# Billing for inpatient hospital care

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**Abstract:** Pharmacy personnel billing patients for services rendered is discussed.

Billing for services is a critical function for maintaining the financial viability of health care institutions. Poor understanding of the system can lead to incorrect documentation, which can result in a claim rejection. The UB-92 provides hospitals with the proper format to request reimbursement for services provided. To ensure proper reimbursement, appropriate coding of International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes for diagnosis, procedures, and services provided is necessary. Ancillary services, such as pharmacy, play a crucial role in the completion of the bill by ensuring that the charge-master accurately represents the service provided. This information includes identification, charge, cost, and revenue codes. Hospital billing agents must also account for any outpatient visits that may have occurred within three days of admission, since these charges may need to be included on the hospital bill. In order for the billing process to be effective, it is important that all personnel have a thorough understanding of the billing process and be able to effectively communicate with each other.

**Index terms:** Billing; Codes; Hospitals; Pharmaceutical services; Pharmacy, institutional, hospital; Reimbursement
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Accurate and timely billing is critical to the financial success of any service organization. The complexity of the health care industry has resulted in an equally complex process for billing medical care. Mastering this process requires intense training and ongoing education. To ensure appropriateness, government agencies have developed numerous standards for billing, coding, and documentation of medical care. Billing errors may have significant ramifications because they can be classified as fraud under the False Claims Act.[1] For these reasons, it is necessary that pharmacy personnel develop and maintain an understanding of the billing process. The objectives of this paper are (1) to provide an overview of the process for initiating a bill for inpatient services, (2) to review the forms used for inpatient and outpatient care, and (3) to emphasize the importance of accurate and timely billing for pharmacy services.

Hospitals are classified by type of ownership, number of beds, and teaching status. Hospitals may also be classified based on specialty or services provided (e.g., surgical, ophthalmologic, orthopedic).[2] The two major types of hospital settings are general, which is often referred to as acute care, and specialty, which is often more long-term care in focus.[3]

A third-party payer reimburses hospitals for services provided. These payers are grouped into government (e.g., Medicare, Medicaid), private (e.g., Blue Cross, Blue Shield), and HMOs (e.g., Kaiser Permanente). Hospital charges are often divided into two types: facility charges (e.g., room and board) and ancillary charges (e.g., radiology, laboratory, pharmacy).[3]

## Billing Forms

Generation and submission of a hospital bill are the mechanisms by which hospitals request reimbursement for services provided. There are several steps that comprise the bill creation process (Figure 1). In order for this process to be successful and capture appropriate reimbursement, these steps must be performed effectively. This section will review specific billing forms used in the process.

Billing forms are necessary for consistency in the information required to provide reimbursement for services provided. Two major billing forms currently used to obtain reimbursement include the Uniform Billing Form rev 92 (UB-92) and the Health Care Finance Administration Billing Form Number 1500 (HCFA 1500), now known as CMS

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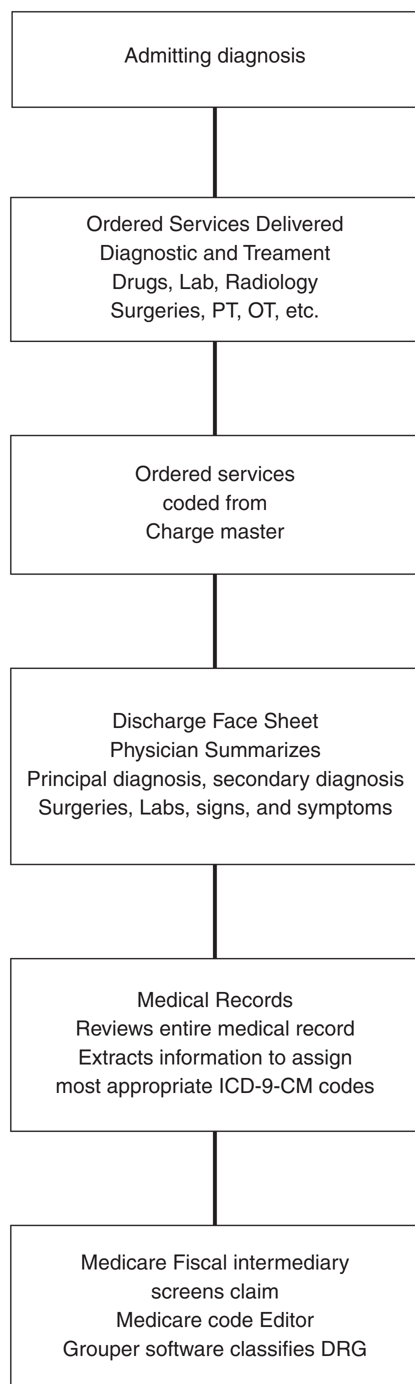
**Figure 1.** Overview of billing process.




1450 and CMS 1500, respectively. Reimbursement of inpatient and outpatient hospital care is obtained through submission of the UB-92.[4] Non-hospital services, such as in-hospital physician services and private office visits require the CMS 1500.[3,4]

The UB-92 Form contains many fields in which to capture a comprehensive itemization of services. A sample of item characteristics includes the reason and date of admission, condition codes, occurrence codes, revenue codes (for services rendered), and payer information. Up to nine International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic codes and six procedure codes may be documented. Detailed completion of this form provides the fiscal intermediary with necessary data to process the reimbursement request.

Governmental and non-governmental payers use the UB-92 form for claims submissions. While Medicare and Medicaid require the use of this form, other programs may modify the form to fit the needs of their organization.[3] These modifications are often unique to a given payer and must be used for all claims. Under the lead of the Uniform Billing Committee and new legislation, more payers may be required to use the UB-92, which is under revision.[5] This revision, known as UB-02, is expected to be completed and implemented by 2004–2005.

## Charges

There are several types of charges that are incorporated into the hospital bill: facility, ancillary, and physician. Depending on the payer, service type and setting, the coding of these charges may vary.[6] The facility and ancillary charges are coded on the UB-92 form using the ICD-9-CM system for inpatient hospital care for diagnoses and procedures. In addition, 23-hour outpatient admissions, which use inpatient services, and outpatient services that occur in a hospital-owned or operated facility must have the charges submitted using the UB-92. Due to significant growth in diagnostic and procedural services, the ICD-9-CM coding system has come under scrutiny, as there is a shortage of available codes. This concern has led many groups to support a transition to ICD-10-PCS as the new standard, which will be discussed in a later article.[7]

**Facility Charges.** Hospital facility charges consist of room, board, and continuous nursing care. This is the daily charge for a patient to occupy a bed in the hospital. The charge is dependent upon the level of care that the patient requires, with higher intensity of care being reflected with a higher charge. The ICD-9-CM, which is the coding system for hospital inpatients, serves as documentation and substantiation for a given facility charge.[7,8] The ICD-9-CM system is used for medical treatments and surgical procedures. Relevant diagnostic and procedural codes are assigned either during the hospitalization (concurrently) or upon discharge (retrospectively) to document the need for admission and patient condition. From this documentation, subsequent facility charges are applied.[3] To ensure appropriate coding, periodic chart reviews (known as coding compliance reviews) are performed. Once assigned, codes are entered into the hospital billing system and into the UB-92 form.[3]

**Ancillary Charges.** Services provided by ancillary departments are not captured by the facility charge. Ancillary charges are generated by the department providing service, such as radiology, pharmacy, and laboratory services. These charges must be coded separately and are captured at the time of service.[3,4] Departments providing a particular service ensure that the necessary code and charge information are included as part of the reimbursement process.[3,4] This is most often done through use of the charge master, which is a file that encompasses all necessary information for a service such as code, identification, and charge. The charge master, which is also known as the charge description master (CDM), drives the charges not captured by other mechanisms.

In order to ensure appropriate documentation within the charge master, several details must be present, including Healthcare Common Procedural Coding System (HCPCS) codes (if one exists), correct revenue codes, and units of service (e.g., doxorubicin comes as 10-mg vials so a dose of 100 mg equals 10 units of service). Another crucial function of a charge master is to ensure that medications with multiple uses have multiple entries that correspond to each use. Contained within the charges are the cost of the service, item provided, and any applicable service charge and relative mark-ups.[3] Service charges are incorporated into the charge master because ancillary departments may not directly bill for services. These charges are then uploaded into the institutional billing system and processed onto the applicable UB-92, in locator field 42, as a revenue code.

**Physician Charges.** Typically, physician and physician assistant charges are not part of the facility and ancillary charges, irrespective of the employment status of the provider.[3] Physicians' and physician assistants' services must be billed separately, except in the case of inclusive rate and teaching hospitals, where combined billing can be done.[4] The hospital will submit charges for physicians it employs on CMS Form 1500 and reimbursement will come directly to the hospital. Physicians not employed by the hospital are responsible for their own billing and will do so through their offices on a CMS Form 1500.[3,4]

The separate billing mechanism for physician charges may result in the patient receiving multiple bills. This can lead to significant patient confusion and complaints. It is imperative that patients be made aware of this process in order to prevent confusion.[3]

## The 72-hour rule

The 72-hour rule is associated with the prospective payment service (PPS) of Medicare Part A. This rule pertains to certain preadmission services that occur within three calendar days of admission.[3,4] The rationale for the 72-hour rule is based upon the reimbursement formula for inpatient admissions, which accounts for outpatient services that occur within three days of admission. These services do not have to be related to the reason for admission. The primary determinant of the rule is ownership.[3,4] For the 72-hour rule to apply, the outpatient facility must be wholly owned or operated by the hospital. Services not included in this rule include dialysis, ambulance, hospice, and home health care unless they are part of Medicare Part B.[4] Violations of the 72-hour rule are classified as fraud under the False Claims Act. The most common source of violations occur when the hospital and outpatient facilities are part of a large network in which the admitting hospital may not be aware of the preadmission tests.[4] The following examples demonstrate particular violations that may occur:[3]

- Billing for outpatient services is processed before patient is admitted to the hospital and, therefore, is not combined with hospital charges.
- Clerical errors in recognizing and combining outpatient and inpatient charges that fall within the 72-hour rule.
- Lack of staff or inadequately trained staff able to coordinate inpatient and outpatient services, resulting in duplicate billing.
- Lack of computerized audits to detect and prevent duplicate billing.

## Revenue Codes

Revenue codes serve as the mechanism through which hospitals capture the services associated with individual cost centers, often referred to as ancillary departments.[3,4] These codes, which are captured in the charge master, are numeric descriptors of specific accommodations, ancillary services, or billing calculations. They are required on all hospital-based claim forms for inpatient and outpatient services.[3]

Codes are assigned for each procedure or service documented in locator field 42 of the UB-92.[4] There is a specific format and convention used for revenue codes. The codes range from 0001 – 0999 with each number corresponding to a specific cost center. The first three digits of the code are used by individual states with the fourth reserved for national use. It is important to note that revenue codes established on a national basis are not always recognized by a given state, necessitating that hospitals maintain both state and national codes.[3,4]

The last digit of the code series has the option of zero to nine. These options correspond with certain "service classifications," with zero representing "general" and nine being "other." The remaining options vary based on specific third-party payer requirements. The following is a list of revenue codes most commonly associated with pharmacy:

- 250 General Classification
- 251 Generic Drugs
- 252 Non-generic Drugs
- 253 Take-home Drugs
- 254/255 Drugs incident to diagnostic or radiologic services
- 256 Pharmacy Experimental
- 257 Pharmacy Non-prescription
- 258 i.v. solutions only, NOT supplies
- 259 Pharmacy Other
- 260 i.v. Therapy–General Administration
- 636 Drugs requiring detailed coding (HCPCS)
- 637 Self-administered

## Conclusion

Creation of the bill is a critical step in the reimbursement process. Appropriate billing begins with a full understanding of the setting in which care was provided, since this dictates

the billing form to be used. An effective billing program can have a significant impact on an organization's revenue. Therefore, understanding the fundamentals of the billing process will allow practitioners to ensure an effective billing system is in place.

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