Room and Bed Charging:

Sample Policy

# Policy

1. [Organization Name] establishes room and bed charges for each inpatient hospital accommodation.
2. Charges must reasonably and consistently relate to cost.
3. Charges must be applied uniformly to all patients, regardless of assigned patient financial class. Charges must not vary based on payer.
4. Charges for room and bed include:
   1. Overhead for 24/7 operations such as water, heating/air conditioning, electrical, and maintenance.
   2. Permanent or multiple-use equipment such as patient beds, IV poles, transport tables, and wheel chairs.
   3. Clinical support services such as care management and social services; unit coordination; nursing assistance; transport; patient access; and financial counseling.
   4. Dietary and Nutritional Services including meals
   5. Housekeeping Services
   6. Health Information Management services
   7. Support services including operations, finance, and patient financial services.
   8. Routine nursing services generally available to all patients, including, but not limited to:
      1. Nursing assessments
      2. IV injection and infusion administration, including IV and midline placement
      3. Nebulizer treatments
      4. Minor (routine) medical and surgical supplies (See Supply Charging Policy)
5. Charges for room and bed will not include (not an exhaustive list):
   1. Anesthesia
   2. Behavioral Health Treatments
   3. Blood, blood products, and blood administration
   4. Delivery room (including maternity labor room) (defined by CMS)
   5. Dialysis
   6. Drugs/Pharmacy (defined by CMS)
   7. Emergency Room and Trauma Response
   8. Electroencephalography
   9. Implants, durable medical equipment, and non-routine supplies and devices (See Supply Charging Policy)
   10. Laboratory/ Pathology (defined by CMS)
   11. Operating room (defined by CMS)
   12. Physical, Occupational, and Speech Therapy Language Pathology
   13. Polysomnography
   14. Post-operative recovery room (defined by CMS)
   15. Preventive Services (defined by CMS)
   16. Professional Fees (defined by CMS)
   17. Radiology (defined by CMS)
   18. Respiratory and Pulmonary Function Services
   19. Specialty (ancillary) nursing services, including the following services when provided by specialty-trained nurses:
       1. Wound care and wound vac
       2. Central line placement

# Background and Justification

To maintain participation in good stead with Medicare, [Organization Name] must file an annual Medicare hospital cost report and also follow general ledger accounting requirements of Medicare such that each annual cost report is accepted to be valid by Medicare. Requirements concerning cost reporting are located in the Provider Reimbursement Manual, Part 1, particularly applicable are definitions found in Chapter 22, which include:

**2202.4 Charges –** Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. 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 and discounts deductions.

**2202.6 Routine Services** – Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services are composed of two board components; (l) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's).Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and use of certain equipment and facilities for which a separate charge is not customarily made. (Provider Reimbursement Manual – Part 1, Chapter 22, Section 2202.6)

**2202.8 Ancillary Services** – Ancillary services… include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. (Provider Reimbursement Manual – Part 1, Chapter 22, Section 2202.8)

**2203. Provider Charge Structure as a Basis for Apportionment** - To assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary (or MAC), in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program 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…

[Organization Name] has ensured that its charges meet CMS’ definition of charges as defined at 2202.4 above. Furthermore, we have ensured that our routine charges include required expenses, but we have also defined separate charges per the definition of both routine and ancillary services. These charges are applied consistently to all patient accounts regardless of patient status or financial class. Additionally, we disclose our charge structure to the Medicare Administrative Contractor, National Government Services (NGS), through our cost report filing.