



Medicare Hospital and Chargemaster Version LifePoint Custom

Module 12: Revenue Integrity, Charge Description Master Structure, and Charge Capture Principles

I. Overview of Revenue Integrity

- A. The basis of revenue integrity is to prevent recurrence of issues that can cause revenue leakage and/or compliance risks through effective, efficient, replicable processes and internal controls across the continuum of patient care, supported by the appropriate documentation and the application of sound financial practices that can withstand audits at any point in time. <National Association of Healthcare Revenue Integrity (NAHRI)>

Link: National Association of Healthcare Revenue Integrity (NAHRI) under HCPro Websites

- B. It is essential to understand revenue integrity in the context of key functions of the revenue cycle, which may be organized into the front, middle, and back functions.
- C. Front end functions include pre-service and time of service processes.
1. Pre-service functions include “credentialing” the provider with the payer (i.e., enrolling), managing referrals and eligibility, managing authorizations and coverage validation, and pre-registration.
 2. Functions at the time of service include registration and demographics collection, creation of account for the encounter or stay, verifying insurance information, and providing required notices to the patient.
 3. Departments who may be involved in front end functions include patient access/patient registration, insurance verification departments, and administrative staff that manage enrollment.
- D. Middle revenue cycle functions include documentation of services, revenue capture and other functions occurring during or shortly after the service delivery.

1. Documentation functions include patient order management, documentation directly into the electronic medical record (EMR) which may include entry of free text or pre-scripted questions or forms, and transcription.
 2. Authorizations for inpatient and emergent services may occur during service delivery by or through case management/utilization review, certification and/or authorization and discharge management.
 3. At this point, charges are also “captured” for services delivered, the charges are associated with codes through the chargemaster (i.e., “hard coded”) or individually assigned codes (i.e., “soft coded”).
 4. Departments who may be involved in middle revenue cycle processes include patient care staff, case managers/utilization review nurses or physicians, chargemaster personnel (for maintaining the chargemaster) and coding staff, including clinical documentation integrity staff.
- E. Back end functions include the processes required for submission of the claim as well as post submission processes.
1. Claims functions related to submission of the claim include resolution of internal and clearinghouse claim edits and managing special claims processing and billing issues to allow submission of a “clean claim.”
 2. Post submission processes include resolution of external claim edits and follow-up, submission to secondary insurance, posting the payment to the account, verifying the correct payment was made, appealing clinical or billing denials, and even payer contract management.
 3. Departments who may be involved in back end functions include patient accounting, business office, coding staff, denials management staff, administrative staff that manage contracts.

II. Definition and Standard Charge Description Master (CDM) Fields

- A. A CDM is a file in a patient accounting system that contains specific standard fields; its purpose is to produce claims that meet HIPAA transaction set requirements, payer requirements, and financial reporting requirements.
1. The CDM may also be known as the chargemaster, line-item master, EAP file (Epic systems), financial item master, service item master, price list, or charge list.
 2. Access to the CDM should be limited, and changes tracked due to the significant compliance and financial risks associated with its use.

3. The CDM has multiple purposes, including:
 - a. Facilitating accurate financial reporting of revenue;
 - b. Facilitating comprehensive and compliant billing;
 - c. Supporting capture and categorization of patient care revenue;
 - d. Providing data to assess and manage resource utilization;
 - e. Providing one source of data to support inventory management; and
 - f. Facilitating Medicare and Medicaid cost reporting.

B. Standard fields

1. Charge or item number
 - a. Is a hospital-specific (and possibly but not necessarily department-specific) unique line-item identifier.
 - b. Is typically seven to nine digits long; the first two digits can represent a range.
 - c. Allows system interface between order entry and billing.
 - d. May also be known as CDM number, line-item number, or financial item number.
 - e. Charge number schemes:
 - (i) The first two digits represent the department or type of service
 - (a) This facilitates global price updates by department or service line (e.g., one department or range increases by 2% and another range increases by 5%);
 - (ii) The next four digits represent the department charge number;
 - (iii) Check digit.
2. General ledger (GL) revenue department code
 - a. Hospital-specific and correlates to GL numbers.
 - b. Typically four digits long.

- c. Links between the department and charge code for revenue and usage reporting, which varies by the system (e.g., Epic, Cerner, Meditech, McKesson).
 - d. Considerations related to the GL revenue department code include:
 - (i) Revenue centers vs. cost centers; and
 - (ii) Departmentalized vs. standardized CDM.
3. Charge description
- a. Is hospital-specific.
 - b. May be subject to system/file-specific character limitations.
 - c. Supports hard-coded CPT/HCPCS.
 - d. Is designed to prevent duplication and support consistency.
 - e. Considerations related to the charge description:
 - (i) Description standardization—pros and cons;
 - (ii) Clinically relevant descriptions; and
 - (iii) Patient-friendly descriptions.
4. Main revenue code
- a. Is universal, not hospital-specific.
 - b. Is defined by and proprietary to the National Uniform Billing Committee, a division of the American Hospital Association.
 - c. Characterizes either the type or location of the service (e.g., drugs or ED).
 - d. May differ based on patient type.
 - e. Considerations related to the main revenue code:
 - (i) General vs. detailed classification; and
 - (ii) Relationship to cost reporting for Medicare and Medicaid.
5. Main HCPCS code
- a. Is universal, not hospital-specific, and is specific to the item or service.

- b. May vary by payer.
 - c. Must accurately reflect the service or item provided to the patient.
 - d. HCPCS codes include:
 - (i) Level I—Current Procedural Terminology (CPT®) codes, defined by the American Medical Association;
 - (ii) Level II—Healthcare Common Procedure Coding System (HCPCS), maintained by the Centers for Medicare & Medicaid Services (CMS); and
 - (iii) Level III—payer defined, typically used by state Medicaid agencies (e.g., Medi-Cal Z codes).
6. Modifier(s)
- a. Can be a separate field or included with the HCPCS field.
7. Price, discussed in further detail later in this module.
- a. Is the list or “gross” price, not what is paid.
 - b. Is used to generate overall gross revenue for financial reporting purposes.
8. Effective date
- a. Represents the date the charge was established.
9. Active or inactive flag and date
- a. Used to provide historical data.
 - b. Note: Items in the CDM cannot be deleted due to the historical nature of the accounts receivable (AR) database and the possible need to rebill for prior time frames.
10. Proration or additional revenue and HCPCS code fields
- a. Allows for alternate revenue or HCPCS codes for different patient types and financial classes.
 - b. Defaults to the main revenue or HCPCS code if not populated.
 - c. Considerations for additional revenue code and HCPCS code fields:

- (i) Most providers use outpatient Medicare as their default (main) revenue and HCPCS code;
 - (a) Example: Revenue code 0250 for self-administered drugs for inpatient claims and 0637 for outpatient claims
- (ii) Medicare HCPCS;
- (iii) Medicaid outpatient revenue code; and
- (iv) Medicaid HCPCS.

11. User-defined or optional fields

- a. Billing description
- b. Supply item master cross reference
- c. Cost, to enable monitoring of markup policy
- d. Relative value units (RVU)

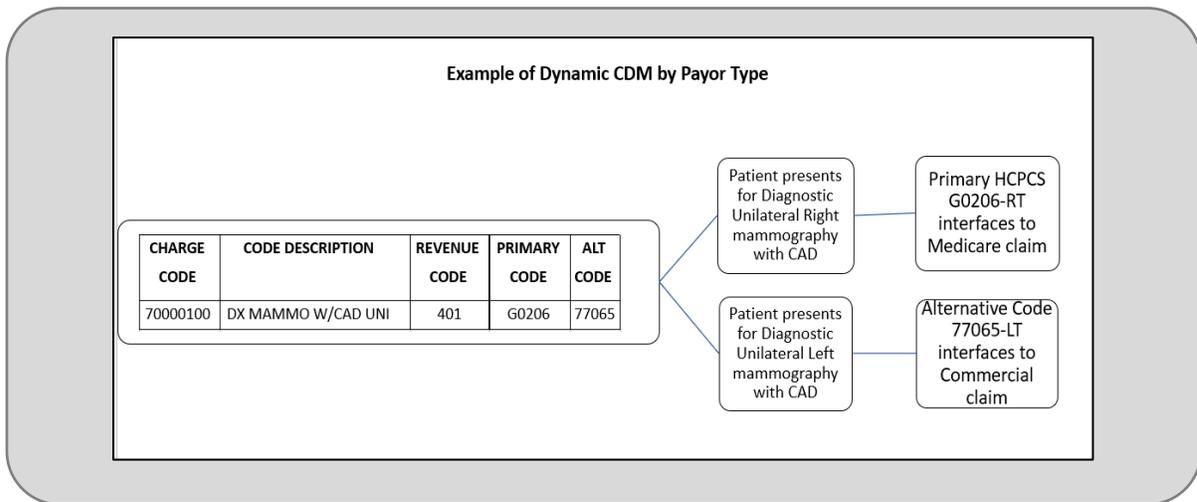
C. Dynamic vs. static CDMs

- 1. A static CDM is a file with all charge attributes defined in the CDM or file in the patient account system.

Example of a Static Charge Description Master								
RECORD STATUS	DEPT	GL #	DEPT NAME	CHARGE NUMBER	CHARGE DESCRIPTION	PROCEDURE CHARGE	REV CODE	CPT4 CODE
A	1200	12001000	Diabetic Clinic	12003000	DIABETIC ED INDV 30MIN G0108	150.00	942	G0108
A	1200	12001000	Diabetic Clinic	12003000	DIABETIC ED GRP 30MIN G0109	75.00	942	G0109
A	3990	39901000	Nursery	39901001	NEWBORN LEVEL 1	800.00	170	
A	3990	39901000	Nursery	39901002	NEWBORN LEVEL 2	800.00	171	
A	3990	39901000	Nursery	39901003	NEWBORN LEVEL 3	1000.00	172	
A	3990	39901000	Nursery	39901004	NEWBORN LEVEL 4	2000.00	173	
A	3990	39901000	Nursery	39901005	NEWBORN LEVEL 5	3000.00	174	

- 2. A dynamic CDM has a more limited set of fields in the core file, and other files allow different attributes to work with the key CDM fields.
 - a. Different attributes are allowed for each item depending on requirements such as location.
 - b. It allows the same CDM code to be used in multiple areas of the hospital.

- c. It allows multiple fee schedules that the charge router can select from based on patient location, provider type (physical therapy vs. occupational therapy, etc.), and other attributes.
 - d. Example attributes include:
 - (i) CDM item number and CPT® code are static;
 - (ii) Revenue center is assigned within the charge router based on patient department or user login; or
 - (iii) Information is evaluated to assign the most specific revenue code by patient type and financial class.
3. Many patient accounting systems are converting to dynamic chargemasters.



D. Exploding charges

1. Refers to a feature in the CDM and patient accounting system that allows a single charge number to be posted to a patient account and results in two or more charges posting simultaneously to the account.

- a. Good examples and uses of exploding charges include vaccine administration triggered from vaccine drug charges and Protime clinic charges.

Exploding Charges			
Exploding Charges - Configuration 1			
CDM Number	Charge Description	Revenue Code	CPT/HCPCS
1234567	Flu Vaccine	0636	90666
2345678	Flu Vaccine Administration	0771	G0008
Exploding Charges - Configuration 2			
CDM Number	Charge Description	Revenue Code	CPT/HCPCS
3456789	Flu Vaccine Exploding charge		
1234567	Flu Vaccine	0636	90666
2345678	Flu Vaccine Administration	0771	G0008

Configuration 1 = A single charge is defined as exploding and that charge and its "baby" both populate the claim. In this case, the Flu Vaccine is the exploding charge.

Configuration 2 - A single charge is the "shell" and only the associated baby charges populate the claim. In this case, the Flu Vaccine Exploding Charge is the shell.

III. Relationship of CDM to health information management (HIM) coding

A. HIM coding responsibility

1. Inpatient vs. outpatient coding and types of outpatient services
2. Coding abstract module in AR system
3. Grouper programs & abstract edits

B. Claim/billing process

1. Bill form set up by patient type/financial class.
2. Relationship to proration

C. Hard coding vs. soft coding

1. Hard coding refers to entering the HCPCS procedure code in the CDM for the charge code and may be thought of as static.
 - a. Modifiers may also be hardcoded (e.g., a set of ED visit codes 99281–99285 and another set at the same prices with modifier -25 [99281-25 through 99285-25]).

- Soft coding refers to CDM codes with no HCPCS code entered—the HCPCS procedure code is determined by HIM and entered in the HIM coding abstract that “matches up” to the charge; soft coding may be thought of as dynamic.

Example Outpatient HIM Coding Abstract

Patient Demographics	Medical Record Number	Account Number	Emergency or Outpatient	
	Date(s) of Service	Attending Physician	Patient Type	
	Payer	Admission Source	Discharge Status	

Revenue Code	HCPCS Code	Modifier	Date of Service	Units	Operating Physician(s)
250			1/15/18	17	
278	C1758		1/15/18	1	
300	85025		1/15/18	1	
300	85025	91	1/15/18	1	
360			1/15/18	3	
370			1/15/18	3	
710			1/15/18	4	

- Mutually exclusive definition by revenue code (e.g., 0360, 0750).

Example of Mutually Exclusive HIM Soft vs CDM Hard Coding Set up

Department	CDM Number	Charge Description	Revenue Code	CPT/HCPCS
Surgery	3000031	OR EA ADDITIONAL 15 MIN	0360	
Surgery	3000064	OR 1ST 30 MIN	0360	
Department	CDM Number	Charge Description	Revenue Code	CPT/HCPCS
Lab	5201520	CHEMSTRIPS	0300	82962
Lab	5100961	URINALYSIS COMPLETE	0300	81001
Lab	5500632	RH	0300	86901
Lab	5500012	CROSSMATCH-PACKED CELLS	0300	86920

In this example, revenue code 0360 used for surgery in main OR suites and other departments such as OB is always set up in the CDM without any CPT/HCPCS because these charges are always to be CPT/HCPCS coded by HIM/Coding.
Conversely, revenue code 0300 for lab services always has a CPT/HCPCS code hard coded in the CDM for all departments.

- HCPCS ranges (e.g., surgery range 1xxxx–6xxxx vs. per revenue code).
- Priority—if HCPCS are present in the CDM with revenue code 0360 and HIM also codes 0360 charges, how does the system know which HCPCS to print on the claim?

D. Coding edits may be applied at various levels:

1. HIM coding
2. Claim production
3. Claim submission

E. Ways to address payer differences in the CDM:

1. Proration fields
2. Payer claim
3. Bridge routines from claim load to claim scrubber/clearinghouse

IV. Relationship with Overall AR System and Master Files

A. Major patient types (inpatient, outpatient, ED)

1. Different screens may be set up for HIM coding by patient type, and different fields may print to the claim.
2. Example: Patient reason for visit diagnoses required on emergent and observation claims.

B. Financial classes (Medicare, Medicaid, commercial)

1. Medicare as a financial class usually has a specific bill type that ensures each field meets CMS claim requirements.
2. Medicare Advantage or Part C can be set up as a Medicare financial class or a commercial, financial class. This is a decision made by the organization and contracted Medicare Advantage plans may be in the contracted commercial insurance financial class while non-contracted plans may be in the Medicare financial class.

C. Bill or claim or account type.

1. How the patient accounting system is programmed may differ based on these settings. For example, the system may either auto-discharge the account or remain open until the account is manually discharged.
 - a. Inpatient—requires manual discharge by patient registration.
 - b. Outpatient—auto discharge (e.g., at 2359 or one-minute post-registration as an automatic setting).

- c. Outpatient—repetitive/recurring/series (these usually also require manual discharge by patient registration).
- D. Settings and master files govern whether charges per revenue code appear in detail on a claim or are summarized on a claim, summarize all units to one per date of service, prioritize HIM codes over CDM codes, match HIM codes to charges by revenue code, etc.
 - 1. To identify root causes of problems, work issues backward from the UB04 claim, identify the 837I loops and segments, and follow the trail to the originating source of data through any system transitions and files.
 - 2. Automate/reduce opportunities for variation whenever possible.
- V. Relationship to Cost Report and Requirements for Pricing Services
 - A. To participate in Medicare, all hospitals must file annual cost reports.
 - 1. What is a cost report?
 - a. A cost report is a year-end report of statistical and financial data used in determining the cost of services provided to Medicare beneficiaries throughout the year.
 - b. State Medicaid programs often require cost reports to be filed using the Medicare annual cost report.
 - 2. Cost reporting requirements apply to all patients, not just Medicare patients, as they dictate the general accounting principles and additional requirements for expense and patient revenue accounting practices.
 - 3. Instructions are sub-regulatory in the Provider Reimbursement Manual.
 - a. Part 1 contains definitions and instructions
 - b. Part 2 contains various cost reporting forms
 - (i) Some expenses (i.e., organ procurement and CAHs) are still paid reasonable costs.
 - B. The PRM1 contains a definition of charges:
 - 1. Charges refer to the rates established by the provider for services rendered.
 - 2. Charges should be:
 - a. related consistently to the costs of the services

- b. uniformly applied to all patients, whether inpatients or outpatients.
3. All charges should be recorded at the gross value (i.e., charges before applying allowances and discounts deductions). <Provider Reimbursement Manual Part 1, Section 2202.4, Charges>
- a. There is no requirement that the same service performed in different departments have the same rate.
 - b. Charges are to be related consistently to the costs of the service.
 - (i) An outpatient department's costs are often different from those in an emergency or other department; therefore, the hospital is allowed to have different prices per department for the same service as defined by a HCPCS/CPT code.
 - (ii) Hospitals may establish the same price for the same CPT service across departments. Caution is advised because it may distort the relationship to costs.
 - c. CMS has taken the position that hospitals can have lower outpatient prices for services in the same department.
 - (i) For example, MRI prices for inpatients and emergency patients are higher than scheduled outpatients.
 - (ii) Finance and cost reporting must be involved before lowering any outpatient prices because the lower prices must be "grossed up" to the inpatient price for the correct allocation of costs in the cost report. <PRRB Case 92-0507 at <https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/1998D071.pdf>>
4. How hospitals set charges:
- a. Hospitals can set charges for items properly so that charges converted to costs can appropriately account fully for their acquisition and overhead costs. <70 Fed. Reg. 68654>
 - b. Each facility should have an established charge structure applied uniformly to each patient as services are furnished, which is reasonably and consistently related to the cost of providing the services.

- c. Medicare cannot dictate to a provider what its charges or charge structure may be. The program may determine whether or not the charges are allowable for use in apportioning costs under the program. <Provider Reimbursement Manual, Part 1, Section 2203, Provider Charge Structure as Basis for Apportionment>
 - (i) "Apportionment" is an accounting term where charges are used as a statistic to allocate expense.
 - (ii) The statistic is often the amount of revenue in one department (e.g., radiology) compared to another (e.g., surgery).
 - (iii) If charges are not posted consistently at the same price for the same service, the charges are not reasonable or reliable for apportionment or for use as a statistic to allocate expense from non-revenue departments to revenue departments.
- C. Financial statements and expected revenue are based on pricing information, including historical pricing. One role of chargemaster coordinators is to avoid significant variations in gross revenue.
1. This includes preventing significant variations:
 - a. By department
 - b. By type of service
 2. Gross revenue is estimated by multiplying the price by the year to date or the annualized volume.
 - a. Note that the GL has a "cutoff" date—midnight of the last day of the month or the next date. GL revenue "posted" in a month may not equal AR revenue reported in a month (e.g., claims can "bill" in one month that have posted charges from a prior month).
- D. Best practice for charges:
1. Have written policies on:
 - a. Room rates - What is included in each inpatient unit's room rates – this does not have to be consistent and should be unique to the patient population treated in each nursing unit.
 - b. Supply markup – including a CCR-based mark-up when items are considered new technology and/or pass-through devices.

- c. Purchased or “under arrangement” services should be treated as “expense” based services (which they are) and receive a markup consistent with the cost-to-charge ratio (CCR) of the department to which the expense is charged.
- (i) Common “under arrangement” services include:
- (a) Purchased reference lab tests—consider paying the lab no more than the Medicare CLFS allowable amount and then mark up with the lab CCR. **Caution** if your state has a lab anti-markup policy applicable to hospital providers.
 - (b) Purchased dialysis services—the contract agreement with the dialysis company should detail out the CDM services and also charge capture within 24 hours of service. Consider using the hospital overall CCR for markup.
 - (c) Specialized imaging such as open MRIs—use the MRI department CCR as the basis of markup.
 - (d) ECG/teleheart monitoring—use the applicable CCR based on the department/revenue code with the revenue.
 - (e) Lithotripsy—use the OR CCR for markup.

Note: Ambulance transports to and from “under arrangement” service providers like an open MRI provider are not billable as “ambulance” with revenue code 0540. The patient transport expense is to be charged to the department representing the service to increase the CCR (in this case, the MRI department).

- d. Pharmacy markup
- (i) Consider no markup or not charging a price for low-cost, over-the-counter medications below a low-cost threshold such as \$10 or \$20.
 - (ii) CMS has instructions for no-cost pharmacy items when furnished for free or at no cost, including under a clinical trial. <See MM10521 Effective January 1, 2009>
- e. What supplies are separately charged vs. packaged with procedure/service charge?

- (i) For ease of cost estimations, price transparency, and charge capture, consider packaging all non-implant/C-code device supply charges into the procedure and visit charges in all departments but those itemizing detailed supplies such as surgery and endoscopy suites.
 - f. The owning department for certain charges to ensure accountability for charge capture (e.g., blood administration, code blue).
 - 2. Do not increase expense-based charges like supplies and drugs by the annual price increase; rather, ensure expense is updated and follow markup policies.
 - 3. Charge/price reductions are possible and often times appropriate but consider phasing them in to reduce their impact on financials, revenue and contracting.
- E. Types of charges:
- 1. Time-based charges (e.g., OR, PACU)
 - 2. Service-based charges (e.g., visits, CPT procedures, respiratory therapy procedures)
 - 3. Expense-based charges (e.g., drugs & supplies & “under arrangement” purchased services)
- F. Providers should consider price transparency, the complexity of up-front estimates and collections, and patient experience in addition to finance and managed care contract considerations when pricing services.
- G. Revenue codes and GL revenue departments can be used to segment types of services for variable percentage price increases.
- 1. Expense & revenue should match in the GL and with revenue codes for accurate CCR development from the cost report.
 - 2. Generally, CMS does not instruct hospitals on assigning HCPCS codes to revenue codes for services provided under OPSS since hospital assignment of cost varies. Where explicit instructions are not provided, hospitals should report their charges under the revenue code, resulting in the charges being assigned to the same cost center. The cost of those services is assigned in the cost report. < *Medicare Claims Processing Manual*, Chapter 4 § 20.5 >

Link: Revenue Code to Cost Center Crosswalk under Medicare-Related Sites - Hospital

More about the Medicare cost report and the Medicare revenue center crosswalk applicable to CMS rate setting for inpatient and outpatient services is included in the materials behind the outline.

- H. Due to significant packaging policy and composite and comprehensive APCs, OPSS payment rates **should NEVER be used** as the sole gauge for pricing procedures. Prices should not be set using a multiple of the APC payment rate. Note that the APC system is a prospective payment system, and the APC

Cost report cost centers vs. GL departments

Cost centers:

- May include more than one GL department
- Segregate non-allowable costs from GL departments

GL departments:

- Specific to the entity
- Expense and revenue need to be reclassified to correct cost centers

payment rate will pay irrespective of the billed charge being higher or lower than the APC payment rate.

1. Consider MPFS facility RVUs for each CPT/HCPCS within an APC payment rate to determine the relative expense of one procedure compared to another.
2. Consider comparing other similar hospitals in market/region/state/nation based on CMS claims data. Remember, hospitals are required to charge all patients the same charge for the same service, so it is reasonable to assume that Medicare charges on Medicare claims represent the standard hospital's charge to all patients for the service.
3. Consider reviewing the HCPCS cost file published with each OPSS proposed and final rule.
4. **Caution:** Other payers try to follow APCs, but they may pay lower charges or payment rates even though the single/composite rate represents packaged services. Educate payers and attempt to negotiate an end to lesser than provisions when the payer espouses use of a prospective payment methodology.

I. Charge Compression

1. A low-cost item is marked up by a higher percentage than a high-cost item.
2. When the expense and revenue are aggregated into one cost center, the higher utilization of the lower-cost items outweighs the higher-cost items, and the overall cost-to-charge ratio (CCR) is suppressed.
3. When CMS applies the CCR to the charge for the device on the claim, the resulting calculation is much less than the invoice cost. It is critical to price supplies and devices correctly so that CMS will calculate close to the invoice.
4. Ensure the hospital correctly aggregates all implantable device expenses and revenue into the designated cost center in the cost report. The implantable device CCR is used for hospital-specific outpatient device pass-through payment calculations and for APC payment rate calculations.

J. Additional Information Regarding the CDM and Cost Reporting

1. Reimbursement/finance staff tend to file consistent cost reports year after year to avoid controversy, which may not be correct.
2. Point-of-service lab tests create a mismatch because the expense is in the performing department, but it must be billed with the revenue code for lab.
3. GL natural class is for supply expense, but no separate supply charge is reported.
4. Imaging services that are no longer billable and part of surgical CPT codes create a mismatch because imaging staff and equipment perform services, likely in the radiology cost center; however, the revenue is billed under the surgery revenue center.
5. Consider running a report no less often than annually to share with the reimbursement manager or cost report preparer that shows the revenue codes used to bill each departments' services.

VI. Charge Principles

A. Charges must meet multiple requirements:

1. CMS' definition of a charge:
 - a. Charges refer to the rates established by the provider for services rendered.
 - b. Uniformly applied to all patients, whether inpatients or outpatients.

- (i) If a charge cannot be reported separately for an outpatient, then that same charge cannot be separately reported on an inpatient account.
 - (ii) Some charges are specific to the status of the patient. For example, ED and observation services can only be charged on outpatient accounts. Room charges can only be charged on inpatient accounts after the inpatient admission order.
- c. All patients' charges used in the development of apportionment ratios should be recorded at the gross value (i.e., charges before the application of allowances, discounts, and deductions). < *Provider Reimbursement Manual* Part 1, § 2202.4, Charges >
- d. Charges should be consistently related to the reasonable costs of the services they represent.
- (i) Service-based with overhead and margin
 - (ii) Expense-based with overhead and margin
2. Charges must meet HIPAA transaction set rules, including code sets.
- a. NUBC defines revenue codes that differentiate the location of services and types of services.
- (i) Examples include but are not limited to ICU, Labor & Delivery, ED, Pulmonary Function (diagnostic), Respiratory Therapy (therapeutic), Clinical Lab, Blood Administration, MRI, and CT.
 - (ii) Charges must be differentiated to these revenue codes to meet NUBC reporting requirements applicable to all providers and payers.
 - (iii) Some revenue codes are designated as packaged and do not require a HCPCS code, while others require a HCPCS code, or edits will return the claim for correction.
 - (iv) For example, NUBC instructions do not require a HCPCS code on revenue code 0250 (Pharmacy – General Classification), and CMS has designated this revenue code as packaged. However, 0636 (Pharmacy – Drugs Requiring Detailed Coding) requires a HCPCS code, and then the status indicator will be used to determine if the drug is separately paid or packaged.
- b. Charges reported with a HCPCS code must meet the requirements for reporting of that HCPCS code and follow all applicable coding rules.

- (i) Caution: CMS sometimes issues guidance on reporting of HCPCS codes that varies from the standard reporting requirements.
- 3. A hospital's charge structure is valid for all accounts, Medicare and non-Medicare, as long as it meets the definition of charges and HIPAA transaction sets.
 - a. Do not accept charge denials from payers as improper if the charges meet the CMS definition of charges and the charges also meet NUBC reporting requirements and HCPCS definition requirements.
 - b. MACs audit each hospital's cost report. When patient charges from the chart of accounts or income statement are accepted by the MAC when the hospital files its cost report, it is a de facto approval of the charge structure and customary charge practices of your hospital.

VII. Charges for Routine and Ancillary Services

- A. Each facility should have an established charge structure that is uniformly applied to each patient as services are furnished to the patient and that is reasonably and consistently related to the cost of providing the services. *<Provider Reimbursement Manual, Part 1, Chapter 22 § 2203 "Provider Charge Structure as Basis for Apportionment">*
 - 1. The common or established practice of providers of the same class in the same State should be followed. If there is no common or established classification of an item or service as routine or ancillary among providers of the same class in the same State, a provider's customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program.
 - 2. The Medicare program cannot dictate to a provider its charges or charge structure.
 - 3. Medicare may determine whether or not the charges are allowable for use in apportioning costs under the program.
- B. If an item is not specifically enumerated as a routine item or service in Section 2202.6 or an ancillary item or service in Section 2202.8, then the general rules in Section 2203 of the PRM-I apply.
 - 1. Sections **2202.6 Routine Services**—Inpatient routine services in a hospital or skilled nursing facility are generally included by the provider in a daily service charge—sometimes referred to as the "room and board" charge.
 - a. Routine services are composed of two board components:

- (i) general routine services, and
- (ii) special care units (SCUs), including coronary care units (CCUs) and intensive care units (ICUs).
- (iii) Included in routine services are the following, for which a separate charge is not customarily made:
 - (a) regular room,
 - (b) dietary,
 - (c) nursing services,
 - (d) minor medical and surgical supplies,
 - (e) medical social services,
 - (f) psychiatric social services, and
 - (g) the use of certain equipment and facilities.

2. **2202.8 Ancillary Services**—Ancillary services in a hospital or SNF include:

- a. laboratory,
- b. radiology,
- c. drugs,
- d. delivery room (including maternity labor room),
- e. operating room (including post-anesthesia and postoperative recovery rooms), and
- f. therapy services (physical, speech, occupational).
- g. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. <See §2203.1 and §2203.2>

C. Separate Charges for Nursing Ancillary Services

1. CMS has discussed the appropriateness of charging nursing services in addition to the room rates. The discussion centers on blood administration services but is applicable to other necessary services and unique charges in addition to the room rate. <73 Fed. Reg. 48464-48466 (FY2009 IPPS Final Rule)>
2. Nursing services may or may not have a separate charge established depending upon the classification of an item or service as routine or ancillary among providers of the same class in the same State.
 - a. Examples of common nursing services provided by the floor nurse: IV infusions and injections, blood administration, and nebulizer treatments.
 - b. If the PRM–1 instructions are not followed, a provider cannot bill these services as separate charges. Additionally, it is important that the charges for service rendered and documentation meet the definition of the HCPCS to bill separately. <Medicare Claims Processing Manual, Chapter 4 § 240>

D. Supply Charges

1. Medicare requirements, under *Provider Reimbursement Manual Part 1*, Section 2203 [for SNFs], for supply charges to be considered ancillary [i.e., separately chargeable under 027x], the item must be:
 - a. Directly identifiable to individual patients;
 - b. Not generally furnished to most patients; and
 - c. One of the following:
 - 1) Not reusable (e.g., artificial limbs and organs, braces, intravenous fluids or solutions, oxygen [including medications], disposable catheters)
 - 2) Represent a cost for each preparation (e.g., catheters and related equipment, colostomy bags, drainage equipment, trays, and tubing)
 - 3) Complex medical equipment (e.g., ventilator or support surfaces)

VIII. Concept of Bundled Services vs. Packaged Payments and Charges for Services

- A. Bundling is a coding rule that doesn't allow separate reporting of a HCPCS code if it is "bundled" into a more comprehensive HCPCS code.
 1. When a service is bundled, consider the following:

- a. Increasing the price of the more comprehensive HCPCS code (this may require a new CDM for the combined service); or
 - b. Reporting the charge without HCPCS so that it sums/rolls to the comprehensive HCPCS (e.g., imaging CPT in support of surgery)
2. If the definition of a code changes or a new NCCI procedure-to-procedure edit applies, and a code can no longer be billed separately (i.e., it's bundled), the cost of that item must be accounted for on the claim.
- a. This can be accomplished by one of the following:
 - (i) Increasing the charge amount for the column one code, in the case of a new NCCI edit.
 - (a) A changed description may be necessary, or an entirely new CDM line and education to help the department understand when and when not to bill the separate code for the column two service.
 - (b) This is often referred to as "packaging" or "rolling" or "including" the charge for one service into another.
 - (ii) Continuing to charge a separate charge without the HCPCS code.
 - (a) This is only possible if the revenue code may be reported without a HCPCS code and CMS' claim edits allow the charge line to be billed without a HCPCS code.
3. The method used to account for bundled services on the claim may depend on the cost center where the item is expensed to ensure the charge is matched to the correct cost center.
- a. Example:
 - (i) Imaging services into a procedure charge
 - (a) Three options for handling a radiology code that can no longer be billed when performed with a surgery:
 - 1. Eliminate the charge code from the radiology chargemaster and increasing surgery charges or increase these procedures to the next higher surgery level.
 - a. Consider how the radiology expense may need to be reclassified to surgery with this option.

2. Set up a new charge code in the surgery department with revenue code 0360 and no HCPCS code.
 - a. Radiology can expense their time to surgery when they perform these services, so expense and revenue match or reclass at the end of the year.
 3. Maintain the radiology department charge code but change the revenue code to 0360 and remove the HCPCS code.
 - a. Radiology revenue codes require a HCPCS code, so it is not possible to continue to report with the radiology revenue code and no HCPCS.
 - b. This enables the revenue to be captured in the radiology department so they continue to get "credit" for the services but will require reclassification of the revenue to radiology (to match where the expense is taken) OR reclassification of the expense from the radiology department to the surgery department (to match where the revenue was billed).
 - c. The option may be required to enable radiology information systems to continue to display appropriate templates.
- B. Packaging is a payment policy rule that "packages" the payment for a separately reported item or service into the payment for the claim. Packaged services can be charged separately, with or without a HCPCS code. If a HCPCS code is reported, coding rules must be followed.
1. Packaged revenue codes
 - a. Revenue codes considered to be packaged and which NUBC does not require HCPCS codes can be reported without HCPCS (e.g., revenue code 0710 for recovery services and 0370 for any type of anesthesia does not require HCPCS).
 - b. Caution: CMS does not always follow the NUBC requirements (e.g., NUBC requires a HCPCS code for revenue code 0637 "Self-administrable Drugs", but it is considered an excluded revenue code by Medicare and the edit for a HCPCS code is deactivated).
 - c. Note: The Outpatient Code Editor (OCE) has always allowed APC payment for CPT®/HCPCS codes billed with packaged revenue codes such as 0710, so claim edits cannot be relied upon to prevent payment for improperly reported and paid HCPCS codes because they are billed with packaged revenue codes.

2. It is important to report costs associated with packaged services by including charges for these services on claims. There are generally two choices for reporting:
 - a. Report charges with a packaged HCPCS code or packaged revenue code (e.g., 0710 for recovery, 027x for supplies).
 - b. Include the average costs in the associated procedure (e.g., include the supply charge in the procedure charge).
 - c. Example:
 - (i) Supply charge into a procedure charge
 - (a) If a supply does not have a separate HCPCS code (e.g., it's not an implant or device), the cost of the item may be packaged into the charge for the procedure or reported separately in the supply revenue code 0270. For example, the cost of a lumbar puncture tray may be included in the charge for the lumbar puncture procedure code or reported separately without a HCPCS code in revenue code 0270, depending on the cost center where the expense of the lumbar puncture tray is expensed.
 - d. Note that these options are not hospital-wide or enterprise-wide decisions, but more often department by department decisions. For example, sterile and non-sterile supplies may be included in Emergency Department procedure charges, but the same supplies may be separately billed when used in Surgery Suites for the same or other procedures.
3. Integral Services
 - a. Under the OPPI, items and services that are an integral part of another service that is paid under the OPPI are packaged and no separate payment is made—for example, routine supplies, anesthesia, recovery room, and most drugs.
 - b. Some integral services have specific HCPCS codes for reporting the service when not performed as an integral part of another procedure.
 - (i) For example, CPT® code 36000 (introduction of needle or intracatheter into a vein) is integral to all nuclear medicine procedures requiring an injection of a radiopharmaceutical into a vein. It is not separately reportable with these types of nuclear medicine procedures but may be reported alone if the only service provided is the introduction of a needle into a vein.

- c. Other integral services do not have specific HCPCS codes.
 - (i) For example, wound irrigation is integral to treating all wounds and does not have a HCPCS code.
 - d. Services integral to HCPCS code-defined procedures are included in those procedures based on medical/surgical practice standards. It is inappropriate to report services integral to another procedure with that procedure separately. <NCCI Manual, Chapter 1>
 - (i) Many NCCI edits are based on the standards of medical/surgical practice. Services that are integral to another service are component parts of the more comprehensive service. <NCCI Manual, Chapter 1>
- C. CMS' terminology for packaged services and relationship to charges
1. CMS defines concepts that impact charges on outpatient claims in the Outpatient Prospective Payment System (OPPS)
 - a. Unconditional
 - (i) Unconditionally packaged services are ALWAYS packaged; no separate payment is ever made under OPPS. These services have status indicator N.
 - (ii) HCPCS code definitions or revenue codes may require a separate charge to report the expenses/resources, but no separate payment should be expected. Example, add-on HCPCS codes, and ancillary revenue codes.
 - b. Conditional
 - (i) Conditionally packaged services are packaged based on the presence of other services reported on the same claim, and separate payment may be made in certain circumstances as determined by OPPS policy and reflected in the I/OCE OPP pricer program
 - (ii) Conditionally packaged services are typically reported as separate CDM charges.

IX. Principles of Charge Capture

- A. Electronic medical record (EMR) creates workflow where charge entry can be automated from required documentation.

Caution:

Charges should not be generated from orders, only completed, or "executed" orders that are fully documented should trigger or result in a charge for the service. The risk is that the ordered service may not be performed at all or maybe altered or updated before being performed.

B. The Logic of Charge Capture

1. Every patient encounter results in a registered/activated patient account.
2. The creation of a patient account establishes an electronic folder to populate medical record documentation.
3. Charges require supporting documentation.
4. If every patient encounter results in an activated account, then it follows that every activated patient account should have at least one charge to represent the service performed (e.g., one ED visit charge); this is a form of reconciling patient accounts.
 - a. This may not be true if no billable services were rendered after the patient account was activated. Prevent encounters that lack charges altogether.
 - (i) Inactivate accounts where the patient never arrived or received services. See Attachment A for a Sample Cancelled Account Policy and Sample Terminated Procedure Policy.
5. Charges must be monitored to prevent lost and late charges.
 - a. Late charges can be defined as charges posted after a time period set forth by the organization's policy (e.g., more than 24 hours from the date of service). See Attachment A for a Sample Late Charges Policy.
 - (i) This definition of late charges may require a special report to identify late charges by the revenue department based on this time frame.
 - (ii) These late charges may cause the accounts to qualify for work queues or worklists based on the type of account and other associated charges that are not late—for example, a drug is charged on an ED or clinic account, but there is not a drug administration code.

- b. A definition of late charges as charges posted after the account has qualified for billing (e.g., after coding and after the claim is produced in the AR system) may be too late for effective monitoring of late charges.
 - (i) The claim may or may not have been transmitted to the payer. Charges posted after this time frame require a determination as to whether to submit an adjustment claim—remember, all charges contribute to future rate-setting and outlier payments.
- c. Both types of late charges (those after 24 hours and those after the claim has been billed) likely result in manual correction effort and represent high administrative cost or “waste” in the system because these should be avoided and are preventable.

Common late charges:

- *Reference lab tests*
- *Cultures on specimens*
- *Services provided “under arrangement”*

Tip: Set up a charge for lab with the pseudo HCPCS code “HOLD” to communicate to HIM/coding to place the account on a coding hold until all send-out or culture lab tests are posted.

- 6. Charges should be reconciled.
 - a. Match charges to the services provided and documented.
 - b. Ensure charges are posted within the defined timeframes, and that batch charges are posted to patient accounts.
 - c. Monitor any rejected charges.
 - d. Ensure work queues of charges yet to be posted are worked regularly.
- C. There is a required workflow for charges.
 - a. Services and items are ordered.
 - (i) There are very few self-referred healthcare services, with mammograms being one of the few.
 - (ii) Most hospital services start with an order; therefore, it is logical that this is the first step for the capture of charges.

- b. The order is “executed,” meaning the service is provided and appropriately documented, including the date, time, name, and credentials of the individual who carried out the service.
- c. Charges are matched or associated with services ordered, provided, and documented.
- d. Charges are “captured” (i.e., a charge number is entered or posted on the patient account with the date of service).
 - (i) Manual—charges are manually entered into the system (real-time or batch). An example is the charge navigator in Epic that staff must select the charge and post to a patient account after all their clinical documentation is complete.
 - (ii) Electronic—charges are interfaced from the module of EMR or Departmental Information System (DIS) to AR system (real-time or batch), or charges are set up to be triggered at the completion of the clinical documentation.
- e. Posted charges result in captured revenue—posting the charge results in the patient account being “stamped” with the charge number, and all the CDM fields or attributes of the charge are associated with or posted to the patient account. Revenue is captured for the department, for the patient account, and for the date and month of service, and it is tracked and categorized in the GL.
- f. At least some charges must be captured before the account can qualify for additional steps in the life cycle of a patient account.

ATTACHMENT A

Sample Cancelled Account Policy

APPLICABLE POLICY HEADER

Policy Summary:

At times it will be necessary to cancel admissions, inpatient or outpatient, after the patient arrives and all of the paperwork has been completed. The purpose of this policy and procedure is to provide guidelines concerning the cancellation of a patient's account. This policy does not include "Patient No Show" or Pre-Admitted accounts that have not been activated.

Policy Detail:

- When a patient is registered, and all registration paper work is completed, signed, and the account is activated, and when the patient reaches the treating department, and the treating department cannot, for any reason, start the scheduled test/procedure or begins simple preparation such as patient dressing, but no diagnostic tests or clinical services were rendered, and the treating department cancels the test or procedure the department will:
- Notify the Patient Registration Site Supervisor of canceled patients daily. The cancellation notice will contain the patient's name, account number and the reason the test/procedure could not be completed.
- The Patient Registration Site Supervisor or designee will cancel the accounts in the SYSTEM daily BY _____. These accounts automatically return to the pre-registration status. Pre-registered accounts that are 30 days old or older will be purged out of the system once a week by the Registration Supervisor or designee.
- If an account previously had charges posted and then the account was returned to a zero balance, the account would be inactivated in the account inquiry screen instead of purged. Accounts that have had any charge activity cannot be purged.

****Note: When a procedure is begun and aborted, OR when a clinical assessment occurs which results in the cancellation of a procedure due to clinical information obtained during the assessment, aborted and/or canceled procedure charges should be billed and the account would not qualify for cancellation, rather the aborted/termination procedure policy should be consulted.**

APPLICABLE POLICY FOOTER

Sample Late Charge Policy

APPLICABLE POLICY HEADER

Policy Summary:

All late charges shall be reviewed on a weekly basis by each revenue-producing Department Director or designee. Late charges are defined as charges posted more than 24 hours after the date/time of the service. Late charges delay billing and result in claim edits which result in research costing anywhere from \$25 to \$60 per late charge. Late charges result in wasted resources, and therefore, reduction and elimination of late charges at the root cause is the objective of this policy.

Affected Departments:

All revenue-producing departments, Patient Financial Services (PFS) Department, HIM, IT

Policy Detail:

- A. The Late Charges Report is sent to all Department Directors on a weekly basis for review.
- B. Upon review of this report by the Department Director, any late charges should be researched to determine the cause and necessary action needed to prevent future late charges.
- C. An increase in late charges from one report to the next report must be addressed by the Director of the affected department, reviewed for the reasons behind the increase, and action taken to prevent further late charge increases.
- D. The Revenue Integrity Director will review late charges on a weekly basis and discuss findings with Department Directors, as necessary.
- E. Questions or concerns about system errors concerning late charges should be addressed with the PFS and Revenue Integrity Department to determine if a system error has generated a late charge.
- F. A monthly Late Charge Report is sent to Administrative Line Officers detailing monthly late charges for review. This monthly report includes trending to determine whether late charges are decreasing or increasing or remaining at historic levels.

APPLICABLE POLICY FOOTER

SAMPLE TERMINATED PROCEDURE POLICY

Policy Summary:

At times, patients present for scheduled procedures and the patient is prepped for the procedure and the procedure or services is either aborted before it has begun due to clinical reasons, or it is attempted and not completed due to clinical issues. It is important that each department charge appropriately for any treatment room time, supplies, and drugs used in the preparation of the patient and/or during the attempted procedure. The procedure department should also charge based on the extent of the procedure performed. By virtue of cancelling the procedure, the physician documentation of the cancellation and order to discharge the patient home equates to an outpatient status order unless the physician makes or continues a specific inpatient order after the cancellation of the procedure due to medical necessity. The purpose of this policy is to provide guidance concerning charges to a patient's account in these circumstances. Please see the Cancellation Policy if the case is canceled before the patient is prepped.

Policy Detail:

1. When a patient is registered, and all registration paperwork is completed, signed, and the account is activated, and when the patient reaches the treating department, and the treating department prepares the patient for the procedure by doing any one of the following and the treating department cannot either start or complete the scheduled test/procedure, the treating department will charge the patient's account according to this policy.
 - Patient assessment/history taken and documented, including any lab or other ancillary department test orders made.
 - Patient undresses to prepare for test, and room is prepped and/or sterile supplies are opened.
 - IV access is obtained and documented.

2. If the treating department is Surgery or GI Lab and the procedure is canceled in the holding area or short stay area after one or more of the above services are completed, the reason for cancellation is documented in the Peri-Operative medical record or a procedure note by the physician, the department will charge patient the "SURGICAL SVC ASSESSMENT" charge in lieu of procedure or OR time. If the patient is taken into the OR suite or GI Lab and the procedure is canceled, the department will charge the applicable OR or GI Lab time. The reason for the cancellation must be documented in the Peri-Operative record or a procedure note by the physician. Note that all supplies and/or drugs used should also be charged.

3. If the physician made an inpatient order as part of the scheduled procedure due to the needs of post-operative recovery care and the procedure is canceled

or aborted, the physician documentation of the cancellation and the order to discharge the patient home constitutes a cancellation of the inpatient admission order, and the patient is then considered an outpatient. When the department enters the "SURGICAL SVC ASSESSMENT" charge or procedure/OR time when a surgery is canceled. The patient's status will be checked in the AR System to ensure the status is outpatient. If not, the department will send a message to Patient Registration to update the account to outpatient.

4. If the treating department is other than surgery or GI Lab and the procedure is aborted or canceled after one or more of the above services are completed, the reason for cancellation is documented in the medical record. The department selects the appropriate procedure CPT code(s) based on the planned service. This code must have the abbreviation "ABRTD" in its description and either modifier "52" or "73" attached to the CPT code in the Chargemaster. If no such charge exists in the department's Chargemaster, the Department must make an urgent Chargemaster Request for the appropriate charge. Note that all supplies and/or drugs used should also be charged if they are typically charged separately.

CY2023 OPPS Revenue Code to Cost Center Crosswalk combined with FY2023 Supplemental Cost Center Information Table

Revenue Code	Description	Used in OPPS	Used in IPPS	IPPS Cost Group	Cost Report Line Description for IPPS	Primary cost center source for CCR	Primary cost center name	Secondary cost center source for CCR	Secondary cost center name	Tertiary cost center source for CCR	Tertiary cost center name
0110	Room & Board (Private)	N	Y	Routine	Adult & Pediatrics						
0111	Medical/Surgical/Gyn	N	Y	Routine	Adult & Pediatrics						
0112	OB	N	Y	Routine	Adult & Pediatrics						
0113	Pediatric	N	Y	Routine	Adult & Pediatrics						
0114	Psychiatric	N	Y	Routine	Adult & Pediatrics						
0115	Hospice	N	Y	Routine	Adult & Pediatrics						
0116	Detoxification	N	Y	Routine	Adult & Pediatrics						
0117	Oncology	N	Y	Routine	Adult & Pediatrics						
0118	Rehab	N	Y	Routine	Adult & Pediatrics						
0119	Other	N	Y	Routine	Adult & Pediatrics						
0120	Room & Board (Semi-Private 2 beds)	N	Y	Routine	Adult & Pediatrics						
0121	Medical/Surgical/Gyn	N	Y	Routine	Adult & Pediatrics						
0122	OB	N	Y	Routine	Adult & Pediatrics						
0123	Pediatric	N	Y	Routine	Adult & Pediatrics						
0124	Psychiatric	N	Y	Routine	Adult & Pediatrics						
0125	Hospice	N	Y	Routine	Adult & Pediatrics						
0126	Detoxification	N	Y	Routine	Adult & Pediatrics						
0127	Oncology	N	Y	Routine	Adult & Pediatrics						
0128	Rehab	N	Y	Routine	Adult & Pediatrics						
0129	Other	N	Y	Routine	Adult & Pediatrics						
0130	Room&Board (Semi private 3-4 beds)	N	Y	Routine	Adult & Pediatrics						
0131	Medical/Surgical/Gyn	N	Y	Routine	Adult & Pediatrics						
0132	OB	N	Y	Routine	Adult & Pediatrics						
0133	Pediatric	N	Y	Routine	Adult & Pediatrics						
0134	Psychiatric	N	Y	Routine	Adult & Pediatrics						
0135	Hospice	N	Y	Routine	Adult & Pediatrics						
0136	Detoxification	N	Y	Routine	Adult & Pediatrics						
0137	Oncology	N	Y	Routine	Adult & Pediatrics						
0138	Rehab	N	Y	Routine	Adult & Pediatrics						
0139	Other	N	Y	Routine	Adult & Pediatrics						
0140	Room & Board (Private Deluxe)	N	Y	Routine	Adult & Pediatrics						
0141	Medical/Surgical/Gyn	N	Y	Routine	Adult & Pediatrics						
0142	OB	N	Y	Routine	Adult & Pediatrics						
0143	Pediatric	N	Y	Routine	Adult & Pediatrics						
0144	Psychiatric	N	Y	Routine	Adult & Pediatrics						
0145	Hospice	N	Y	Routine	Adult & Pediatrics						
0146	Detoxification	N	Y	Routine	Adult & Pediatrics						
0147	Oncology	N	Y	Routine	Adult & Pediatrics						
0148	Rehab	N	Y	Routine	Adult & Pediatrics						
0149	Other	N	Y	Routine	Adult & Pediatrics						
0150	Room & Board (Ward)	N	Y	Routine	Adult & Pediatrics						
0151	Medical/Surgical/Gyn	N	Y	Routine	Adult & Pediatrics						
0152	OB	N	Y	Routine	Adult & Pediatrics						
0153	Pediatric	N	Y	Routine	Adult & Pediatrics						
0154	Psychiatric	N	Y	Routine	Adult & Pediatrics						
0155	Hospice	N	Y	Routine	Adult & Pediatrics						
0156	Detoxification	N	Y	Routine	Adult & Pediatrics						
0157	Oncology	N	Y	Routine	Adult & Pediatrics						
0158	Rehab	N	Y	Routine	Adult & Pediatrics						
0159	Other	N	Y	Routine	Adult & Pediatrics						
0160	Room & Board (other)	N	Y	Routine	Adult & Pediatrics						
0164	Sterile Environment	N	Y	Routine	Adult & Pediatrics						
0167	Self care	N	Y	Routine	Adult & Pediatrics						
0169	Other	N	Y	Routine	Adult & Pediatrics						

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0170	Nursery	N									
0171	Newborn-Level I	N									
0172	Newborn-Level II	N									
0173	Newborn-Level III	N									
0174	Newborn-Level IV	N									
0179	Other Nursery	N									
0180	Leave of Absence	N									
0182	Patient Convenience	N									
0183	Therapeutic Leave	N									
0185	Hospitalization	N									
0189	Other leave of absence	N									
0190	Subacute care	N									
0191	Subacute care-Level I	N									
0192	Subacute care-Level II	N									
0193	Subacute care-Level III	N									
0194	Subacute care-Level IV	N									
0199	Other subacute care	N									
0200	Intensive care	N	Y	Intensive	Intensive Care Unit						
0201	Surgical	N	Y	Intensive	Surgical Intensive Care						
0202	Medical	N	Y	Intensive	Intensive Care Unit						
0203	Pediatric	N	Y	Intensive	Intensive Care Unit						
0204	Psychiatric	N	Y	Intensive	Intensive Care Unit						
0206	Intermediate ICU	N	Y	Intensive	Intensive Care Unit						
0207	Burn care	N	Y	Intensive	Burn Intensive Care						
0208	Trauma	N	Y	Intensive	Intensive Care Unit						
0209	Other intensive care	N	Y	Intensive	Other Intensive Care						
0210	Coronary care	N	Y	Intensive	Coronary Care Unit						
0211	Myocardial Infarction	N	Y	Intensive	Intensive Care Unit						
0212	Pulmonary Care	N	Y	Intensive	Intensive Care Unit						
0213	Heart Transplant	N	Y	Intensive	Intensive Care Unit						
0214	Intermediate CCU	N	Y	Intensive	Intensive Care Unit						
0219	Other Coronary Care	N	Y	Intensive	Intensive Care Unit						
0220	Special charges	N	Y	Other							
0221	Admission charge	N	Y	Other							
0222	Technical support charge	N	Y	Other							
0223	U.R. service charge	N	Y	Other							
0224	Late discharge, medically necessary	N	Y	Other							
0229	Other special charges	N	Y	Other							
0230	Incremental nursing charge rate	N	Y	Other							
0231	Nursery	N	Y	Other							
0232	OB	N	Y	Other							
0233	ICU	N	Y	Other							
0234	CCU	N	Y	Other							
0235	Hospice	N	Y	Other							
0239	Other	N	Y	Other							
0240	All inclusive Ancillary	N	Y	Other							
0241	Basic	N	Y	Other							
0242	Comprehensive	N	Y	Other							
0243	Specialty	N	Y	Other							
0249	Other all inclusive ancillary	N	Y	Other							
0250	Pharmacy	Y	Y	Drugs		5600	Drugs Charged to Patients				
0251	Pharmacy: Generic	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0252	Pharmacy: Nongeneric	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0253	Take home drugs	N	Y	Drugs	Drugs Charged to Pt						

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0254	Pharmacy: Incident to other diagnostic services	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0255	Pharmacy: Incident to radiology	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0256	Pharmacy: Experimental drugs	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0257	Pharmacy: Non-prescription	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0258	Pharmacy: IV solutions	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0259	Pharmacy: Other	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0260	IV Therapy	Y	Y	Drugs	Intreuous Therapy	4800	Intravenous Therapy				
0261	IV Therapy: Infusion pump	Y	Y	Drugs	Intreuous Therapy	4800	Intravenous Therapy				
0262	IV Therapy: IV Therapy, pharm services	Y	Y	Drugs	Intreuous Therapy	4800	Intravenous Therapy				
0263	IV Therapy: IV Therapy: drug/supp/delivery	Y	Y	Drugs	Intreuous Therapy	4800	Intravenous Therapy				
0264	IV Therapy: supplies	Y	Y	Drugs	Intreuous Therapy	4800	Intravenous Therapy				
0269	IV Therapy: Other IV therapy	Y	Y	Drugs	Intreuous Therapy	4800	Intravenous Therapy				
0270	Medical/Surgical Supplies	Y	Y	Supplies	Med Supplies	5500	Med Supplies Charged to Patient				
0271	Medical/Surgical Supplies: Nonsterile supplies	Y	Y	Supplies	Med Supplies	5500	Med Supplies Charged to Patient				
0272	Medical/Surgical Supplies: Sterile supplies	Y	Y	Supplies	Med Supplies	5500	Med Supplies Charged to Patient				
0273	Medical/Surgical Supplies: Take home supplies	Y	Y	Supplies	Med Supplies	5500	Med Supplies Charged to Patient				
0274	Medical/Surgical Supplies: Prosthetic/Orthotic devices	Y	Y	Supplies	Med Supplies	3540	Prosthetic Devices	5500	Med Supplies Charged to Patient		
0275	Medical/Surgical Supplies: Pacemaker	Y	Y	Implantable	implantable Device Ch	5530	Implantable Devices Charged to Patie	3540	Prosthetic Devices	5500	Med Supplies Charged to Patie
0276	Medical/Surgical Supplies: Intraocular lens	Y	Y	Implantable	implantable Device Ch	5530	Implantable Devices Charged to Patie	3540	Prosthetic Devices	5500	Med Supplies Charged to Patie
0277	Oxygen-Take home	N	Y	Supplies	Med Supplies						
0278	Medical/Surgical Supplies: Other implants	Y	Y	Implantable	implantable Device Ch	5530	Implantable Devices Charged to Patie	5500	Med Supplies Charged to Patient		
0279	Medical/Surgical Supplies: Other supplies/devices	Y	Y	Supplies	Med Supplies	5500	Med Supplies Charged to Patient				
0280	Oncology	Y	Y	Radiology	Radiology Diagnostic	3480	Oncology				
0289	Oncology: Other oncology	Y	Y	Radiology	Radiology Diagnostic	3480	Oncology				
0290	Durable Medical Equipment	N	Y	Supplies	DME-Rented						
0291	DME Rental	N	Y	Supplies	DME-Rented						
0292	Durable Medical Equipment: Purchase - new equipment	N	Y	Supplies	DME-Rented						
0293	Durable Medical Equipment: Purchase of used DME	N	Y	Supplies	DME-Sold						
0294	Supplies/Drugs for DME effectiveness (HHA only)	N	Y	Supplies	DME-Rented						
0299	Durable Medical Equipment: Other equipment	Y	Y	Supplies	DME-Rented	6700	Durable Medical Equip. - Sold	5500	Med Supplies Charged to Patient		
0300	Laboratory - Clinical Diagnostic	Y	Y	Laboratory	Laboratory	3390	Laboratory - Clinical	4400	Laboratory		
0301	Laboratory - Clinical Diagnostic: Chemistry	Y	Y	Laboratory	Laboratory	3180	Chemistry	3390	Laboratory - Clinical	4400	Laboratory
0302	Laboratory - Clinical Diagnostic: Immunology	Y	Y	Laboratory	Laboratory	3380	Immunology	3390	Laboratory - Clinical	4400	Laboratory
0303	Laboratory - Clinical Diagnostic: Renal patient (home)	Y	Y	Laboratory	Laboratory	3390	Laboratory - Clinical	4400	Laboratory		

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Revenue Code	Description	Used in OPPTS	Used in IPPS	IPPS Cost Group	Cost Report Line Description for IPPS	Primary cost center source for CCR	Primary cost center name	Secondary cost center source for CCR	Secondary cost center name	Tertiary cost center source for CCR	Tertiary cost center name
0304	Laboratory - Clinical Diagnostic: Nonroutine dialysis	Y	Y	Laboratory	Laboratory	3390	Laboratory - Clinical	4400	Laboratory		
0305	Laboratory - Clinical Diagnostic: Hematology	Y	Y	Laboratory	Laboratory	3350	Hematology	3390	Laboratory - Clinical	4400	Laboratory
0306	Laboratory - Clinical Diagnostic: Bacteriology/microbiology	Y	Y	Laboratory	Laboratory	3050	Bacteriology and Microbiology	3390	Laboratory - Clinical	4400	Laboratory
0307	Laboratory - Clinical Diagnostic: Urology	Y	Y	Laboratory	Laboratory	3390	Laboratory - Clinical	4400	Laboratory		
0309	Laboratory - Clinical Diagnostic: Other laboratory	Y	Y	Laboratory	Laboratory	3390	Laboratory - Clinical	4400	Laboratory		
0310	Laboratory - Pathology:	Y	Y	Laboratory	Laboratory	3420	Laboratory - Pathological	4400	Laboratory		
0311	Laboratory - Pathology: Cytology	Y	Y	Laboratory	Laboratory	3240	Laboratory - Pathological	3420	Laboratory - Pathological	4400	Laboratory
0312	Laboratory - Pathology: Histology	Y	Y	Laboratory	Laboratory	3360	Histology	3420	Laboratory - Pathological	4400	Laboratory
0314	Laboratory - Pathology: Biopsy	Y	Y	Laboratory	Laboratory	3060	Biopsy	3420	Laboratory - Pathological	4400	Laboratory
0319	Laboratory - Pathology: Other	Y	Y	Laboratory	Laboratory	3420	Laboratory - Pathological	4400	Laboratory		
0320	Radiology - Diagnostic:	Y	Y	Radiology		4100	Radiology-Diagnostic				
0321	Radiology - Diagnostic: Angiocardiology	Y	Y	Radiology	Radiology Diagnostic	3030	Angiocardiology	3120	Cardiac Catheterization Lab	3140	Cardiology
0322	Radiology - Diagnostic: Arthrography	Y	Y	Radiology	Radiology Diagnostic	4100	Radiology-Diagnostic				
0323	Radiology - Diagnostic: Arteriography	Y	Y	Radiology	Radiology Diagnostic	3650	Vascular Lab	4100	Radiology-Diagnostic		
0324	Radiology - Diagnostic: Chest X-ray	Y	Y	Radiology	Radiology Diagnostic	4100	Radiology-Diagnostic				
0329	Radiology - Diagnostic: Other	Y	Y	Radiology	Radiology Diagnostic	4100	Radiology-Diagnostic				
0330	Radiology - Therapeutic:	Y	N			4200	Radiology-Therapeutic				
0331	Radiology - Therapeutic: Chemotherapy - injected	Y	Y	Radiology	Radiology Therapeutic	3190	Chemotherapy	3480	Oncology		
0332	Radiology - Therapeutic: Chemotherapy - oral	Y	Y	Radiology	Radiology Therapeutic	3190	Chemotherapy	3480	Oncology		
0333	Radiology - Therapeutic: Radiation therapy	Y	Y	Radiology	Radiology Therapeutic	4200	Radiology-Therapeutic				
0335	Radiology - Therapeutic: Chemotherapy - IV	Y	Y	Radiology	Radiology Therapeutic	3190	Chemotherapy	4200	Radiology-Therapeutic		
0339	Radiology - Therapeutic: Other	Y	Y	Radiology	Radiology Therapeutic	4200	Radiology-Therapeutic				
0340	Nuclear Medicine	Y	N			3450	Nuclear Medicine - Diagnostic	4100	Radiology-Diagnostic		
0341	Nuclear Medicine: Diagnostic	Y	N			3450	Nuclear Medicine - Diagnostic	4100	Radiology-Diagnostic		
0342	Nuclear Medicine: Therapeutic	Y	Y	Radiology	Radiology Therapeutic	3470	Nuclear Medicine - Therapeutic	4200	Radiology-Therapeutic		
0343	Diagnostic Radiopharms	Y	Y	Radiology	Radioisotope	3450	Nuclear Medicine - Diagnostic	4100	Radiology-Diagnostic		
0344	Therapeutic Radiopharms	Y	Y	Radiology	Radioisotope	3470	Nuclear Medicine - Therapeutic	4200	Radiology-Therapeutic		
0349	Nuclear Medicine: Other	Y	N			3450	Nuclear Medicine - Diagnostic	4100	Radiology-Diagnostic		
0350	CT Scan	Y	Y	CT Scan	CT Scan	3230	CAT Scan	4100	Radiology-Diagnostic		
0351	CT Scan: Head	Y	Y	CT Scan	CT Scan	3230	CAT Scan	4100	Radiology-Diagnostic		
0352	CT Scan: Body	Y	Y	CT Scan	CT Scan	3230	CAT Scan	4100	Radiology-Diagnostic		
0359	CT Scan: Other CT scans	Y	Y	CT Scan	CT Scan	3230	CAT Scan	4100	Radiology-Diagnostic		
0360	Operating Room Services:	Y	Y	Operating Rm	Operating Room	3700	Operating Room				
0361	Operating Room Services: Minor surgery	Y	Y	Operating Rm	Operating Room	3700	Operating Room				
0362	Operating Room Services: Organ trnsplnt, not kidney	Y	Y	Operating Rm	Operating Room	3700	Operating Room				

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0367	Operating Room Services: Kidney transplant	Y	Y	Operating Rm	Operating Room	3700	Operating Room				
0369	Operating Room Services: Other operating room services	Y	Y	Operating Rm	Operating Room	3700	Operating Room				
0370	Anesthesia	Y	Y	Anesthesia	Anesthesiology	4000	Anesthesiology				
0371	Anesthesia: Incident to radiology	Y	Y	Anesthesia	Anesthesiology	4000	Anesthesiology	4200	Radiology-Therapeutic		
0372	Anesthesia: Incident to other diag services	Y	Y	Anesthesia	Anesthesiology	4000	Anesthesiology				
0374	Acupuncture	N	Y	Anesthesia	Anesthesiology						
0379	Anesthesia: Other anesthesia	Y	Y	Anesthesia	Anesthesiology	4000	Anesthesiology				
0380	Blood	Y	Y	Blood	Whole Blood & Packed	4600	Whole Blood & Packed Red Blood Cells				
0381	Blood: Packed red cells	Y	Y	Blood	Whole Blood & Packed	4600	Whole Blood & Packed Red Blood Cells				
0382	Blood: Whole blood	Y	Y	Blood	Whole Blood & Packed	4600	Whole Blood & Packed Red Blood Cells				
0383	Blood: Plasma	Y	Y	Blood	Whole Blood & Packed	4600	Whole Blood & Packed Red Blood Cells				
0384	Blood: Platelets	Y	Y	Blood	Whole Blood & Packed	4600	Whole Blood & Packed Red Blood Cells				
0385	Blood: Leukocytes	Y	Y	Blood	Whole Blood & Packed	4600	Whole Blood & Packed Red Blood Cells				
0386	Blood: Other components	Y	Y	Blood	Whole Blood & Packed	4600	Whole Blood & Packed Red Blood Cells				
0387	Blood: Other derivatives	Y	Y	Blood	Whole Blood & Packed	4600	Whole Blood & Packed Red Blood Cells				
0389	Blood: Other blood	Y	Y	Blood	Whole Blood & Packed	4600	Whole Blood & Packed Red Blood Cells				
0390	Blood Storage/Processing	Y	Y	Blood	Blood Storing, Proc	4700	Blood Storing, Processing, & Trans.				
0391	Blood: Administration (e.g. Transfusion)	Y	Y	Blood	Blood Storing, Proc	4700	Blood Storing, Processing, & Trans.				
0392	Blood: Processing and Storage	Y	Y	Blood	Blood Storing, Proc	4700	Blood Storing, Processing, & Trans.				
0399	Other blood handling	Y	Y	Blood	Blood Storing, Proc	4700	Blood Storing, Processing, & Trans.				
0400	Other Imaging Services	Y	Y	Radiology	Radiology Diagnostic	4100	Radiology - Diagnostic				
0401	Other Imaging Services: Diagnostic mammography	Y	Y	Radiology	Radiology Diagnostic	3440	Mammography	4100	Radiology-Diagnostic		
0402	Other Imaging Services: Ultrasound	Y	Y	Radiology	Radiology Diagnostic	3630	Ultra Sound	4100	Radiology-Diagnostic		
0403	Other Imaging Services: Screening mammography	Y	Y	Radiology	Radiology Diagnostic	3440	Mammography	4100	Radiology-Diagnostic		
0404	Other Imaging Services: PET scan	Y	Y	Radiology	Radiology Diagnostic	3450	Nuclear Medicine-Diagnostic	4100	Radiology-Diagnostic		
0409	Other imaging services	Y	Y	Radiology	Radiology Diagnostic	4100	Radiology - Diagnostic				
0410	Respiratory Services	Y	Y	Inhalation	Respiratory Therapy	4900	Respiratory Therapy				
0412	Respiratory Services: Inhalation services	Y	Y	Inhalation	Respiratory Therapy	4900	Respiratory Therapy				
0413	Respiratory Services: Hyperbaric oxygen therapy	Y	Y	Inhalation	Respiratory Therapy	4900	Respiratory Therapy	4900	Respiratory Therapy		
0419	Respiratory Services: Other respiratory services	Y	Y	Inhalation	Respiratory Therapy	4900	Respiratory Therapy				
0420	Physical Therapy	Y	Y	Therapy	Physical Therapy	5000	Physical Therapy				
0421	Physical Therapy: Visit charge	Y	Y	Therapy	Physical Therapy	5000	Physical Therapy				
0422	Physical Therapy: Hourly charge	Y	Y	Therapy	Physical Therapy	5000	Physical Therapy				
0423	Physical Therapy: Group rate	Y	Y	Therapy	Physical Therapy	5000	Physical Therapy				
0424	Physical Therapy: Evaluation/re-evaluation	Y	Y	Therapy	Physical Therapy	5000	Physical Therapy				
0429	Physical Therapy: Other physical therapy	Y	Y	Therapy	Physical Therapy	5000	Physical Therapy				
0430	Occupational Therapy	Y	Y	Therapy	Occupational Therapy	5100	Occupational Therapy				

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Revenue Code	Description	Used in OPPS	Used in IPPS	IPPS Cost Group	Cost Report Line Description for IPPS	Primary cost center source for CCR	Primary cost center name	Secondary cost center source for CCR	Secondary cost center name	Tertiary cost center source for CCR	Tertiary cost center name
0431	Occupational Therapy: Visit charge	Y	Y	Therapy	Occupational Therapy	5100	Occupational Therapy				
0432	Occupational Therapy: Hourly charge	Y	Y	Therapy	Occupational Therapy	5100	Occupational Therapy				
0433	Occupational Therapy: Group rate	Y	Y	Therapy	Occupational Therapy	5100	Occupational Therapy				
0434	Occupational Therapy: Evaluation/re-evaluation	Y	Y	Therapy	Occupational Therapy	5100	Occupational Therapy				
0439	Occupational Therapy: Other occupational therapy	Y	Y	Therapy	Occupational Therapy	5100	Occupational Therapy				
0440	Speech-Language Pathology	Y	Y	Therapy	Speech Pathology	5200	Speech Pathology				
0441	Speech-Language Pathology: Visit charge	Y	Y	Therapy	Speech Pathology	5200	Speech Pathology				
0442	Speech-Language Pathology: Hourly charge	Y	Y	Therapy	Speech Pathology	5200	Speech Pathology				
0443	Speech-Language Pathology: Group rate	Y	Y	Therapy	Speech Pathology	5200	Speech Pathology				
0444	Speech-Language Pathology: Evaluation/ re-evaluation	Y	Y	Therapy	Speech Pathology	5200	Speech Pathology				
0449	Speech-Language Pathology: Other speech language pathology	Y	Y	Therapy	Speech Pathology	5200	Speech Pathology				
0450	Emergency Room	Y	Y	Emergency Rm	Emergency	6100	Emergency				
0451	Emergency Room: EM/EMTALA	Y	Y	Emergency Rm	Emergency	6100	Emergency				
0452	Emergency Room: ER/ Beyond EMTALA	Y	Y	Emergency Rm	Emergency	6100	Emergency				
0456	Emergency Room: Urgent care	Y	Y	Emergency Rm	Emergency	6100	Emergency				
0459	Emergency Room: Other emergency room	Y	Y	Emergency Rm	Emergency	6100	Emergency				
0460	Pulmonary Function	Y	Y	Inhalation	Respiratory Therapy	3560	Pulmonary Function Testing	3160	Cardiopulmonary		
0469	Pulmonary Function: Other	Y	Y	Inhalation	Respiratory Therapy	3560	Pulmonary Function Testing	3160	Cardiopulmonary		
0470	Audiology	Y	Y	Therapy	Speech Pathology	3040	Audiology	5200	Speech Pathology		
0471	Audiology: Diagnostic	Y	Y	Therapy	Speech Pathology	3040	Audiology	5200	Speech Pathology		
0472	Audiology: Treatment	Y	Y	Therapy	Speech Pathology	3040	Audiology	5200	Speech Pathology		
0479	Audiology: Other audiology	Y	Y	Therapy	Speech Pathology	3040	Audiology	5200	Speech Pathology		
0480	Cardiology	Y	Y	Cardiology	Electrocardiology	3140	Cardiology				
0481	Cardiology: Cardiac catheter lab	Y	Y	Cardiac Cath	Cardiac Catheterization	3120	Cardiac Catheterization Laboratory	3140	Cardiology		
0482	Cardiology: Stress test	Y	Y	Cardiology	Electrocardiology	3620	Stress Test	3140	Cardiology		
0483	Cardiology: Echocardiology	Y	Y	Cardiology	Electrocardiology	3260	Echocardiography	3140	Cardiology		
0489	Cardiology: Other cardiology	Y	Y	Cardiology	Electrocardiology	3140	Cardiology				
0490	Ambulatory Surgery	Y	Y	Other	ASC (non-distinct)	5800	ASC	3700	Operating Room		
0499	Ambulatory Surgery: Other ambulatory surgical care	Y	Y	Other	ASC (non-distinct)	5800	ASC	3700	Operating Room		
0500	Outpatient services	N	N								
0509	Other Outpatient	N	N								
0510	Clinic	Y	Y	Other	Clinic	6000	Clinic				
0511	Clinic: Chronic pain center	Y	Y	Other	Clinic	6000	Clinic				
0512	Clinic: Dental clinic	Y	Y	Other	Clinic	3250	Dental Services	6000	Clinic		
0513	Clinic: Psychiatric clinic	Y	Y	Other	Clinic	3550	Psychiatric/Psychological Services	6000	Clinic		
0514	Clinic: OB/GYN clinic	Y	Y	Other	Clinic	6000	Clinic				
0515	Clinic: Pediatric clinic	Y	Y	Other	Clinic	6000	Clinic				
0516	Clinic: Urgent care clinic	Y	Y	Other	Clinic	6000	Clinic				
0517	Clinic: Family clinic	Y	Y	Other	Clinic	4040	Family Practice	6000	Clinic		
0519	Clinic: Other clinic	Y	Y	Other	Clinic	6000	Clinic				

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Revenue Code	Description	Used in OPSS	Used in IPPS	IPPS Cost Group	Cost Report Line Description for IPPS	Primary cost center source for CCR	Primary cost center name	Secondary cost center source for CCR	Secondary cost center name	Tertiary cost center source for CCR	Tertiary cost center name
0520	Free-Standing Clinic	N	Y	Other							
0521	Rural health-clinic	N	Y	Other							
0522	Rural health-home	N	Y	Other							
0523	Family Practice Clinic	N	Y	Other							
0524	RHC/FQHC visit in Part A covered SNF	N	Y	Other							
0525	RHC/FQHC visit in noncovered SNF, NF, ICFMR or other	N	Y	Other							
0526	Urgent Care Clinic	N	Y	Other							
0527	Nurse visit to home in a HH shortage area	N	Y	Other							
0528	RHC/FQHC visit to other non RHC/FQHC site	N	Y	Other							
0529	Free-Standing Clinic: Other	N	Y	Other							
0530	Osteopathic Services	Y	Y	Other		3530	Osteopathic Therapy				
0531	Osteopathic Services: Osteopathic therapy	Y	Y	Other		3530	Osteopathic Therapy				
0539	Osteopathic Services: Other osteopathic services	Y	Y	Other		3530	Osteopathic Therapy				
0540	Ambulance	N	Y	Other	Ambulance						
0541	Supplies	N	Y	Other	Ambulance						
0542	Medical Transport	N	Y	Other	Ambulance						
0543	Heart Mobile	N	Y	Other	Ambulance						
0544	Oxygen	N	Y	Other	Ambulance						
0545	Air ambulance	N	Y	Other	Ambulance						
0546	Neonatal ambulance services	N	Y	Other	Ambulance						
0547	Pharmacy	N	Y	Other	Ambulance						
0548	Telephone Transmission EKG	N	Y	Other	Ambulance						
0549	Other ambulance	N	Y	Other	Ambulance						
0550	Skilled nursing	N	Y	Other							
0551	Visit charge	N	Y	Other							
0552	Hourly charge	N	Y	Other							
0559	Other skilled nursing	N	Y	Other							
0560	Home Health (HH) -- Medical Social Services	N	Y	Other							
0561	Home Health (HH) Medical Social Services: Visit charge	N	Y	Other							
0562	Home Health (HH) Medical Social Services: Hourly charge	N	Y	Other							
0569	Home Health (HH) Medical Social Services: Other Medical Social Services	N	Y	Other							
0570	Home health-Home health aide	N	Y	Other							
0571	Visit charge	N	Y	Other							
0572	Hourly charge	N	Y	Other							
0579	Other home health aide	N	Y	Other							
0580	Home health-other visits	N	Y	Other							
0581	Visit charge	N	Y	Other							
0582	Hourly charge	N	Y	Other							
0583	Assessment	N	Y	Other							
0589	Other home health visit	N	Y	Other							
0590	Home health-units of service	N	Y	Other							
0600	Home health-oxygen	N	Y	Other							

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0601	Oxygen-state/equip/suppl/ or cont	N	Y	Other							
0602	Oxygen-state/equip/suppl/ or under 1 LPM	N	Y	Other							
0603	Oxygen-state/equip/over 4 LPM	N	Y	Other							
0604	Oxygen-Portable Add-on	N	Y	Other							
0609	Other oxygen	N	Y	Other							
0610	Magnetic Resonance Tech. (MRT)	Y	Y	MRI	MRI	3430	Magnetic Resonance Imaging (MRI)	4100	Radiology-Diagnostic		
0611	Magnetic Resonance Tech. (MRT): Brain (incl. Brainstem)	Y	Y	MRI	MRI	3430	Magnetic Resonance Imaging (MRI)	4100	Radiology-Diagnostic		
0612	Magnetic Resonance Tech. (MRT): Spinal cord (incl. spine)	Y	Y	MRI	MRI	3430	Magnetic Resonance Imaging (MRI)	4100	Radiology-Diagnostic		
0614	Magnetic Resonance Tech. (MRT): MRI - Other	Y	Y	MRI	MRI	3430	Magnetic Resonance Imaging (MRI)	4100	Radiology-Diagnostic		
0615	Magnetic Resonance Tech. (MRT): MRA - Head and	Y	Y	MRI	MRI	3430	Magnetic Resonance Imaging (MRI)	4100	Radiology-Diagnostic		
0616	Magnetic Resonance Tech. (MRT): MRA - Lower Ext	Y	Y	MRI	MRI	3430	Magnetic Resonance Imaging (MRI)	4100	Radiology-Diagnostic		
0618	Magnetic Resonance Tech. (MRT): MRA - Other	Y	Y	MRI	MRI	3430	Magnetic Resonance Imaging (MRI)	4100	Radiology-Diagnostic		
0619	Magnetic Resonance Tech. (MRT): Other MRT	Y	Y	MRI	MRI	3430	Magnetic Resonance Imaging (MRI)	4100	Radiology-Diagnostic		
0621	Med - Surg Supplies Ext. of 270: Incident to radiology	Y	Y	Supplies	Med Supplies	5500	Med Supplies Charged to Patient	4100	Radiology-Diagnostic	4200	Radiology - Therapeutic
0622	Med - Surg Supplies Ext. of 270: Incident to other diag.	Y	Y	Supplies	Med Supplies	5500	Med Supplies Charged to Patient				
0623	Surgical dressings	Y	Y	Supplies	Med Supplies	5500	Med Supplies Charged to Patient				
0624	Med - Surg Supplies Ext. of 270: Investigational Device (IDE)	Y	Y	Implantable	Implantable Device Ch	5530	Implantable Devices Charged to Patie	5500	Med Supplies Charged to Patient		
0631	Drugs Require Specific ID: Single source drug	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0632	Drugs Require Specific ID: Multiple source drug	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0633	Drugs Require Specific ID: Restrictive prescription	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0634	Drugs Require Specific ID: EPO under 10,000 units	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0635	Drugs Require Specific ID: EPO over 10,000 units	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0636	Drugs Require Specific ID: Drugs requiring detail coding	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0637	Drugs Require Specific ID: Self admin drugs (insulin admin in emergency-diabetes coma)	Y	Y	Drugs	Drugs Charged to Pt	5600	Drugs Charged to Patients				
0640	Home IV Therapy Services	N	Y	Other							
0641	Nonroutine nursing, central line	N	Y	Other							
0642	IV site care, Central line	N	Y	Other							
0643	IV start/change, peripheral line	N	Y	Other							

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0644	Nonroutine nursing, peripheral line	N	Y	Other							
0645	Training patient/caregiver, central line	N	Y	Other							
0646	Training, Disabled patient, central line	N	Y	Other							
0647	Training, patient/caregiver, peripheral line	N	Y	Other							
0648	Training, disabled patient, peripheral line	N	Y	Other							
0649	Other IV therapy services	N	Y	Other							
0650	Hospice service	N	Y	Other							
0651	routine home care	N	Y	Other							
0652	continuous home care	N	Y	Other							
0655	inpatient respite care	N	Y	Other							
0656	general inpatient care (non-respite)	N	Y	Other							
0657	physician services	N	Y	Other							
0658	Hospice Room & Board-Nursing facility	N	Y	Other							
0659	Other hospice service	N	Y	Other							
0660	Respite Care	N	Y	Other							
0661	Hourly Repite Care Charge Nursing	N	Y	Other							
0662	Hourly Respite Care Charge Aide/Homemaker/Companion	N	Y	Other							
0663	Daily Respite Charge	N	Y	Other							
0669	Other respite care	N	Y	Other							
0670	Outpatient Special Residence Charges	N	Y	Other							
0671	Hospital based	N	Y	Other							
0672	Contracted	N	Y	Other							
0679	Other special residence charge	N	Y	Other							
0680	Not Used	N	Y	Other							
0681	Trauma Response: Level I	Y	Y	Other		6100	Emergency				
0682	Trauma Response: Level II	Y	Y	Other		6100	Emergency				
0683	Trauma Response: Level III	Y	Y	Other		6100	Emergency				
0684	Trauma Response: Level IV	Y	Y	Other		6100	Emergency				
0689	Trauma Response: Other	Y	Y	Other		6100	Emergency				
0700	Cast Room	Y	Y	Other		6000	Clinic				
0710	Recovery Room	Y	Y	Operating Rm	Recovery Room	3800	Recovery Room				
0720	Labor Room	Y	Y	Labor/Delivery	Delivery Room	3900	Delivery Room & Labor Room				
0721	Labor Room: Labor	Y	Y	Labor/Delivery	Delivery Room	3900	Delivery Room & Labor Room				
0722	Labor Room: Delivery	Y	Y	Labor/Delivery	Delivery Room	3900	Delivery Room & Labor Room				
0723	Labor Room: Circumcision	Y	Y	Labor/Delivery	Delivery Room	3220	Circumcision	3900	Delivery Room & Labor Room		
0724	Labor Room: Birthing center	Y	Y	Labor/Delivery	Delivery Room	3070	Birthing Center	3900	Delivery Room & Labor Room		
0729	Labor Room: Other labor room/delivery	Y	Y	Labor/Delivery	Delivery Room	3900	Delivery Room & Labor Room				
0730	EKG/ECG	Y	Y	Cardiology	Electrocardology	3280	EKG and EEG	5300	Electrocardiology	3140	Cardiology
0731	EKG/ECG: Holter monitor	Y	Y	Cardiology	Electrocardology	3370	Holter Monitor	5300	Electrocardiology	3140	Cardiology
0732	EKG/ECG: Telemetry	Y	Y	Cardiology	Electrocardology	3280	EKG and EEG	5300	Electrocardiology	3140	Cardiology
0739	EKG/ECG: Other EKG/ECG	Y	Y	Cardiology	Electrocardology	3280	EKG and EEG	5300	Electrocardiology	3140	Cardiology
0740	EEG	Y	Y	Laboratory	Electro-Encephalog	3280	EKG and EEG	5400	Electroencephalography		
0750	Gastrointestinal	Y	Y	Laboratory		3340	Gastro Intestinal Services				
0760	Treatment/Observation Room	Y	Y	Other		6000	Clinic				

CY2023 OPPS Revenue Code to Cost Center Crosswalk combined with FY2023 Supplemental Cost Center Information Table

Revenue Code	Description	Used in OPPS	Used in IPPS	IPPS Cost Group	Cost Report Line Description for IPPS	Primary cost center source for CCR	Primary cost center name	Secondary cost center source for CCR	Secondary cost center name	Tertiary cost center source for CCR	Tertiary cost center name
0761	Treatment/Observation Room: Treatment room	Y	Y	Other		6000	Clinic				
0762	Treatment/Observation Room: Observation room	Y	Y	Other		6201	Observation Beds (Distinct Part)	6200	Observation Beds (Non-Distinct Part)		
0769	Treatment/Observation Room: Other treatment room	Y	Y	Other		6000	Clinic				
0770	Preventive Care Services:	Y	Y	Other		6000	Clinic				
0771	Admin. of vaccine	Y	Y	Other		6000	Clinic				
0780	Telemedicine	N	Y	Other							
0790	Extra-Corp Shock Wave Therapy	Y	Y	Other	Other Ancillary	3640	Urology				
0800	Inpatient Dialysis	Y	Y	Other	Renal Dialysis	5700	Renal Dialysis				
0801	Inpatient Hemodialysis	Y	Y	Other	Renal Dialysis	5700	Renal Dialysis				
0802	Inpatient peritoneal dialysis	Y	Y	Other	Renal Dialysis	5700	Renal Dialysis				
0803	inpatient dialysis CAPD	Y	Y	Other	Renal Dialysis	5700	Renal Dialysis				
0804	Inpatient dialysis CCPD	Y	Y	Other	Renal Dialysis	5700	Renal Dialysis				
0809	Other inp dialysis	Y	Y	Other	Renal Dialysis	5700	Renal Dialysis				
0810	Organ Acquisition	Y	N			8600	Other Organ Acquisition (Specify)				
0811	Organ Acquisition: Living donor	Y	N			8600	Other Organ Acquisition (Specify)				
0812	Organ Acquisition: Cadaver donor	Y	N			8600	Other Organ Acquisition (Specify)				
0813	Organ Acquisition: Unknown donor	Y	N			8600	Other Organ Acquisition (Specify)				
0814	Organ Acquisition: Unsuccessful Organ Search Donor Bank Charges	Y	N			8600	Other Organ Acquisition (Specify)				
0819	Organ Acquisition: Other donor	Y	N			8600	Other Organ Acquisition (Specify)				
0820	Hemo OPD/Home	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0821	Hemo OPD/Home: Hemodialysis comp or other rate	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0822	Hemo OPD/Home supplies	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0823	Hemo OPD/home equipment	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0824	Hemo OPD/Home Maintenance 100%	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0825	Hemo OPD/Home Support Services	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0829	Hemo OPD/Home: Other HEMO outpatient	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0830	Peritoneal OPD/Home	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0831	Peritoneal OPD/Home: Peritoneal comp or other rate	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0832	Home supplies	N	Y	Other	Home Dialysis						
0833	Home equipment	N	Y	Other	Home Dialysis						
0834	Maintenance/100%	N	Y	Other	Home Dialysis						
0835	Support services	N	Y	Other	Home Dialysis						
0839	Peritoneal OPD/Home: Other peritoneal dialysis	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0840	CAPD OPD/Home	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0841	CAPD OPD/Home: CAPD comp or other rate	Y	Y	Other	Home Dialysis	5700	Renal Dialysis				
0842	Home supplies	N	Y	Other	Home Dialysis						
0843	Home equipment	N	Y	Other	Home Dialysis						
0844	Maintenance/100%	N	Y	Other	Home Dialysis						

CY2023 OPPTS Revenue Code to Cost Center Crosswalk combined with FY2023 Supplemental Cost Center Information Table

Revenue Code	Description	Used in OPPTS	Used in IPPS	IPPS Cost Group	Cost Report Line Description for IPPS	Primary cost center source for CCR	Primary cost center name	Secondary cost center source for CCR	Secondary cost center name	Tertiary cost center source for CCR	Tertiary cost center name
0913	Psychiatric/Psychological Svcs: Partial Hosp - Intensive	Y	Y	Other		3550	Psychiatric/Psychological Services	6000	Clinic		
0914	Psychiatric/Psychological Svcs: Individual therapy	Y	Y	Other		3550	Psychiatric/Psychological Services	6000	Clinic		
0915	Psychiatric/Psychological Svcs: Group therapy	Y	Y	Other		3550	Psychiatric/Psychological Services	6000	Clinic		
0916	Psychiatric/Psychological Svcs: Family therapy	Y	Y	Other		3550	Psychiatric/Psychological Services	6000	Clinic		
0917	Psychiatric/Psychological Svcs: Biofeedback	Y	Y	Other		3550	Psychiatric/Psychological Services	6000	Clinic		
0918	Psychiatric/Psychological Svcs: Testing	Y	Y	Other		3550	Psychiatric/Psychological Services	6000	Clinic		
0919	Psychiatric/Psychological Svcs: Other behavioral treat/serv	Y	Y	Other		3550	Psychiatric/Psychological Services	6000	Clinic		
0920	Other Diagnostic Services	Y	Y	Other							
0921	Other Diagnostic Services: Peripheral vascular lab	Y	Y	Other		3650	Vascular Lab	4100	Radiology-Diagnostic		
0922	Other Diagnostic Services: Electromyelogram	Y	Y	Other		3290	Electromyography				
0923	Other Diagnostic Services: Pap smear	Y	Y	Other		3240	Cytology	3420	Laboratory - Pathological	4400	Laboratory
0924	Other Diagnostic Services: Allergy test	Y	Y	Other		3380	Immunology	6000	Clinic		
0925	Other Diagnostic Services: Pregnancy test	Y	Y	Other		3390	Laboratory - Clinical	4500	PBP Clinical Lab. Service - Prgm. Only		
0929	Other Diagnostic Services: Other diagnostic services	Y	Y	Other							
0931	Medical rehab; half day	N	Y	Other							
0932	Medical rehab; full day	N	Y	Other							
0940	Other Therapeutic Serv	Y	Y	Other							
0941	Other Therapeutic Serv: Recreation Rx	Y	Y	Other		6000	Clinic				
0942	Other Therapeutic Serv: Educ/training	Y	Y	Other		6000	Clinic				
0943	Other Therapeutic Serv: Cardiac rehab	Y	Y	Other		3140	cardiology	6000	Clinic		
0944	Other Therapeutic Serv: Drug rehab	Y	Y	Other		3550	Psychiatric/Psychological Services	6000	Clinic		
0945	Other Therapeutic Serv: Alcohol rehab	Y	Y	Other		3550	Psychiatric/Psychological Services	6000	Clinic		
0946	Complex medical equipment-Routine	N	Y	Other							
0947	Complex medical equipment-Ancillary	N	Y	Other							
0948	Pulmonary Rehabilitation	Y	Y	Other		4900	respiratory	6000	Clinic		
0949	Other Therapeutic Serv: Additional RX SVS	Y	Y	Other							
0951	Other therapeutic services-(940x) Athletic training	N	Y	Other							
0952	Other therapeutic services-(940x) Kinesiotherapy	N	Y	Other							
0960	Professional fees	N	Y	Other	Other Outpatient						
0961	Psychiatric	N	Y	Other	Other Outpatient						
0962	Ophthalmology	N	Y	Other	Other Outpatient						
0963	Anesthesiologist (MD)	N	Y	Other	Other Outpatient						
0964	Anesthetist (CRNA)	N	Y	Other	Other Outpatient						

Medicare Cost Report Worksheet Series

Worksheet	Description / Purpose
S series	Hospital demographics, patient statistics, Wage Index survey
A	Operating Expenses
A-6	Reclassifications
A-7	Capital cost detail
A-8 series	Adjustments
B series	Allocation of overhead and capital costs
C	Patient care revenue
D series	Determination of Medicare's share of cost
E series	Settlements (DSH/UC, GME/IME, Medicare bad debts)
G series	"Financial Statements"
H & K	Home Health & Hospice
M	Provider-Based Rural Health Clinics

Worksheet A - From Trial Balance or Chart of Accounts

Cost Center Description		Salaries	Other
		1.00	2.00
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		0
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0
3.00	00300 OTHER CAP REL COSTS		0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0
5.00	00500 ADMINISTRATIVE & GENERAL	0	0
6.00	00600 MAINTENANCE & REPAIRS	0	0
7.00	00700 OPERATION OF PLANT	0	0
8.00	00800 LAUNDRY & LINEN SERVICE	0	0
9.00	00900 HOUSEKEEPING	0	0
10.00	01000 DIETARY	0	0
11.00	01100 CAFETERIA	0	0
12.00	01200 MAINTENANCE OF PERSONNEL	0	0
13.00	01300 NURSING ADMINISTRATION	0	0
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0
15.00	01500 PHARMACY	0	0
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0
17.00	01700 SOCIAL SERVICE	0	0
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0
20.00	02000 NURSING SCHOOL	0	0
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	0	0
31.00	03100 INTENSIVE CARE UNIT	0	0
32.00	03200 CORONARY CARE UNIT	0	0
33.00	03300 BURN INTENSIVE CARE UNIT	0	0
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0
40.00	04000 SUBPROVIDER - IPF	0	0
41.00	04100 SUBPROVIDER - IRF	0	0
42.00	04200 SUBPROVIDER	0	0
43.00	04300 NURSERY	0	0
44.00	04400 SKILLED NURSING FACILITY	0	0
45.00	04500 NURSING FACILITY	0	0
46.00	04600 OTHER LONG TERM CARE	0	0

ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0	0
51.00	05100 RECOVERY ROOM	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300 ANESTHESIOLOGY	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0
56.00	05600 RADIOISOTOPE	0	0
57.00	05700 CT SCAN	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0
59.00	05900 CARDIAC CATHETERIZATION	0	0
60.00	06000 LABORATORY	0	0
60.01	06001 BLOOD LABORATORY	0	0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0
64.00	06400 INTRAVENOUS THERAPY	0	0
65.00	06500 RESPIRATORY THERAPY	0	0
66.00	06600 PHYSICAL THERAPY	0	0
67.00	06700 OCCUPATIONAL THERAPY	0	0
68.00	06800 SPEECH PATHOLOGY	0	0
69.00	06900 ELECTROCARDIOLOGY	0	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0
74.00	07400 RENAL DIALYSIS	0	0
75.00	07500 ASC (NON-DISTINCT PART)	0	0
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0	0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0
90.00	09000 CLINIC	0	0
91.00	09100 EMERGENCY	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0

Worksheet A6 - Reclassification of Expense

Examples of expense reclassifications

- Medical supplies expense related to supplies charged to patients under revenue codes 0270, 0271, 0272
 - But not medical supply expense packaged or included in procedure charges
- Pharmacy/drug cost in non-pharmacy cost centers
- Implantable device expense related to devices charged to patients under revenue codes 0275, 0276, 0278, 0624
- Lab expense related to point of care lab tests performed and charged under revenue code 300 in ancillary departments like ED and clinics

Worksheet A-7 Capital Costs

Purpose:

- Fixed Asset Roll-forward
- Breakdown of capital costs
 - Depreciation
 - Leases
 - Interest
 - Insurance
 - Other

Worksheet A-8 Adjustments

- Worksheet used to add and/or offset expenses from the cost report
- Examples of adjustments (See PRM 15-1 Chapter 21)
 - Medicare Part B related costs (worksheet A-8-2) for professional services billed to Part B on 1500 claims
 - Part A cost of physicians can be claimed as facility expense following time-studies and instructions
 - Related party activity (worksheet A-8-1)
 - Cafeteria revenue
 - Interest revenue
 - Patient related finance charges

Worksheet B Series - Allocation/Step-down

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP	
	0	1.00	2.00	4.00
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS-BLDG & FIXT	0	0	0	0
2.00 00200 CAP REL COSTS-MVBLE EQUIP	0	0	0	0
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0
5.00 00500 ADMINISTRATIVE & GENERAL	0	0	0	0
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0
7.00 00700 OPERATION OF PLANT	0	0	0	0
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	0
9.00 00900 HOUSEKEEPING	0	0	0	0
10.00 01000 DIETARY	0	0	0	0
11.00 01100 CAFETERIA	0	0	0	0
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0
13.00 01300 NURSING ADMINISTRATION	0	0	0	0
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0
15.00 01500 PHARMACY	0	0	0	0
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0
17.00 01700 SOCIAL SERVICE	0	0	0	0
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0
20.00 02000 NURSING SCHOOL	0	0	0	0
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0

Worksheet C Series - Matching Expense to Revenue

ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		
90.00	09000	CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000

Worksheet D Series - Calculating Medicare's Share

Cost Center Description		Ratio of cost to charges	Inpatient Program charges
		1.00	2.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		0
31.00	03100 INTENSIVE CARE UNIT		0
32.00	03200 CORONARY CARE UNIT		0
33.00	03300 BURN INTENSIVE CARE UNIT		0
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0
40.00	04000 SUBPROVIDER - IPF		0
41.00	04100 SUBPROVIDER - IRF		0
42.00	04200 SUBPROVIDER		0
43.00	04300 NURSERY		0
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000	0
51.00	05100 RECOVERY ROOM	0.000000	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0
53.00	05300 ANESTHESIOLOGY	0.000000	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0
56.00	05600 RADIOISOTOPE	0.000000	0
57.00	05700 CT SCAN	0.000000	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0
60.00	06000 LABORATORY	0.000000	0
60.01	06001 BLOOD LABORATORY	0.000000	0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0
64.00	06400 INTRAVENOUS THERAPY	0.000000	0
65.00	06500 RESPIRATORY THERAPY	0.000000	0
66.00	06600 PHYSICAL THERAPY	0.000000	0
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0
68.00	06800 SPEECH PATHOLOGY	0.000000	0
69.00	06900 ELECTROCARDIOLOGY	0.000000	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0
74.00	07400 RENAL DIALYSIS	0.000000	0
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0

Medicare Program Charges From PS&R Report

Summarizes Covered Charges from All Claims:

- Inpatient
- Outpatient OPPS
- Outpatient non-OPPS

Worksheet D Series (Cont.)

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)
	1.00	2.00	3.00	4.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000	0	0
51.00	05100 RECOVERY ROOM	0.000000	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0
53.00	05300 ANESTHESIOLOGY	0.000000	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0
56.00	05600 RADIOISOTOPE	0.000000	0	0
57.00	05700 CT SCAN	0.000000	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0
60.00	06000 LABORATORY	0.000000	0	0
60.01	06001 BLOOD LABORATORY	0.000000	0	0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0
66.00	06600 PHYSICAL THERAPY	0.000000	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0
74.00	07400 RENAL DIALYSIS	0.000000	0	0
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0

How does CMS Use Cost Report

Three primary purposes generally:

- Revise DRG & APC weights each year
- Update/revise market basket relative weights to update payment rates for various prospective payment systems - like IPPS and OPPS
- Analyze payment adequacy (is Medicare paying fair and efficient rates for different classes of providers for different types of services)

Hospital-specific purposes:

- IPPS and OPPS cost outlier calculations
- IPPS new technology add-on payments
- OPPS pass-through device payments

IPPS Rate Setting

- Expense is aggregated from all IPPS hospital cost reports into 19 groups
- Revenue is aggregated from all IPPS hospital cost reports into the same 19 groups
- National Cost-to-Charge Ratios are created for each of the 19 groups
- Claims are grouped to MS-DRGs and charges from all hospital claims per MS-DRG are summed by revenue code
- One of the applicable 19 CCRs is applied to the charges to calculate cost per revenue code group
- Costs are summed per MS-DRG to create the new relative weight

OPPS Rate Setting

- Each hospital's claims grouped to APCs and each hospital's cost report CCR by revenue code is multiplied against the billed charges
- The geometric mean of all claims across all hospitals is calculated per APC
- CMS uses the Cost Center to Revenue Code crosswalk for this calculation