

**Healthcare Information Division**

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To: Hospital Chief Financial Officers  
and Other Interested Parties

**Re: Hospital Technical Letter No. 13**

This is the 13<sup>th</sup> in a series of Hospital Technical Letters developed by the Office of Statewide Health Planning and Development (OSHPD) regarding our uniform accounting and reporting system requirements for California hospitals. The purpose of these letters is to provide timely information to assist you in meeting these requirements.

**ADOPTED: CHARGEMASTER REPORTING REQUIREMENTS**

AB 1627 (Chapter 582, Statutes of 2003) requires each licensed hospital to submit pricing information to OSHPD on its goods, services, and procedures. Psychiatric health facilities and chemical dependency recovery hospitals are exempt from these requirements. On April 22, 2005, regulations were adopted that specify the following reporting requirements:

- Beginning July 1, 2005, each hospital is required to annually submit a copy of its chargemaster and list of charges for 25 services or procedures commonly charged to patients using prices in effect on June 1, 2005.
- Beginning July 1, 2006, each hospital is also required to annually submit an estimate of the percentage increase in the hospital's gross revenue due to all price changes since the previous chargemaster was filed with OSHPD. The estimate shall include the estimate calculation and supporting documentation.
- Acceptable file formats for all documents are limited to Microsoft Excel (.xls) and Comma Separated Value (.csv). Hardcopy documents are not acceptable.
- All documents must be submitted together as attachments to one e-mail to OSHPD at [chargemaster@oshpd.ca.gov](mailto:chargemaster@oshpd.ca.gov) or submitted on one CD by mail to the address above.
- Requests for modification to the above requirements must be made in writing. Hospitals must have an OSHPD-approved modification prior to implementation of any change to the applicable requirements. Modification requests must specify the precise changes being requested and the reason(s) the changes are needed. OSHPD will either approve or disapprove requests for modification on a case-by-case basis.

Detailed information on the AB 1627 chargemaster reporting requirements is available on OSHPD's Hospital Chargemaster Program web-site located at:  
<http://www.oshpd.ca.gov/HID/hospital/chrgmster/index.htm>



For questions about the hospital chargemaster reporting requirements, you can send e-mail inquiries to [chargemaster@oshpd.ca.gov](mailto:chargemaster@oshpd.ca.gov) , or call Tim Pasco at (916) 323-1955.

## **HINTS TO IMPROVE ACCURACY IN REPORTING**

### **Revised Standard Units of Measure (SUM)**

Effective with report periods ended June 30, 2004, the standard unit of measure for several revenue/cost centers was changed on the Hospital Annual Disclosure Report. The purpose of the changes is to simplify the recording and reporting of utilization statistics. Transmittal Letter No. 10, issued in August 2003, updated the *Accounting and Reporting Manual for California Hospitals* (Hospital Manual) with the changes.

Many hospitals are still recording and reporting the old statistics, particularly in the ancillary revenue/cost centers. In most cases, this results in an overstatement of utilization. The table below is a summary of the revised standard units of measure for ancillary revenue/cost centers:

<b>Revenue/Cost Center</b>	<b>Former SUM</b>	<b>Revised SUM</b>
Cardiology Services	RVS units	Procedures
Radiology-Diagnostic	RVS units	Procedures
Radiology-Therapeutic	RVS units	Procedures
Nuclear Medicine	RVS units	Procedures
Ultrasonography	RVS units	Procedures
Magnetic Resonance Imaging	MRI Minutes	MRI Procedures
Respiratory Therapy	RT Treatments	RT Adjusted Patient Days
Physical Therapy	30 minute Sessions	15 minute Sessions
Occupational Therapy	30 minute Sessions	15 minute Sessions

### **Live Birth Summary vs. No. of Deliveries**

Beginning with report periods ended June 30, 2004, a live birth summary was added to Report Page 4 (2), Patient Utilization Statistics, on the Hospital Annual Disclosure Report. The purpose of the information is to obtain a complete picture of the birthing services at each hospital. This change was also included in Transmittal Letter No. 10.

Many hospitals are not completing this information correctly or at all. One common error is reporting the same number for total deliveries in Labor and Delivery (page 4, column 1, line 230) and total live births (page 4, column 1, line 625).

For Labor and Delivery, count one delivery for all babies delivered in this cost center, including stillbirths. Multiple births count as one delivery. Cesarean Section births are counted only when performed in the delivery room.

The Live Birth Summary includes all live natural births and live Cesarean Section births that occurred within the hospital. This includes Labor and Delivery Services, Surgery and Recovery Services, Alternate Birthing Center, Obstetrics Acute, Emergency Services, and any other area within the hospital.

Thus, the likelihood of the number of deliveries in Labor and Delivery and the total live births matching would be rare. A hospital would have to perform all deliveries in Labor and Delivery, and the number of stillbirths would have to match exactly the number of multiple births.

### **Use Concise Label Descriptions**

Report Page 14, Supplemental Other Operating Revenue Information, of the Hospital Annual Disclosure Report, contains several lines where report preparers must specify the amount reported. Do not use vague descriptions such as “miscellaneous” or “other”. Providing a specific description of the amount reported allows OSHPD to make a better determination if the amount is being properly reported, resulting in fewer questions for report preparers.

### **Charity Care Reported in Other Payers**

Many hospitals are still reporting large amounts of charity care in Other Payers (page 12, columns 19 and 20), with little or no data in the Other Indigent payer category (page 12, columns 17 and 18). The most common reason cited is the difficulty in distinguishing between indigent patients and self-pay patients at the time of service. According to Sections 7020.17 (Cont. 2) and 8200 (Cont. 5) of the Hospital Manual, the Other Indigent payer category is to include indigent patients who are not recorded in the County Indigent Programs category and are being provided charity care.

The primary revenue deduction in the Other Indigent payer category should be charity care, which is defined as the difference between the amount charged and amount to be received based on a determination that the patient is unable to pay for provided services. The opposite is expected for the Other Payers category, where the predominant revenue deduction should be bad debts related to self-pay patients who are unwilling to pay for provided services.

One suggestion is to create a financial classification or insurance plan code named “Charity Care Pending” to record those patients whose eligibility for charity care cannot be made at the time of service. This is similar to the Medi-Cal Pending classification that some hospitals use. For reporting purposes, this gross revenue, related revenue deductions and utilization data for this classification/code could be reported under or split between Other Indigent and Other Payers based on the historical eligibility trends.

### **Partial Charity Care**

Some hospitals offer full (100%) and partial charity care (also called a sliding fee scale or reduced payment plan) based on the patient’s income level. Patients who are eligible for full charity care must be reported in the Other Indigent payer category. Reporting financial data for partial charity care is not as clear-cut. For example, a hospital may have the following partial charity care policy:

- an uninsured patient whose income level is between 200% and 400% of FPL is expected to pay the Medicare DRG rate or is eligible for a 75% charity care discount, and
- an uninsured patient whose income level is at or above 400% of FPL is eligible for a 25% charity care discount.

If the partial discount is 50% or more of the bill, report all gross revenue and related revenue deductions in the Other Indigent payer category. Since the patient is still responsible for part of the bill, it’s possible to report bad debts in the Other Indigent payer category; but this amount should be small compared to charity care.

Conversely, if the partial discount is less than 50% of the bill, report all gross revenue and related revenue deductions in the Other Payers category. Since the patient is not responsible

for part of the bill, it's possible to report charity care in the Other Payers category; but this amount should be a small amount in comparison to bad debts.

### **Policy Discounts**

Policy discounts (account 5920) are revenue deductions in the nature of courtesy allowances and employee discounts, where ability to pay is not used to determine eligibility. For example, if a hospital provides a discount from its full-established rates to all uninsured patients without performing any financial screening, the revenue deduction is considered a policy discount and not charity care because there was no determination made regarding the patient's ability to pay.

On the OSHPD Hospital Annual Disclosure Report, report policy discounts separately on Report Page 8, line 375; and as Other Deductions on Report Page 12, line 450. On the OSHPD Quarterly Financial and Utilization Report, report policy discounts on line 615, Other Adjustments and Allowances.

### **Section 1011 Reimbursement of Emergency Services Provided to Undocumented Aliens**

The Center for Medicare and Medicaid Services (CMS) recently implemented a new program to provide \$1 billion over four years to address the costs of providing emergency medical care to uninsured patients who cannot pay their hospital bills regardless of their citizenship status. CMS will designate a single contractor for enrolling providers, receiving claims, calculating provider payment amounts, and effectuating payments.

If Section 1011 reimbursements are considered payment-in-full, report financial data in the Other Third Parties – Traditional payer category as Other Government, with the revenue deduction recorded as a contractual adjustment.

Section 1011 includes two provisions where reimbursements are allowed for Medi-Cal and Self-Pay patients. One provision allows a hospital to submit a request for Section 1011 reimbursement for the unpaid deductible, co-insurance, or co-payment related to a Medi-Cal patient. Another provision states that if a patient is uninsured and is deemed able to self-pay for medical care, a hospital may be allowed to "balance bill" Section 1011 for claims that are not fully paid by the patient or for the appropriate costs after a Section 1011 payment has been made. Assuming that the hospital has determined that the patient is responsible and able to pay for all or part of the bill, any Section 1011 reimbursement for amounts written-off to bad debts would be reported as a bad debt recovery. At this time, these are tentative guidelines - more information is needed from the fiscal intermediary about these provisions to confirm these reporting requirements.

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If you would like copies of previous Hospital Technical Letters, or if you have any questions, please call Tim Pasco at (916) 323-1955, or me at (916) 323-7681.

Sincerely,

Kenrick J. Kwong  
Section Manager