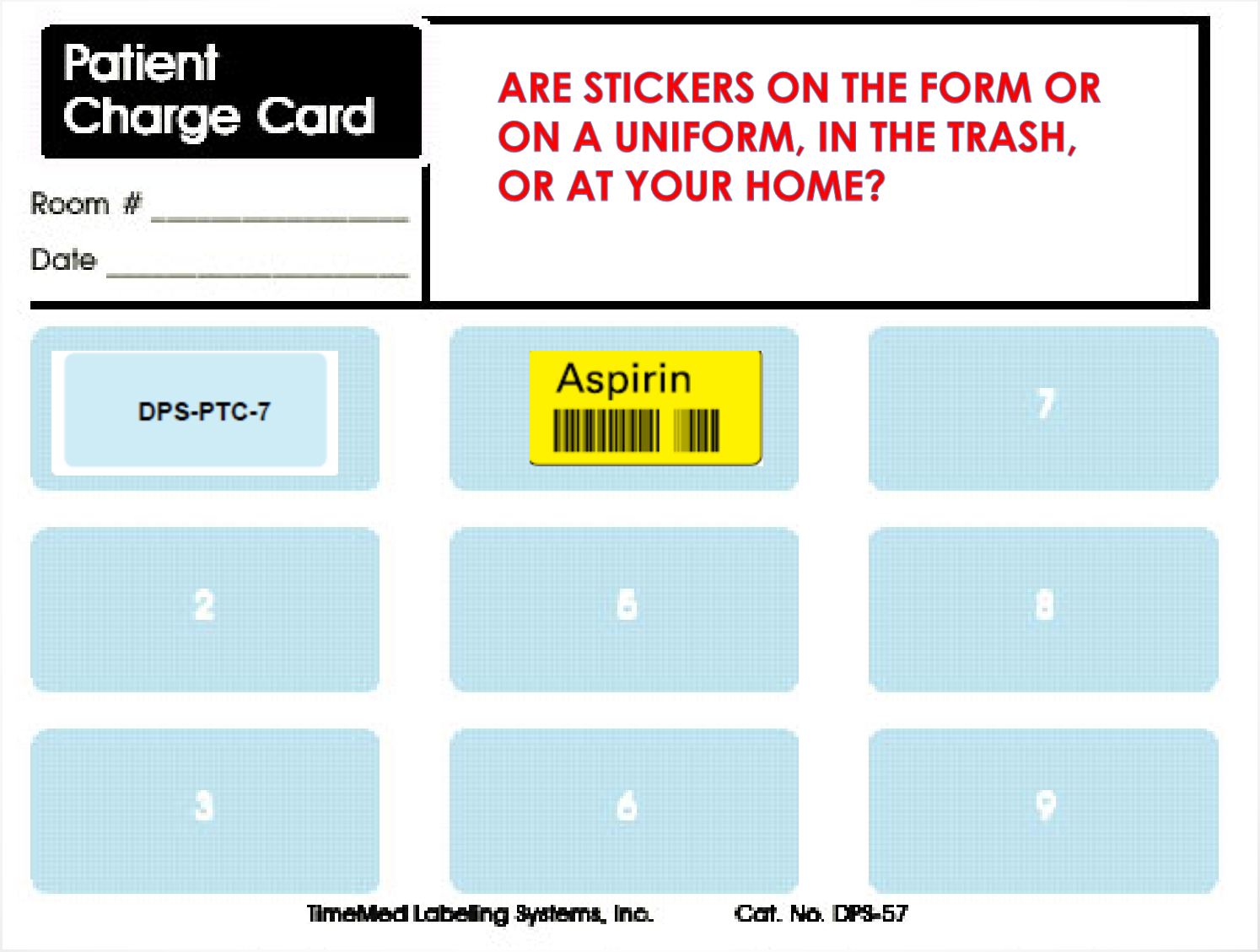
Are identification numbers, codes and descriptions up-to-date?

ER Charge Master

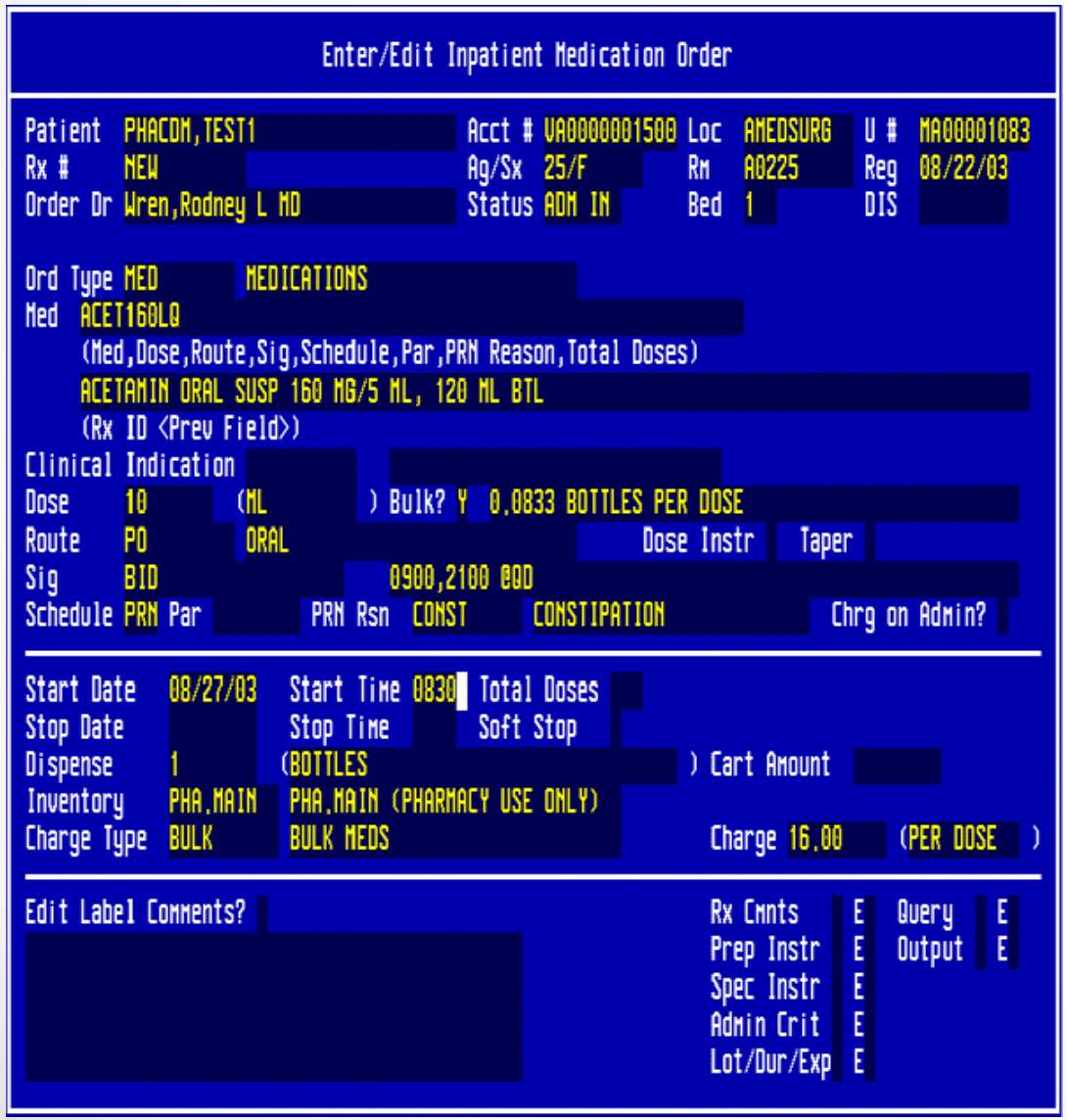
ER #_____ DATE_____

CODE	CPT/HCPC	#	ER LEVELS
11001	99281		Level 1
11002	99282		Level 2
11003	99283		Level 3
11004	99284		Level 4
11005	99285		Level 5
11016	99291		Er Critical Care
12301	99292		Critical Care Add. 30 Min.
CODE	CPT/HCPC	#	PROCEDURES
12437	g0168		Wound Closure/Adhesive
12085	12001		Simple Laceration Total Body <2.5cm
12086	12002		Simple Laceration Total Body 2.6-7.5cm
12087	12004		Simple Laceration Total Body 7.6-12.5cm
12088	12005		Simple Laceration Total Body 12.6-20cm
12089	12006		Simple Laceration Total Body 20.1-30cm
12379	12007		Simple Laceration Total Body >30cm
12090	12011		Simple Laceration Facial Only <2.5cm
12091	12013		Simple Laceration Facial Only 2.6-5.0cm
12092	12014		Simple Laceration Facial Only 5.1-7.5cm
12093	12015		Simple Laceration Facial Only 7.6-12.5cm
12095	12031		Inter. Laceration Total Body <2.5cm
12286	12032		Inter. Laceration Total Body 2.6-7.5cm
12097	12034		Inter. Laceration Total Body 7.6cm-12.5cm
12098	12035		Inter. Laceration Total Body 12.6-20cm
12099	12036		Inter. Laceration Total Body 20.1-30cm
12101	12041		Inter/Lac Hand/Feet/Neck <2.5 cm
12102	12042		Inter/Lac Hand/Feet/Neck 2.6-7.5cm
12103	12044		Inter/Lac Hand/Feet/Neck 7.6-12.5cm
12104	12045		Inter/Lac Hand/Feet/Neck 12.6cm-20cm
12105	12046		Inter/Lac Hand/Feet/Neck 20.1-30cm
12111	12051		Inter. Laceration Facial Only <2.5cm
12110	12052		Inter. Laceration Facial Only 2.6-7.5cm
12109	12054		Inter. Laceration Facial Only 7.6-12.5cm
CODE	CPT/HCPC	#	IV PROCEDURES
12201	36430		Blood Transfusion
12241	36680		Intraosseous Insertion
12409	36400		Venipuncture <3yrs. Femoral/Jug.
12410	36410		Venipuncture >3yrs/Adult Femoral/Jug.
12345	36540		Collection of Blood/Mediport
12414	36600		Arterial Puncture
CODE	CPT/HCPC	#	INCISION/DRAINAGE
12234	10060		I & D Abscess Simple
12431	10061		I & D Abscess Complicate
12368	10080		I & D Pilonidal Cyst Simple
12371	10081		I & D Pilonidal Cyst Complex
12432	10140		I & D Hematoma
12419	46040		I & D Peri-rectal
12233	56420		I & D Bartholin Abscess
12270	46083		I & D Thrombosed Hemorrhoid
12282	26010		I & D Finger Abscess
12230	10120		Incision/Removal F/B Sub Q Simple
12372	10121		Incision/Removal F/B Sub Q Complex
12247	10160		Aspiration Abscess/Hematoma/Cyst
CODE	CPT/HCPC	#	DEBRIDEMENT
12304	11000		Debridement Eczematour to 10%
12330	11001		Each Addiontal 10%
12331	11040		Debride Partial Thickness
12306	11042		Debride Skin Sub Q Tissue
12307	11043		Debride Skin Sub Q Tissue/Muscle
12224	16020		Burn/Debride Small
12223	16025		Burn/Debride Medium
12311	16030		Burn/Debride Large
12337	16000		Initial TX Frist Degree Burn
CODE	CPT/HCPC	#	REMOVAL
12429	11056		Paring/Cutting Benigh Lesion
12373	11100		Biopsy of Skin
12374	11200		Removal of Skin Tag (up to 15)
12375	11400		Excision Benign Lesion 0.5cm or <
12303	11750		Excision Nail Partial / Complete
12334	11752		Excision Nail Amputation Dist. Phala
12256	11765		Excision Ingrown Toe Nail
12333	11740		Evacuation of Subungual Hematoma
12382	20520		Removal of Foreign Body in Muscle
12382	11730		Avulsion Nail Plate Partial/Complete
12332	11732		Each Additional Plate
12335	11760		Repair Nail Bed

Sticker system



Electronic order entry



Carefully verify all information on screen. Beware of any "carry over" information that may not be applicable.

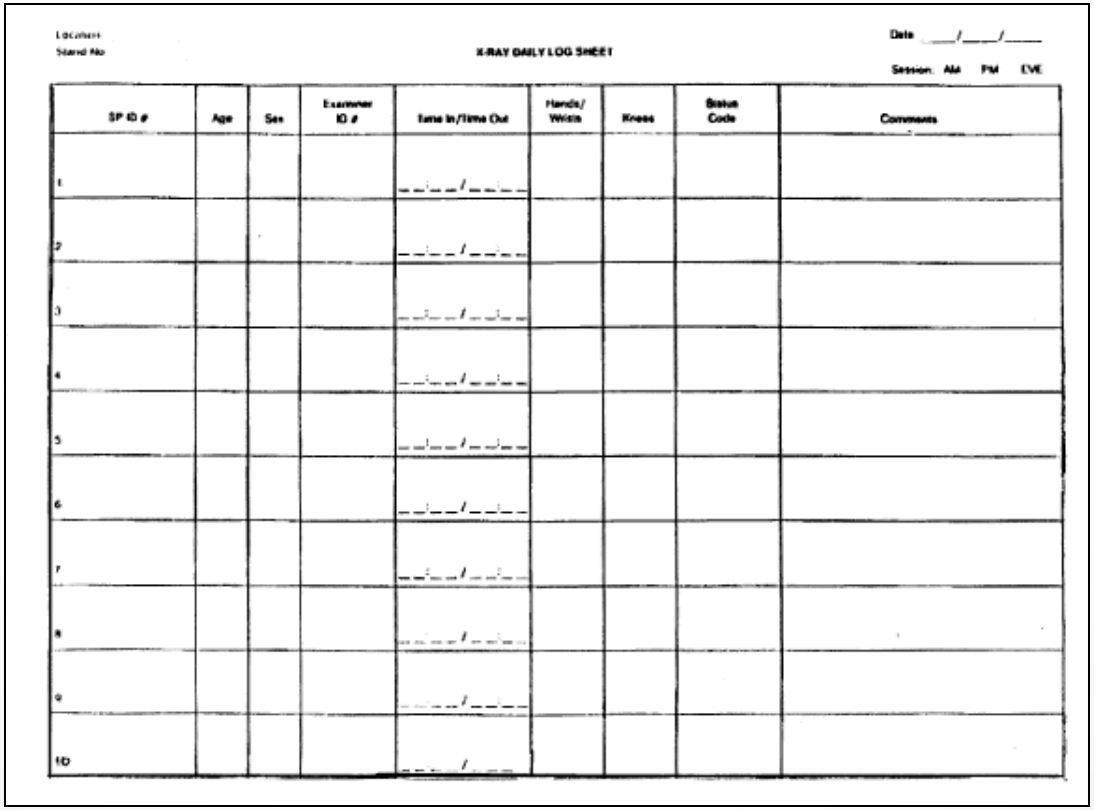
Barcode systems

Unit dose order / charge system

With the different methods of inputting orders and charges, how can we know that all charges are captured?

Every revenue-producing department should perform a **daily charge reconciliation** of services performed to services charged.

Step 1: Radiology has a daily log sheet with a list of patient visits for a day.



Location
Stand No

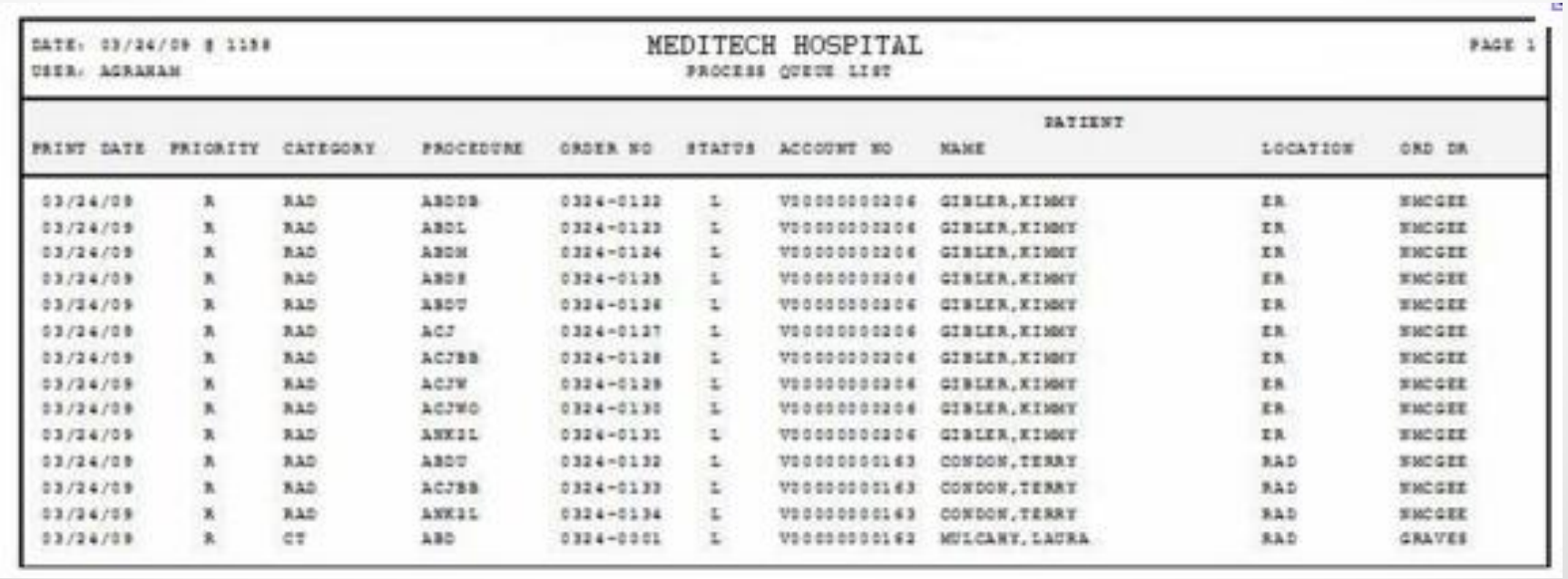
X-RAY DAILY LOG SHEET

Date ____/____/____

Session: AM PM EVE

SP ID #	Age	Sex	Examiner ID #	Time In/Time Out	Hands/ Wrists	Knees	Status Code	Comments
1				__:__ / __:__				
2				__:__ / __:__				
3				__:__ / __:__				
4				__:__ / __:__				
5				__:__ / __:__				
6				__:__ / __:__				
7				__:__ / __:__				
8				__:__ / __:__				
9				__:__ / __:__				
10				__:__ / __:__				

Step 2: Compare daily log sheet to list of charges that were entered into the system for the same date.



DATE: 03/24/09 @ 1158
USER: AGRAHAM

MEDITECH HOSPITAL
PROCESS QUEUE LIST

PAGE 1

PRINT DATE	PRIORITY	CATEGORY	PROCEDURE	ORDER NO	STATUS	PATIENT ACCOUNT NO	PATIENT NAME	LOCATION	ORD DR
03/24/09	R	RAD	ABDDB	0324-0122	L	V00000000206	GIBLER,KIMMY	ER	MMCGEE
03/24/09	R	RAD	ABDL	0324-0123	L	V00000000206	GIBLER,KIMMY	ER	MMCGEE
03/24/09	R	RAD	ABDM	0324-0124	L	V00000000206	GIBLER,KIMMY	ER	MMCGEE
03/24/09	R	RAD	ABDS	0324-0125	L	V00000000206	GIBLER,KIMMY	ER	MMCGEE
03/24/09	R	RAD	ABDU	0324-0126	L	V00000000206	GIBLER,KIMMY	ER	MMCGEE
03/24/09	R	RAD	ACJ	0324-0127	L	V00000000206	GIBLER,KIMMY	ER	MMCGEE
03/24/09	R	RAD	ACJBB	0324-0128	L	V00000000206	GIBLER,KIMMY	ER	MMCGEE
03/24/09	R	RAD	ACJW	0324-0129	L	V00000000206	GIBLER,KIMMY	ER	MMCGEE
03/24/09	R	RAD	ACJWO	0324-0130	L	V00000000206	GIBLER,KIMMY	ER	MMCGEE
03/24/09	R	RAD	ANKSL	0324-0131	L	V00000000206	GIBLER,KIMMY	ER	MMCGEE
03/24/09	R	RAD	ABDU	0324-0132	L	V00000000163	CONDON,TERRY	RAD	MMCGEE
03/24/09	R	RAD	ACJBB	0324-0133	L	V00000000163	CONDON,TERRY	RAD	MMCGEE
03/24/09	R	RAD	ANKSL	0324-0134	L	V00000000163	CONDON,TERRY	RAD	MMCGEE
03/24/09	R	CT	ABD	0324-0001	L	V00000000162	MULCAHY,LAURA	RAD	GRAVES

There should be a charge in the system for every patient listed on the radiology daily log.

If there is not a charge for each patient listed on the daily log, there should be further research to determine the cause.

Daily charge reconciliation should be performed to prevent lost charges. Lost charges often result in large amounts of lost revenue.

In some cases, a charge may have been captured by the ancillary staff, but for some reason the charge may not have made it to the bill.

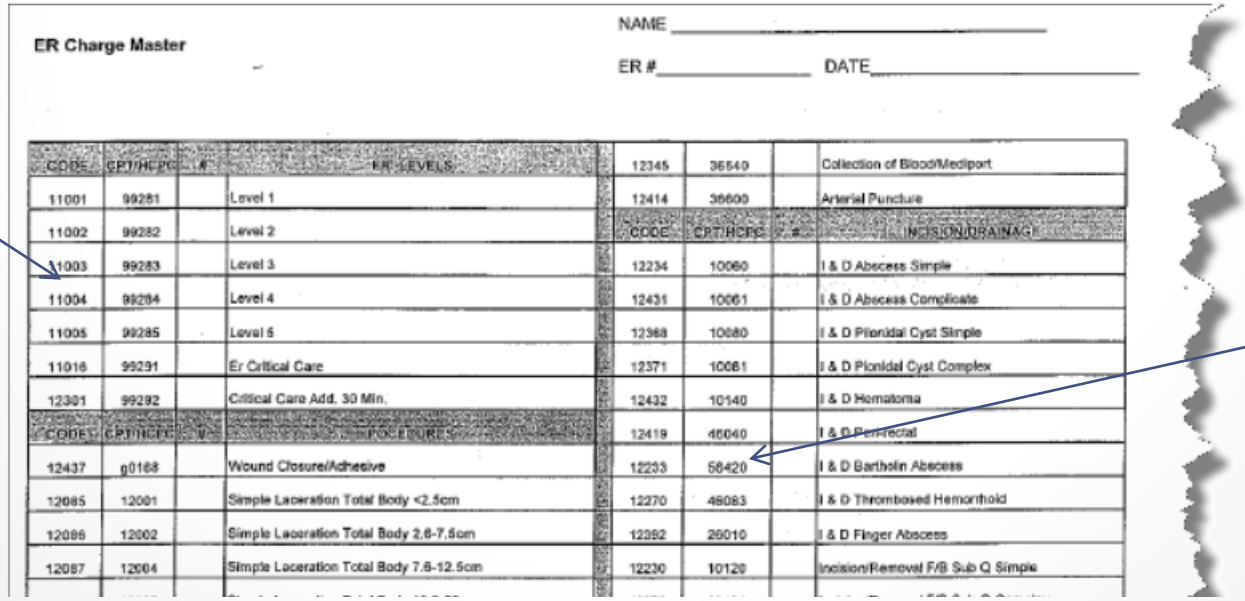
For this reason, there should also be periodic reviews of medical record documentation to charges billed on the UB-04 claim form.

It is not uncommon to find missing charges related to drugs and drug administration services.

Dosage errors
Route of administration
Start and stop times

Outdated requisition forms and charge sheets may also result in charging errors.

Inactive CDM ID numbers



ER Charge Master

NAME _____

ER #_____ DATE_____

CODE	CPT/HCPC	#	ER LEVELS
11001	99281		Level 1
11002	99282		Level 2
11003	99283		Level 3
11004	99284		Level 4
11005	99285		Level 5
11016	99291		Er Critical Care
12301	99292		Critical Care Add. 30 Min.
CODE	CPT/HCPC	#	PROCEDURES
12437	g0168		Wound Closure/Adhesive
12085	12001		Simple Laceration Total Body <2.5cm
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12345	36549		Collection of Blood/Mediport
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CODE	CPT/HCPC	#	INCISION/DRAINAGE
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12368	10080		I & D Pilonidal Cyst Simple
12371	10081		I & D Pilonidal Cyst Complex
12432	10140		I & D Hematoma
12419	46040		I & D Peri-rectal
12233	56420		I & D Bartholin Abscess
12270	46083		I & D Thrombosed Hemorrhoid
12392	26010		I & D Finger Abscess
12230	10120		Incision/Removal F/B Sub Q Simple

Changing CPT codes

If the requisition form or charge sheet does not have the appropriate charge code or CDM code, charge mistakes may occur.

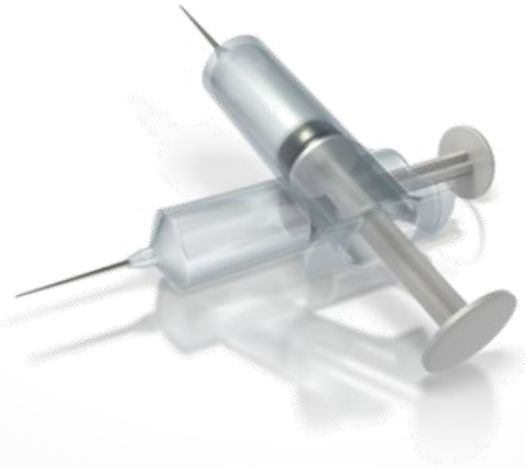
Whenever services are provided, all charges for those services must be captured and charged in the hospital's financial records.

Services not charged will not be billed and will not produce revenue for the hospital.

Now sometimes we get confused about **IF** a service should be charged separately.

There are many supplies used that may be such an integral part of a procedure that the service could not be performed without them.

However, many of the supplies are purchased in bulk quantities and are very minimal in cost.



Some examples are
cotton balls,
alcohol pads,
and syringes.
It would be very difficult to track and charge these items separately.

In these instances, the "charge" for such items are considered as part of the charge for the related service or procedure.

For example, in setting the charge for an infusion, the hospital will include amounts to cover the costs of the alcohol pads, syringe, tubing and needle.

So even though there is no separate charge for these small items, the charges are "bundled" into the infusion charge.

The key to effectively capturing charges is knowing what charges are "bundled" in order to ensure that all costs are covered.

What are some common charge capture related problems?

Common charge capture errors

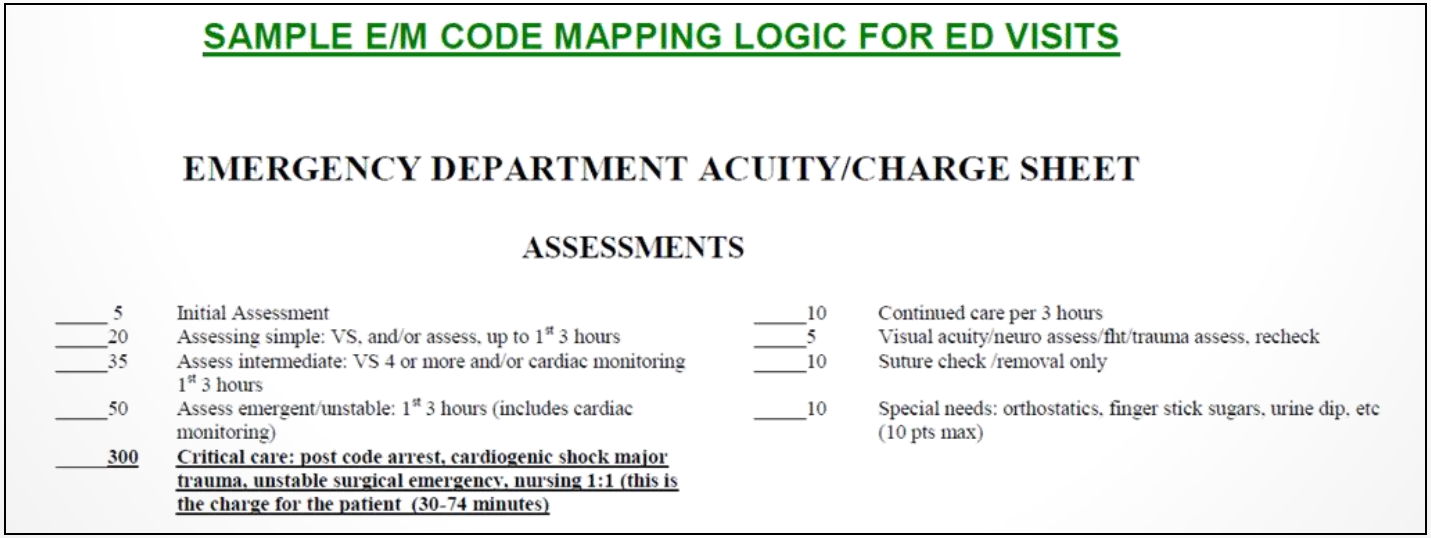
Critical Access

- Units of service
- **Failure to charge**
- Evaluation and management services visit level assignment

PPS

- Units of service
- **Drug administration documentation**
- **Failure to charge**
- Evaluation and management services visit level assignment

All hospitals should use a "mapping sheet" to assign visit level charges in all ED or clinic areas.



SAMPLE E/M CODE MAPPING LOGIC FOR ED VISITS

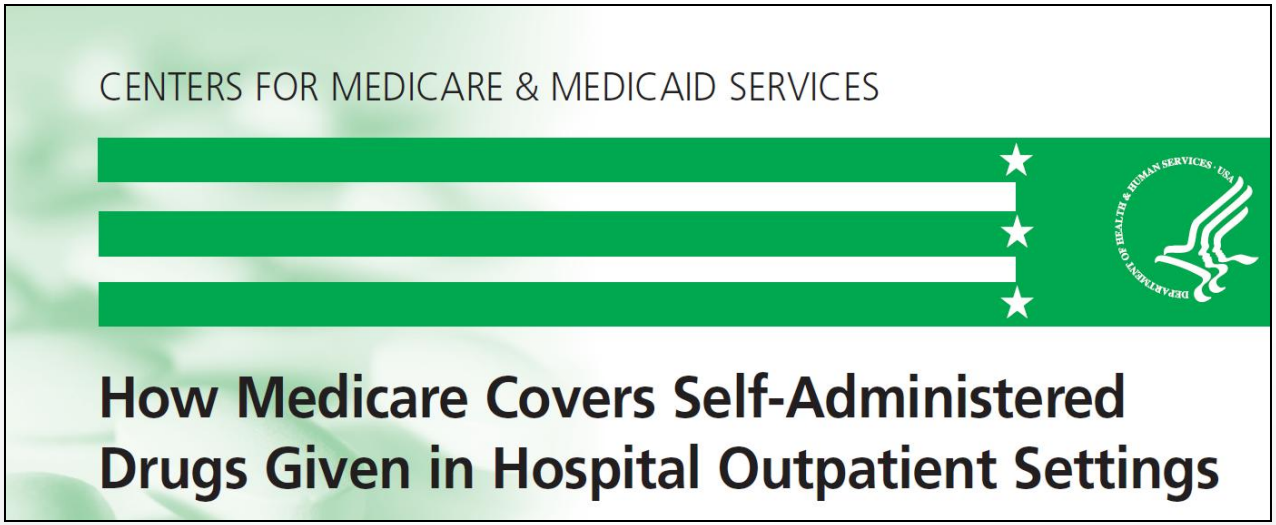
EMERGENCY DEPARTMENT ACUITY/CHARGE SHEET

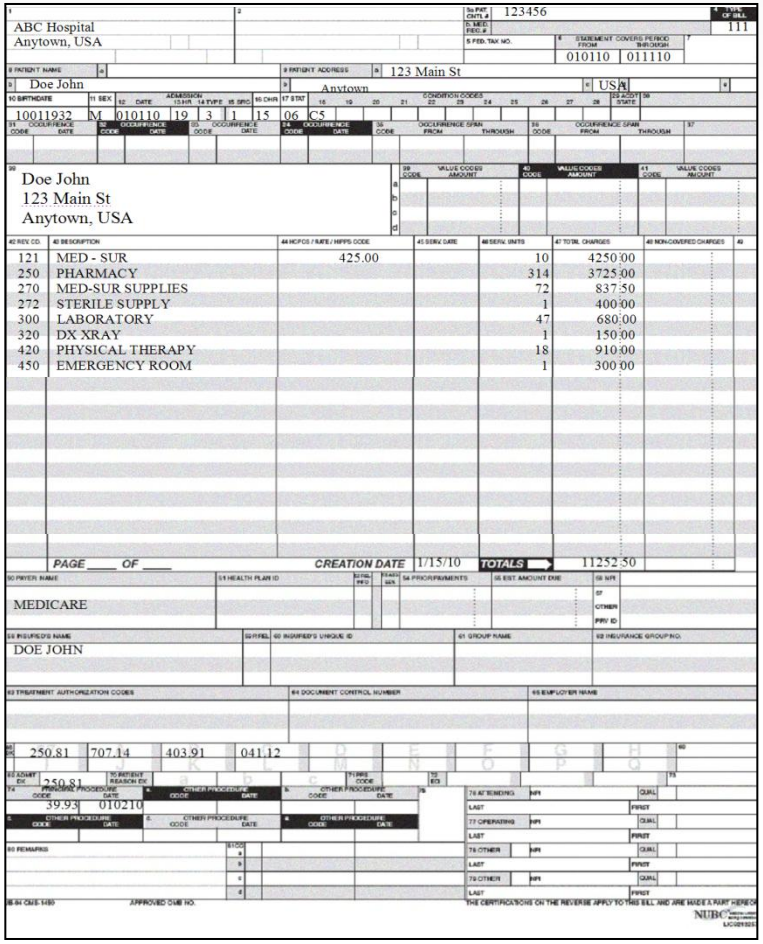
ASSESSMENTS

_____5	Initial Assessment	_____10	Continued care per 3 hours
_____20	Assessing simple: VS, and/or assess, up to 1st 3 hours	_____5	Visual acuity/neuro assess/fht/trauma assess, recheck
_____35	Assess intermediate: VS 4 or more and/or cardiac monitoring 1st 3 hours	_____10	Suture check /removal only
_____50	Assess emergent/unstable: 1st 3 hours (includes cardiac monitoring)	_____10	Special needs: orthostatics, finger stick sugars, urine dip, etc (10 pts max)
_____300	**Critical care: post code arrest, cardiogenic shock major trauma, unstable surgical emergency, nursing 1:1 (this is the charge for the patient (30-74 minutes)**		

Billing self-administered drugs as covered will result in Medicare overpayments.

http://www.medicare.gov/Publications/Pubs/pdf/11333.pdf





ABC Hospital
Anytown, USA

123456

111

010110 011110

Doe John

123 Main St

Anytown

USA

10011932 M 010110 19 3 1 15 06 C5

Doe John
123 Main St
Anytown, USA

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
121	MED - SUR	425.00		10	4250.00	
250	PHARMACY			314	3725.00	
270	MED-SUR SUPPLIES			72	837.50	
272	STERILE SUPPLY			1	400.00	
300	LABORATORY			47	680.00	
320	DX XRAY			1	150.00	
420	PHYSICAL THERAPY			18	910.00	
450	EMERGENCY ROOM			1	300.00	

PAGE ___ OF ___ CREATION DATE 1/15/10 TOTALS 11252.50

MEDICARE

DOE JOHN

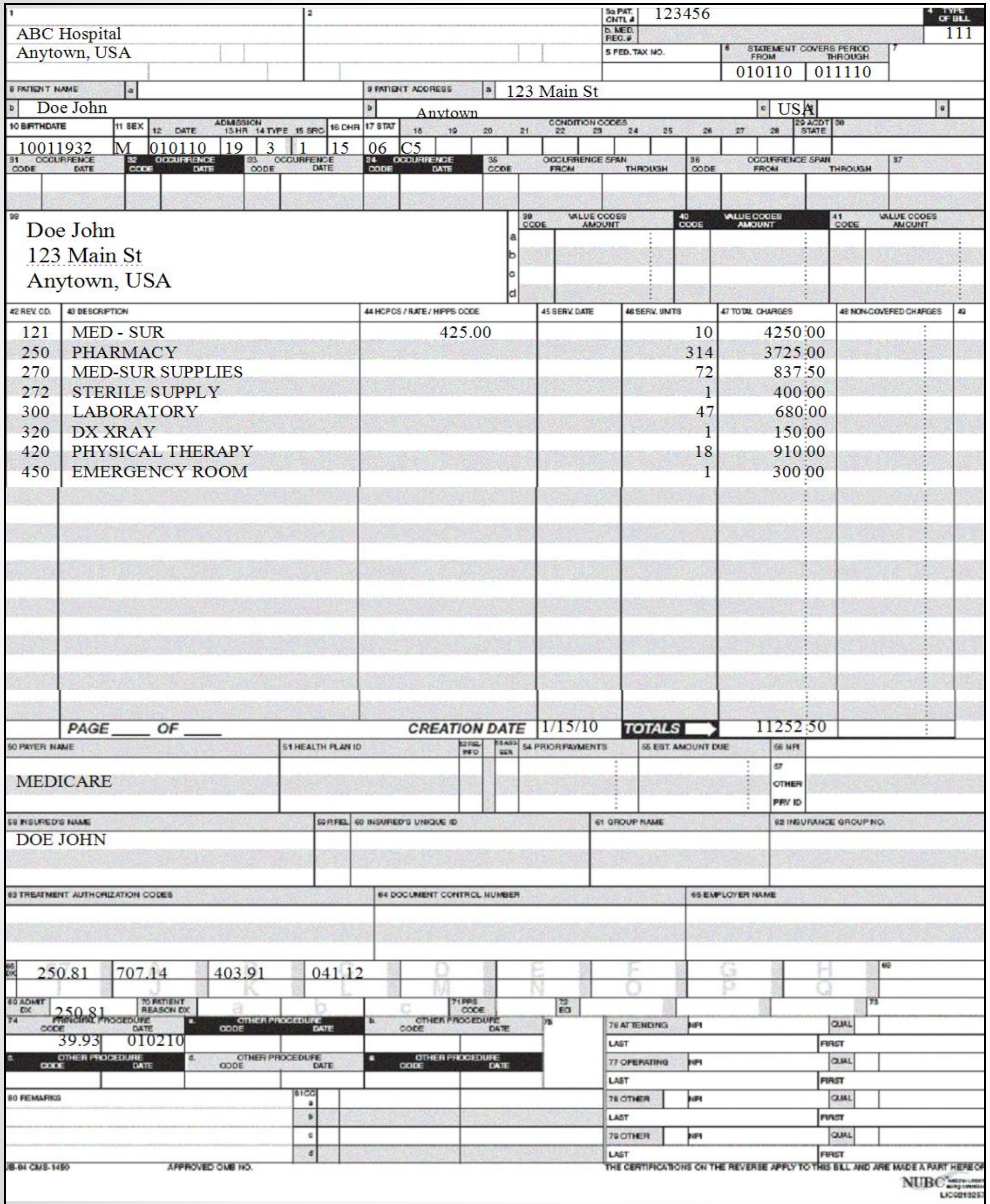
250.81 707.14 403.91 041.12

250.81

39.93 010210

Billing and the UB-04

The UB-04 is a form that most health care entities use to bill for inpatient and outpatient hospital services.



ABC Hospital
Anytown, USA

3a PAT. CNTL # 123456
b. MED. REC. #
4 TYPE OF BILL 111
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 010110 THROUGH 011110

8 PATIENT NAME Doe John
9 PATIENT ADDRESS 123 Main St
Anytown USA

10 BIRTHDATE 10011932 | 11 SEX M | ADMISSION 12 DATE 010110 | 13 HR 19 | 14 TYPE 3 | 15 SRC 1 | 16 DHR 15 | 17 STAT 06 | CONDITION CODES C5

Doe John
123 Main St
Anytown, USA

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
121	MED - SUR	425.00		10	4250 00	
250	PHARMACY			314	3725 00	
270	MED-SUR SUPPLIES			72	837 50	
272	STERILE SUPPLY			1	400 00	
300	LABORATORY			47	680 00	
320	DX XRAY			1	150 00	
420	PHYSICAL THERAPY			18	910 00	
450	EMERGENCY ROOM			1	300 00	
	PAGE ___ OF ___	CREATION DATE	1/15/10	TOTALS	11252 50	

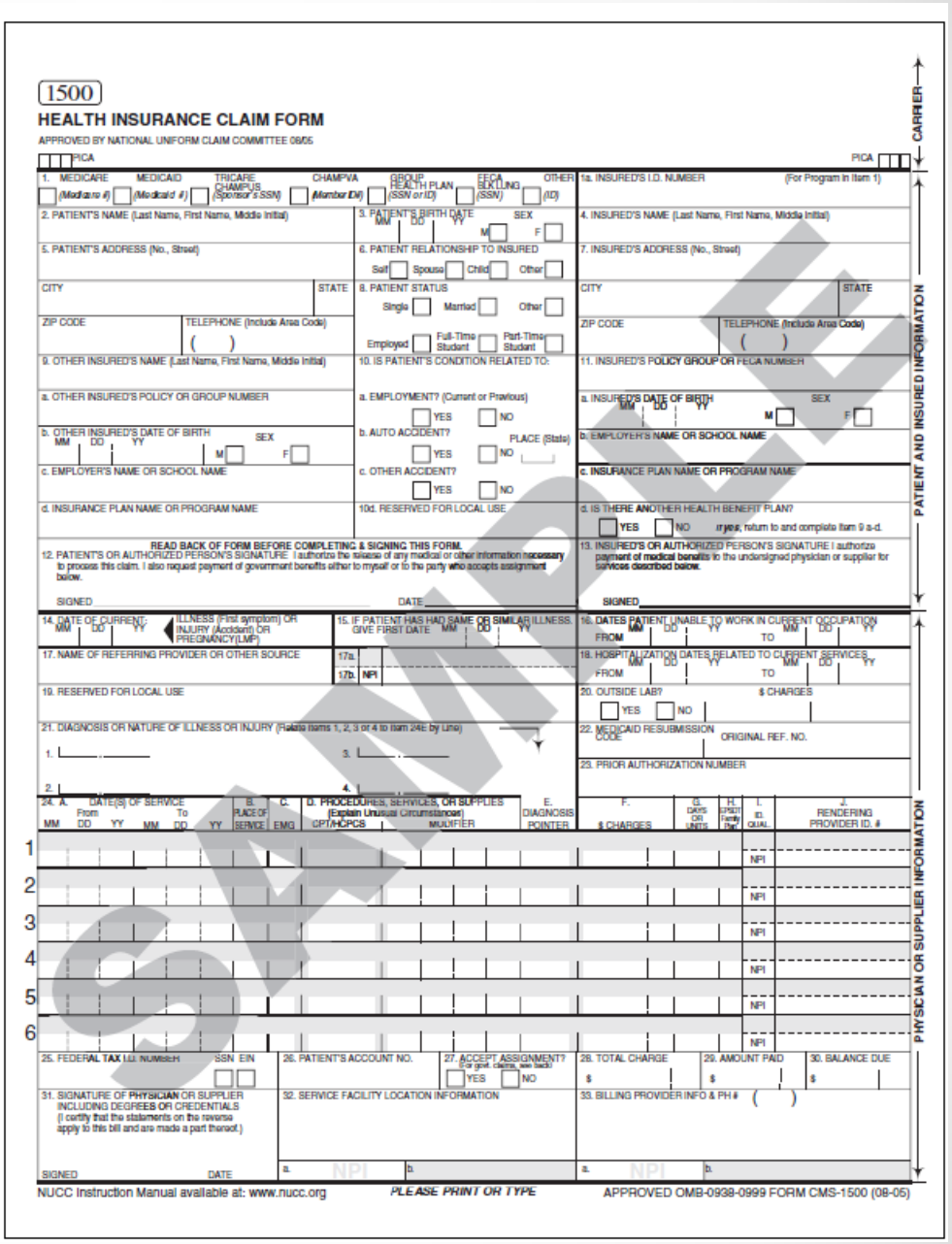
50 PAYER NAME MEDICARE
58 INSURED'S NAME DOE JOHN
63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

67 250.81 | 707.14 | 403.91 | 041.12
69 ADMIT DX 250.81
74 PRINCIPAL PROCEDURE CODE 39.93 DATE 010210
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
UB-04 CMS-1450 APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
NUBC

UB-04

Most providers use electronic media to submit claims to payers. Paper claims must contain the same data as in the electronic files.

Physician's professional services are typically not billed on a UB-04, but rather on a CMS-1500 form.



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

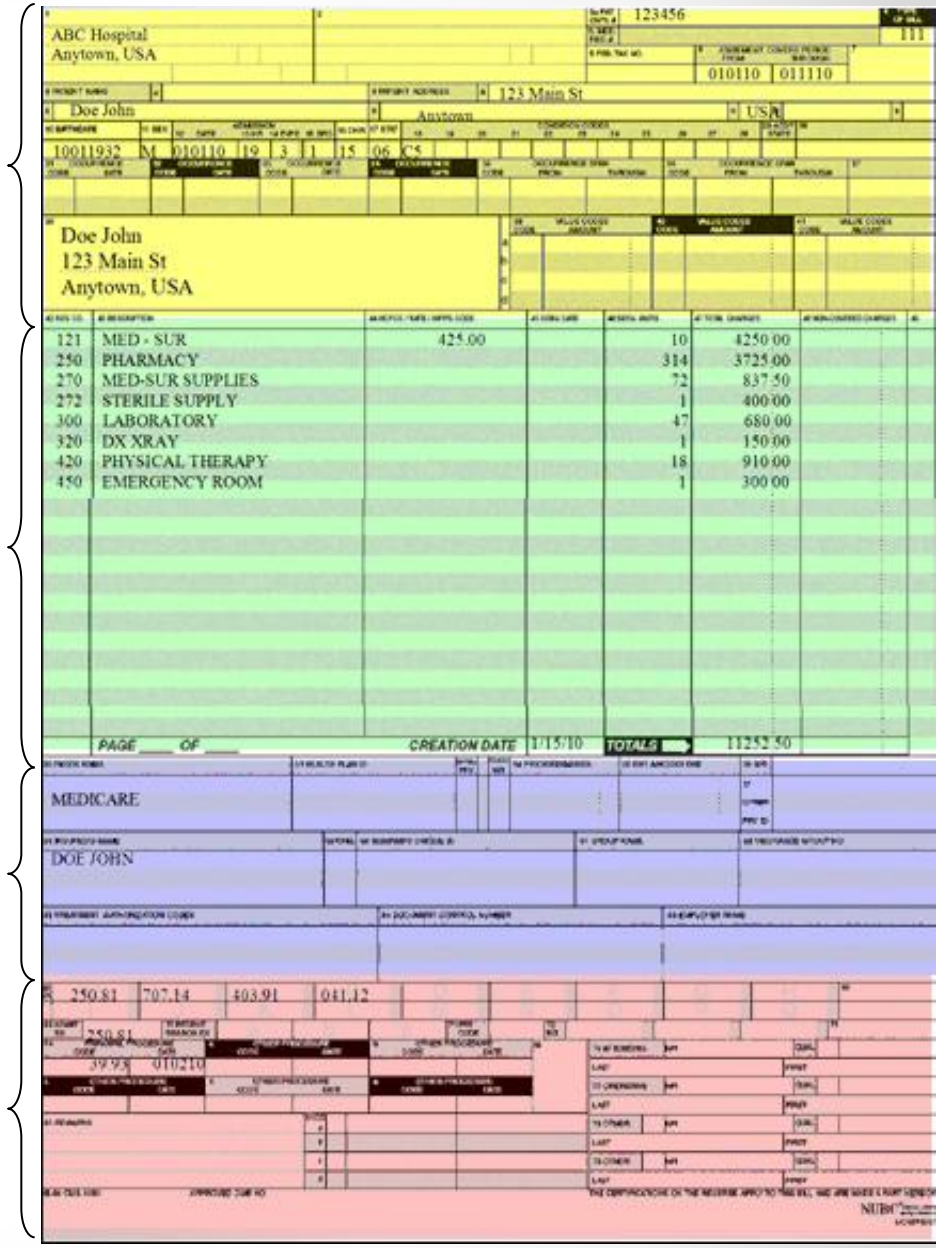
SAMPLE

However, some CAHs may use what is called "Method II" billing for physician services which allows professional fees to be billed on the UB-04.

Let's take a walk through the UB-04 to understand it further.

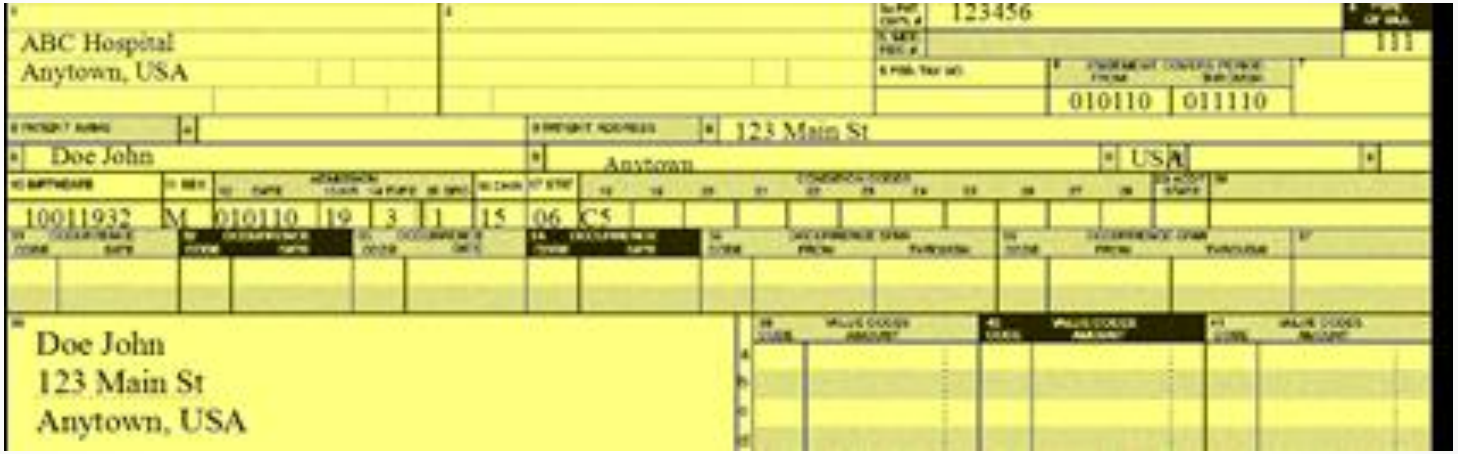
The UB Claim Form can be divided into four different sections.

Section 1 – Patient Information
Section 2 – Billing Information
Section 3 – Payer Information
Section 4 – Diagnosis/Provider Information



Section One

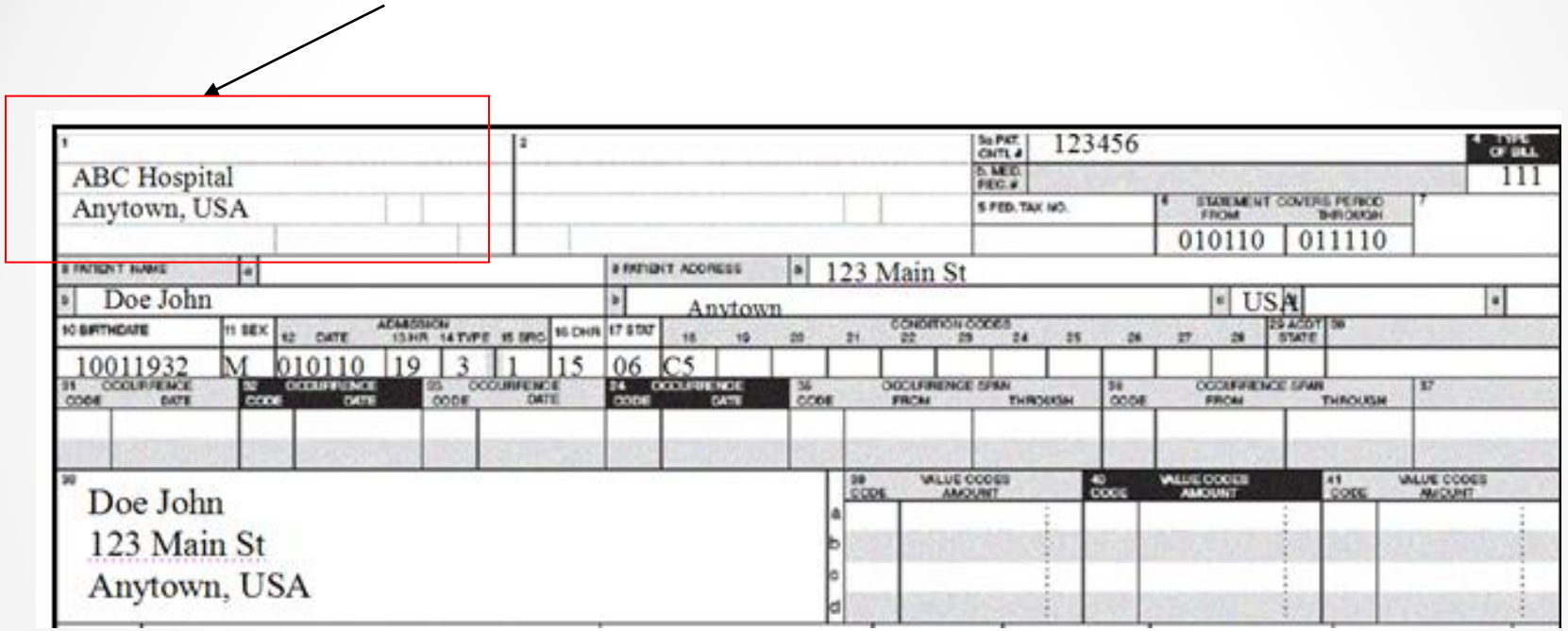
Patient Information



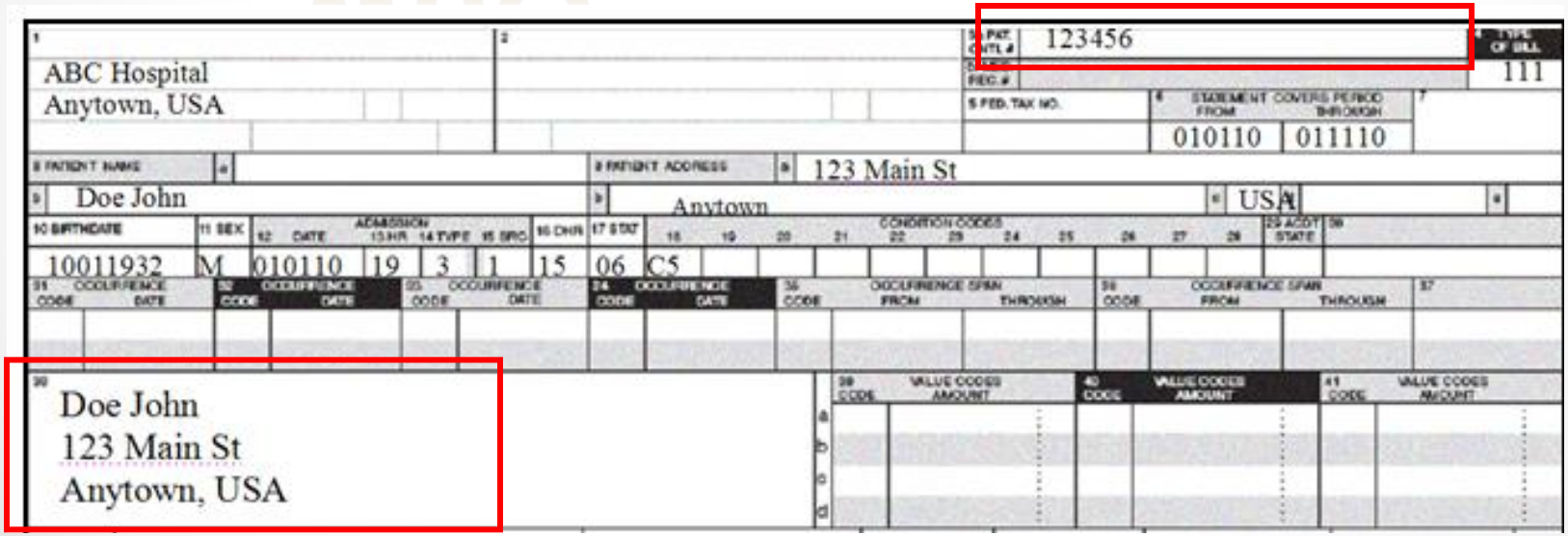
WHERE? WHO? WHEN?

All insurers need to know **WHERE** the patient was treated and where to submit payments.

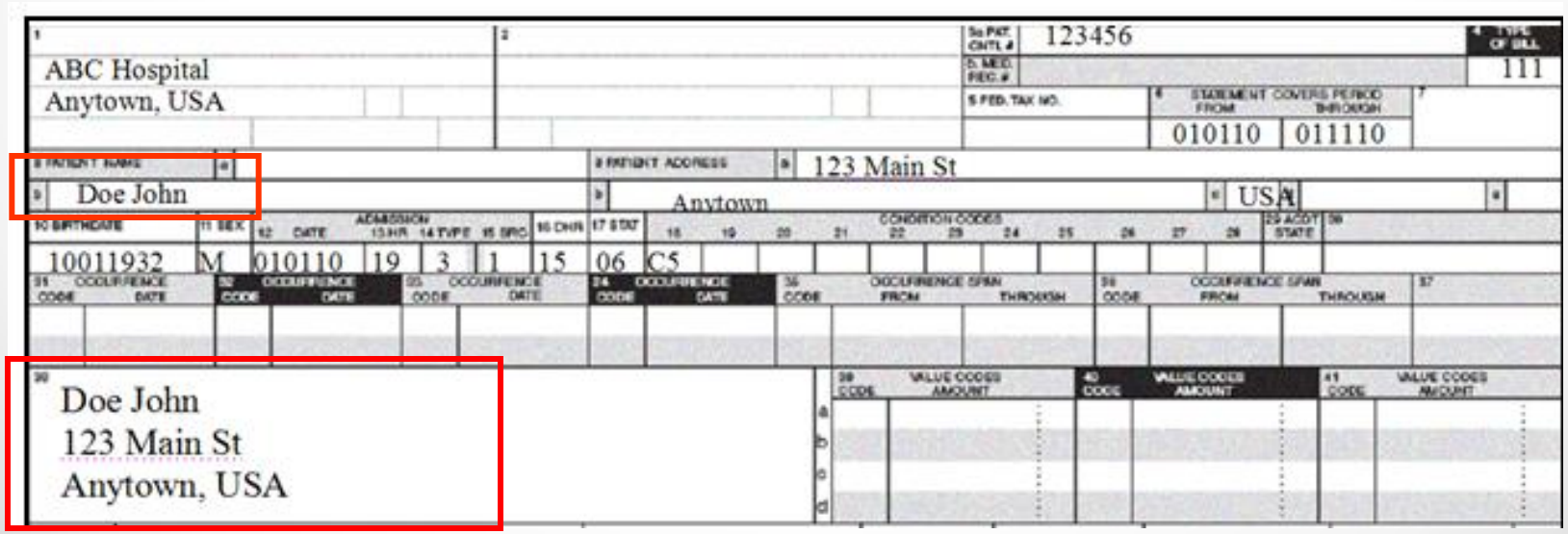
WHERE the patient was treated



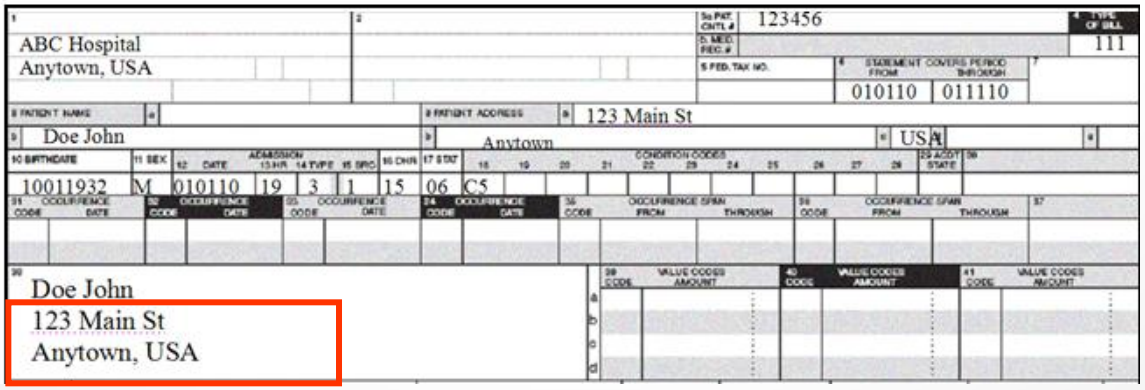
Medicare and other insurers also need to know **WHO** was treated.

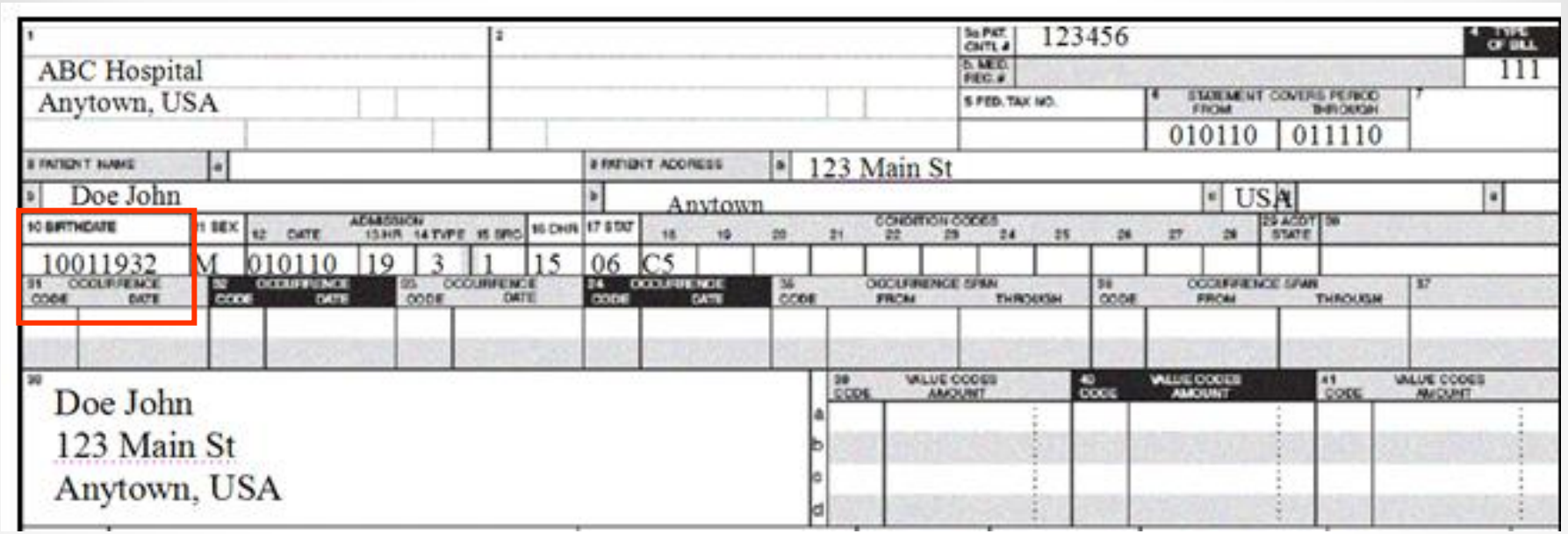


The patient's name, address, and date of birth are also required on the UB-04.



Medicare claims may be rejected if the name on the claim does not match the name on the Medicare card.



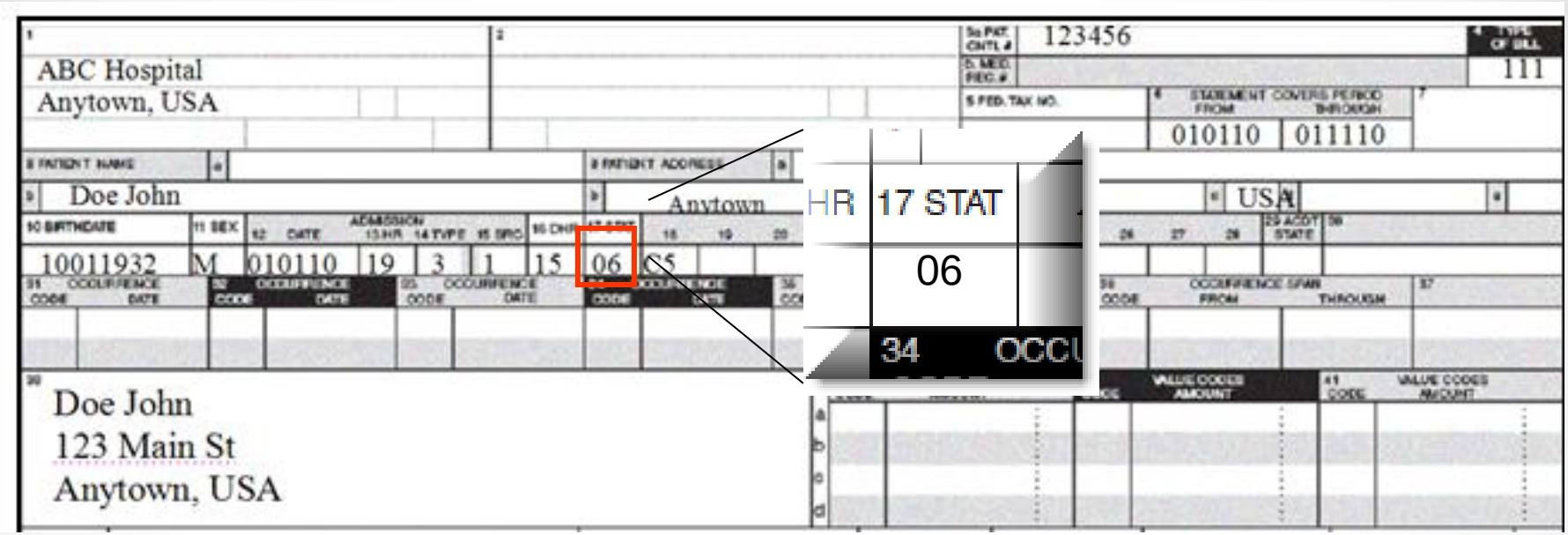


Date of birth field is important to verify insurance coverage.

A patient's age may also be used to determine if a diagnosis is correct.

You would not expect to see a obstetrical diagnosis on a 90 year old.

The insurer needs to know **WHERE** the patient went after treatment. The disposition of a patient can affect payment.



Discharge status codes are used for this information.

Examples of discharge status codes

01

Discharged to home or self-care

02

Transferred to a short-term general hospital

03

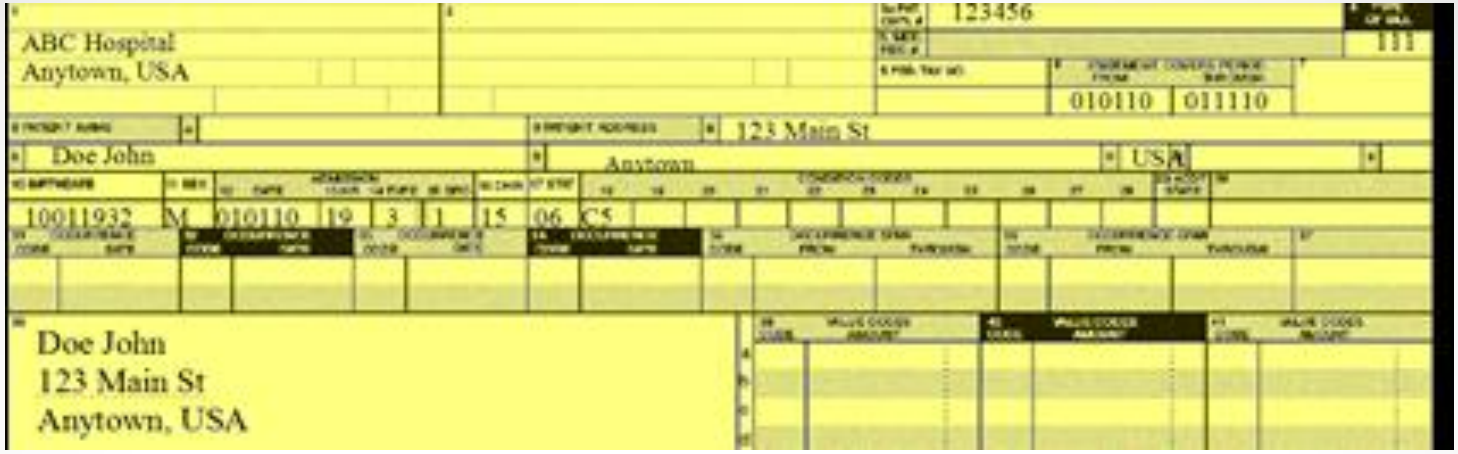
Transferred to a skilled nursing facility

06

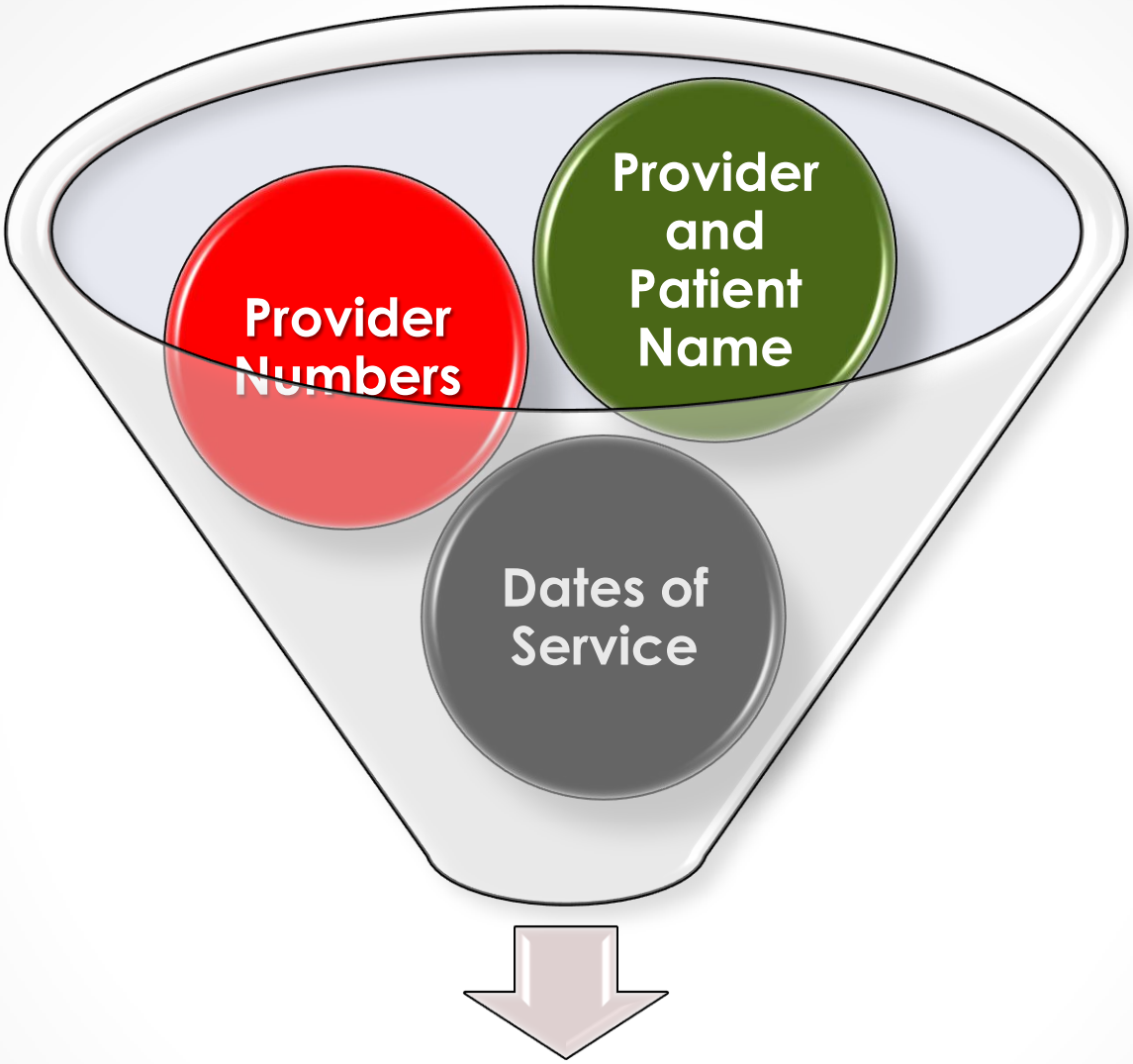
Transferred to a home health agency

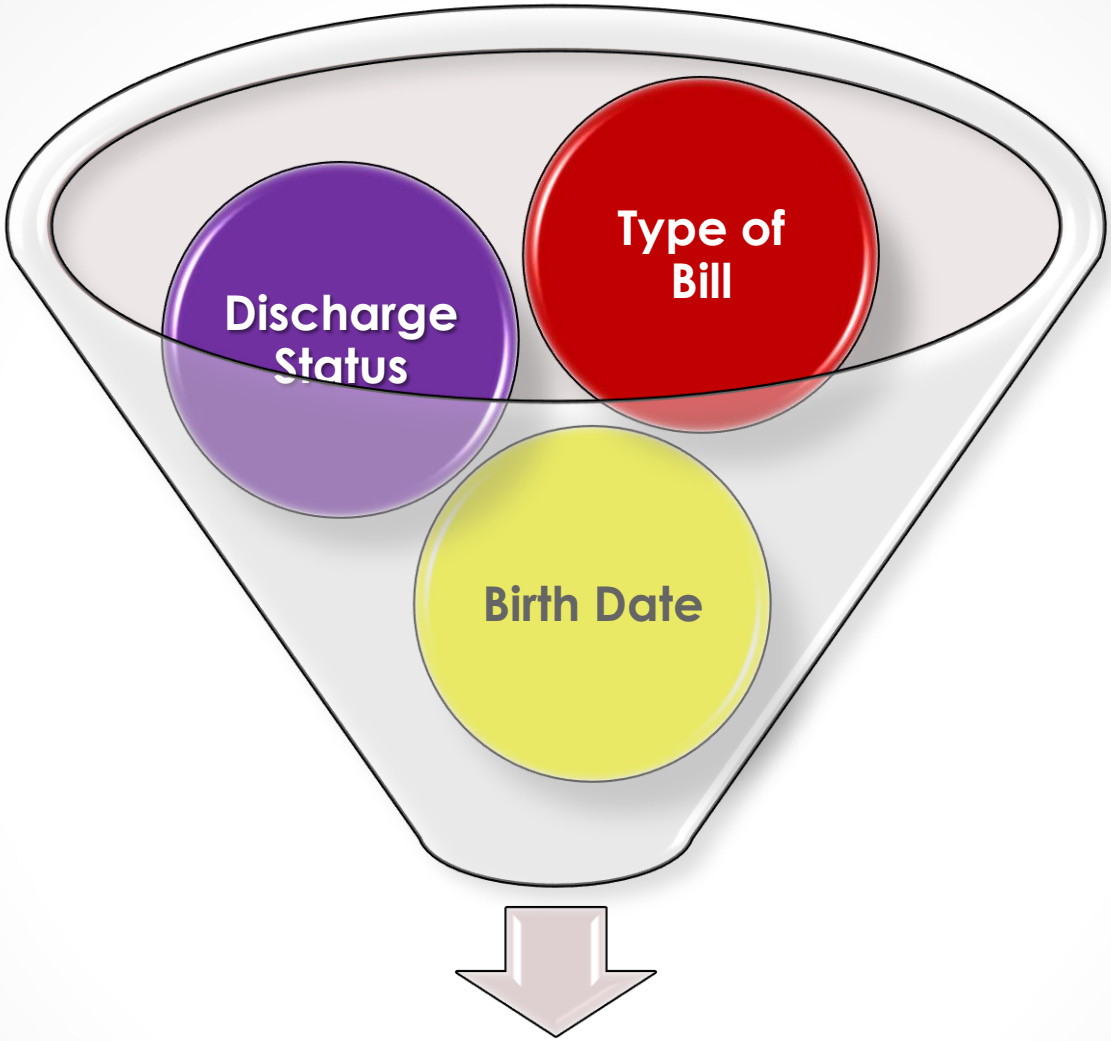
In a PPS hospital, if a patient stay is shorter than Medicare would expect for the assigned diagnosis, payment could be reduced. The reduction is dependent upon the discharge status.

In both CAH and PPS hospitals, a discharge to a nursing home status might raise scrutiny, if the patient was only in the hospital for three days.



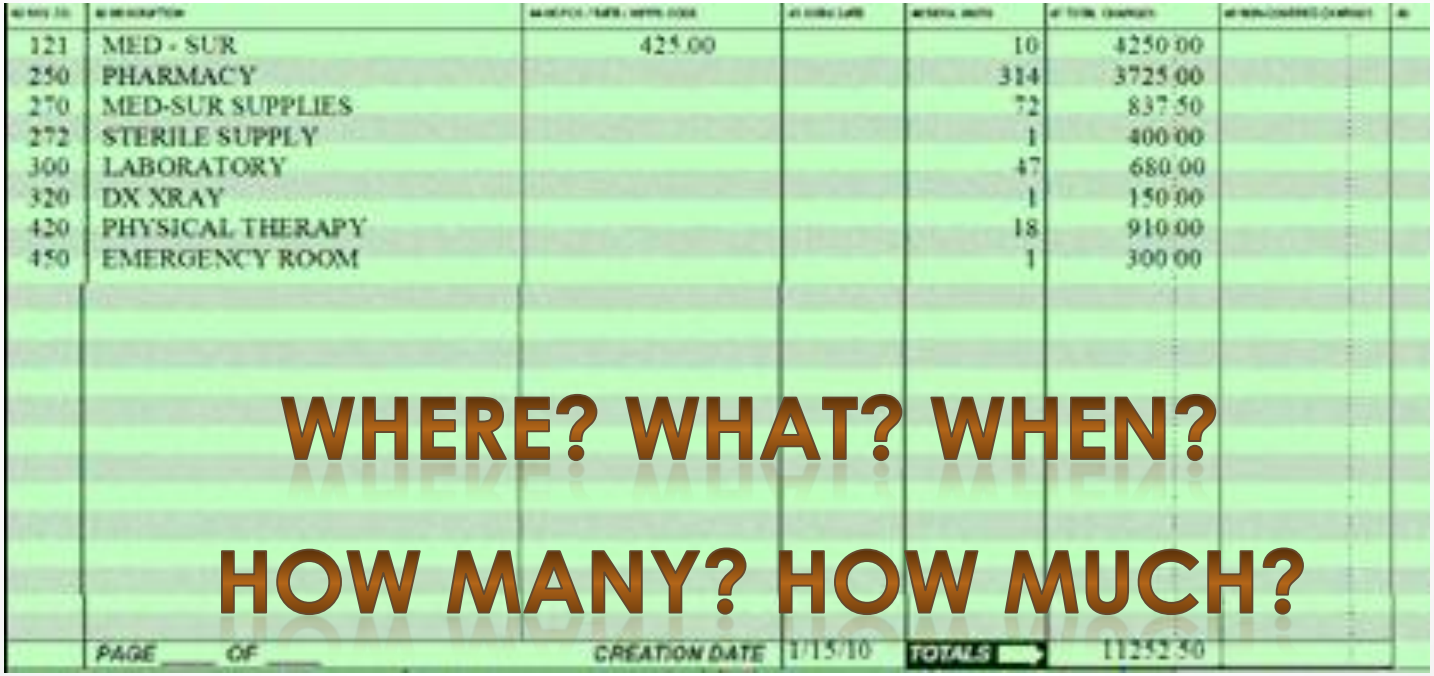
In summary, Section One is critically important in determining both patient eligibility and the amount of payment.


Provider Numbers
Provider and Patient Name
Dates of Service
Eligibility


Discharge Status
Type of Bill
Birth Date
Payment

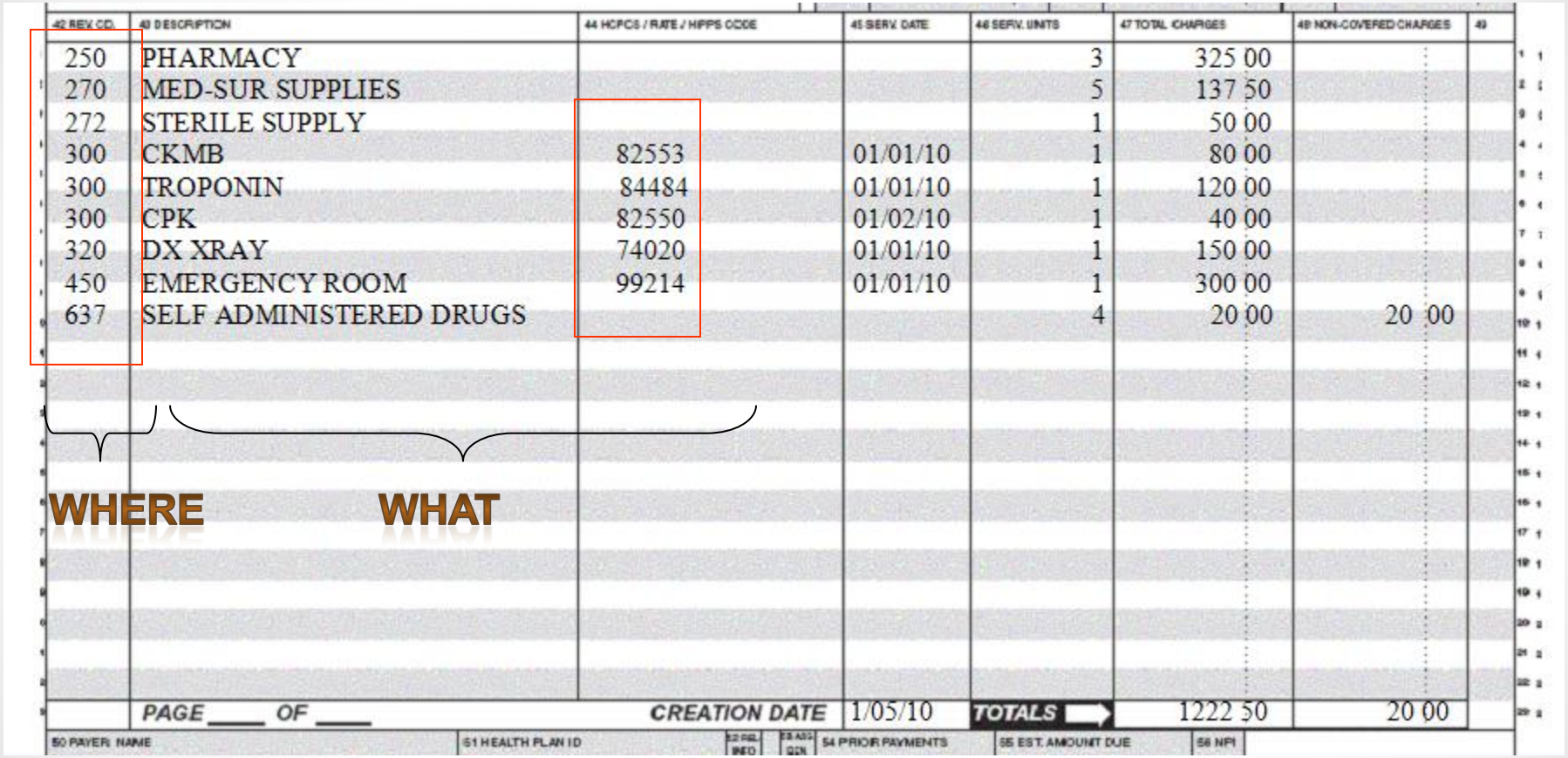
Section Two

Billing Information



Section Two includes which department provided the service, describes the services provided, and states the dollar charge for the service rendered.

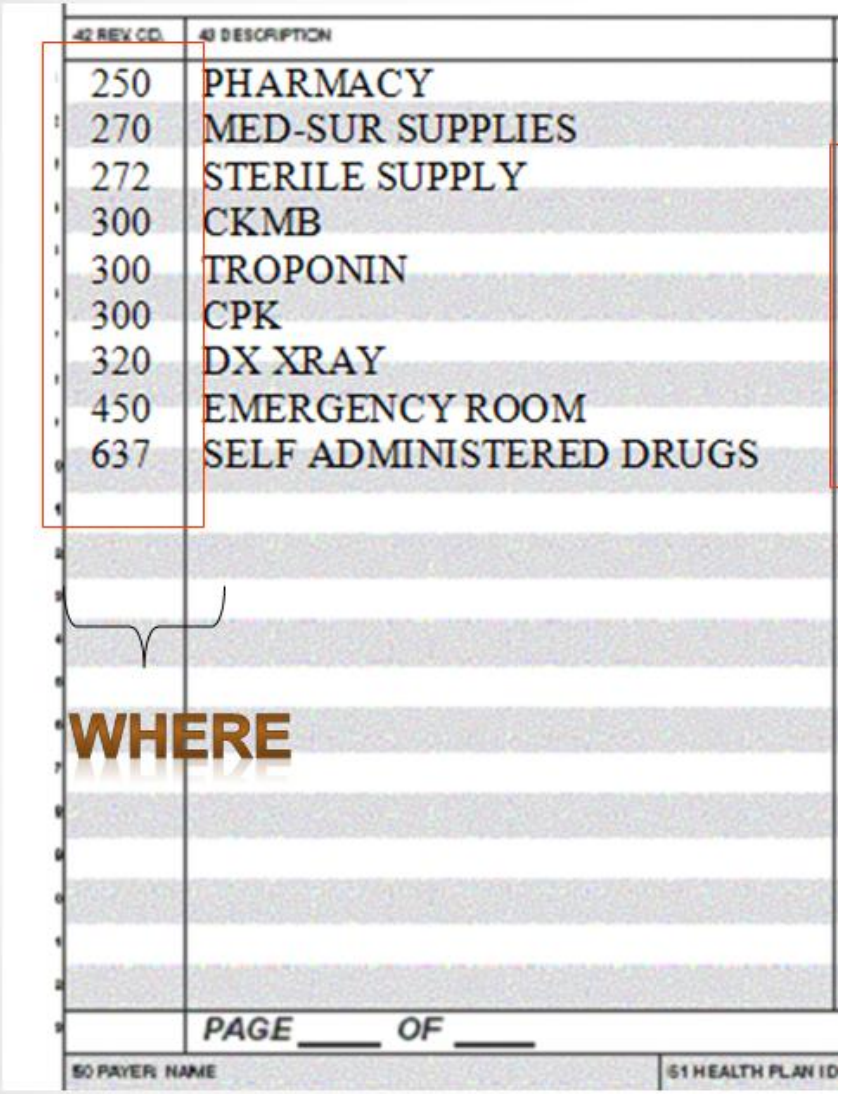
Outpatient Bill



42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
250	PHARMACY			3	325 00		
270	MED-SUR SUPPLIES			5	137 50		
272	STERILE SUPPLY			1	50 00		
300	CKMB	82553	01/01/10	1	80 00		
300	TROPONIN	84484	01/01/10	1	120 00		
300	CPK	82550	01/02/10	1	40 00		
320	DX XRAY	74020	01/01/10	1	150 00		
450	EMERGENCY ROOM	99214	01/01/10	1	300 00		
637	SELF ADMINISTERED DRUGS			4	20 00	20 00	
	PAGE ____ OF ____		CREATION DATE	1/05/10	TOTALS	1222 50	20 00

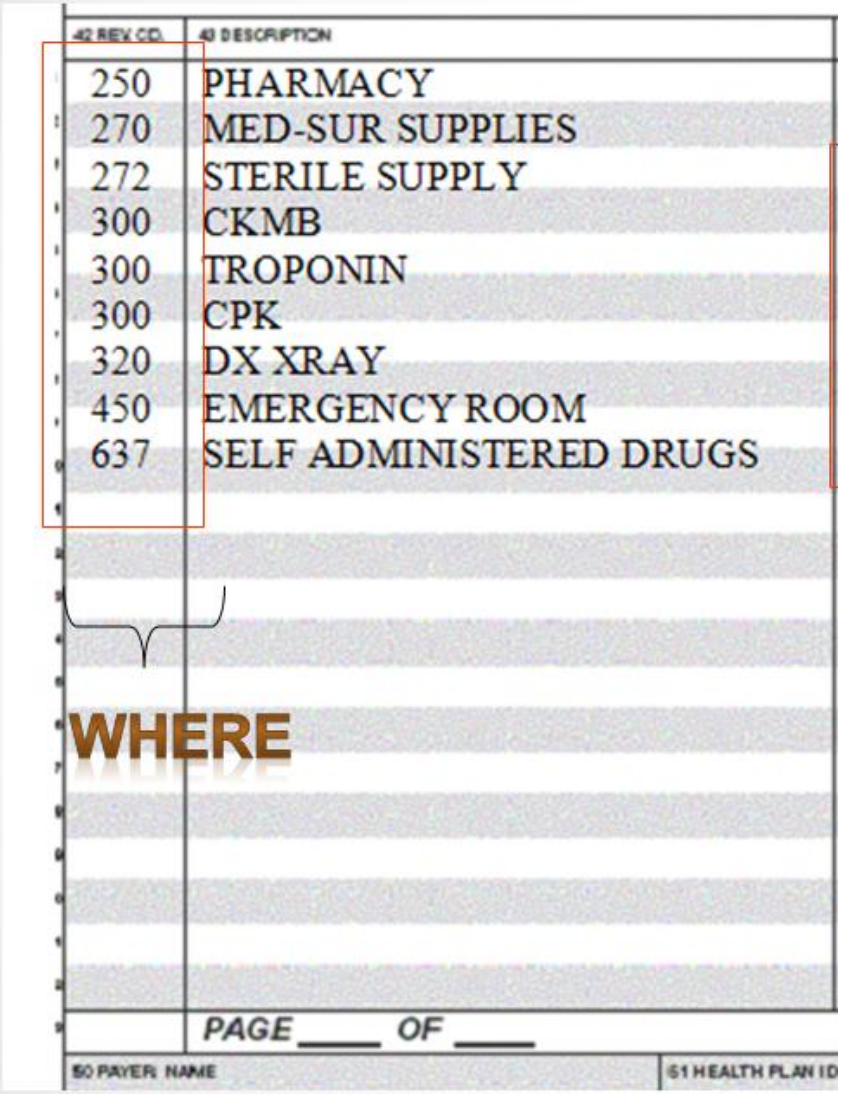
WHERE WHAT

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST AMOUNT DUE | 56 NPI



CAH revenue codes impact hospital final payments.

Revenue codes do not impact final payments in PPS.



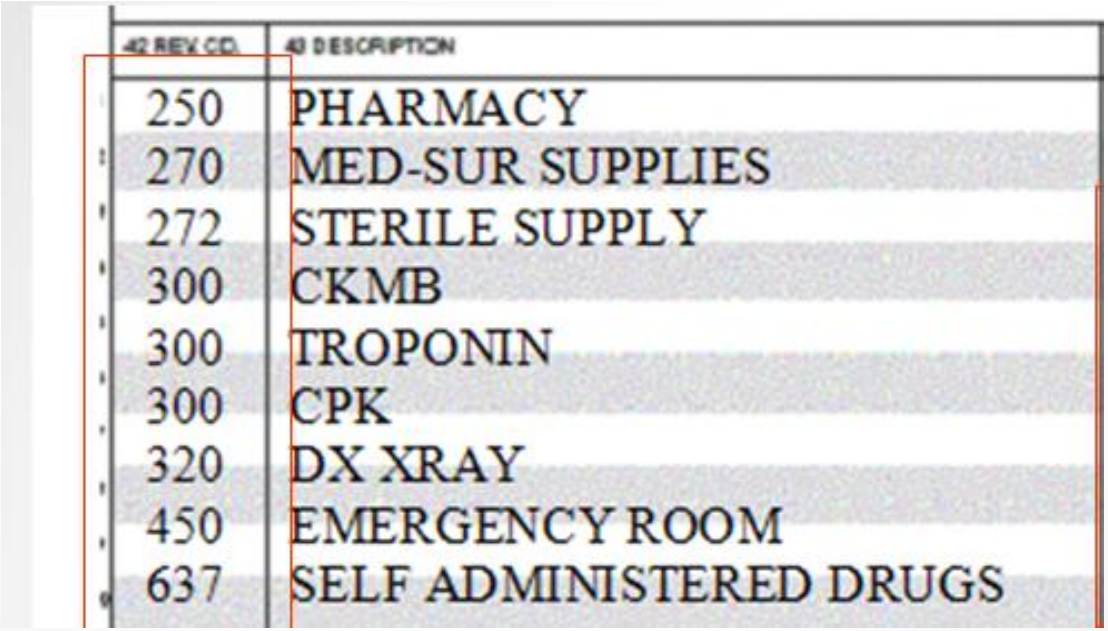
Revenue codes are three digit codes listed in ascending order on the UB claim form.

Applies to both CAH and PPS.

Revenue codes tell a payer **WHERE** or in what department a services was provided to a patient.

Revenue codes are required for Medicare billing in both CAH and PPS hospitals, and are uniformly used by all payers.

Each line item reported on a claim MUST have a revenue code assigned.



42 REV CD.	43 DESCRIPTION
250	PHARMACY
270	MED-SUR SUPPLIES
272	STERILE SUPPLY
300	CKMB
300	TROPONIN
300	CPK
320	DX XRAY
450	EMERGENCY ROOM
637	SELF ADMINISTERED DRUGS

Certain revenue codes indicate that payment should not be made.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
250	PHARMACY			3	325 00	
450	EMERGENCY ROOM	99214	01/01/10	1	300 00	
637	SELF ADMINISTERED DRUGS			4	20 00	20 00

637 – Self-administered drugs are non-covered by Medicare

Revenue codes are usually "hard-coded" in the hospital charge master and are automatically assigned when a charge is entered.

Examples of Revenue Codes

250 – Drugs

270 – Supplies

300 – Laboratory

360 – Operating Room

450 – Emergency Room

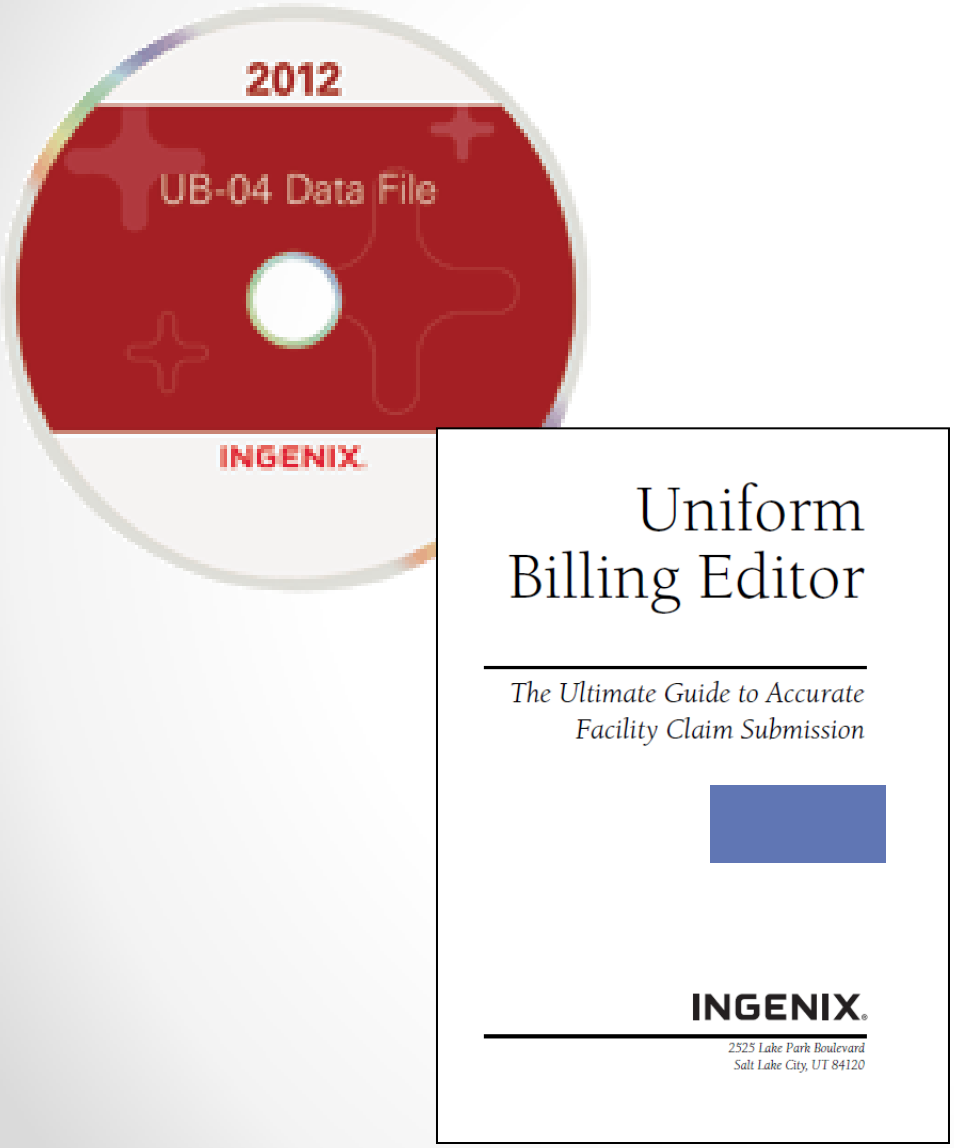
CMS uses a revenue codes to determine the cost of services in both CAH and PPS hospitals.

In a PPS hospital, inaccurate revenue codes may negatively impact future DRG and APC payment rates.

In a CAH, current hospital reimbursement will be directly impacted by the revenue code reporting.

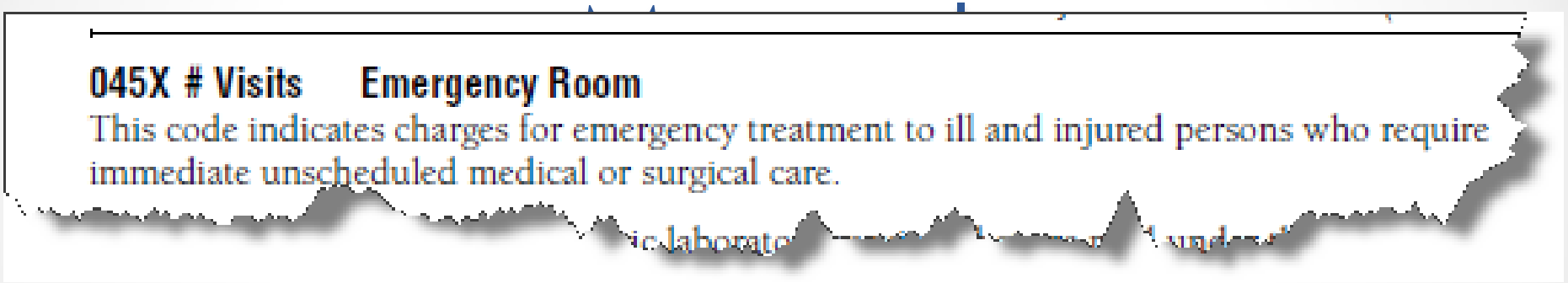
In either case, it is extremely important to ensure that all hospital systems are working properly to assign the appropriate revenue code to the claim form.

Revenue code Resources



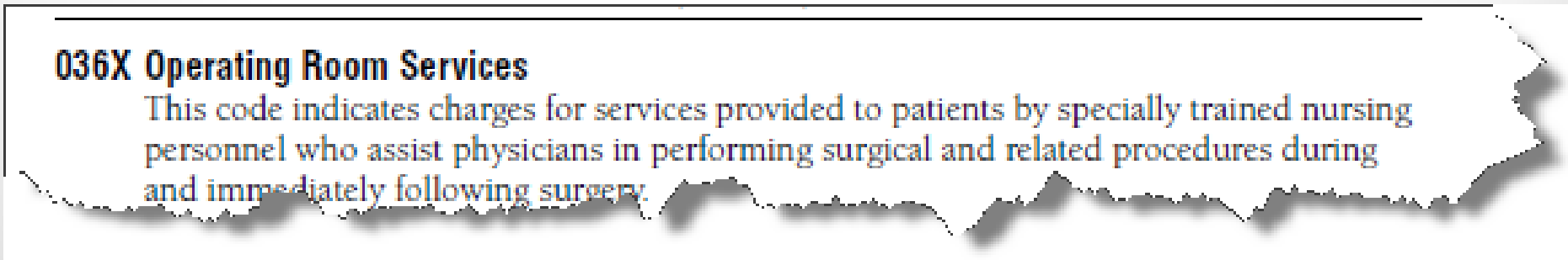
- UB-04 Editor published by Ingenix
- MACs/FIs
- Various other web-sites

Revenue codes are listed in the Uniform Billing Editor



045X # Visits Emergency Room

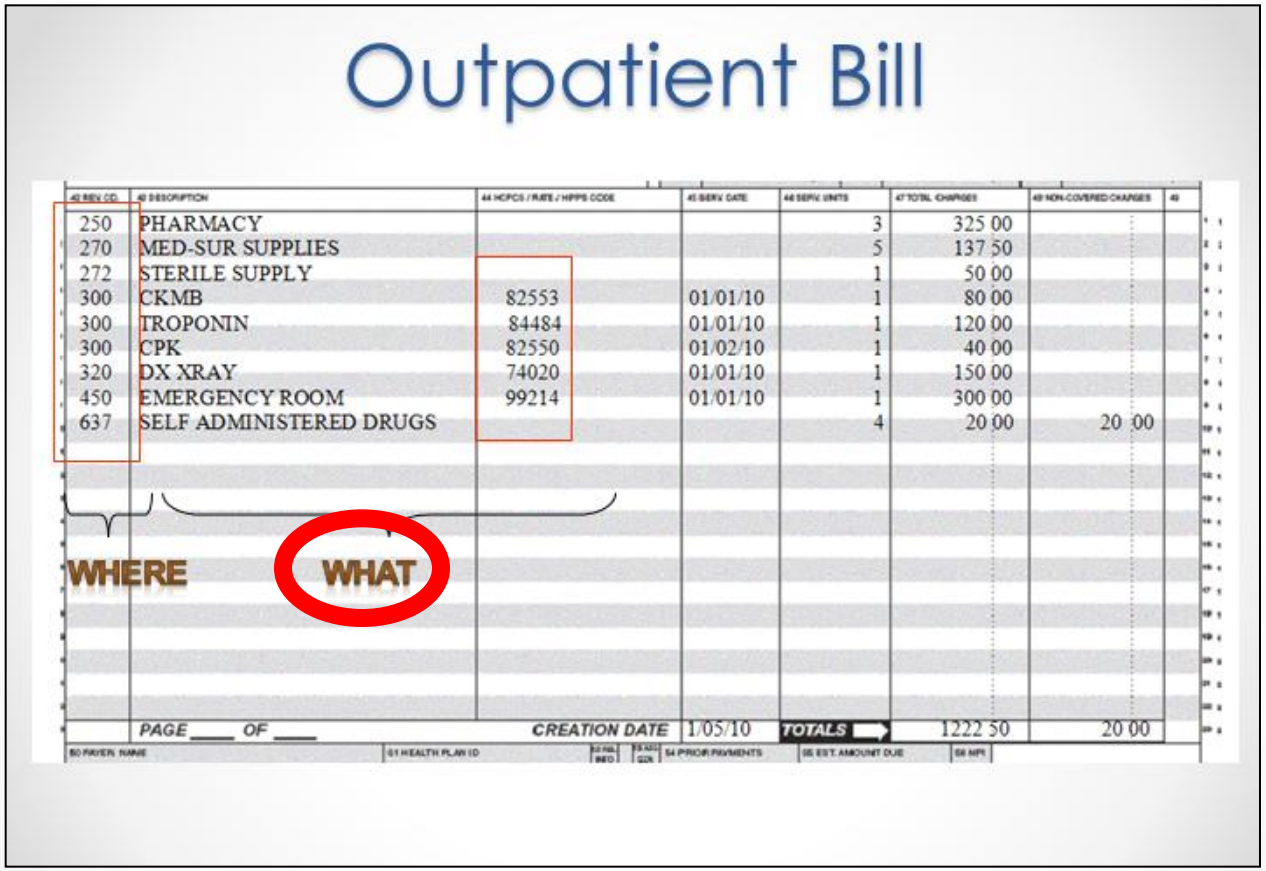
This code indicates charges for emergency treatment to ill and injured persons who require immediate unscheduled medical or surgical care.



036X Operating Room Services

This code indicates charges for services provided to patients by specially trained nursing personnel who assist physicians in performing surgical and related procedures during and immediately following surgery.

CPT/HCPCS Codes



Current **P**rocedural **T**echnology

CPT codes are numbers assigned to specific services or procedures a medical practitioner (and hospitals) may provide to a patient.

PPS hospitals are paid for Medicare outpatient services under a fee system called APCs (ambulatory payment classification).

CPT/HCPCS codes drive outpatient APC reimbursement.

If no CPT/HCPCS codes are reported, there is no separate payment to the PPS hospital for the UB line item.

SAMPLE E/M CODE MAPPING LOGIC FOR ED VISITS

EMERGENCY DEPARTMENT ACUITY/CHARGE SHEET

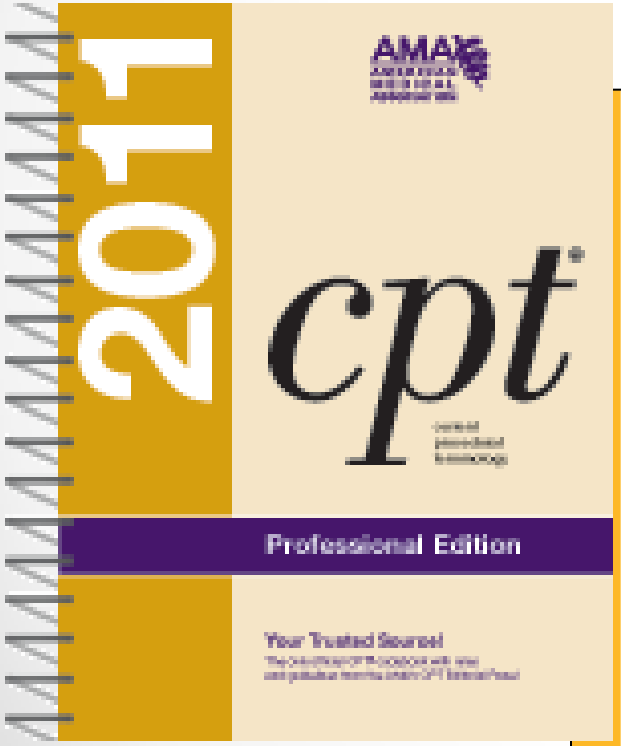
ASSESSMENTS

_____5	Initial Assessment	_____10	Continued care per 3 hours
_____20	Assessing simple: VS, and/or assess, up to 1st 3 hours	_____5	Visual acuity/neuro assess/fht/trauma assess, recheck
_____35	Assess intermediate: VS 4 or more and/or cardiac monitoring 1st 3 hours	_____10	Suture check /removal only
_____50	Assess emergent/unstable: 1st 3 hours (includes cardiac monitoring)	_____10	Special needs: orthostatics, finger stick sugars, urine dip, etc (10 pts max)
_____300	**Critical care: post code arrest, cardiogenic shock major trauma, unstable surgical emergency, nursing 1:1 (this is the charge for the patient (30-74 minutes)**		

	Addendum B.-OPPS Payment by			
HCPCS Code	Short Descriptor	SI	APC	Payment Rate
99281	Emergency dept visit	V	0609	$51.77
99282	Emergency dept visit	V	0613	$87.25
99283	Emergency dept visit	V	0614	$139.14
99284	Emergency dept visit	Q3	0615	$222.58
99285	Emergency dept visit	Q3	0616	$329.54

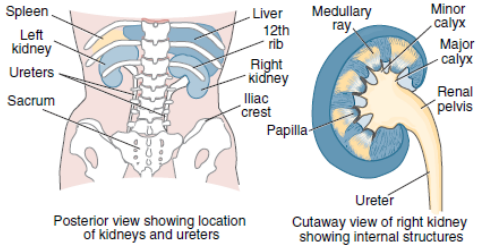
CAHs should also report CPT/HCPCS codes for services paid under a fee schedule. Although Medicare may not pay using CPT codes, other payers may.

CPT codes are published annually by the American Medical Association.



50010-50045 Kidney Procedures for Exploration or Drainage

EXCLUDES *Retroperitoneal*
Abscess drainage (49060)
Exploration (49010)
Tumor/cyst excision (49203-49205)



Posterior view showing location of kidneys and ureters

Cutaway view of right kidney showing internal structures

The kidneys remove waste products of protein metabolism and other excess materials and fluids from the blood. Variations in kidney anatomy are fairly common, though abnormalities can complicate procedures. "Pyelo" refers to the renal pelvis, an important access site to the inner kidney. Each kidney is imbedded in a mass of peritoneal fat that helps to enclose and position it

50010 **Renal exploration, not necessitating other specific procedures** C 80

EXCLUDES *Laparoscopic ablation of mass lesions of kidney (50542)*

22.01 22.01 Global Days 090

50080 **Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm** 62 T 50

EXCLUDES *Nephrostomy without nephrostolithotomy (50040, 50395, 52334)*

28.50 28.50 Global Days 090

AMA: 2009, Jun, 10-11

50081 **over 2 cm** 62 T 80 50

EXCLUDES *Nephrostomy without nephrostolithotomy (50040, 50395, 52334)*

76000, 76001

39.00 39.00 Global Days 090

AMA: 2009, Jun, 10-11

50100 Repair of Anomalous Vessels of the Kidney

EXCLUDES *Retroperitoneal:*
Abscess drainage (49060)
Exploration (49010)
Tumor/cyst excision (49203-49205)

50100 **Transection or repositioning of aberrant renal vessels (separate procedure)** C 80

29.52 29.52 Global Days 090

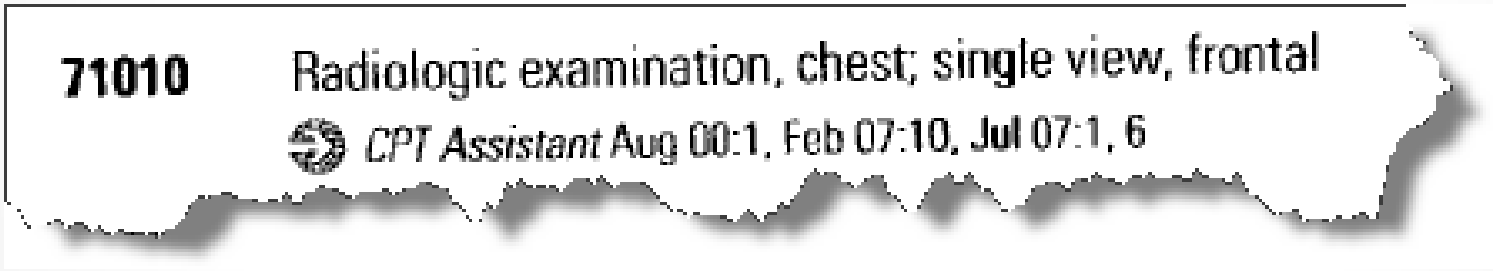
50120-50135 Procedures of Renal Pelvis

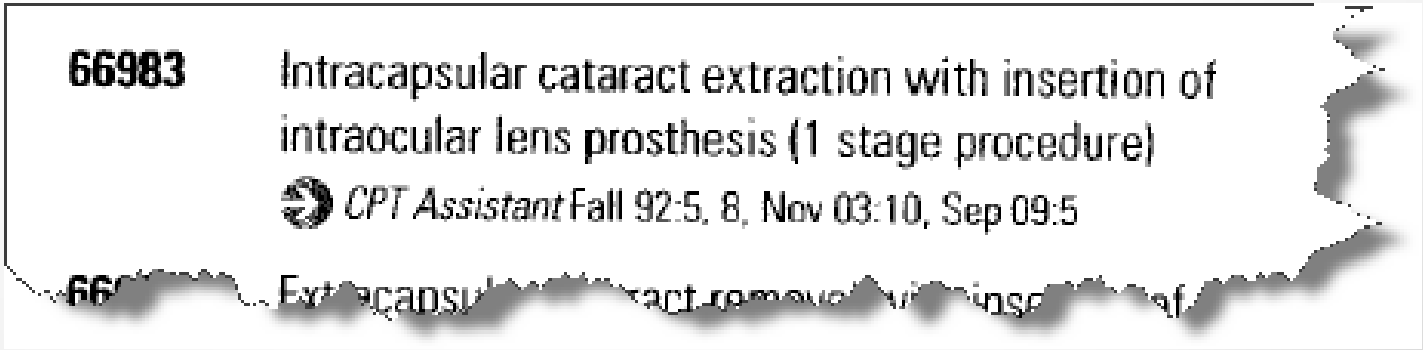
EXCLUDES *Retroperitoneal:*
Abscess drainage (49060)
Exploration (49010)
Tumor/cyst excision (49203-49205)

50120 **Pyelotomy; with exploration** C 80 50

INCLUDES Gol-Vernet pyelotomy

Since providers use the same codes to mean the same thing, they ensure uniformity.





Although all services billed on a UB-04 require revenue codes, CPT/HCPCS codes are NOT required for all line items on the UB.

For example, most supply items used in a hospital do not have a CPT code assigned. Typically CPT codes are used to describe procedures or visits.

Healthcare Common Procedure Coding System (HCPCS)

HCPCS Level II codes are a set of standardized alphanumeric codes that describe health care equipment and supplies that are not identified by CPT codes.

Ambulance services
Drugs

Durable Medical Equipment
Prosthetics
Orthotics
(DMEPOS)

Since there are fixed payments assigned to some HCPCS codes, PPS hospitals should assign these codes, when available.

	Addendum B.-OPPS Payment by			
HCPCS Code	Short Descriptor	SI	APC	Payment Rate
G0008	Admin influenza virus vac	S	0350	$26.35
G0009	Admin pneumococcal vaccine	S	0350	$26.35
G0010	Admin hepatitis b vaccine	S	0436	$26.35

HCPCS "J" codes related to drugs should be assigned by both OPPS and CAH hospitals.

J1756	Iron sucrose injection
J1786	Imuglucerase injection
J1790	Droperidol injection
J1800	Propranolol injection
J1810	Droperidol/fentanyl inj
J1815	Insulin injection
J1817	Insulin for insulin pump use
J1826	Interferon Beta-1A inj
J1830	Interferon beta-1b / .25 MG

NCCI - National Correct Coding Initiative

NCCI edits were developed to control improper coding that leads to inappropriate payment in outpatient claims (unbundling).

Unbundling refers to "fragmenting of services" and reporting them with separate codes.

One code may accurately report the entire procedure; however, the component codes are reported separately.

Comprehensive / component edits apply to code combinations where one of the codes is a component of a more comprehensive code.

Sigmoidoscopy and colonoscopy

The comprehensive / component edit allows payment for the comprehensive code only.

Mutually exclusive code edits apply to codes representing services that cannot reasonably be **done** in the same session.

77012 – CT guidance for needle placement
77021 – MRI guidance for needle placement

CPT coded claims information is maintained in governmental data bases and is used to track hospital activity.

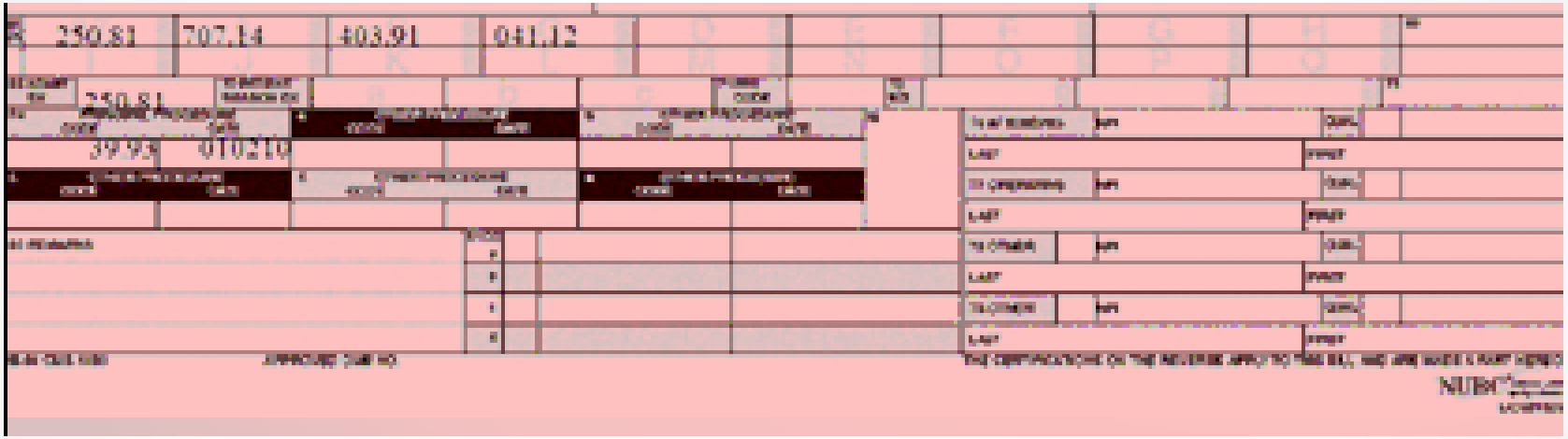
Abnormal coding results in governmental audits. Therefore it is important to ensure that the correct code is assigned.

Section Three

Payer information

WHO will pay?

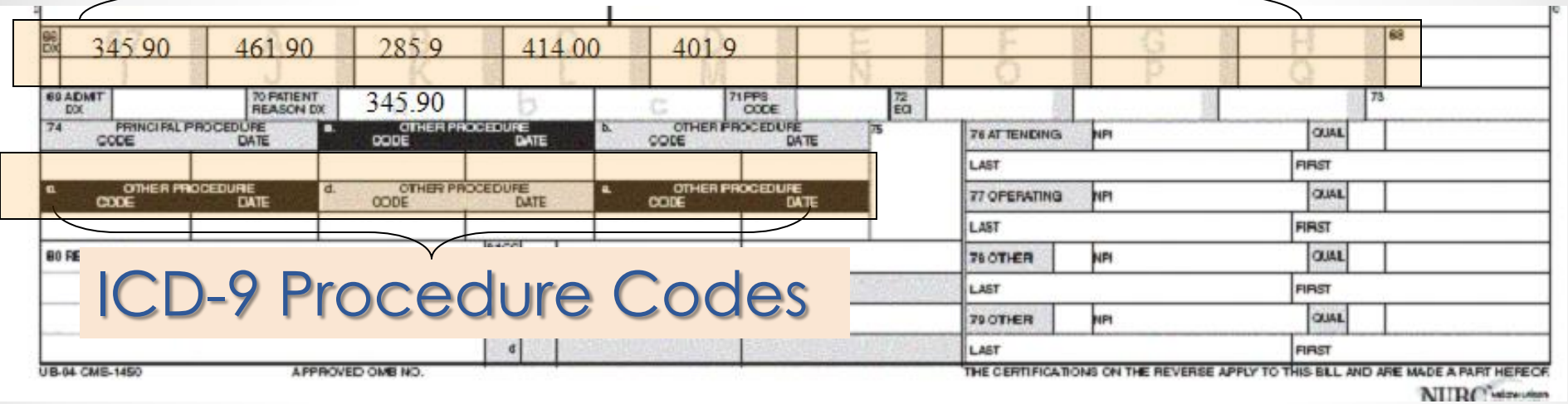
Section Four



Diagnoses/Provider Information

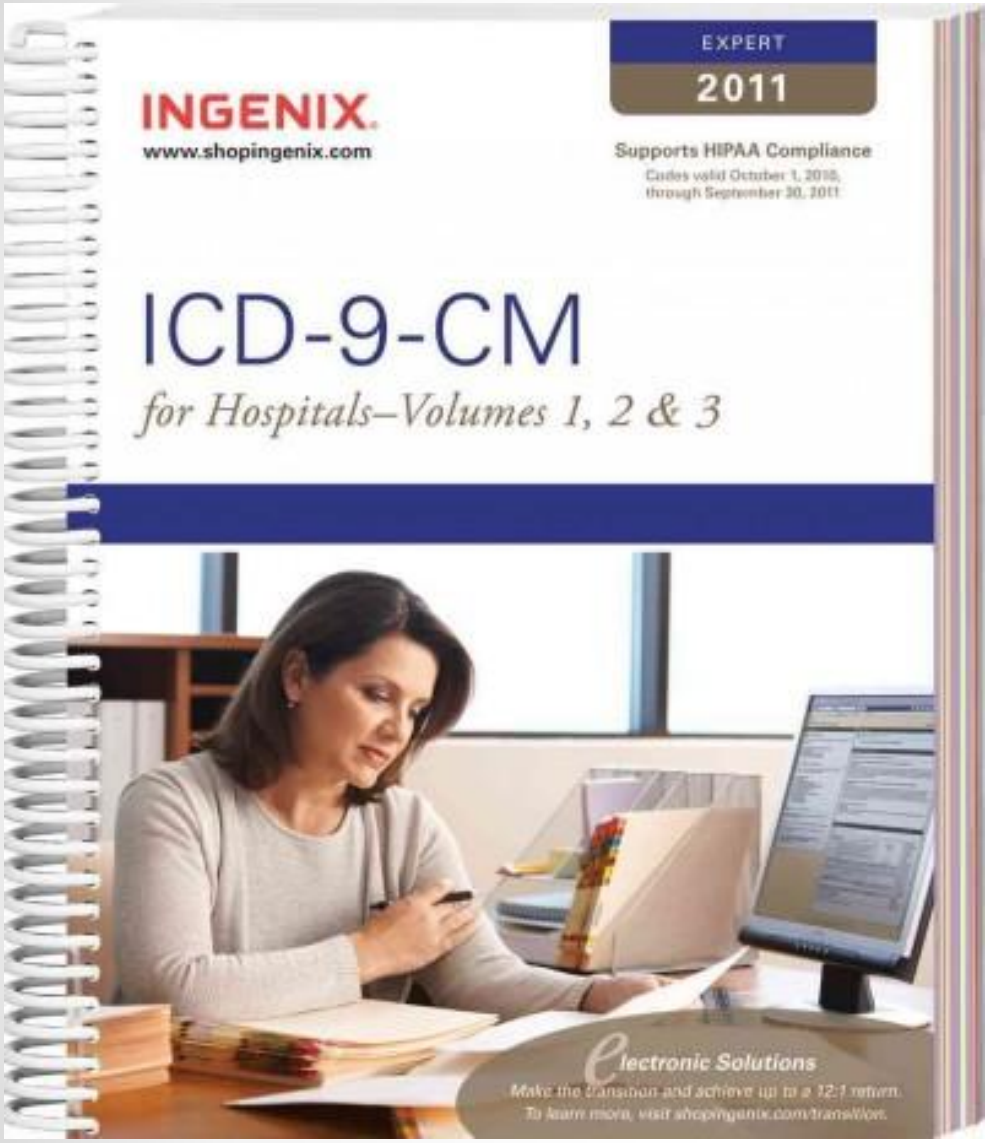
WHY?

ICD-9 Diagnosis Codes



ICD-9 Procedure Codes

ICD-9 is the abbreviation for International Statistical Classification of Diseases.



ICD codes are alphanumeric designations given to every diagnosis, description of symptoms and cause of death attributed to humans.

ICD codes are used by government health authorities to track certain diseases and causes of death. These codes are used internationally.

Examples of ICD-9 codes

7. Diseases of the Circulatory System (390-459)

✓4th **422 Acute myocarditis**

EXCLUDES *acute rheumatic myocarditis (391.2)*

DEF: Acute inflammation of the muscular walls of the heart (myocardium).

422.0 Acute myocarditis in diseases classified elsewhere MCC

Code first underlying disease, as:
myocarditis (acute):
influenzal (487.8)
tuberculous (017.9)

EXCLUDES *myocarditis (acute) (due to):*
aseptic, of newborn (074.23)
Coxsackie (virus) (074.23)
diphtheritic (032.82)
meningococcal infection (036.43)
syphilitic (093.82)
toxoplasmosis (130.3)

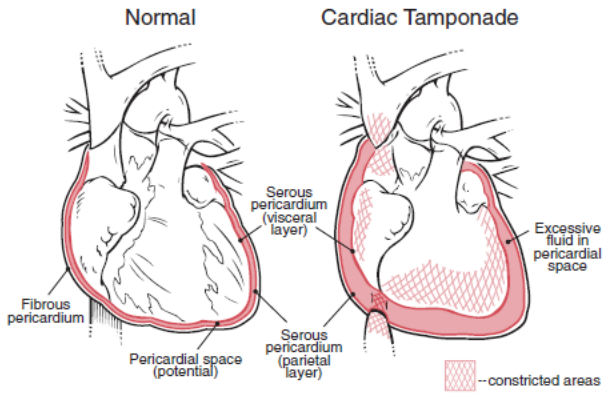
CC Excl: 391.2, 398.0, 422.0-422.99, 429.0, 429.71-429.79, 459.89-459.9

✓5th **422.9 Other and unspecified acute myocarditis**

422.90 Acute myocarditis, unspecified MCC HIV
Acute or subacute (interstitial) myocarditis
CC Excl: See code: 422.0

422.91 Idiopathic myocarditis MCC HIV

Cardiac Tamponade



423.3 Cardiac tamponade CC
Code first the underlying cause

DEF: Life-threatening condition in which fluid or blood accumulates between the muscle of the heart (myocardium) and the outer sac (pericardium), resulting in compression of the heart, which decreases cardiac output.

CC Excl: 074.21, 093.81, 391.0, 393, 420.0-420.99, 423.3-423.9, 459.89-459.9

AHA: 4Q, '07, 86, 87

ICD codes are also used to determine if inpatient and outpatient services were medically necessary.

ICD codes are also used in determining hospital DRG payments (Medicare and sometimes, Medicaid).

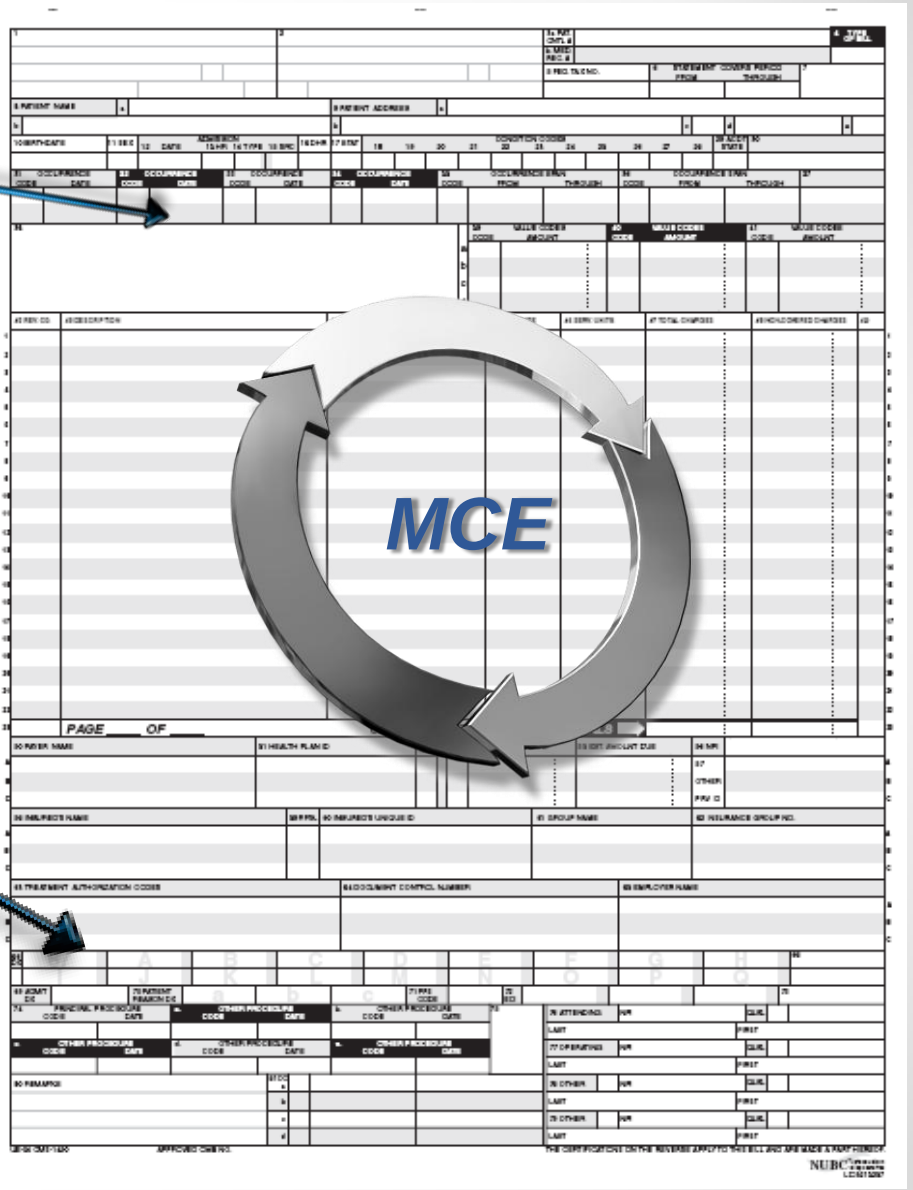
DRG is the abbreviation for Diagnosis Related Group. Let's discuss how diagnoses and DRGs interact.

It all starts with the UB-04. There are many elements on the claim form, but four in particular that determine the DRG payment.

Age
Discharge Status

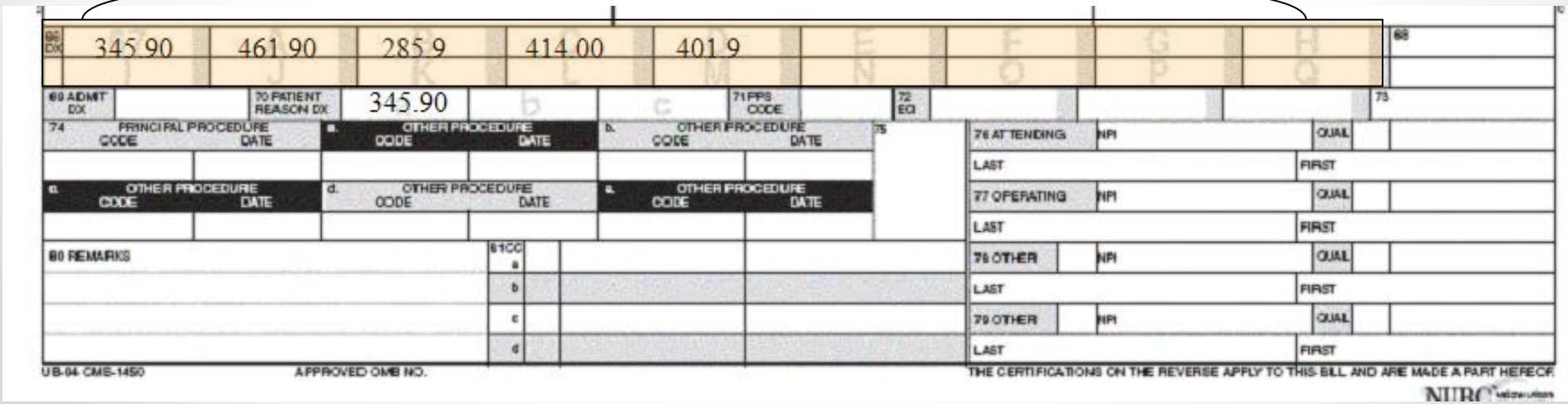
Diagnoses
Procedures

Medicare Code Editor

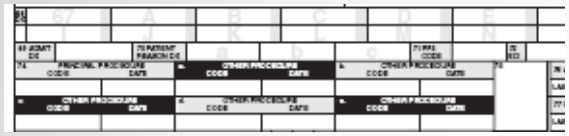


Remember, the UB-04 contains diagnosis codes.

ICD-9 Diagnosis Codes



Diagnosis codes are grouped together in a software program. Based on the codes assigned, a DRG will be assigned to be claim.

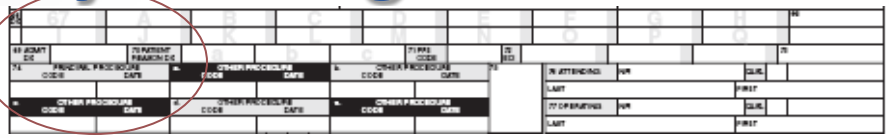


Principal Diagnosis

Major Diagnostic Category

	Description
0	Pre-MDC
1	Nervous System
2	Eye
3	Ear, Nose, Mouth And Throat
4	Respiratory System
5	Circulatory System
6	Digestive System
7	Hepatobiliary System And Pancreas
8	Musculoskeletal System And Connective Tissue
9	Skin, Subcutaneous Tissue And Breast
10	Endocrine, Nutritional And Metabolic System
11	Kidney And Urinary Tract
12	Male Reproductive System
13	Female Reproductive System
14	Pregnancy, Childbirth And Puerperium
15	Newborn And Other Neonates (Perinatal Period)
16	Blood and Blood Forming Organs and Immunological Disorders
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)
18	Infectious and Parasitic DDs
19	Mental Diseases and Disorders
20	Alcohol/Drug Use or Induced Mental Disorders
21	Injuries, Poison And Toxic Effect of Drugs
22	Burns
23	Factors Influencing Health Status
24	Multiple Significant Trauma
25	Human Immunodeficiency Virus Infection

Major Diagnostic Category

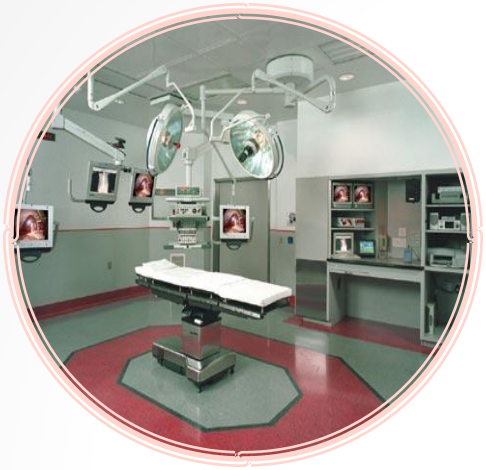


MDC

Surgical

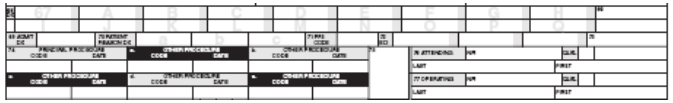
Medical

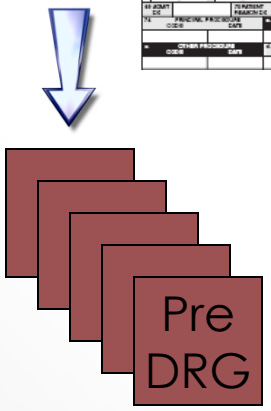
Major Diagnostic Category

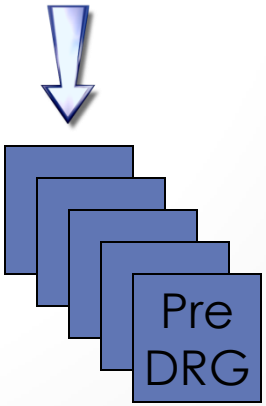


Procedures

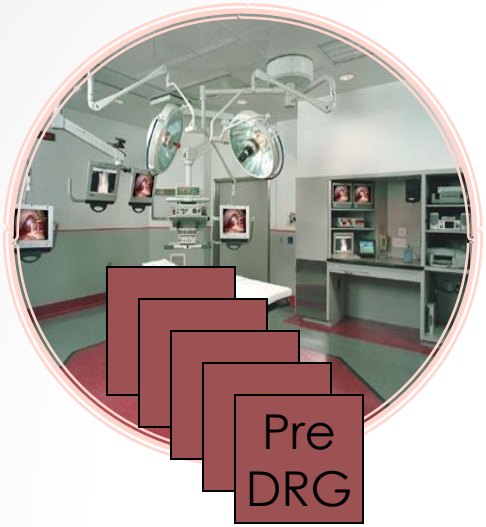
Age & Diagnosis

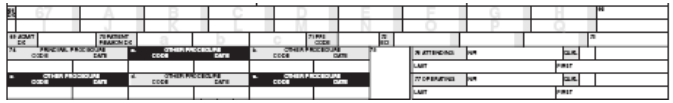




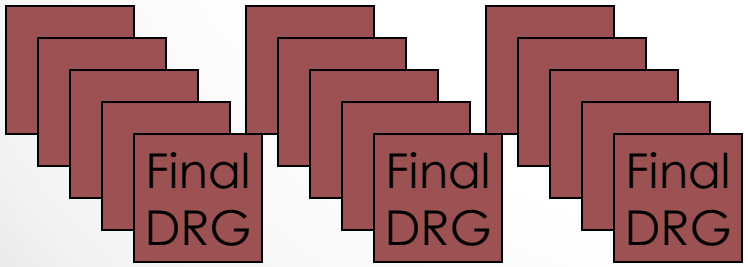


Major Diagnostic Category

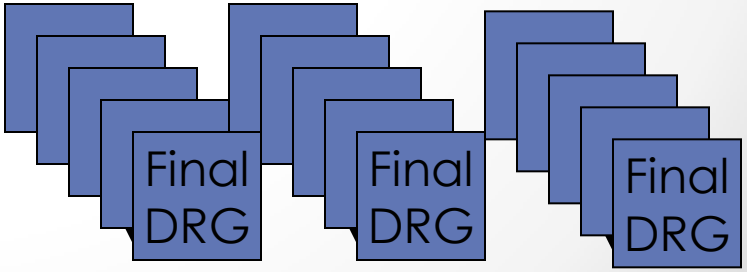




Complications
Co-morbidities

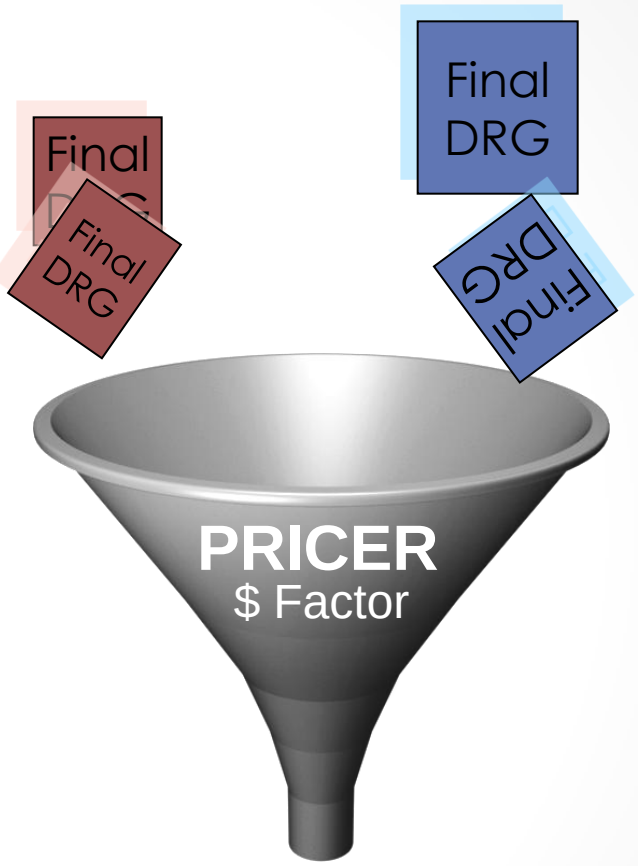


Complications
Co-morbidities



Complications and co-morbidities are secondary diagnoses that cause an increase in the length of stay by at least one day in at least 75% of patients.

The DRG assigned is then converted into a payment rate using "Pricer" software.



In addition to the initial DRG assignment, diagnoses may also be used to determine if a DRG payment should be reduced.

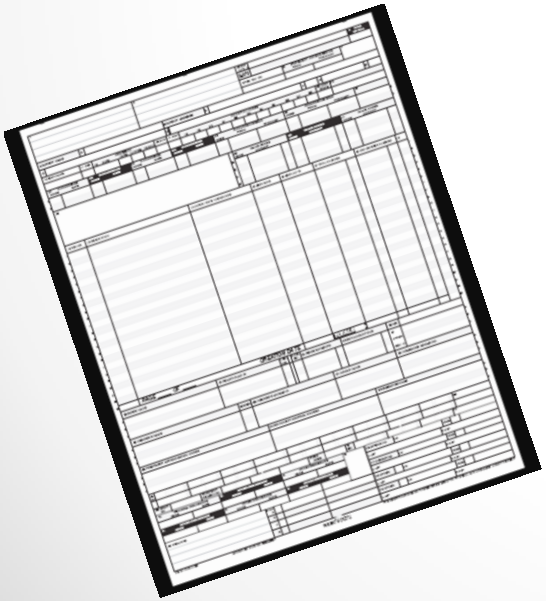
DRG payment reductions will depend on whether certain diagnoses were present at time of admission (POA) or acquired during the hospital stay.

For instance, if a patient acquired an infection while hospitalized, Medicare will not pay additional costs associated with that infection.

But if the infection was "Present on Admission" (POA) Medicare will pay for the additional costs of treating the patient.

To be considered “Present on Admission”, the diagnosis or condition must have present at the time the order for INPATIENT admission occurs.

The POA information appears as a modifier on every diagnosis code appearing on the UB-04 claim form.



Medicare does not require Critical Access Hospitals to report the POA modifiers.

Pay Full DRG

Yes (present at the time of inpatient admission)

Clinically undetermined (provider is unable to clinically determine whether condition was present at time of inpatient admission or not)

Reduced DRG

N: No (not present at the time of inpatient admission)

U: Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)

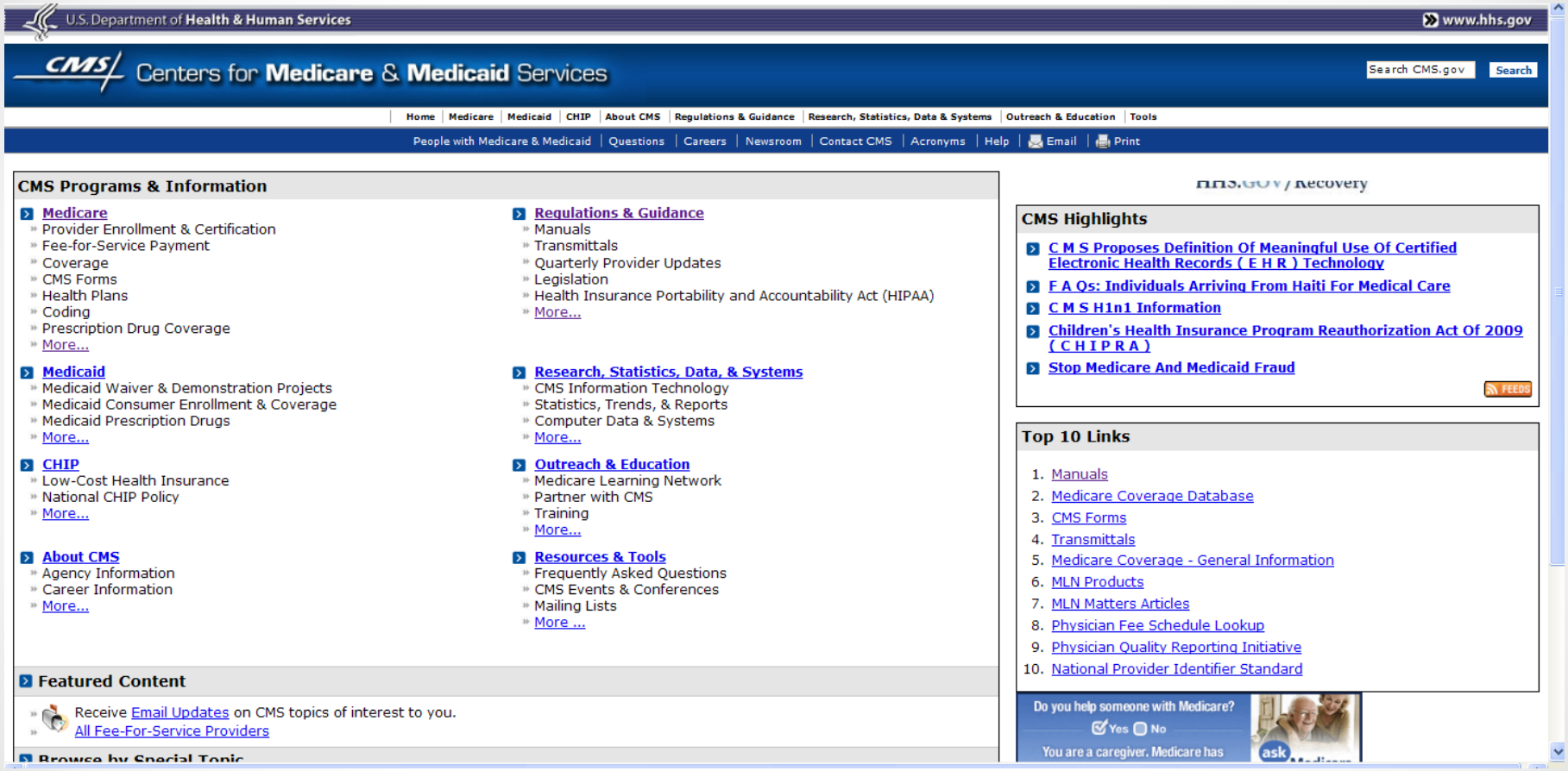
As you can see, UB coded information is easily "sliced and diced" to identify unusual trends and is often used by auditors to identify fraud and abuse.

Where can we find all of this valuable information?

www.cms.gov

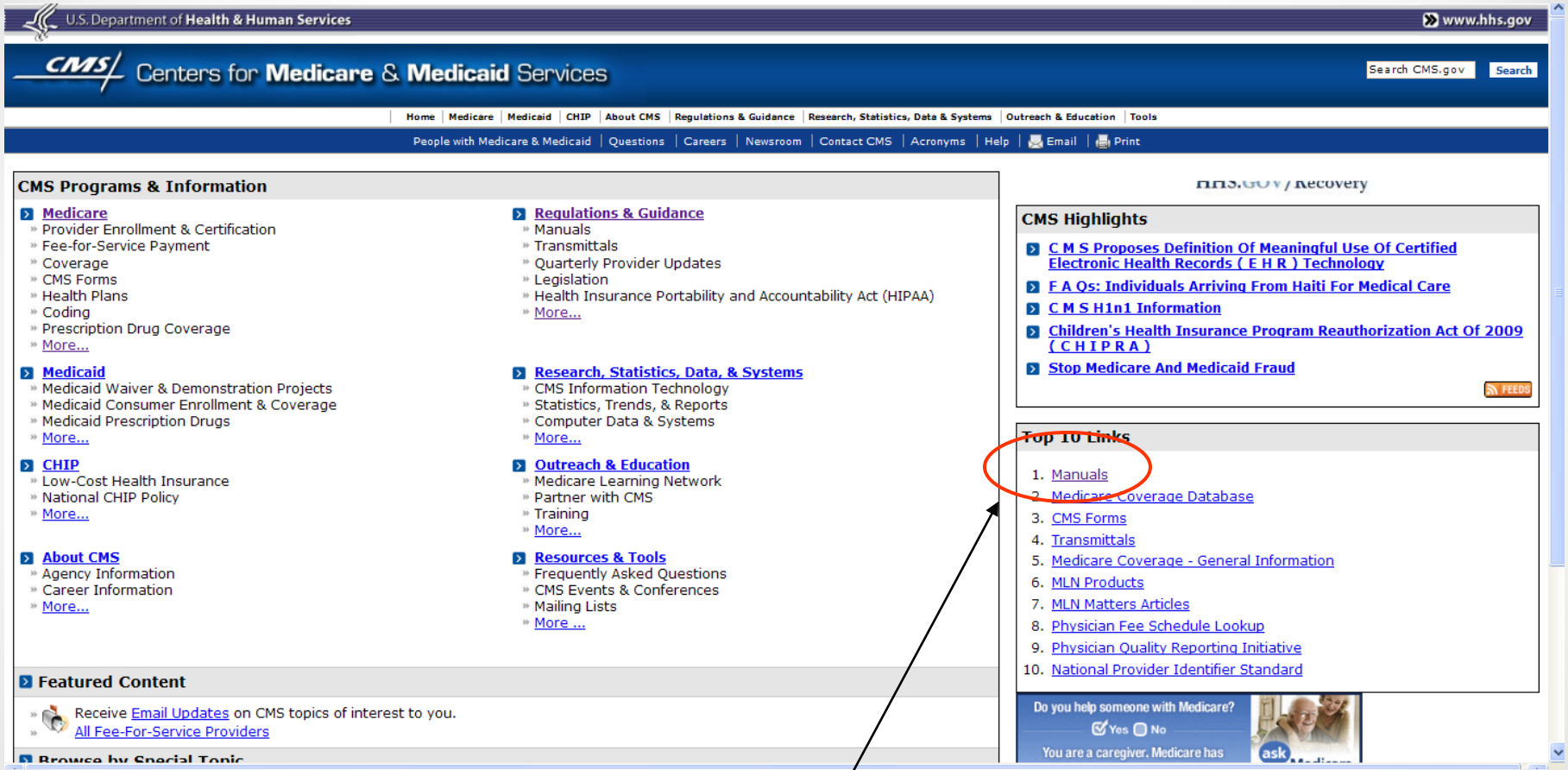
The CMS website provides most information needed in order to submit accurate claims and determine expected payments.

Starting Point

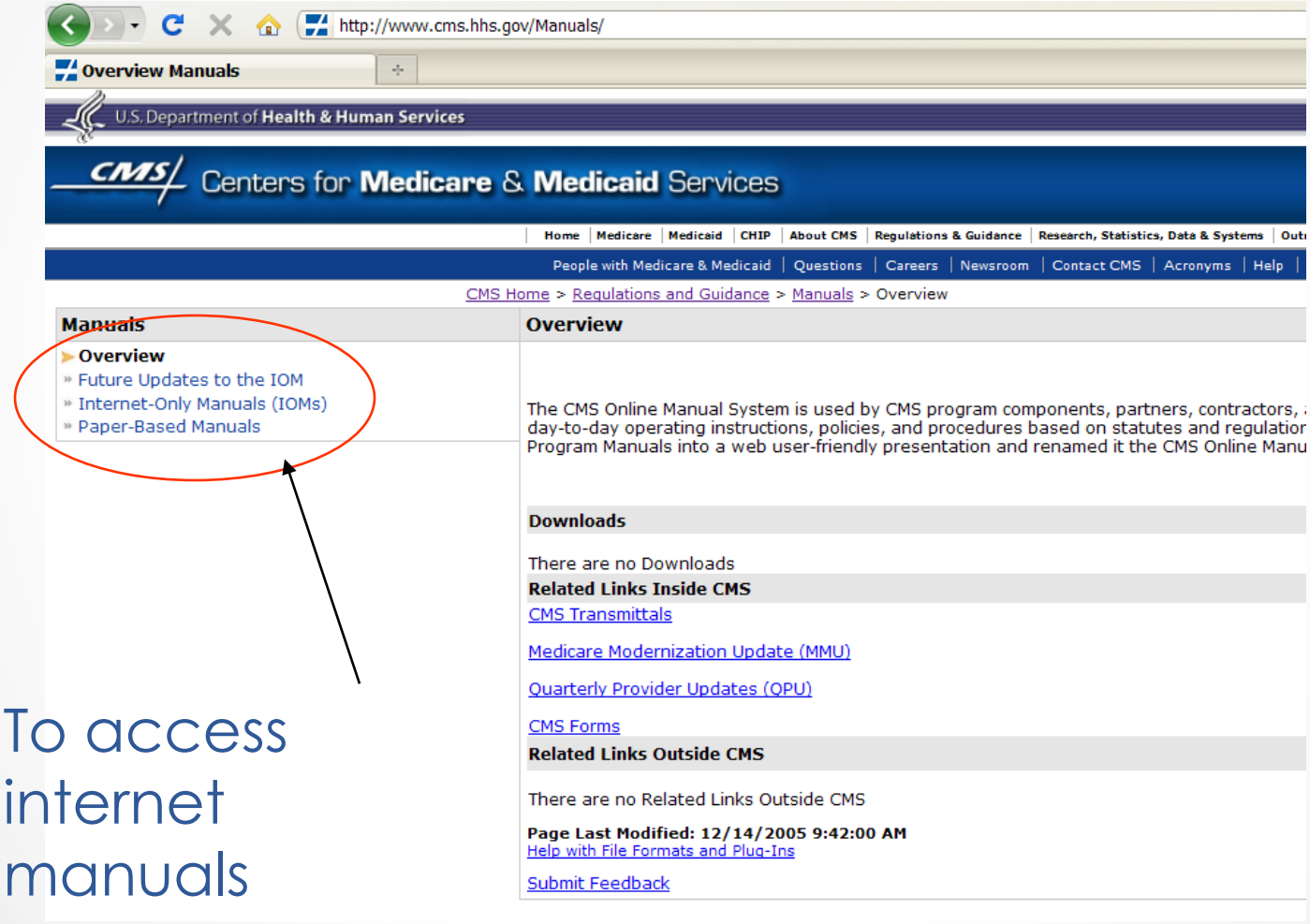


http://www.cms.gov/

http://www.cms.gov/

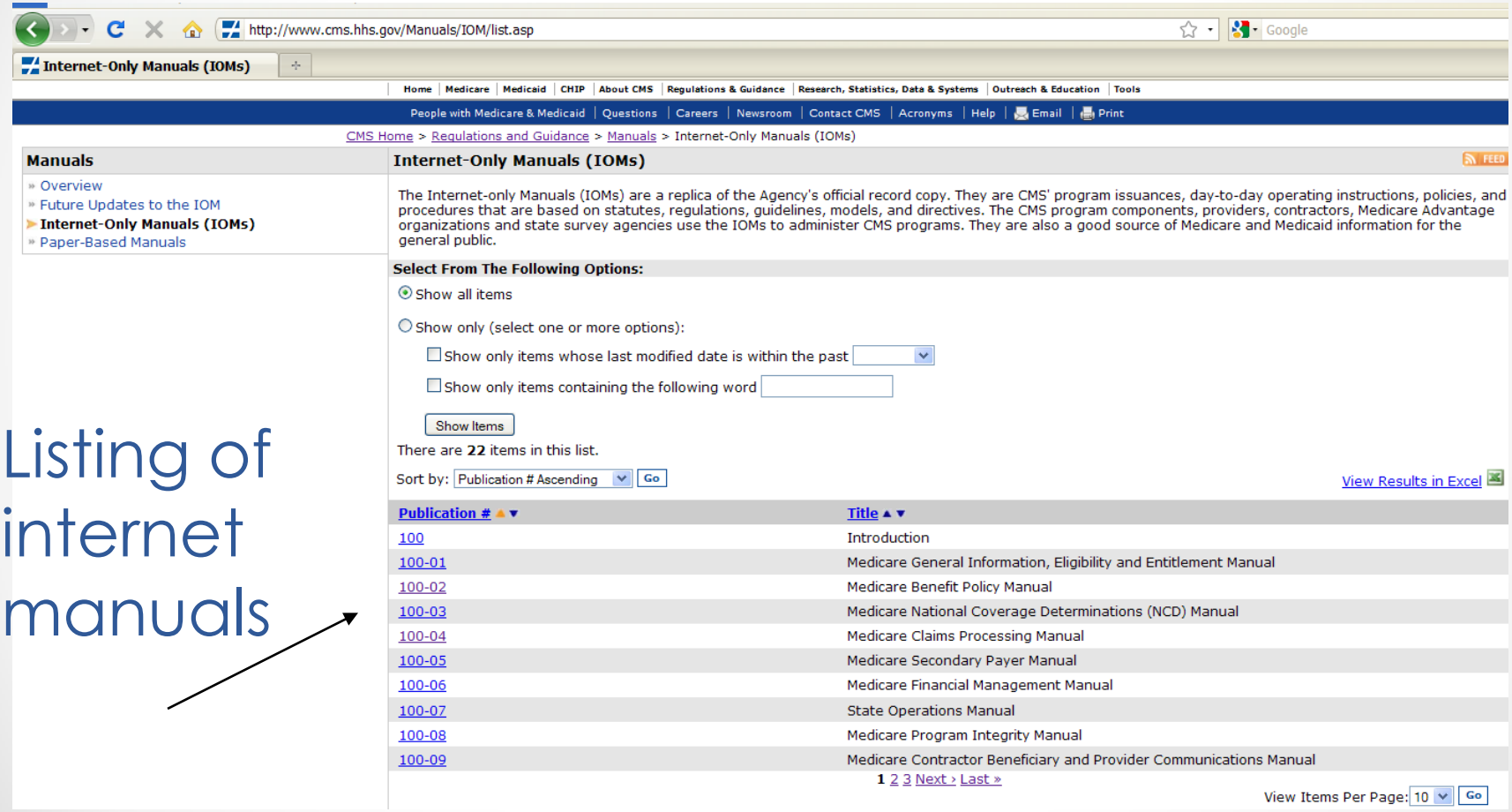


To find manuals . . .



To access internet manuals

Listing of internet manuals



For example: Claims processing manual contains information about billing for Medicare services.

Publication #	Title
100-17	CMS/Business Partners Systems Security Manual
100-19	Demonstrations
100	Introduction
100-13	Medicaid State Children's Health Insurance Program (Under Development)
100-02	Medicare Benefit Policy Manual
100-04	Medicare Claims Processing Manual
100-09	Medicare Contractor Beneficiary and Provider Communications Manual
100-14	Medicare ESRD Network Organizations Manual
100-06	Medicare Financial Management Manual
100-01	Medicare General Information, Eligibility and Entitlement Manual

1 2 3 Next › Last »

View Items Per Page: 10 Go

Within Claims Processing Manual are numerous chapters related to types of providers.

Downloads

Chapter 1 - General Billing Requirements [PDF, 4 MB]
Chapter 1 Crosswalk [PDF, 485 KB]

Chapter 2 - Admission and Registration Requirements [PDF, 280 KB]
Chapter 2 Crosswalk [PDF, 355 KB]

Chapter 3 - Inpatient Hospital Billing [PDF, 4 MB]
Chapter 3 Crosswalk [PDF, 376 KB]

Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS) [PDF, 941 KB]
Chapter 4 Crosswalk [PDF, 353 KB]

Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services [PDF, 337 KB]
Chapter 5 Crosswalk [PDF, 120 KB]

Chapter 6 - Inpatient Part A Billing and SNF Consolidated Billing [PDF, 464 KB]
Chapter 6 Crosswalk [PDF, 177 KB]

Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule) [PDF, 875 KB]
Chapter 7 Crosswalk [PDF, 98 KB]

Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims [PDF, 858 KB]
Chapter 8 Crosswalk [PDF, 333 KB]

Chapter 9 - Rural Health Clinics/Federally Qualified Health Centers [PDF, 260 KB]
Chapter 9 Crosswalk [PDF, 198 KB]

Chapter 10 - Home Health Agency Billing [PDF, 286 KB]
Chapter 10 Crosswalk [PDF, 203 KB]

Chapter 11 - Processing Hospice Claims [PDF, 320 KB]
Chapter 11 Crosswalk [PDF, 104 KB]

Chapter 12 - Physicians/Nonphysician Practitioners [PDF, 391 KB]
Chapter 12 Crosswalk [PDF, 314 KB]

Chapter 13 - Radiology Services and Other Diagnostic Procedures [PDF, 158 KB]

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

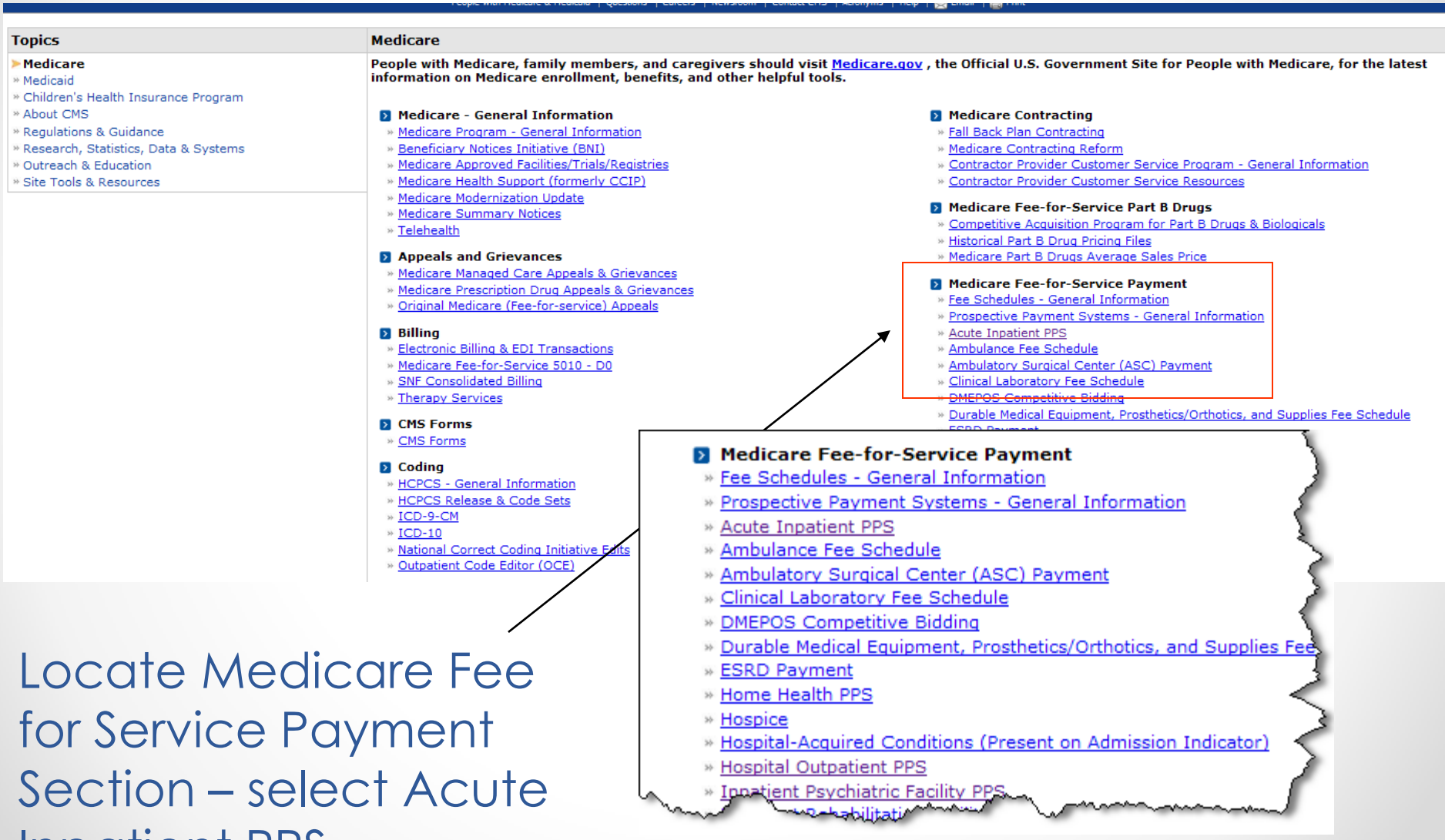
Table of Contents
(Rev. 1808, 08-28-09)
(Rev. 1816, 09-17-09)
(Rev. 1828, 10-09-09)

Chapter 3 discusses Inpatient Hospital Billing.

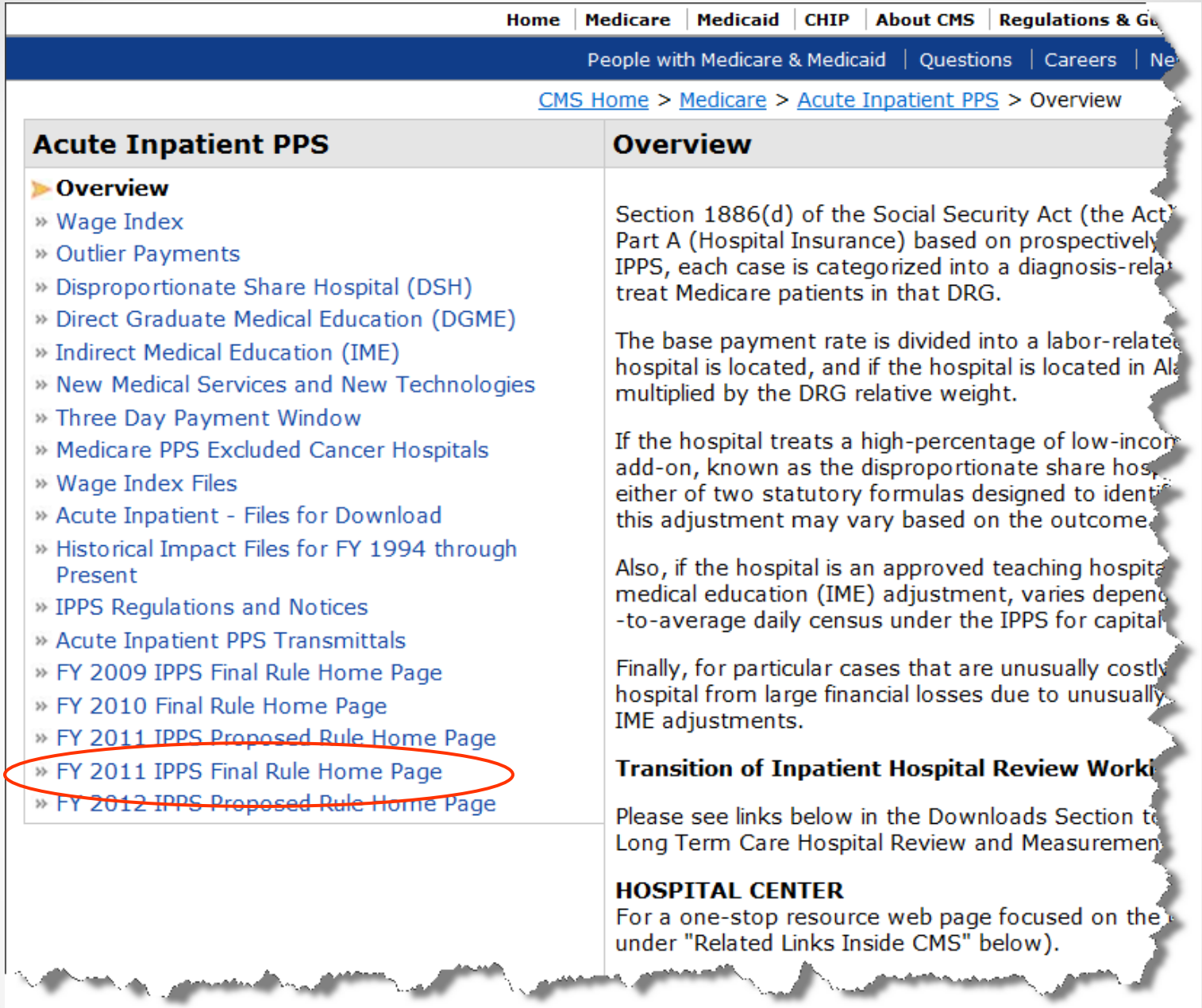
To find DRG rates: Return to CMS Home Page – select Medicare

http://www.cms.gov/

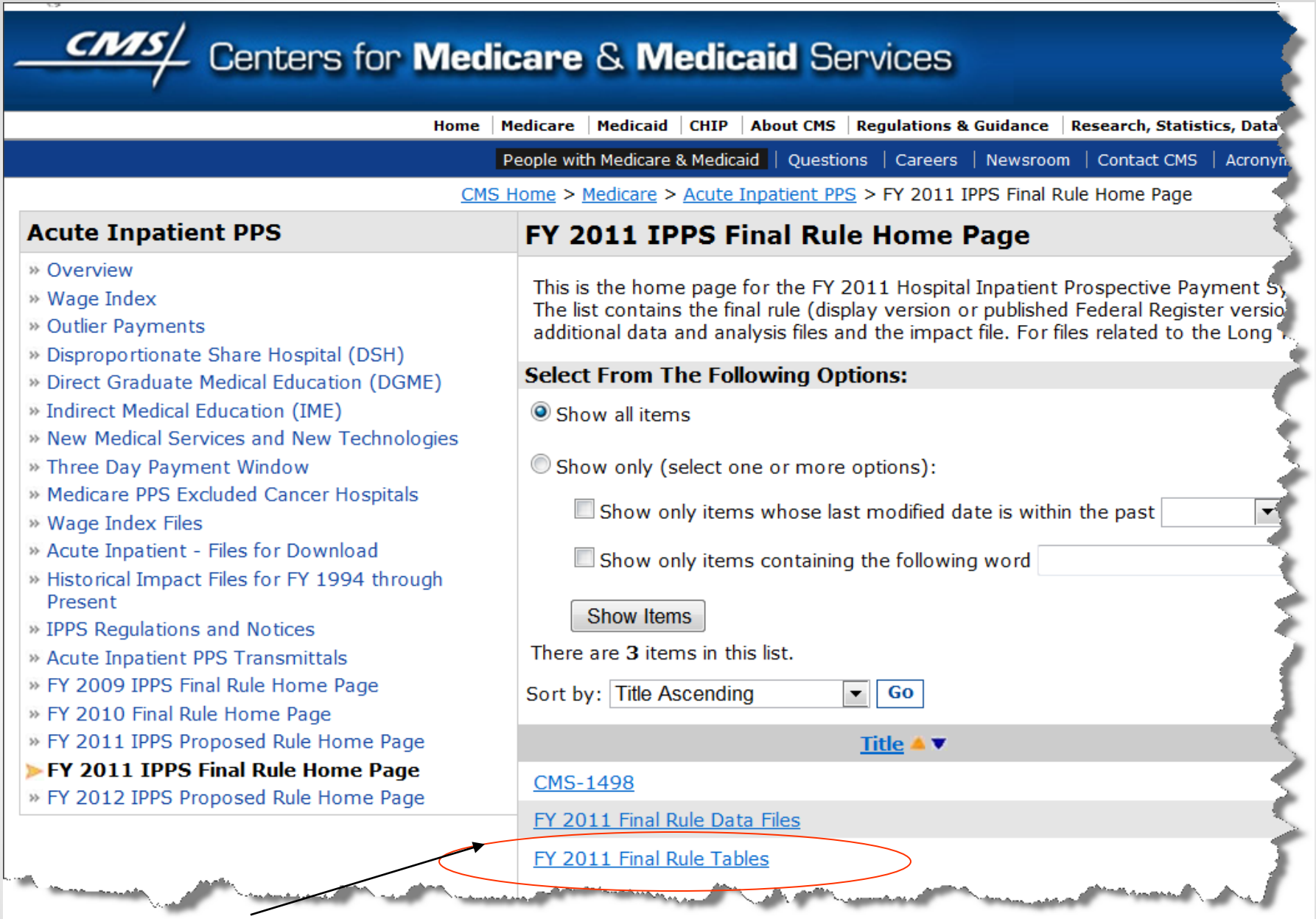
http://www.cms.gov/



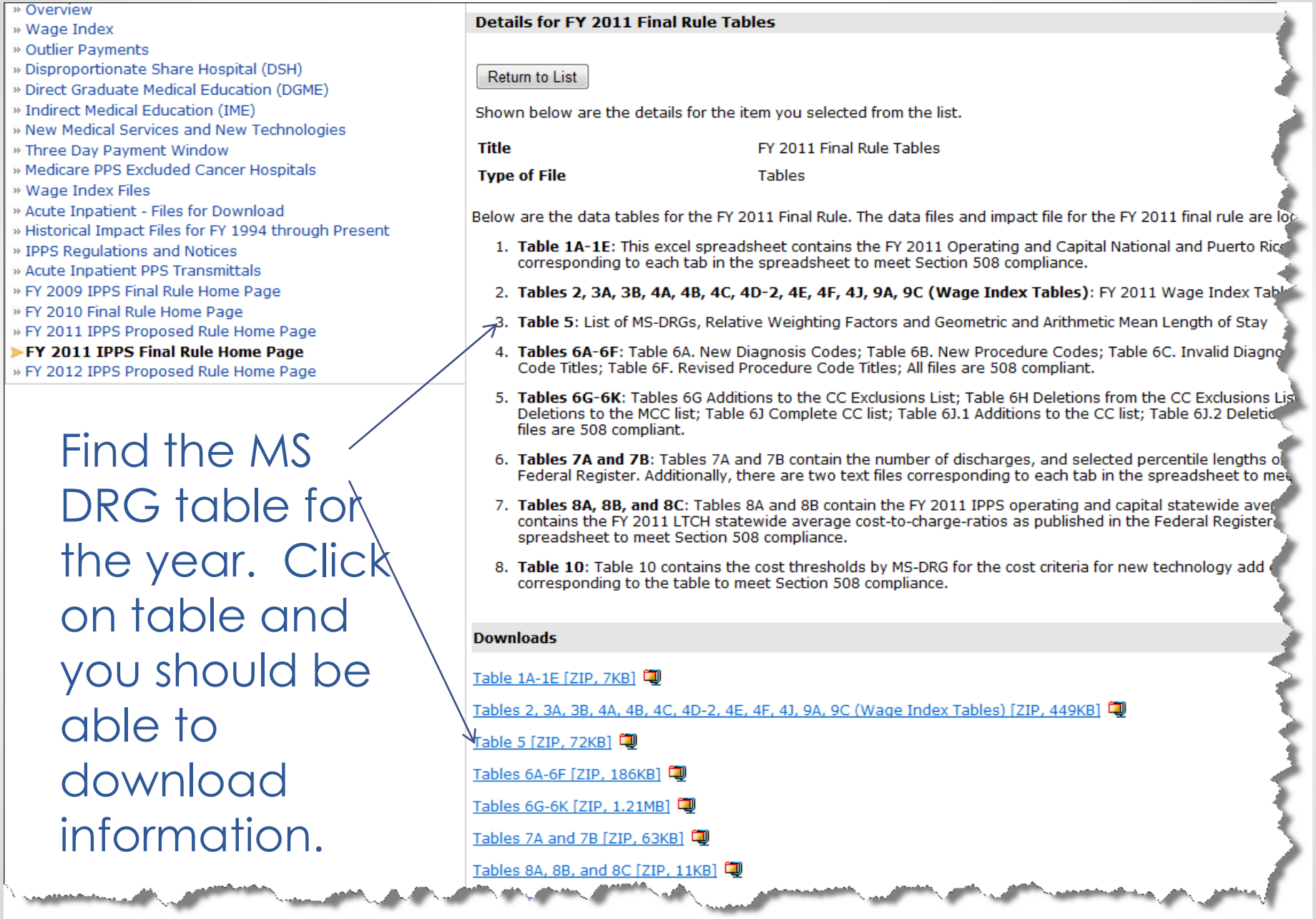
Locate Medicare Fee for Service Payment Section – select Acute Inpatient PPS



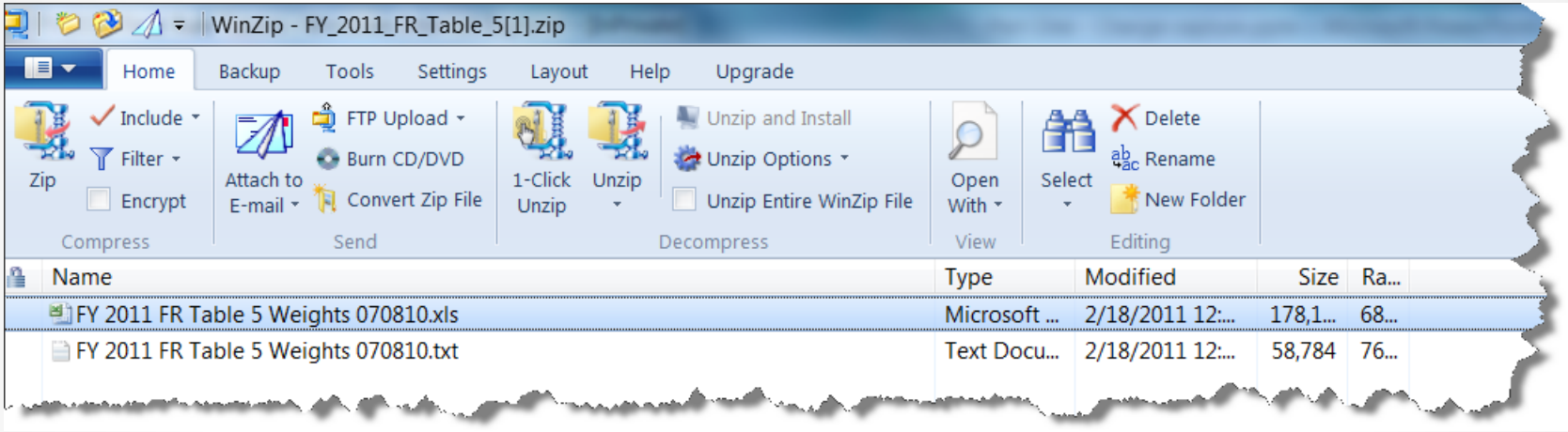
Select applicable fiscal year



Scroll until you find the final rule tables for the year you are researching.


» Overview
» Wage Index
» Outlier Payments
» Disproportionate Share Hospital (DSH)
» Direct Graduate Medical Education (DGME)
» Indirect Medical Education (IME)
» New Medical Services and New Technologies
» Three Day Payment Window
» Medicare PPS Excluded Cancer Hospitals
» Wage Index Files
» Acute Inpatient - Files for Download
» Historical Impact Files for FY 1994 through Present
» IPPS Regulations and Notices
» Acute Inpatient PPS Transmittals
» FY 2009 IPPS Final Rule Home Page
» FY 2010 Final Rule Home Page
» FY 2011 IPPS Proposed Rule Home Page
» FY 2011 IPPS Final Rule Home Page
» FY 2012 IPPS Proposed Rule Home Page
Find the MS DRG table for the year. Click on table and you should be able to download information.
Details for FY 2011 Final Rule Tables
Return to List
Shown below are the details for the item you selected from the list.
Title FY 2011 Final Rule Tables
Type of File Tables
Below are the data tables for the FY 2011 Final Rule. The data files and impact file for the FY 2011 final rule are loc
1. Table 1A-1E: This excel spreadsheet contains the FY 2011 Operating and Capital National and Puerto Ric corresponding to each tab in the spreadsheet to meet Section 508 compliance.
2. Tables 2, 3A, 3B, 4A, 4B, 4C, 4D-2, 4E, 4F, 4J, 9A, 9C (Wage Index Tables): FY 2011 Wage Index Tabl
3. Table 5: List of MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay
4. Tables 6A-6F: Table 6A. New Diagnosis Codes; Table 6B. New Procedure Codes; Table 6C. Invalid Diagno Code Titles; Table 6F. Revised Procedure Code Titles; All files are 508 compliant.
5. Tables 6G-6K: Tables 6G Additions to the CC Exclusions List; Table 6H Deletions from the CC Exclusions Lis Deletions to the MCC list; Table 6J Complete CC list; Table 6J.1 Additions to the CC list; Table 6J.2 Deletio files are 508 compliant.
6. Tables 7A and 7B: Tables 7A and 7B contain the number of discharges, and selected percentile lengths o Federal Register. Additionally, there are two text files corresponding to each tab in the spreadsheet to me
7. Tables 8A, 8B, and 8C: Tables 8A and 8B contain the FY 2011 IPPS operating and capital statewide ave contains the FY 2011 LTCH statewide average cost-to-charge-ratios as published in the Federal Register spreadsheet to meet Section 508 compliance.
8. Table 10: Table 10 contains the cost thresholds by MS-DRG for the cost criteria for new technology add corresponding to the table to meet Section 508 compliance.
Downloads
Table 1A-1E [ZIP, 7KB]
Tables 2, 3A, 3B, 4A, 4B, 4C, 4D-2, 4E, 4F, 4J, 9A, 9C (Wage Index Tables) [ZIP, 449KB]
Table 5 [ZIP, 72KB]
Tables 6A-6F [ZIP, 186KB]
Tables 6G-6K [ZIP, 1.21MB]
Tables 7A and 7B [ZIP, 63KB]
Tables 8A, 8B, and 8C [ZIP, 11KB]

Download table

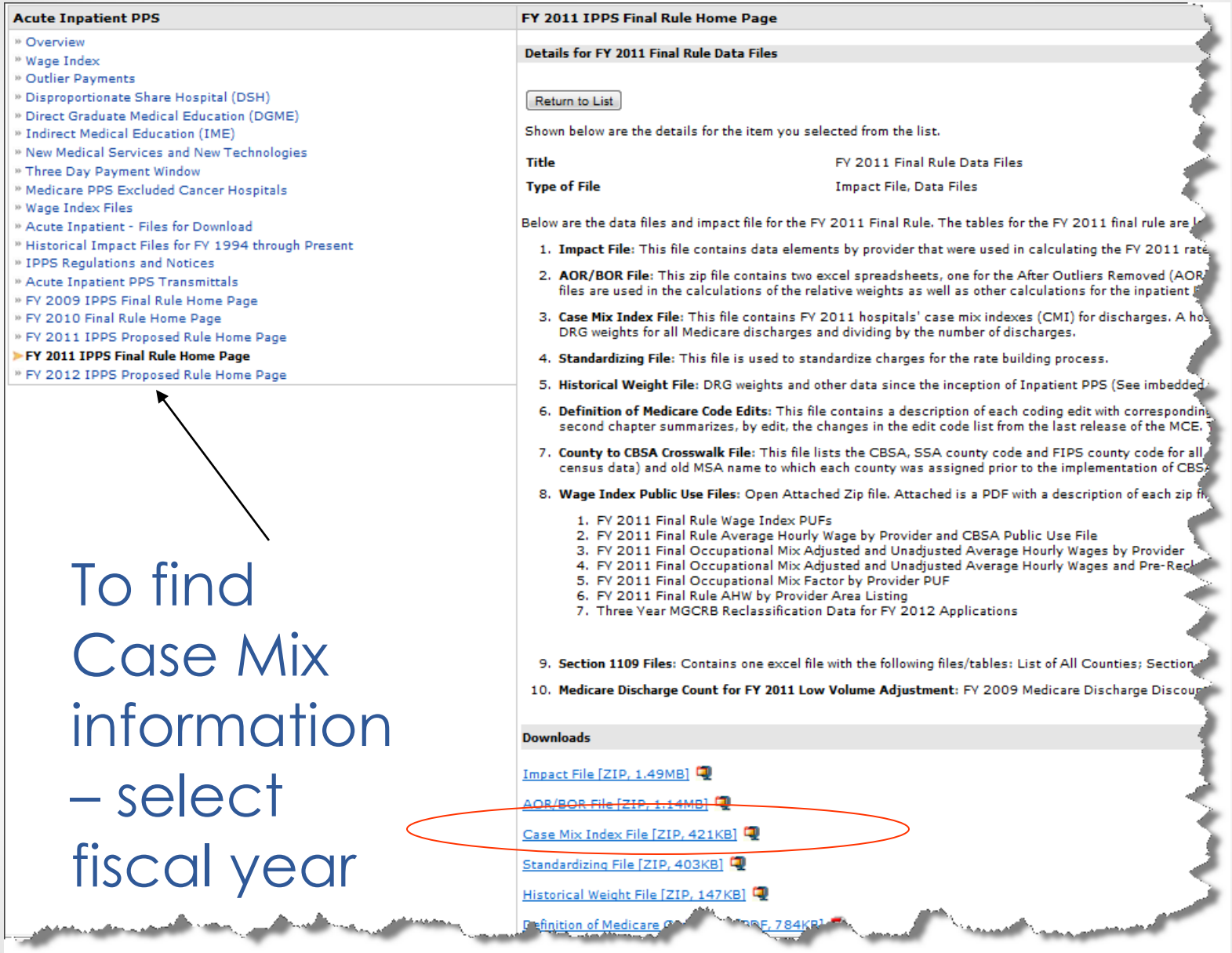


NOTE: Most download files are zipped and must be unzipped in order to use.

Example: MS-DRG Listing

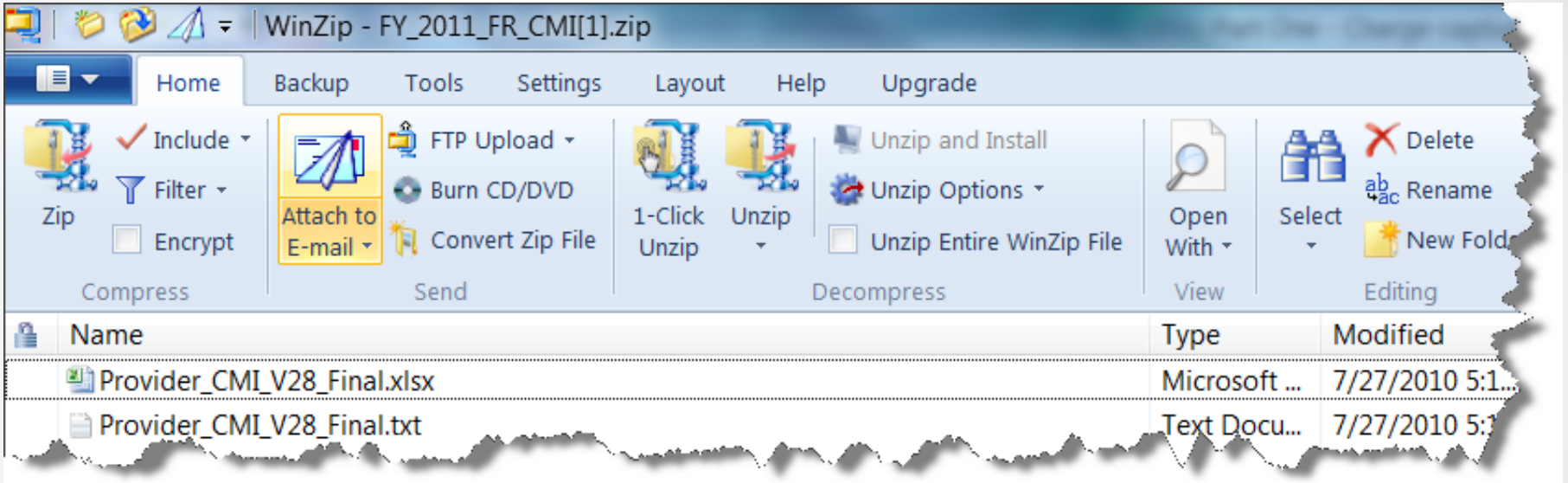
MS-DRG	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
001	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	26.3441	31.6	41.9
002	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.6127	17.6	22
003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.1239	30.1	36
004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.2403	22.2	27
005	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.1771	14.9	19.9
006	LIVER TRANSPLANT W/O MCC	4.8353	8.3	9
007	LUNG TRANSPLANT	9.3350	15.4	18
008	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	4.9632	10.1	11.7
010	PANCREAS TRANSPLANT	3.7831	8.6	9
011	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.7666	12.3	15.5
012	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.1311	8.5	10
013	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	1.9505	5.7	6
014	ALLOGENEIC BONE MARROW TRANSPLANT	11.5947	21.1	28
015	AUTOLOGOUS BONE MARROW TRANSPLANT	5.9504	16.7	19.3
020	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	8.2479	14.1	17
021	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	6.2886	12.1	13

FY 2011 FR Table 5.xls



To find Case Mix information – select fiscal year

Download Table



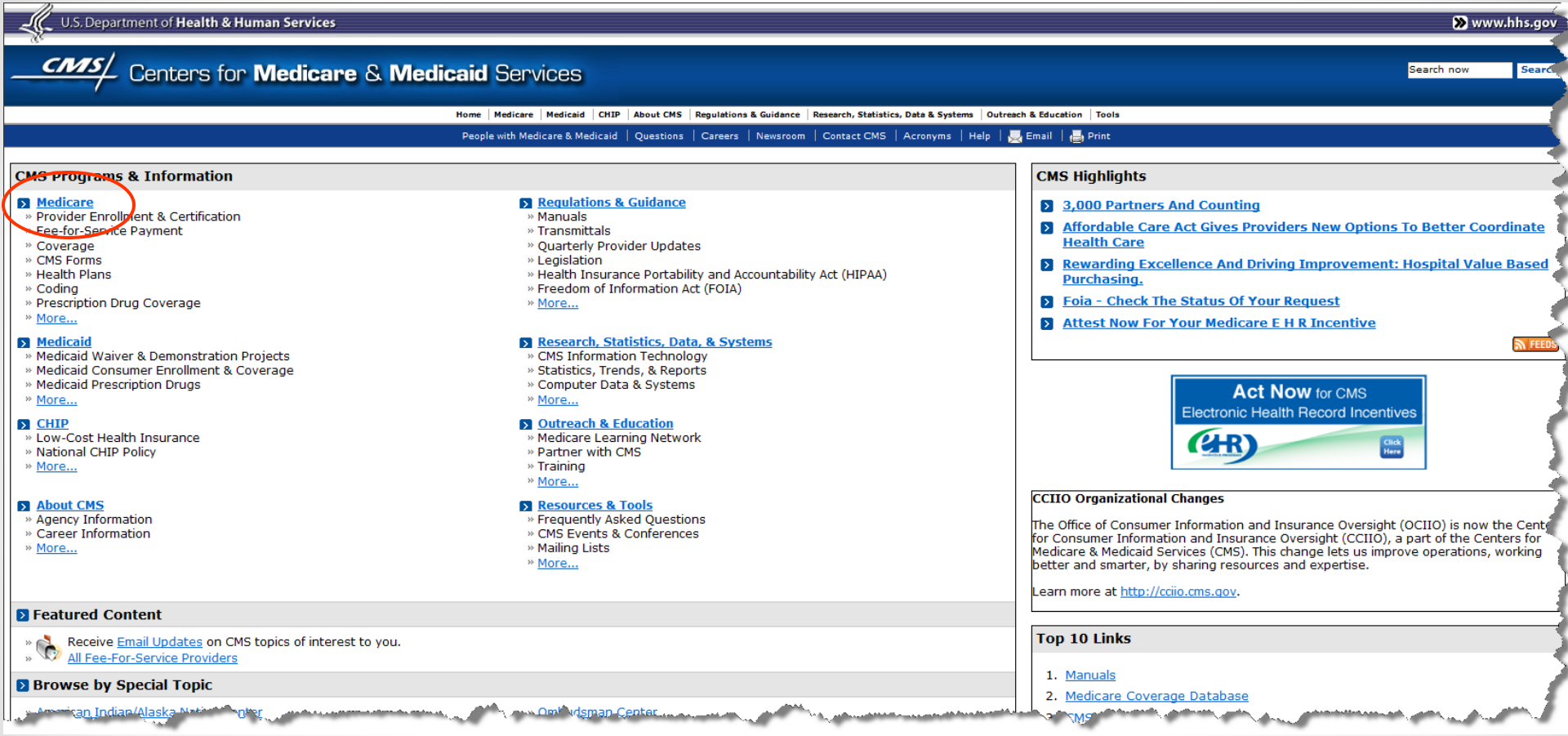
NOTE: Most download files are zipped and must be unzipped in order to use.

Example of Case Mix Index Table

Provider ID	Cases	Total Case Mix	CMI	Transfer Adjusted Cases	Transfer Adjusted Case Mix	Transfer Adjusted CMI
010001	8178	13823.4333	1.690319553	8086.135317	13532.49007	1.673542371
010005	2232	2830.1339	1.267981138	2199.355254	2772.443294	1.260570928
010006	5477	8182.5859	1.493990488	5440.686154	8115.596925	1.491649527
010007	1265	1336.5281	1.056543953	1257.334445	1320.69308	1.050391235
010008	376	421.5684	1.121192553	371.3997852	414.2503022	1.115375718
010009	792	803.3717	1.014358207	783.4863423	792.6691256	1.011720413
010010	1992	2419.1718	1.214443675	1966.885239	2378.686578	1.209367242
010011	4522	7251.6505	1.603637882	4492.483382	7177.53648	1.597676801
010012	1795	2126.2262	1.184527131	1772.308456	2097.133407	1.183277889
010015	537	489.2444	0.911069646	530.8771885	481.1523584	0.906334589
010016	3335	5251.7061	1.574724468	3293.915583	5152.376887	1.564210361
010018	49	61.2605	1.250214286	49	61.2605	1.250214286
010019	3238	4477.9733	1.382944194	3210.983903	4422.444784	1.377286501
010021	873	1173.7823	1.344538717	850.0807561	1133.942434	1.333923
010022	606	554.6779	0.915310066	601.2108262	550.4171621	0.915514389
010023	5253	9360.7055	1.781973253	5180.600677	9080.031524	1.752698594
010024	4724	7872.1713	1.666420682	4662.583133	7616.194571	1.633471051
010025	1400	2030.9896	1.450706857	1384.60147	1992.999482	1.440026

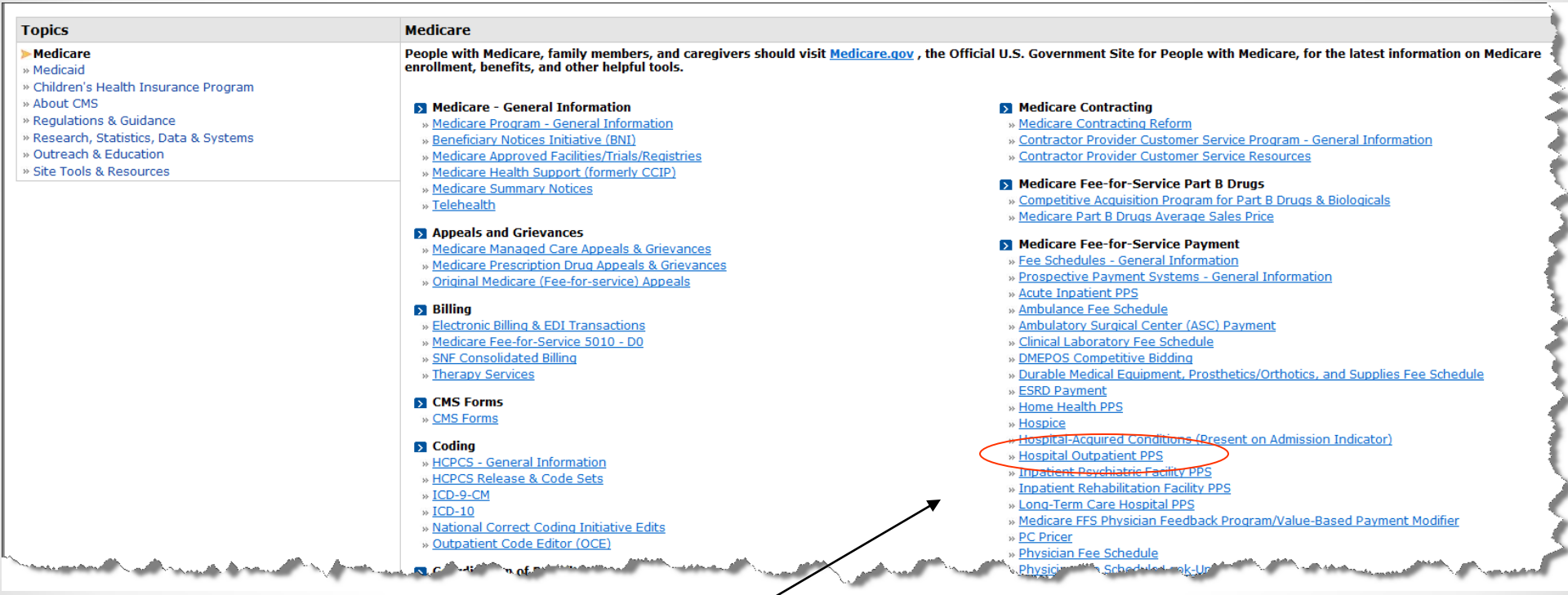
Provider_CMI_V28_Final.xls

To find APC rates



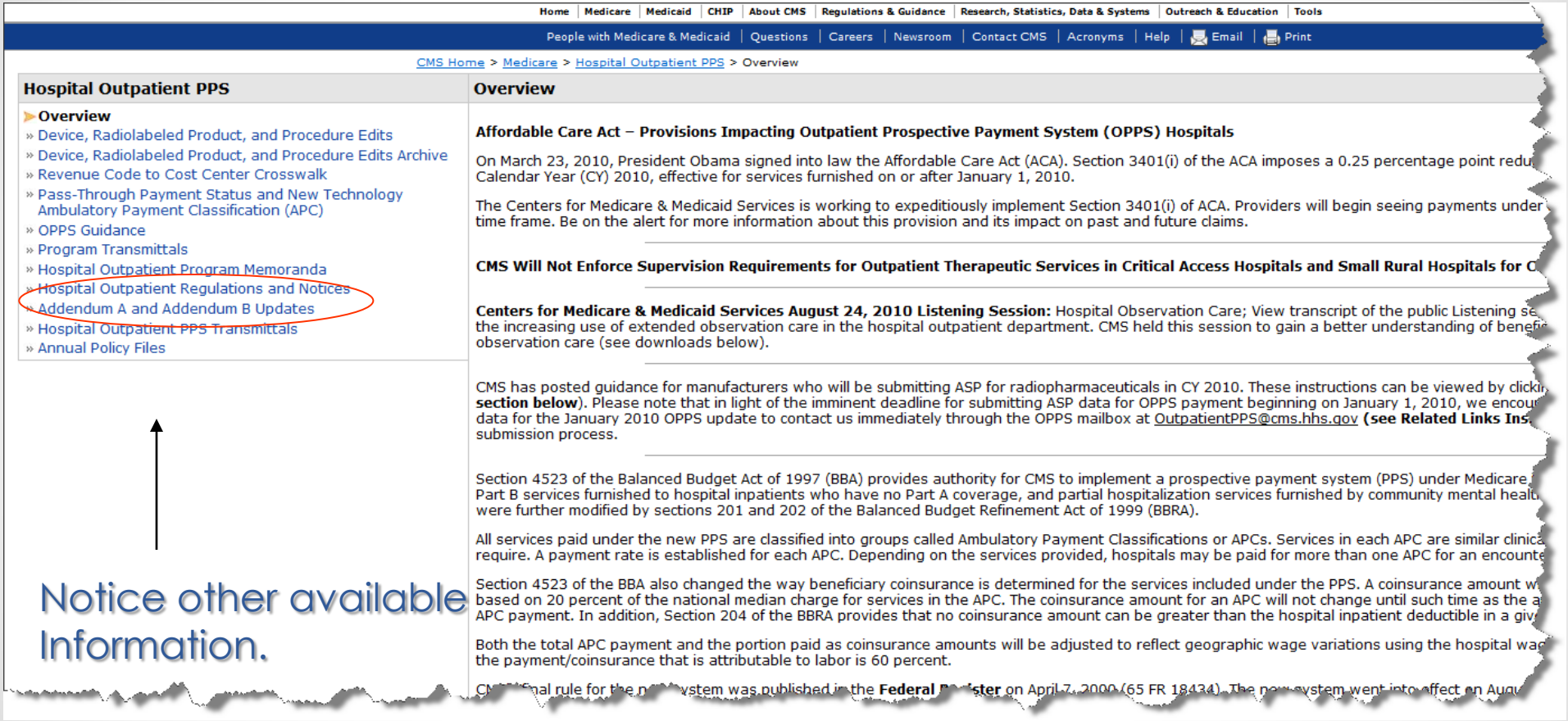
http://www.cms.gov/

APC Rates

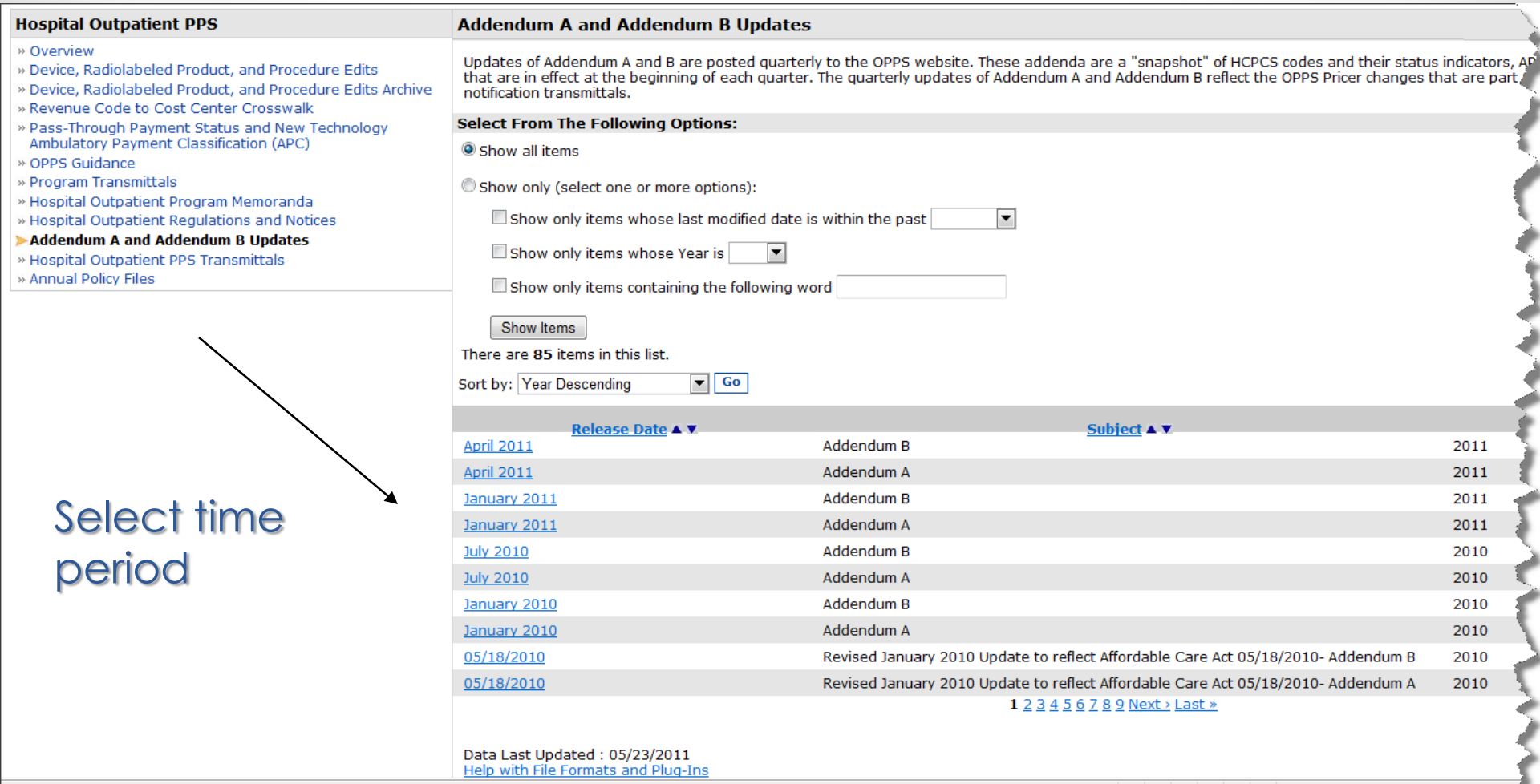


Select Hospital Outpatient PPS information

Addendum A and B give APC data

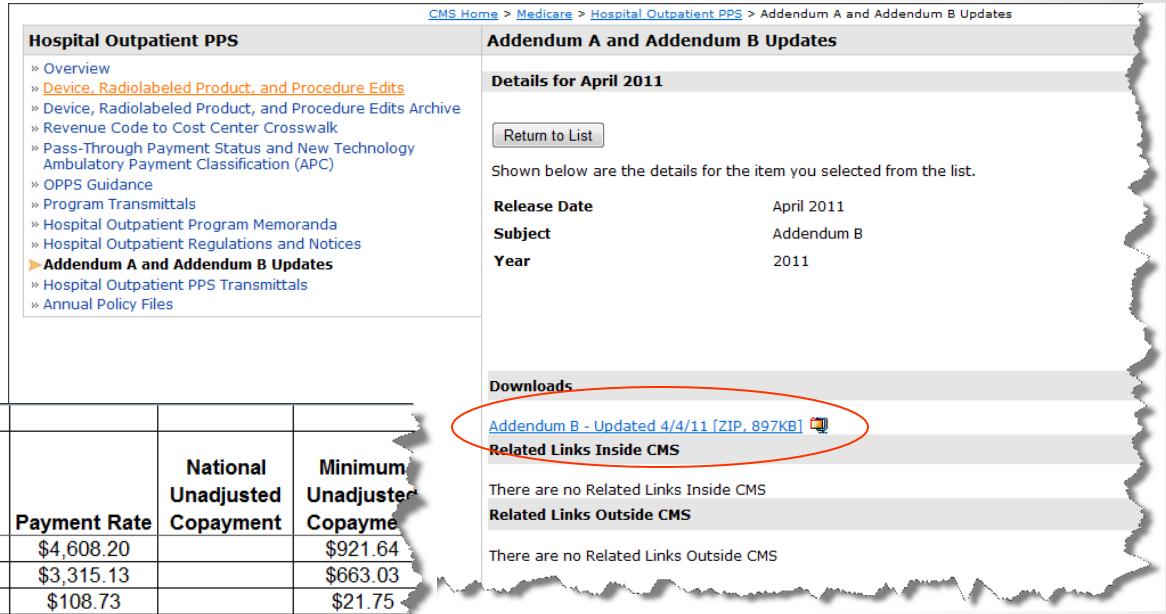


Addendum A and B detail



Select time period

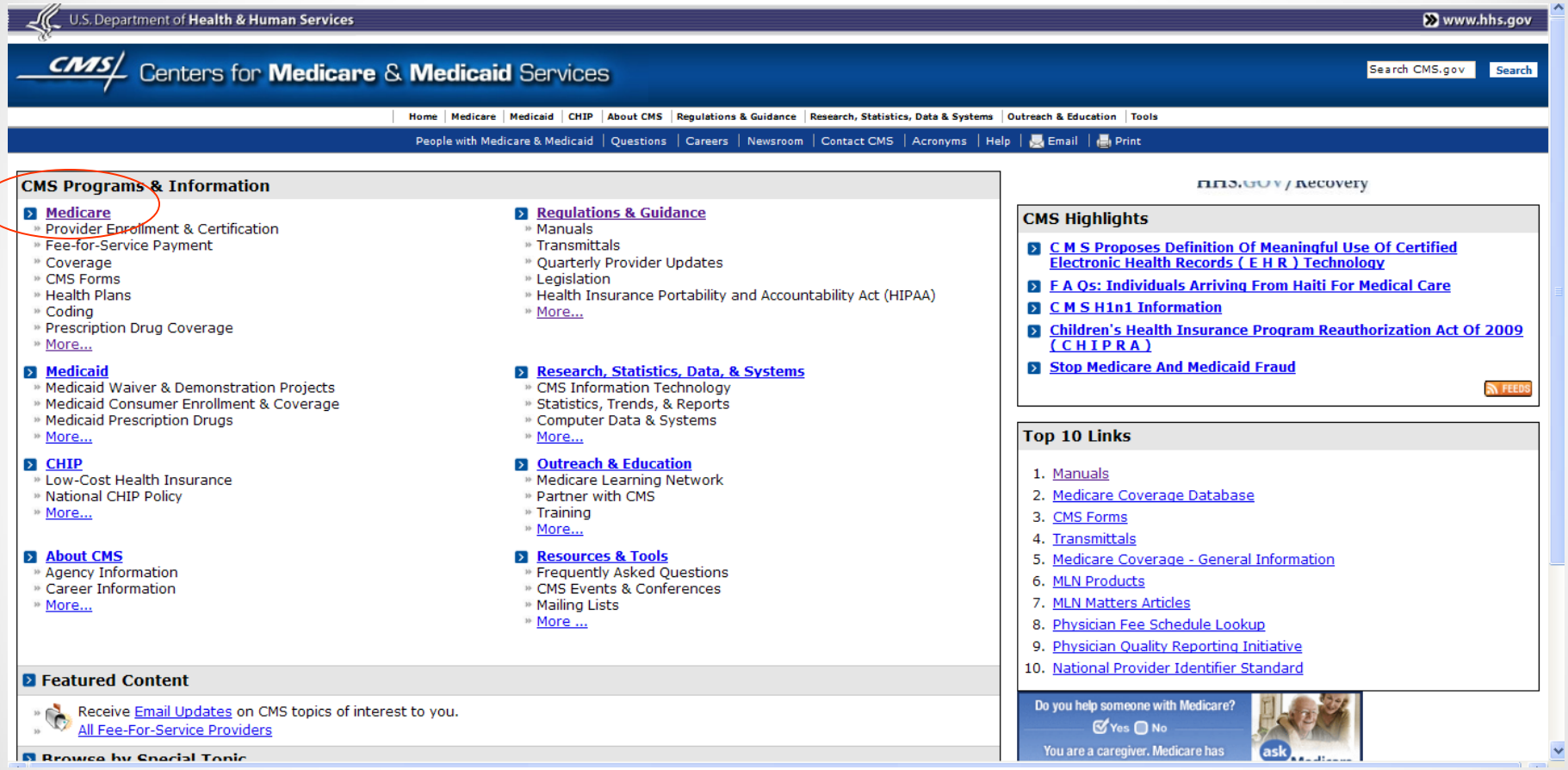
Select Addendum



	Addendum B.-OPPS Payment by						
HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayme
28415	Treat heel fracture	T	0064	66.9057	$4,608.20		$921.64
28420	Treat/graft heel fracture	T	0063	48.1318	$3,315.13		$663.03
28430	Treatment of ankle fracture	T	0129	1.5787	$108.73		$21.75
28435	Treatment of ankle fracture	T	0129	1.5787	$108.73		$21.75
28436	Treatment of ankle fracture	T	0062	26.5543	$1,828.95	$372.87	$365.79
28445	Treat ankle fracture	T	0063	48.1318	$3,315.13		$663.03
28446	Osteochondral talus autogrft	T	0056	55.2578	$3,805.94		$761.19
28450	Treat midfoot fracture each	T	0129	1.5787	$108.73		$21.75
28455	Treat midfoot fracture each	T	0129	1.5787	$108.73		$21.75
28456	Treat midfoot fracture	T	0062	26.5543	$1,828.95	$372.87	$365.79
28465	Treat midfoot fracture each	T	0063	48.1318	$3,315.13		$663.03
28470	Treat metatarsal fracture	T	0129	1.5787	$108.73		$21.75
28475	Treat metatarsal fracture	T	0129	1.5787	$108.73		$21.75
28476	Treat metatarsal fracture	T	0062	26.5543	$1,828.95	$372.87	$365.79
28485	Treat metatarsal fracture	T	0063	48.1318	$3,315.13		$663.03
28490	Treat big toe fracture	T	0129	1.5787	$108.73		$21.75
28495	Treat big toe fracture	T	0129	1.5787	$108.73		$21.75
28496	Treat big toe fracture	T	0062	26.5543	$1,828.95	$372.87	$365.79
28505	Treat big toe fracture	T	0062	26.5543	$1,828.95	$372.87	$365.79
28510	Treatment of toe fracture	T	0129	1.5787	$108.73		$21.75
28515	Treatment of toe fracture	T	0129	1.5787	$108.73		$21.75

2011 AprilWeb.Add B.03.31.2011.xlsx

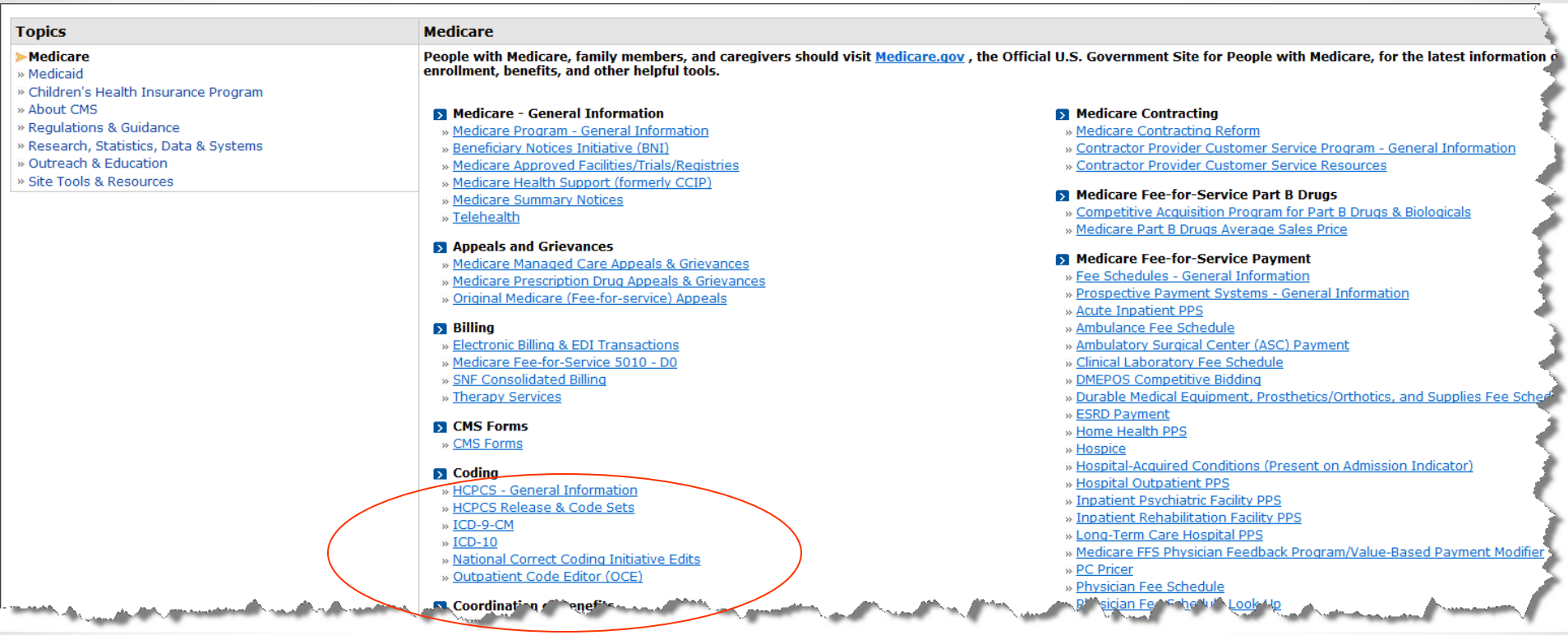
ICD-9 and ICD-10 Coding



http://www.cms.gov/

Return to CMS Home Page – select Medicare

HCPCS/CPT Coding Information



Topics

- **Medicare**
- Medicaid
- Children's Health Insurance Program
- About CMS
- Regulations & Guidance
- Research, Statistics, Data & Systems
- Outreach & Education
- Site Tools & Resources

Medicare

People with Medicare, family members, and caregivers should visit Medicare.gov , the Official U.S. Government Site for People with Medicare, for the latest information o enrollment, benefits, and other helpful tools.

Medicare - General Information
- Medicare Program - General Information
- Beneficiary Notices Initiative (BNI)
- Medicare Approved Facilities/Trials/Registries
- Medicare Health Support (formerly CCIP)
- Medicare Summary Notices
- Telehealth

Appeals and Grievances
- Medicare Managed Care Appeals & Grievances
- Medicare Prescription Drug Appeals & Grievances
- Original Medicare (Fee-for-service) Appeals

Billing
- Electronic Billing & EDI Transactions
- Medicare Fee-for-Service 5010 - D0
- SNF Consolidated Billing
- Therapy Services

CMS Forms
- CMS Forms

Coding
- HCPCS - General Information
- HCPCS Release & Code Sets
- ICD-9-CM
- ICD-10
- National Correct Coding Initiative Edits
- Outpatient Code Editor (OCE)

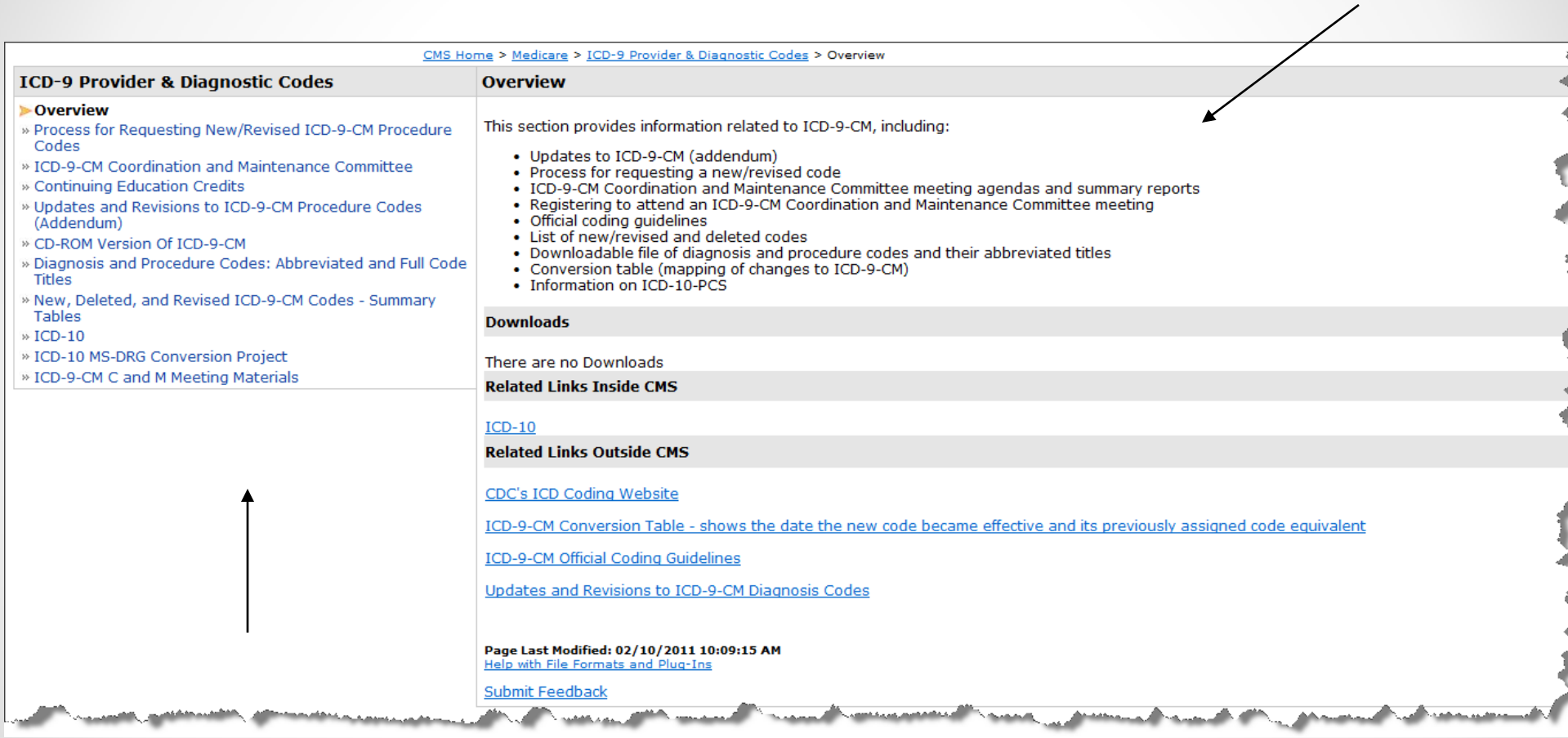
Coordination

Medicare Contracting
- Medicare Contracting Reform
- Contractor Provider Customer Service Program - General Information
- Contractor Provider Customer Service Resources

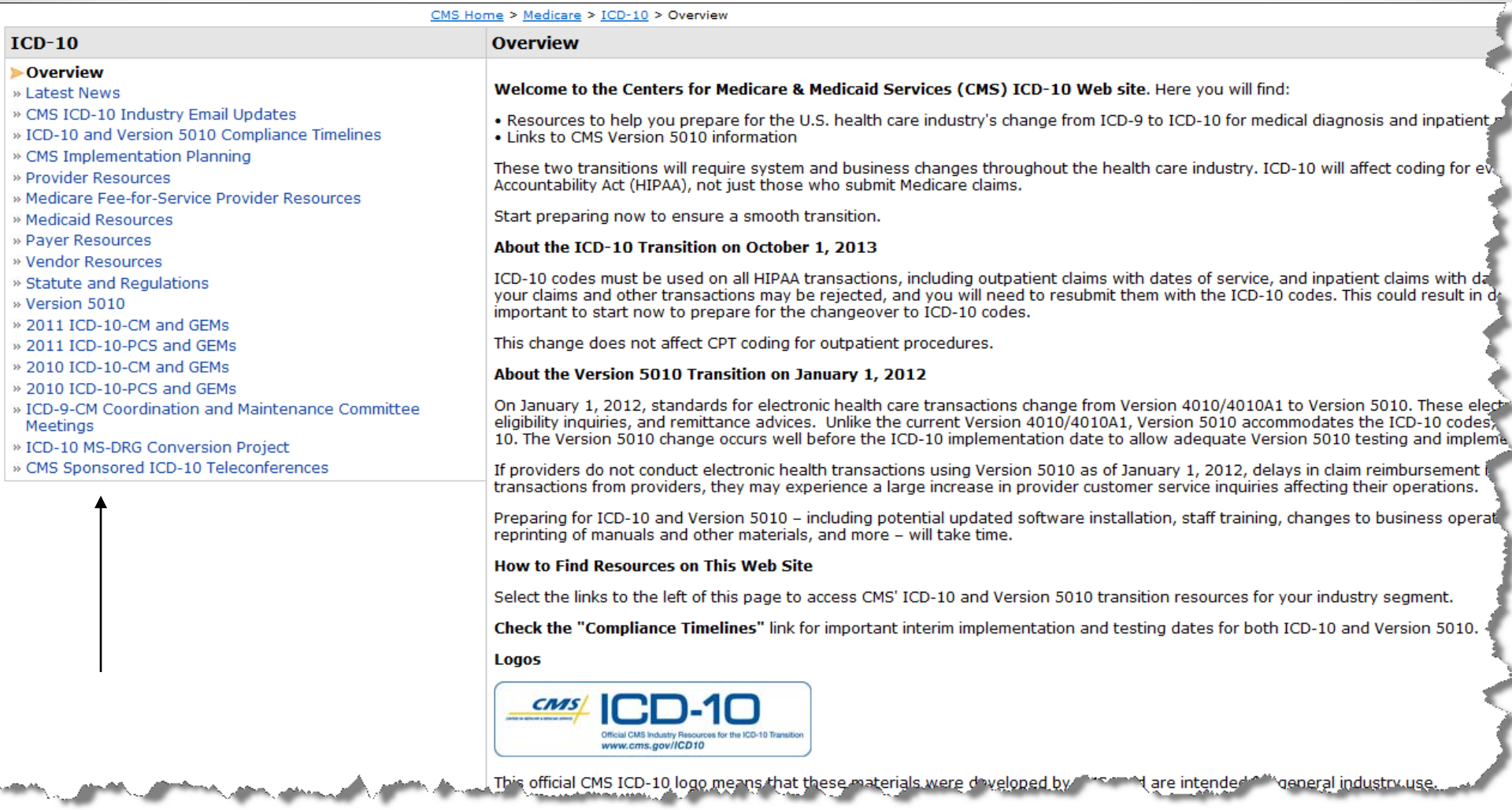
Medicare Fee-for-Service Part B Drugs
- Competitive Acquisition Program for Part B Drugs & Biologicals
- Medicare Part B Drugs Average Sales Price

Medicare Fee-for-Service Payment
- Fee Schedules - General Information
- Prospective Payment Systems - General Information
- Acute Inpatient PPS
- Ambulance Fee Schedule
- Ambulatory Surgical Center (ASC) Payment
- Clinical Laboratory Fee Schedule
- DMEPOS Competitive Bidding
- Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Sched
- ESRD Payment
- Home Health PPS
- Hospice
- Hospital-Acquired Conditions (Present on Admission Indicator)
- Hospital Outpatient PPS
- Inpatient Psychiatric Facility PPS
- Inpatient Rehabilitation Facility PPS
- Long-Term Care Hospital PPS
- Medicare FFS Physician Feedback Program/Value-Based Payment Modifier
- PC Pricer
- Physician Fee Schedule
- Physician Fee Schedule Look Up

ICD-9 Code Information



ICD-10 information



CMS Home > Medicare > ICD-10 > Overview

ICD-10

- **Overview**
- Latest News
- CMS ICD-10 Industry Email Updates
- ICD-10 and Version 5010 Compliance Timelines
- CMS Implementation Planning
- Provider Resources
- Medicare Fee-for-Service Provider Resources
- Medicaid Resources
- Payer Resources
- Vendor Resources
- Statute and Regulations
- Version 5010
- 2011 ICD-10-CM and GEMs
- 2011 ICD-10-PCS and GEMs
- 2010 ICD-10-CM and GEMs
- 2010 ICD-10-PCS and GEMs
- ICD-9-CM Coordination and Maintenance Committee Meetings
- ICD-10 MS-DRG Conversion Project
- CMS Sponsored ICD-10 Teleconferences

Overview

Welcome to the Centers for Medicare & Medicaid Services (CMS) ICD-10 Web site. Here you will find:

- Resources to help you prepare for the U.S. health care industry's change from ICD-9 to ICD-10 for medical diagnosis and inpatient
- Links to CMS Version 5010 information

These two transitions will require system and business changes throughout the health care industry. ICD-10 will affect coding for ev Accountability Act (HIPAA), not just those who submit Medicare claims.

Start preparing now to ensure a smooth transition.

About the ICD-10 Transition on October 1, 2013

ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with da your claims and other transactions may be rejected, and you will need to resubmit them with the ICD-10 codes. This could result in d important to start now to prepare for the changeover to ICD-10 codes.

This change does not affect CPT coding for outpatient procedures.

About the Version 5010 Transition on January 1, 2012

On January 1, 2012, standards for electronic health care transactions change from Version 4010/4010A1 to Version 5010. These elect eligibility inquiries, and remittance advices. Unlike the current Version 4010/4010A1, Version 5010 accommodates the ICD-10 codes, 10. The Version 5010 change occurs well before the ICD-10 implementation date to allow adequate Version 5010 testing and impleme

If providers do not conduct electronic health transactions using Version 5010 as of January 1, 2012, delays in claim reimbursement i transactions from providers, they may experience a large increase in provider customer service inquiries affecting their operations.

Preparing for ICD-10 and Version 5010 – including potential updated software installation, staff training, changes to business operat reprinting of manuals and other materials, and more – will take time.

How to Find Resources on This Web Site

Select the links to the left of this page to access CMS' ICD-10 and Version 5010 transition resources for your industry segment.

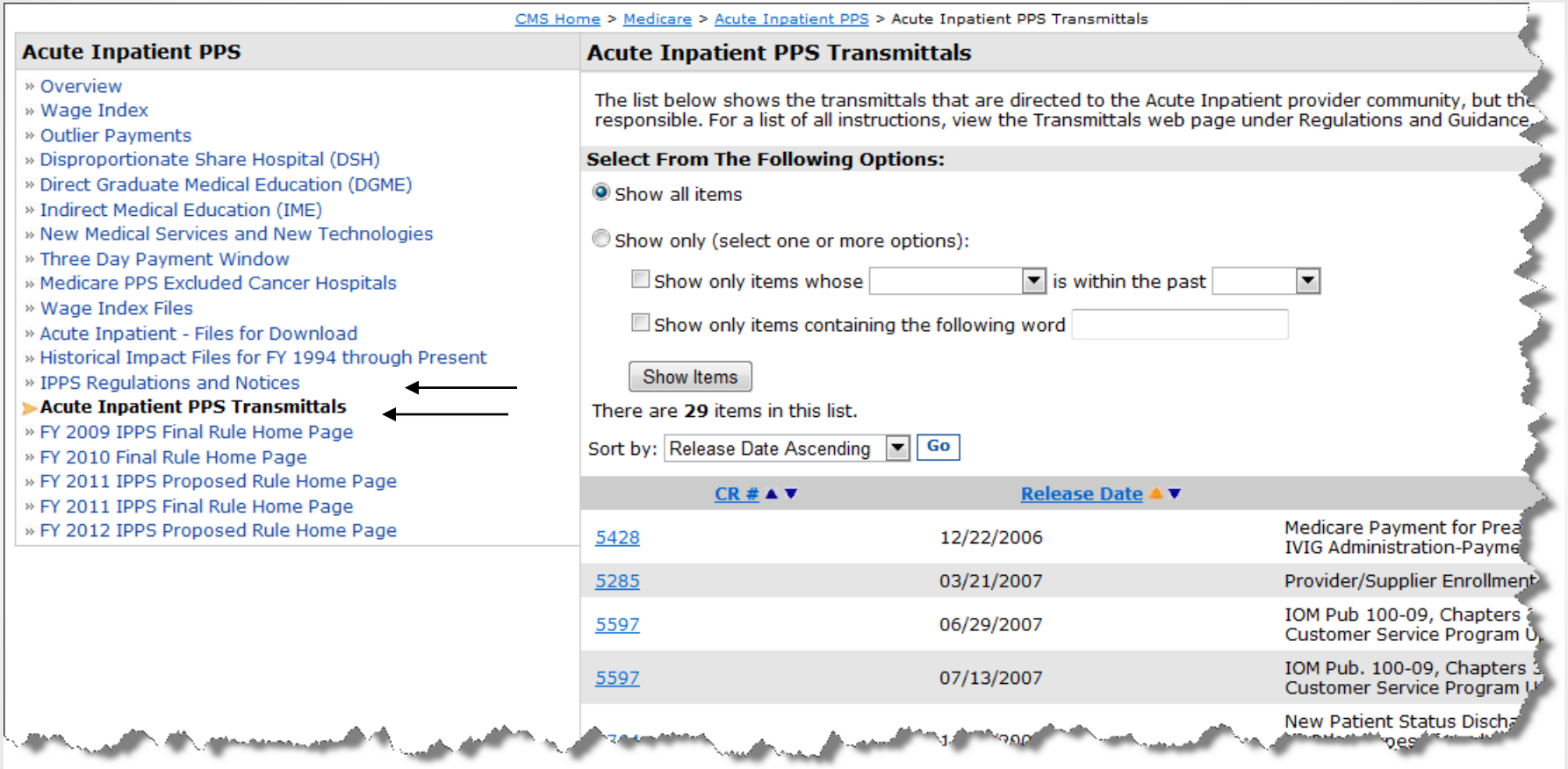
Check the "Compliance Timelines" link for important interim implementation and testing dates for both ICD-10 and Version 5010.

Logos

CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

This official CMS ICD-10 logo means that these materials were developed by and are intended for general industry use.

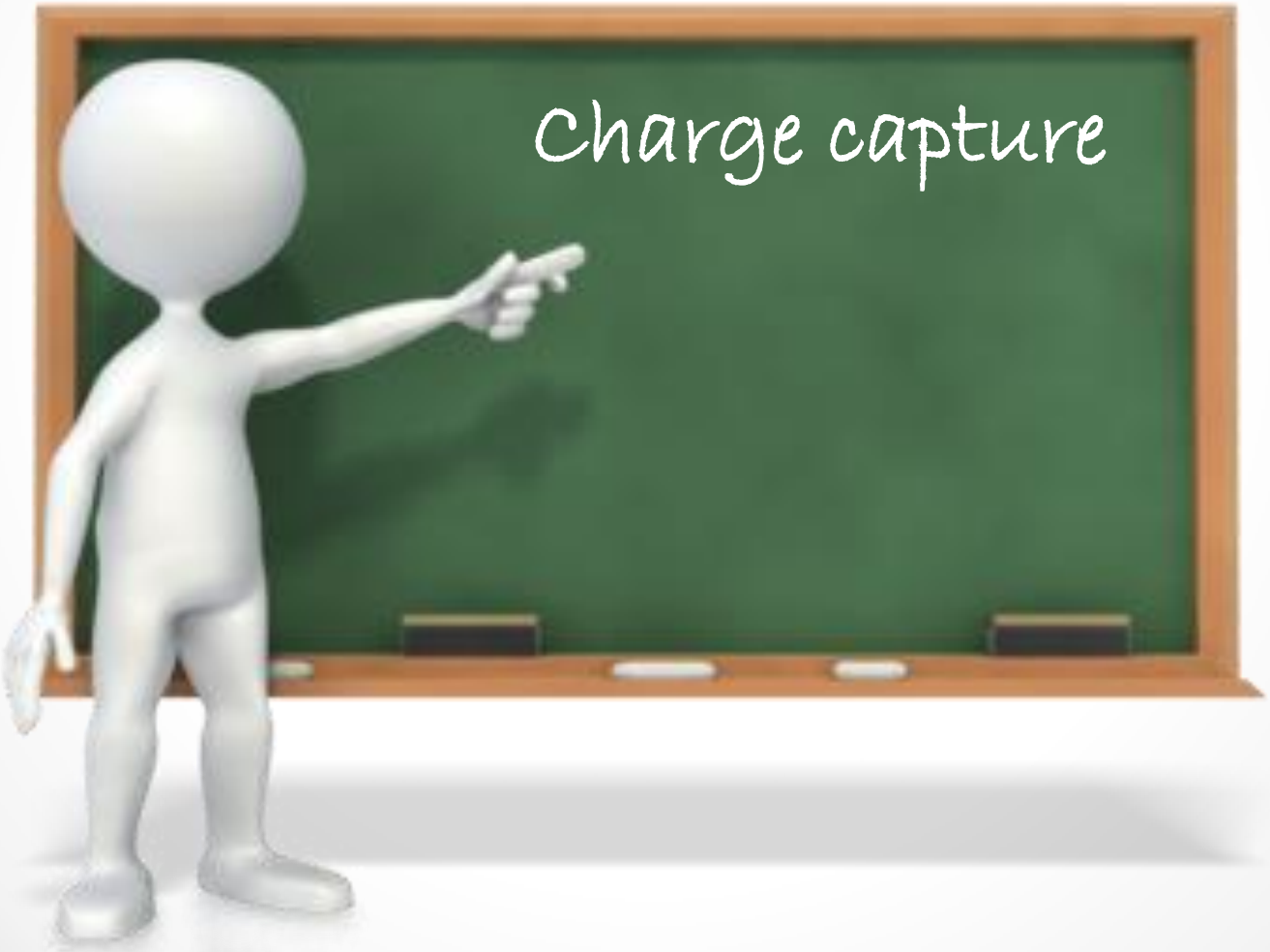
Regulations / Transmittals



For OPPS regulations, go to OPPS page.

Or to really make it easy, call your hospital's accounting firm!

What have we learned?



Draffin & Tucker, LLP
CERTIFIED PUBLIC ACCOUNTANTS

IT'S ALL ABOUT YOU! – PART 2

Departmental Responsibilities for the Charge Description Master

End of webinar