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Components of a Cost/Charge Scenario as Utilized in the Life Care Plan

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Abstract

Life care planners regularly utilize medical coding systems and medical databases in their work. The goal of this article is to provide life care planners with procedural guidance in developing a cost/ charge scenario to project the cost of future hospitalizations, procedures, and surgeries that may be included in a life care plan. The basic components of cost/charge scenarios illustrate this process. Medical coding systems and various medical databases that a life care planner can utilize are discussed. The descriptions of the Current Procedural Terminology (CPT®) codes noted in this article are simplified due to American Medical Association (AMA) copyright terms. An appendix to the article is provided for step-by-step instructions to obtain inpatient and outpatient facility charges utilizing one of the medical database options.

Life Care Planning Methods

A life care plan is a comprehensive dynamic document developed to outline appropriate care with associated costs over the individual's lifetime while ensuring medical stability and quality of life. Life care planning tenets and methodologies have been in place for over three decades. Life care planners strive to identify the needs of the evaluee, without regard to funding sources or referral source. Deutsch & Sawyer (2004) instruct:

Plans are individualized to meet the unique needs of each patient. Needs, rather than funding sources, drive the planning process. At no time during the plan development process should budgetary concerns influence care and rehabilitation recommendations. The life care plan was designed with the intention of citing all of the items and services made necessary by the onset of a disability/injury (p.5-6). Life care plans based upon funding considerations may endanger the health and well-being of patients who require more care, equipment, or services than financial resources allow (p. 5-9).

These fundamental tenets of how a life care plan should be developed are still true today, more than 15 years after this was originally published.

Usual, Customary & Reasonable

In the preparation of life care plans, professionals are cautioned against utilizing the least expensive pricing or the most expensive pricing, as either choice fails the standard of objectivity. Rather, the life care planner should use what is usual, customary and reasonable (UCR) in the evaluee's geographic area (Berens & Weed, 2000; Johnson, Pomeranz & Stettn, 2018; Maniha & Watson, 2018). For purposes on this article, the terms UCR, cost, charge, and reimbursement are defined below.

According to the American Medical Association (AMA, Policy H-385.923, 2013), UCR is defined as follows: " (a) "**usual**" fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee); (b) a fee is "**customary**" when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and (c) a fee is "**reasonable**" when it meets the above two criteria and is justifiable, considering the special circumstance of the particular case in question, without regard to payments that have been discounted under governmental or private plans. It is the AMA's position there is no relationship between the Medicare Fee Schedule and UCR fees (AMA Policy H-385.923, 2013)."

Charge: What the physician/provider charges for services rendered

Cost: What it actually costs to provide the service(s) with no mark-up

Reimbursement: What the payor source actually pays for the service(s)

The words cost and charge are often used interchangeably by life care planners with the word cost actually meaning charge. This author, in preparing a cost/charge scenario, elects to utilize 75th or 80th percentile of billed charges noted in Medical Fees, FAIR Health, Physicians' Fee Reference, and/or Context Healthcare as UCR (Maniha & Watson 2018). This method has been reviewed in the court system as recently as 2017 and deemed to be a reasonable, notably in a California case, Cuevas v. Contra Costa (2017). De Saint Phalle and Clay (2018), note the following about using the 80th percentile for pricing, (2018, p. 1), "Crucially, the Cuevas court approved the use of UCR (Usual, Customary and Reasonable) pricing, where the range of medical prices for a given service is measured through national price surveys, and the market rate determined at the 80th percentile of actual prices" (*Cuevas, supra*, 11 Cal.App.5th at 182). Additionally, this author adopted this method in her practice because the VA Reasonable Data Charges were developed utilizing the 80th percentile (38 CFR§17.101).

Cost/ Charge Scenario

The cost/charge scenario is a future cost/charge estimate for a recommended service/item. It is essentially a simplified itemized statement of UCR charges. It should not be

confused with the more complicated process of a bill review. A cost/ charge scenario includes **what** has been recommended (the procedure); **why/reason** it was recommended (diagnosis); **where** it will take place (facility [hospital], non-facility, inpatient or outpatient); **who** is involved in performing the procedure (physician, assistant surgeon, anesthesiologist); and at times, additional **items used**, such as the IPG (implanted pulse generator) of the spinal cord stimulator. All of these items come together to create the scenario that has been recommended. Once all these components have been obtained, the process of applying the reasonable accompanying costs to each service is required. To do this, the life care planner may use medical coding systems and medical databases for UCR pricing.

Tools Used in Developing a Cost/Charge Scenario

In developing a cost/ charge scenario, life care planners should be familiar with the basic components of the process. Life care planners regularly rely upon medical databases for usual, customary and reasonable pricing of medical service(s) and item(s). According to Maniha and Watson (2018) databases commonly used by life care planners include American Hospital Directory; Context4 Healthcare; FAIR Health; Medical Fees (Davis, 2020); Physicians' Fee Reference (Wasserman, 2020); VA Reasonable Data Charges (38 CFR§17.101); and InHealth Physician Fee and Coding Guide 2020 (InHealth, 2020). It is this author's understanding that there are limitations of funding sources. Health insurance coverage either does not cover or only partially provides funding for many of the items included in the life care plan. There are many variables associated with insurance pricing. For example, there is variability among plans with what is or is not covered. If covered, how much of the service will be paid and what are the deductible or co-pay amounts, and out-of-pocket limits (Maniha & Watson, 2018). Details of the contractual agreement between the healthcare provider and the insurance company vary, as do the contracts for coverage of certain items for each patient. Additionally, the terms of the contract may change from year-to-year when contracts with either party are renegotiated or redefined. The only consistency is inconsistency. Therefore, reliance upon quoted negotiated rates in a life care plan may not accurately represent monies required to pay for items in the life care plan. Life care planning guiding document *Consensus and Majority Statements* convey

#85. Best practices for identifying costs in life care plans include:

a. Verifiable data from appropriately referenced sources
b. Costs identified are geographically specific when appropriate and available.
c. Non-discounted/ market rate prices
d. More than one cost estimate, when appropriate

(Johnson, Pomeranz & Stetten, 2018, p. 17).

Federal programs providing health coverage such as Medicare and Medicaid may not consider all required services identified in the life care plan as medically necessary. If services/items are not deemed "medically necessary" they will not be covered under these healthcare plans. Medical necessity does not necessarily mean quality of life for the person, which is an important part of the life care plan. As one experienced life care planner noted, "coverage does not equate care" (H. Wade, personal communication, June 15, 2017).

In some cases, life care planners are requested to cost items and services in the plan based upon a prescribed reimbursement source, such as workers' compensation. In this scenario, it is advised that the life care planner develop the plan with the appropriate UCR charges addressing the individual's needs consistent with life care planning literature/methodology including *Majority and Consensus Statements* (Johnson, Pomeranz & Stetten, 2018) and *Life Care Planning: Step by Step Guide* (Weed & Owen, 2018). The life care plan would also include an additional column identifying what the workers' compensation payor (or similar prescribed reimbursement source) would reimburse for covered item/services in the plan and whether or not the item/ service is covered (Maniha, 2008). This provides guidance to the reader about the difference in the actual charge for the item and what the negotiated rate with the workers' compensation payor / or other similar prescribed reimbursement source would be. Most importantly, it provides the reader with the amount required to provide the service not covered by the requested entity.

Medical Coding Systems

Many life care planners utilize encoder programs, such as Find-A-Code, RevenueCyclePro and EncoderPro to assist with the medical coding process. When utilizing medical databases, the appropriate medical code is required to obtain pricing. A list of various coding systems necessary to develop a cost/charge scenario for a surgical procedure, office visit, therapies, supplies, equipment, orthotics, diagnostic testing and/or hospitalizations are listed below in Table 1. It is important to the use most recent version. All medical coding systems are updated annually. The MS-DRG, ICD-10-CM and ICD-10-PCS are effective October first of the prior year (i.e., the 2021 version becomes effective 10/1/2020). The CPT and HCPCS codes are updated January 1st every year. It is important for the life care planner to utilize the updated / current code sources.

Table 1
Commonly used medical costing systems (not all inclusive)

Coding System	Abbreviation
International Classification of Diseases 10th Revision Clinical Modification	ICD-10-CM
International Classification of Diseases 10th Revision Procedure Coding System	ICD-10-PCS
Current Procedure Terminology (Level I HCPCS)	CPTs
Healthcare Common Procedure Coding System (Level II HCPCS)	HCPCS
Ambulatory Payment Classification	APCs
Medicare Severity-Diagnosis Related Group	MS-DRGs

The above coding systems serve different purposes. The ICD-10-CM represents the **why** (diagnosis) portion of the scenario. The CPT code represents the **who** (physician), **what** (the procedure) and/or the **where** (outpatient facility). The MS-DRGs represent **where** (inpatient facility). The ICD-10-PCS represents **what** (inpatient procedure). The Healthcare Common Procedure Coding System (HCPCS) includes **what's included**, for example equipment, supplies, orthotics, prosthetics, ambulances, devices, and some professional services. Life care planners should be aware that cost-intensive devices, such as the implantable pulse generator (IPG) for a spinal cord stimulator and certain medications such as Botox may not always be included in these figures contained in a database.

Current Procedure Terminology (CPT)

The CPT code is representative of physician/qualified health care professional, outpatient facilities, therapies and/or diagnostic testing services. It represents the **what, who** and/or the **where** of the scenario. This will depend on what the code represents (i.e., physician or outpatient facility). The CPT code representative of physician services is based on relative value units (RVUs) including 'work expense" (*the physician work required to perform the service*), "practice expense" (*resources required to perform the service*) and "malpractice expense". These components represent the resources involved in performing this service such as education, skill, complexity of procedure, supplies, equipment and overhead which translates to the worth (or value) of the code. The RVUs of a code can change depending on where the procedure is performed, (i.e., place of service or POS), either a facility or non-facility. The work expense component of the RVUs remains the same for POS, but the practice expense will increase if the service is performed in a non-facility (e.g., an office). This is because the physician will be responsible for the overhead expenses instead of the facility. This is not the case for all codes. There are some CPTs that are only performed in a facility (i.e., a total knee, 27447) and codes such as 64479, a cervical transforaminal epidural injection that can be performed either in a non-facility or facility setting. The CPT code used by an outpatient facility (**the "where"**) reflects the charges associated with the procedure(s), exclusive of the professional fees.

International Classification of Diseases 10th Revision Clinical Modification (ICD-10-CM)

The ICD-10-CM identifies diagnoses, signs and symptoms, injuries, conditions, complaints or other reasons (**why**). When the ICD-10-CM is associated with inpatient hospitalizations, these codes drive the appropriate medical MS-DRG (**where**) for inpatient care. The ICD-10-CM is required for creating both the surgical and medical inpatient hospitalization.

International Classification of Diseases 10th Revision Procedure Coding System (ICD-10-PCS)

The ICD-10-PCS represents inpatient procedures and drives the appropriate surgical MS-DRG along with the ICD-10-CM. The ICD-10-PCS was created with the intention of building the code associated with the actual procedure performed. The code consists of seven alpha-numeric characters. The characters represent the following: 1) the section (i.e., medical and surgical), 2) body system (e.g., lower joints), 3) root operation (e.g. replacement), 4) body part (e.g., right knee joint), 5) approach (e.g., open), 6) device (e.g., synthetic substitute) and 7) qualifier. In the medical and surgical section, there are 31 different root operations. Because of this, it is difficult to crosswalk from a CPT code (the physician's service) to the ICD-10-PCS (inpatient procedure) that is required for obtaining the correct MS-DRG. The description of the CPT code does not include such descriptors as right or left, but for some procedures, a code may include bilateral.

It should also be noted that root operation definitions of the ICD-10-PCS may be different than when they are used in a CPT code descriptor. For example, the CPT code 27487 represents the replacement of an already implanted total knee prosthesis, but the description of this code includes the word "revision". However, for ICD-10-PCS coding for this procedure, two codes are used -- both the prosthesis removal (root operation) and prosthesis replacement (root operation).

If one uses the root operation "revision" for the ICD-10-PCS to represent this CPT code, it will lead to an incorrect MS-DRG.

Medicare Severity-Diagnosis Related Group (MS-DRG)

The inpatient hospitalization cost/charge scenario requires a MS-DRG. A MS-DRG represents the inpatient facility charges. These codes are driven by the procedures performed and the primary and secondary diagnoses. MS-DRGs are diagnosis-related *groups* of ICD-10-CMs or ICD-10-PCSs which are grouped based upon similarity of complexity, resources utilized, and education required. The MS-DRG includes all facility charges pertaining to an inpatient hospitalization, excluding professional fees. Some of the services included within the MS-DRGs are room and board and ancillary charges such as recovery room, charges for the operating room, charges for the anesthesia equipment, as well as supplies. It is important to understand that multiple ICD-10-CMs and ICD-10-PCs fall under a surgical or non-surgical (medical) MS-DRG, respectively. Some of the MS-DRGs will include CC (complication/co-morbidity) or MCC (major complication/co-morbidity).

DRG grouper software will assist with the process of obtaining the correct MS-DRG. The software can be downloaded from the CMS website for free. It is important to use the most recent DRG Grouper software. It is updated annually and becomes effective October 1, the year prior; for example, 2021 MS-DRGs became effective 10-01-2020. In addition, the encoder program subscriptions offer this service, usually for an additional cost.

Ambulatory Payment Classification (APC)

The APC was created by Medicare for hospital outpatient facility payment. The APC is like the MS-DRG except representing outpatient facility services instead of inpatient services. Services (CPTs/HCPCS) are grouped under APCs by similar clinical condition, resource utilization and cost. The APC includes facility services and not professional services. The APCs have status indicators effecting how they are paid. The status indicator "C" represents an inpatient only procedure. The author prefers to use CPT codes for outpatient facility instead of APCs. Addendum B found on the CMS website identifies the CPT code and the APC it is grouped under including the status indicator in addition to other information in other words, Addendum B cross crosswalks the CPT to APC (CMS, 2020). This is all a part of the Medicare OPPS (Outpatient Prospective Payment System). Addendum A is a list of APCs, description, relative weight and the status indicator plus (CMS, 2020).

Healthcare Common Procedure Coding System (HCPCS)

HCPCS Level II codes represent drugs, ambulance services, durable medical equipment, orthotics, prosthetics, supplies in addition to other services and items. The HCPCS codes are alpha numerical. "A" codes represent transportation services (Ground mileage, per statute mile: A0425) and medical and surgical supplies (Osteotomy belt, each: A4367); "J" codes represent drugs administered other than oral and chemotherapy (Botox 1 unit: J0585); "B" codes, enteral and parenteral equipment, and supplies (Stomach tube-Levine type: B4083); "L codes, orthotics and prosthetics (AFO, posterior solid ankle, plastic, custom fabricated: L1960), just to mention a few.

There are other medical coding systems not listed here. This information is only scratching the service of medical coding and what is involved. Each carrier (payor source) has their own guidelines. The life care planner should follow the actual guidelines of the medical coding system itself (CPT, ICD-10-CM, ICD-10-PCS, etc.). The cost/charge scenario is a future scenario of a hospitalization and/or procedure, etc. that has not occurred but has been recommended.

Crosswalking

Crosswalking is the process of taking one service (e.g., CPT code) and connecting it to another appropriate service (e.g., ICD-10-PCS). For a life care planner to properly estimate the total cost of a procedure, multiple components of charges must be known. For example, to properly create the cost/charge scenario for a total knee replacement performed in an inpatient setting, pricing for the physician, facility and anesthesia all must be provided. Therefore, in developing a cost/charge scenario for a knee replacement performed in an inpatient setting, the following crosswalks will be involved:

CPT (physician's services) → **ICD-10-PCS** (inpatient procedure) → **MS-DRG** (surgical inpatient facility charges) +

CPT (physician's services) → **anesthesia CPT code**

To assist the life care planner in identifying crosswalking between codes, there are encoder subscriptions such as Find-A-Code, EncoderPro Payers, and Flashcode that may be useful tools in the development of a cost/ charge scenario.

Demonstration of Cost/Charge Scenarios

The following information provides step-by-step instructions on the process of developing cost/charge scenarios.

Cost/ Charge Scenario for Inpatient Hospitalization-Non-Surgical associated with pneumonia

In creating a cost/charge scenario for an inpatient hospitalization, the MS-DRG represents the facility charges while CPT codes are included for physician services. The ICD-10-CM identifies the principal diagnosis which will lead (crosswalk) to the correct MS-DRG. Table 2 below outlines the codes utilized for a hospitalization for pneumonia.

Table 2	*Codes utilized for pneumonia inpatient hospitalization*
Medical MS-DRG (inpatient facility charges)	**193** Simple pneumonia and pleurisy with MCC or **194** Simple pneumonia and pleurisy with CC or **195** Simple pneumonia and pleurisy without CC/MCC
ICD-10-CM (diagnosis)	**J15.9** Unspecified bacterial pneumonia (not only diagnosis that falls under this MS-DRG)
CPT (physician services)	**99221**, **99222** or **99223** for **admission services** (correct one depends on complexity, or they can be ranged; also applies to the following)
	99231, **99232**, or **99233** for **subsequent hospital visits 99238** or **99239 discharge services**
If a four-day length of stay:	One admission day, two subsequent days, and one discharge day

Cost/ Charge Scenario for Inpatient Hospitalization-Surgical

To develop a cost/charge scenario for an inpatient surgical procedure, the MS-DRG will represent the facility costs; ICD-10-PCS (procedure) codes and ICD-10-CM (diagnosis) codes will be used to identify the correct MS-DRG; and CPT codes will be used for physician, assistant surgeon and/or co-surgeon fees as well as anesthesia fees. Table 3 below shows the codes utilized for a hospitalization for a total knee replacement.

Cost/ Charge Scenario for Outpatient Procedure-Surgical

To create a cost/ charge scenario for an outpatient surgical procedure, CPT codes are needed for physician, assistant surgeon and/or co-surgeon and anesthesia fees. CPT

Table 3	*Codes utilized for hospitalization for a total knee replacement*
Surgical MS-DRG (inpatient facility charges)	**469** Major hip and knee joint replacement or reattachment of lower extremity with MCC or total ankle replacement or **470** Major hip and knee joint replacement or reattachment of lower extremity without MCC
ICD-10-PCS (inpatient surgical procedure)	**0SRC0JZ** Replacement of Right Knee Joint with Synthetic Substitute, Open Approach (not only ICD-10-PCS)
CPT (physician services)	**27447** Total knee arthroplasty
CPT (assistant surgeon or co-surgeon)	**27447 (**appropriate for modifier 80 assistant surgeon or 62 Co-surgeon) The assistant surgeon and co-surgeon charge is a percent of the primary surgeon's fee. According to RPC "a reasonable charge is 25% of the reasonable charge for the primary physician. (RPC, 2020, p. 27)." This percent varies among payors, whether commercial or non-commercial.
CPT (anesthesia)	**01402** anesthesia = base units +time units x monetary conversion factor x GAF
	(GAF = geographic adjustment factor)

codes are needed for facility charges (**where**) or to identify appropriate Ambulatory Payment Classification (APC). To determine fees for cost-intensive devices (e.g., IPG for spinal cord stimulator), HCPCS codes are required (**what required**). Medicare HCPCS codes are reported by C codes and non-Medicare HCPCS codes are represented by L codes or E codes associated with cost-extensive devices depending on the item and J codes for drugs/medications. The C, L, E and J codes are not all inclusive of HCPCS codes but are the main ones associated with the cost intensive devices such as the IPG, baclofen pump and medications/drugs such as baclofen, chemotherapy and Botox.

When utilizing the databases for outpatient facility charge determination, it is important to understand what is included pertaining to the CPT code associated outpatient facility charges and the cost intensive devices such as the SCS IPG or the implanted intrathecal pump charges. FAIR Health will usually require two codes, CPT code (outpatient facility) plus the L-codes (HCPCS) (CPT + HCPCS (IPG)). The American Hospital Directory will require the life care planner to locate the CPT code representing the outpatient facility charge plus the HCPCS (C-Code) representing the cost extensive device (CPT+HCPCS (IPG)). If using Context4 Healthcare, the HCPCS (IPG) is included within the CPT charge for outpatient facility (CPT). Table 4 below outlines the codes for implantation or replacement of an IPG for a spinal cord stimulator performed in an outpatient facility or ambulatory surgical center.

If utilizing the APC for the facility charges, the code 5464 is utilized for Level 4 *Neurostimulator and Related Procedures*.

When developing these cost/charge scenarios, it is important to always use deductive reasoning. For example, if American Hospital Directory lists the average charge for APC 5464 as $6,000, it should be reasoned that the IPG is not included, and that a search is needed to identify the pricing

Table 4	*Common Codes utilized for implantation or replacement of IPG for SCS in outpatient facility or ambulatory surgical center*
CPT (facility) (outpatient facility charges)	**63685** Implantation or replacement of IPG
HCPCS (device)	**C1820** Generator, neurostimulator (implantable), with rechargeable battery and charging system, **or** **C1822** Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system, **or** **C1767** Generator, neurostimulator (implantable), non-rechargeable, or **L8685** Implantable neurostimulator pulse generator, single array, rechargeable, includes extension, **or** **L8686** Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension, **or** **L8687** Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension, **or** **L8688** Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
CPT (physician services)	**63685** Implantation or replacement of IPG
CPT (physician services)	**95972** Programing of the IPG (this code is not always included)
CPT (assistant surgeon or co-surgeon)	**63685** (appropriate for modifier 80 assistant surgeon or 62 co-surgeon)
CPT (anesthesia)	**00300** describes the anesthesia utilized for the procedure(s) and area of the body it addresses; one area this code addresses is the posterior trunk, **or** **00400** one area this code addresses is the anterior trunk *(Read the code description, as it depends on where the IPG is implanted; both may be identified separately or range between the two.)*

for the appropriate C code in AHD.

Cost/ Charge Scenario for a Procedure- Physician Office

When creating a cost/charge scenario for a procedure performed in a physician office (e.g., non-facility), a CPT code is required for physician and/or qualified professional services and HCPC codes are needed for additional supplies. In this example, the supplies needed are for Botox. Table 5 below outlines codes associated with Botox injections performed in a physician's office.

Conclusion

Table 5	*Codes used for Botox performed in non-facility*
CPT (physician or qualified health professional)	**64642** Chemodenervation for one extremity for one to four muscles **95873** Electrical stimulation for guidance, **or** **95874** Needle electromyography for guidance **99070** Supplies and materials……
HCPCS (drug-Botox)	**J0585** Injection, onabotulinumtoxinA, one unit *(if 100 units administered, then multiply the amount per unit x 100)* *(i.e., $25.05 x 100 = $2,505.00)*

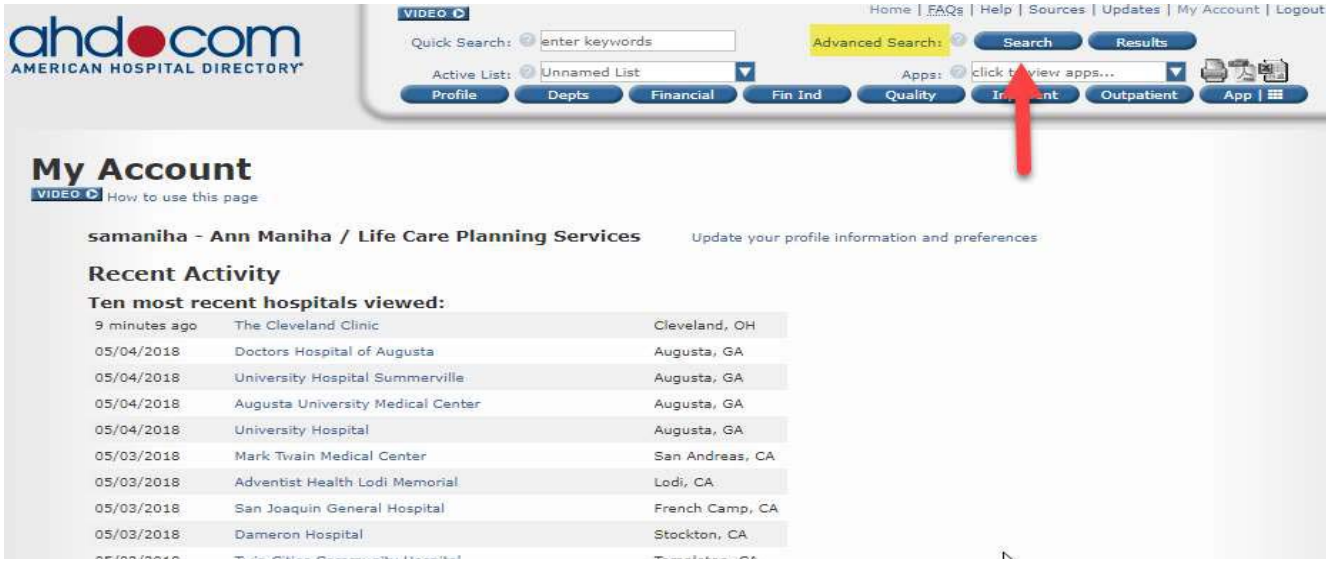
Identifying an individual's needs brought on by a disability, including the impact on one's medical condition and their quality of life, is foundational to the development of a life care plan. Once needs are identified, the cost for these items must be developed by the life care planner, without consideration of funding sources. A consistent approach to determine the cost of medical services is essential to developing a valid life care plan. Developing a cost/charge scenario can provide cost estimates for items in the life care plan. Development of a cost/ charge scenario is a simplified version of a very complex process and the key terms involved in this process and the steps involved in this process are outlined in this article.

Accessing Information in the Database American Hospital Directory

(The following information has been displayed with the permission of William Shoemaker, President of American Hospital Directory.)

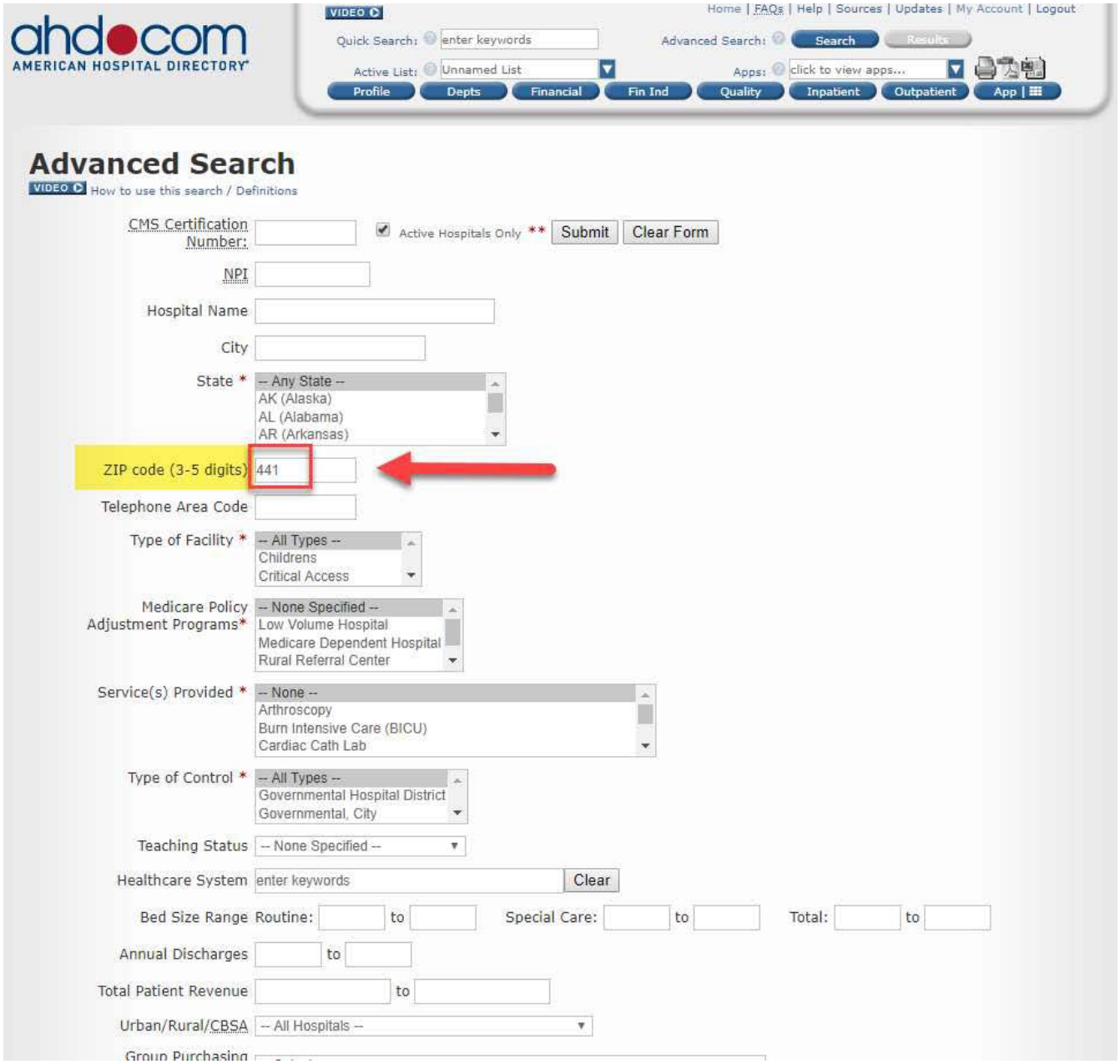
These instructions include one of the processes utilized by the author to access the information needed in American Hospital Directory. There are other methods to access this information.

1. Visit the website: https://www.ahd.com/
2. Log in
3. Once the user is logged in: Go to **"Advanced Search"** at the top of the page and click on the search button



(This is only a portion of the page.)

4. On the Advanced Search page, where the box for **"ZIP code (3-5 digits)"** is, enter the first three numbers of the zip code (geo-zip). This example includes **441** for the Cleveland, Ohio area.



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5. The following will be displayed after entering the geo-zip. Note the highlighted **"The Cleveland Clinic"** information. The information includes most hospitals in the 441 geo-zip.
(This is only a portion of the page.)

6. The **IP button** identifies the inpatient facility information and the **OP button** identifies the outpatient information.

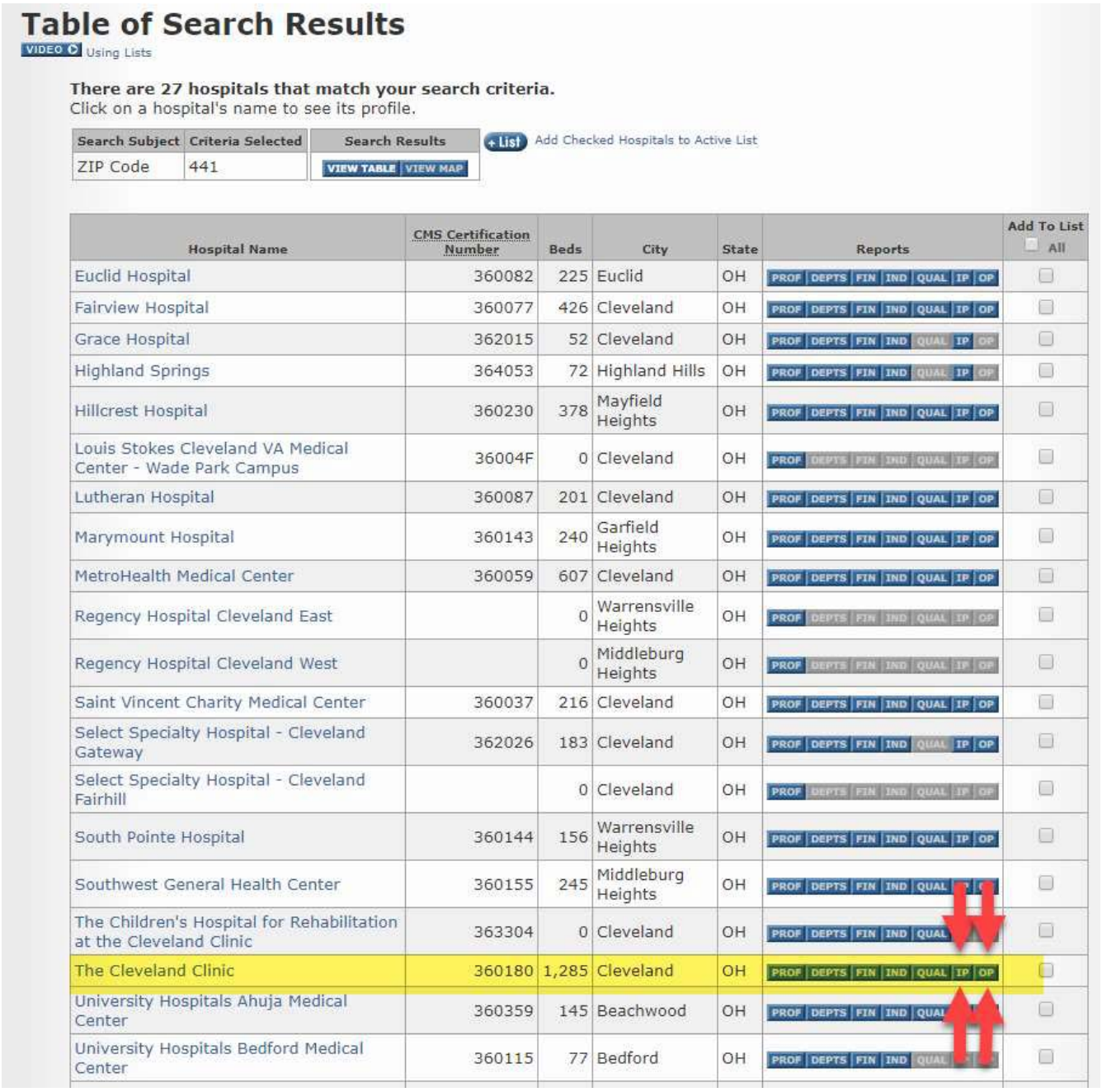


Table of Search Results

VIDEO Using Lists

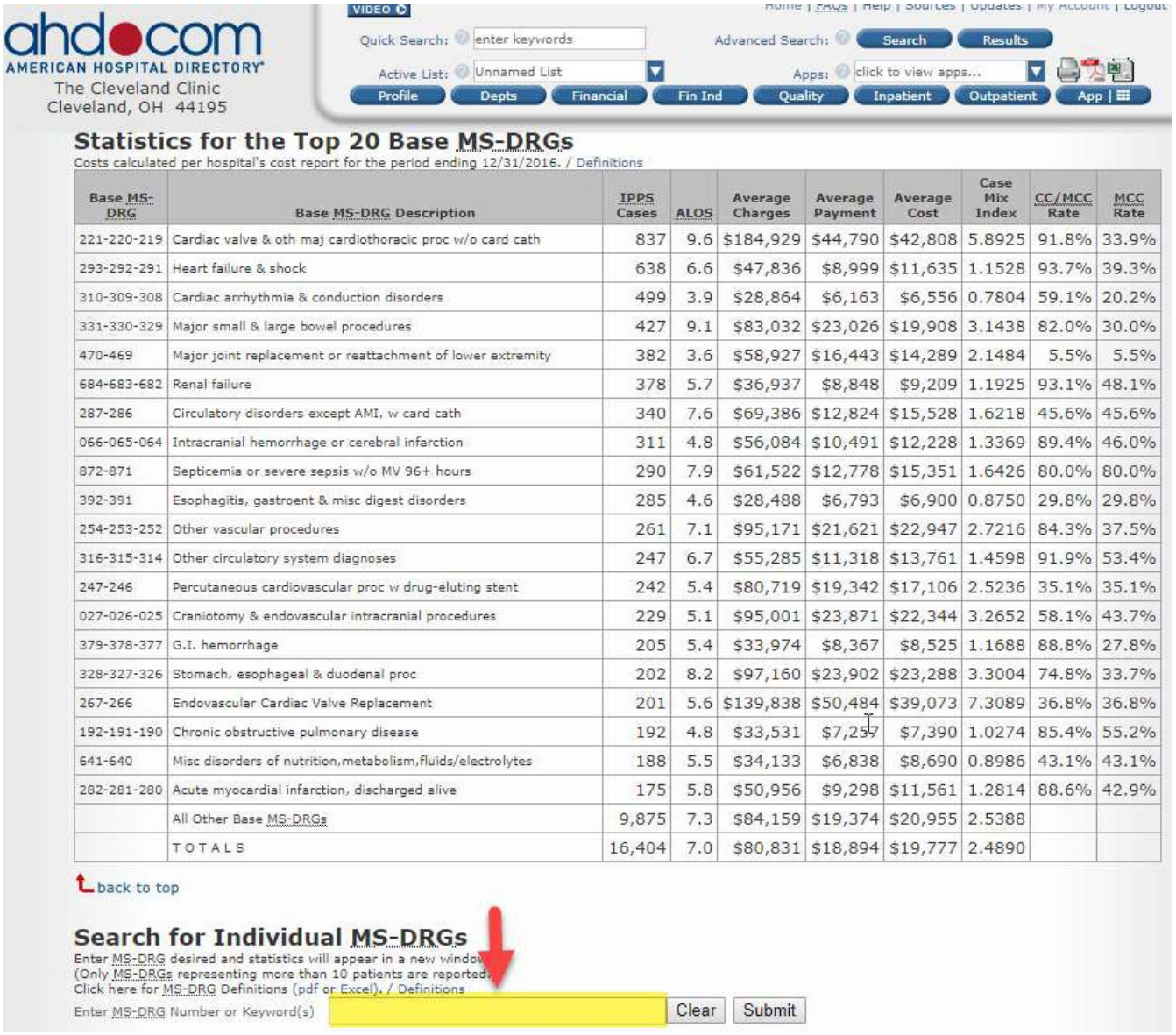
There are 27 hospitals that match your search criteria.
Click on a hospital's name to see its profile.

Search Subject	Criteria Selected	Search Results
ZIP Code	441	VIEW TABLE VIEW MAP

+ List Add Checked Hospitals to Active List

Hospital Name	CMS Certification Number	Beds	City	State	Reports	Add To List All
Euclid Hospital	360082	225	Euclid	OH	PROF DEPTS FIN IND QUAL IP OP	
Fairview Hospital	360077	426	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Grace Hospital	362015	52	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Highland Springs	364053	72	Highland Hills	OH	PROF DEPTS FIN IND QUAL IP OP	
Hillcrest Hospital	360230	378	Mayfield Heights	OH	PROF DEPTS FIN IND QUAL IP OP	
Louis Stokes Cleveland VA Medical Center - Wade Park Campus	36004F	0	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Lutheran Hospital	360087	201	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Marymount Hospital	360143	240	Garfield Heights	OH	PROF DEPTS FIN IND QUAL IP OP	
MetroHealth Medical Center	360059	607	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Regency Hospital Cleveland East		0	Warrensville Heights	OH	PROF DEPTS FIN IND QUAL IP OP	
Regency Hospital Cleveland West		0	Middleburg Heights	OH	PROF DEPTS FIN IND QUAL IP OP	
Saint Vincent Charity Medical Center	360037	216	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Select Specialty Hospital - Cleveland Gateway	362026	183	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Select Specialty Hospital - Cleveland Fairhill		0	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
South Pointe Hospital	360144	156	Warrensville Heights	OH	PROF DEPTS FIN IND QUAL IP OP	
Southwest General Health Center	360155	245	Middleburg Heights	OH	PROF DEPTS FIN IND QUAL	
The Children's Hospital for Rehabilitation at the Cleveland Clinic	363304	0	Cleveland	OH	PROF DEPTS FIN IND QUAL	
The Cleveland Clinic	360180	1,285	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
University Hospitals Ahuja Medical Center	360359	145	Beachwood	OH	PROF DEPTS FIN IND QUAL	
University Hospitals Bedford Medical Center	360115	77	Bedford	OH	PROF DEPTS FIN IND	

7. Once the IP button has been selected, the following will be displayed: (This is only a portion of the page.)



ahdcom
AMERICAN HOSPITAL DIRECTORY
The Cleveland Clinic
Cleveland, OH 44195

VIDEO

Quick Search: enter keywords Advanced Search: Search Results

Active List: Unnamed List Apps: click to view apps...

Profile | Depts | Financial | Fin Ind | Quality | Inpatient | Outpatient | App

Statistics for the Top 20 Base MS-DRGs

Costs calculated per hospital's cost report for the period ending 12/31/2016. / Definitions

Base MS-DRG	Base MS-DRG Description	IPPS Cases	ALOS	Average Charges	Average Payment	Average Cost	Case Mix Index	CC/MCC Rate	MCC Rate
221-220-219	Cardiac valve & oth maj cardiothoracic proc w/o card cath	837	9.6	$184,929	$44,790	$42,808	5.8925	91.8%	33.9%
293-292-291	Heart failure & shock	638	6.6	$47,836	$8,999	$11,635	1.1528	93.7%	39.3%
310-309-308	Cardiac arrhythmia & conduction disorders	499	3.9	$28,864	$6,163	$6,556	0.7804	59.1%	20.2%
331-330-329	Major small & large bowel procedures	427	9.1	$83,032	$23,026	$19,908	3.1438	82.0%	30.0%
470-469	Major joint replacement or reattachment of lower extremity	382	3.6	$58,927	$16,443	$14,289	2.1484	5.5%	5.5%
684-683-682	Renal failure	378	5.7	$36,937	$8,848	$9,209	1.1925	93.1%	48.1%
287-286	Circulatory disorders except AMI, w card cath	340	7.6	$69,386	$12,824	$15,528	1.6218	45.6%	45.6%
066-065-064	Intracranial hemorrhage or cerebral infarction	311	4.8	$56,084	$10,491	$12,228	1.3369	89.4%	46.0%
872-871	Septicemia or severe sepsis w/o MV 96+ hours	290	7.9	$61,522	$12,778	$15,351	1.6426	80.0%	80.0%
392-391	Esophagitis, gastroent & misc digest disorders	285	4.6	$28,488	$6,793	$6,900	0.8750	29.8%	29.8%
254-253-252	Other vascular procedures	261	7.1	$95,171	$21,621	$22,947	2.7216	84.3%	37.5%
316-315-314	Other circulatory system diagnoses	247	6.7	$55,285	$11,318	$13,761	1.4598	91.9%	53.4%
247-246	Percutaneous cardiovascular proc w drug-eluting stent	242	5.4	$80,719	$19,342	$17,106	2.5236	35.1%	35.1%
027-026-025	Craniotomy & endovascular intracranial procedures	229	5.1	$95,001	$23,871	$22,344	3.2652	58.1%	43.7%
379-378-377	G.I. hemorrhage	205	5.4	$33,974	$8,367	$8,525	1.1688	88.8%	27.8%
328-327-326	Stomach, esophageal & duodenal proc	202	8.2	$97,160	$23,902	$23,288	3.3004	74.8%	33.7%
267-266	Endovascular Cardiac Valve Replacement	201	5.6	$139,838	$50,484	$39,073	7.3089	36.8%	36.8%
192-191-190	Chronic obstructive pulmonary disease	192	4.8	$33,531	$7,257	$7,390	1.0274	85.4%	55.2%
641-640	Misc disorders of nutrition,metabolism,fluids/electrolytes	188	5.5	$34,133	$6,838	$8,690	0.8986	43.1%	43.1%
282-281-280	Acute myocardial infarction, discharged alive	175	5.8	$50,956	$9,298	$11,561	1.2814	88.6%	42.9%
	All Other Base MS-DRGs	9,875	7.3	$84,159	$19,374	$20,955	2.5388		
	TOTALS	16,404	7.0	$80,831	$18,894	$19,777	2.4890		

back to top

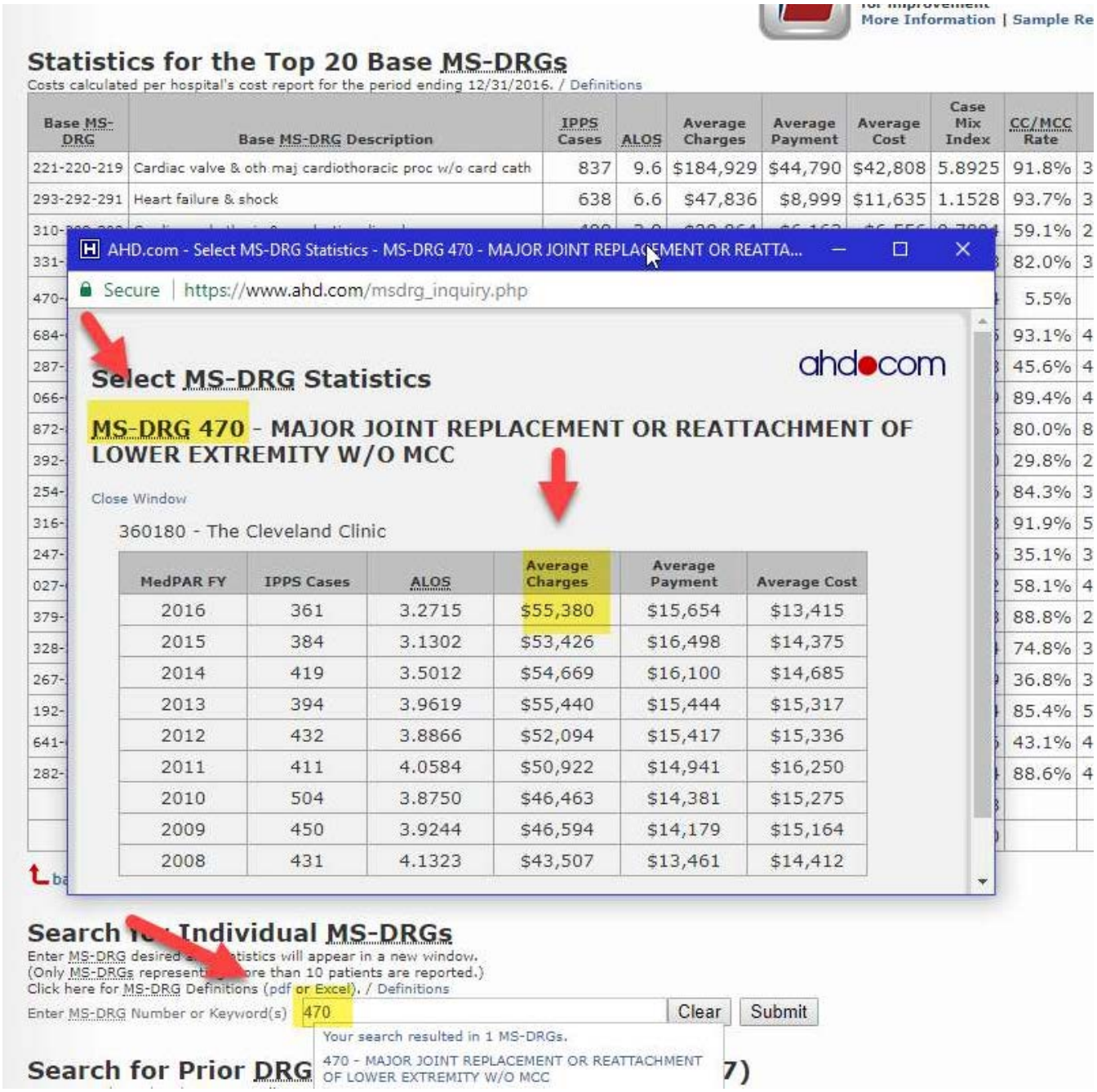
Search for Individual MS-DRGs

Enter MS-DRG desired and statistics will appear in a new window
(Only MS-DRGs representing more than 10 patients are reported.)
Click here for MS-DRG Definitions (pdf or Excel). / Definitions

Enter MS-DRG Number or Keyword(s) Clear Submit

8. Scroll down to **"Search for Individual MS-DRGs"** (where the red arrow points on the example above) and enter the MS-DRG to search for.

9. For this example, the **MS-DRG 470** will be utilized. Input the numbers **"470"** and press enter. If there are 11 or more of this specific MS-DRG performed in the facility per year, this is the information that will be displayed.



Obtaining Outpatient Information

Accessing the outpatient information is the same as the inpatient for **steps 1 through 6** as previously noted. For step 7, instead of clicking on the inpatient button (IP), click on the outpatient button (OP).

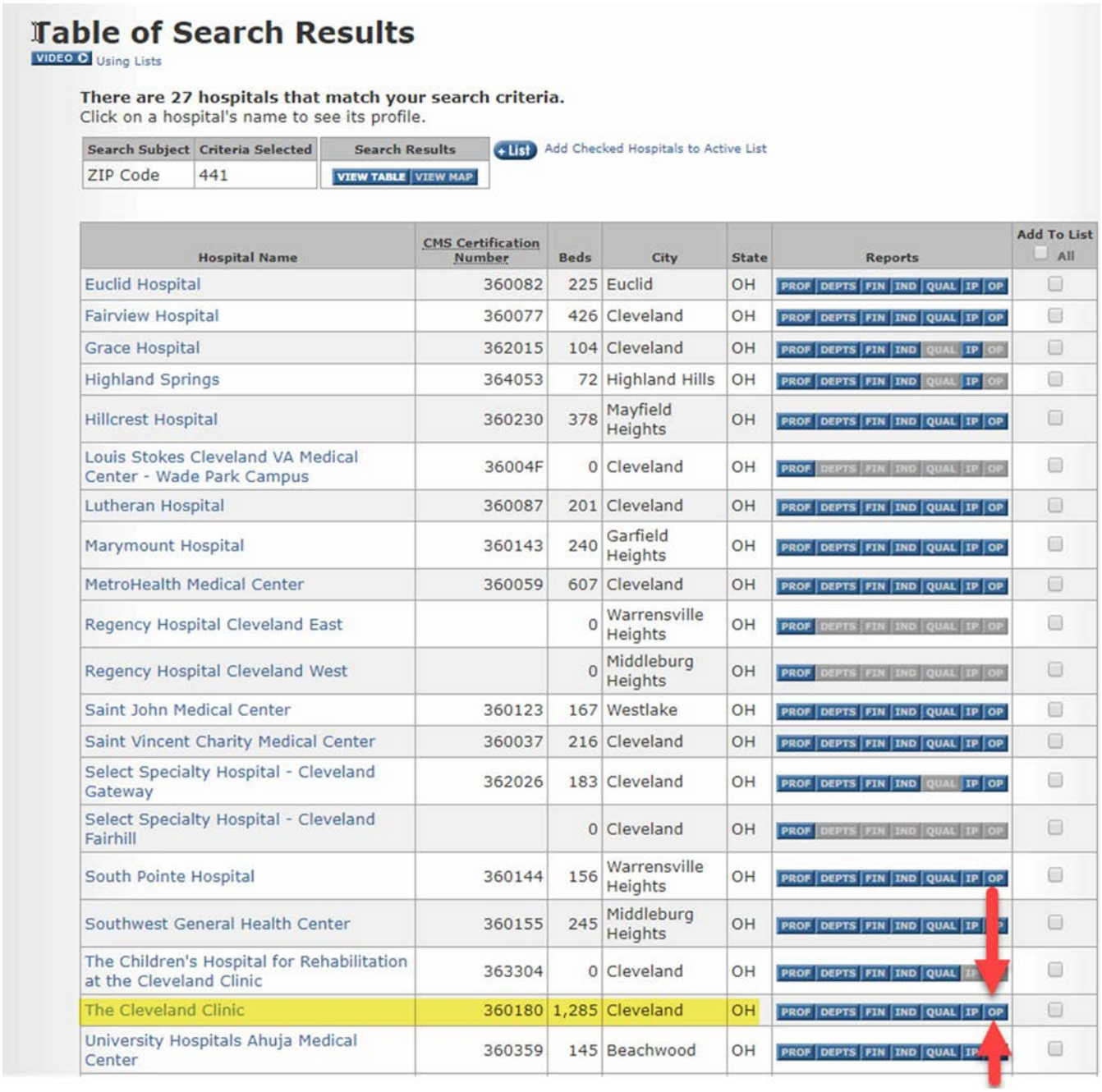


Table of Search Results

VIDEO Using Lists

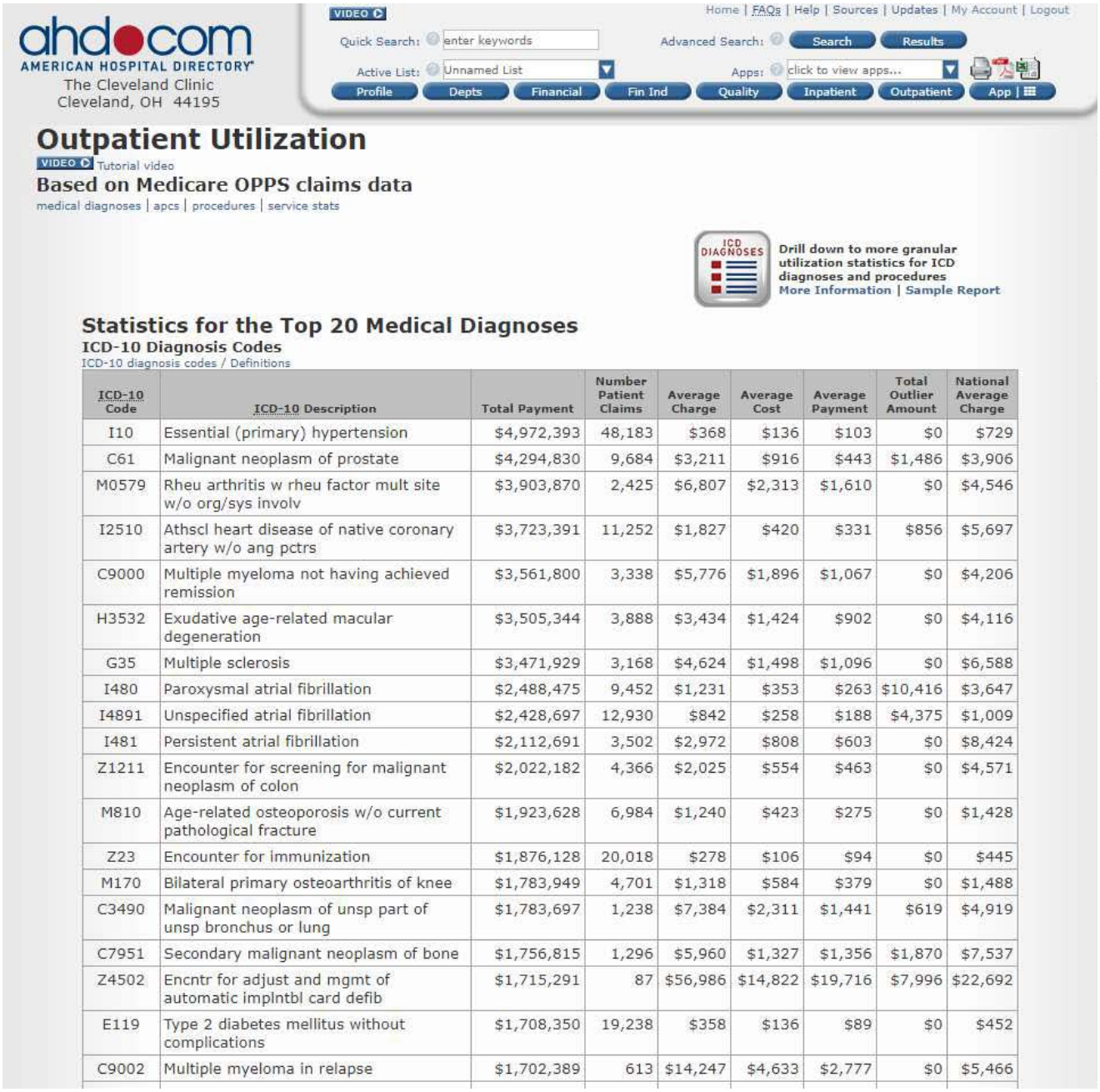
There are 27 hospitals that match your search criteria.
Click on a hospital's name to see its profile.

Search Subject	Criteria Selected	Search Results
ZIP Code	441	VIEW TABLE VIEW MAP

+ List Add Checked Hospitals to Active List

Hospital Name	CMS Certification Number	Beds	City	State	Reports	Add To List All
Euclid Hospital	360082	225	Euclid	OH	PROF DEPTS FIN IND QUAL IP OP	
Fairview Hospital	360077	426	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Grace Hospital	362015	104	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Highland Springs	364053	72	Highland Hills	OH	PROF DEPTS FIN IND QUAL IP OP	
Hillcrest Hospital	360230	378	Mayfield Heights	OH	PROF DEPTS FIN IND QUAL IP OP	
Louis Stokes Cleveland VA Medical Center - Wade Park Campus	36004F	0	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Lutheran Hospital	360087	201	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Marymount Hospital	360143	240	Garfield Heights	OH	PROF DEPTS FIN IND QUAL IP OP	
MetroHealth Medical Center	360059	607	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Regency Hospital Cleveland East		0	Warrensville Heights	OH	PROF DEPTS FIN IND QUAL IP OP	
Regency Hospital Cleveland West		0	Middleburg Heights	OH	PROF DEPTS FIN IND QUAL IP OP	
Saint John Medical Center	360123	167	Westlake	OH	PROF DEPTS FIN IND QUAL IP OP	
Saint Vincent Charity Medical Center	360037	216	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Select Specialty Hospital - Cleveland Gateway	362026	183	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
Select Specialty Hospital - Cleveland Fairhill		0	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
South Pointe Hospital	360144	156	Warrensville Heights	OH	PROF DEPTS FIN IND QUAL IP OP	
Southwest General Health Center	360155	245	Middleburg Heights	OH	PROF DEPTS FIN IND QUAL IP	
The Children's Hospital for Rehabilitation at the Cleveland Clinic	363304	0	Cleveland	OH	PROF DEPTS FIN IND QUAL	
The Cleveland Clinic	360180	1,285	Cleveland	OH	PROF DEPTS FIN IND QUAL IP OP	
University Hospitals Ahuja Medical Center	360359	145	Beachwood	OH	PROF DEPTS FIN IND QUAL IP	

This is a **portion** of the page that will be displayed.



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Active List: Unnamed List | Apps: click to view apps...
Profile | Depts | Financial | Fin Ind | Quality | Inpatient | Outpatient | App

Outpatient Utilization

VIDEO Tutorial video

Based on Medicare OPPS claims data

medical diagnoses | apcs | procedures | service stats

ICD DIAGNOSES **Drill down to more granular utilization statistics for ICD diagnoses and procedures**
More Information | Sample Report

Statistics for the Top 20 Medical Diagnoses

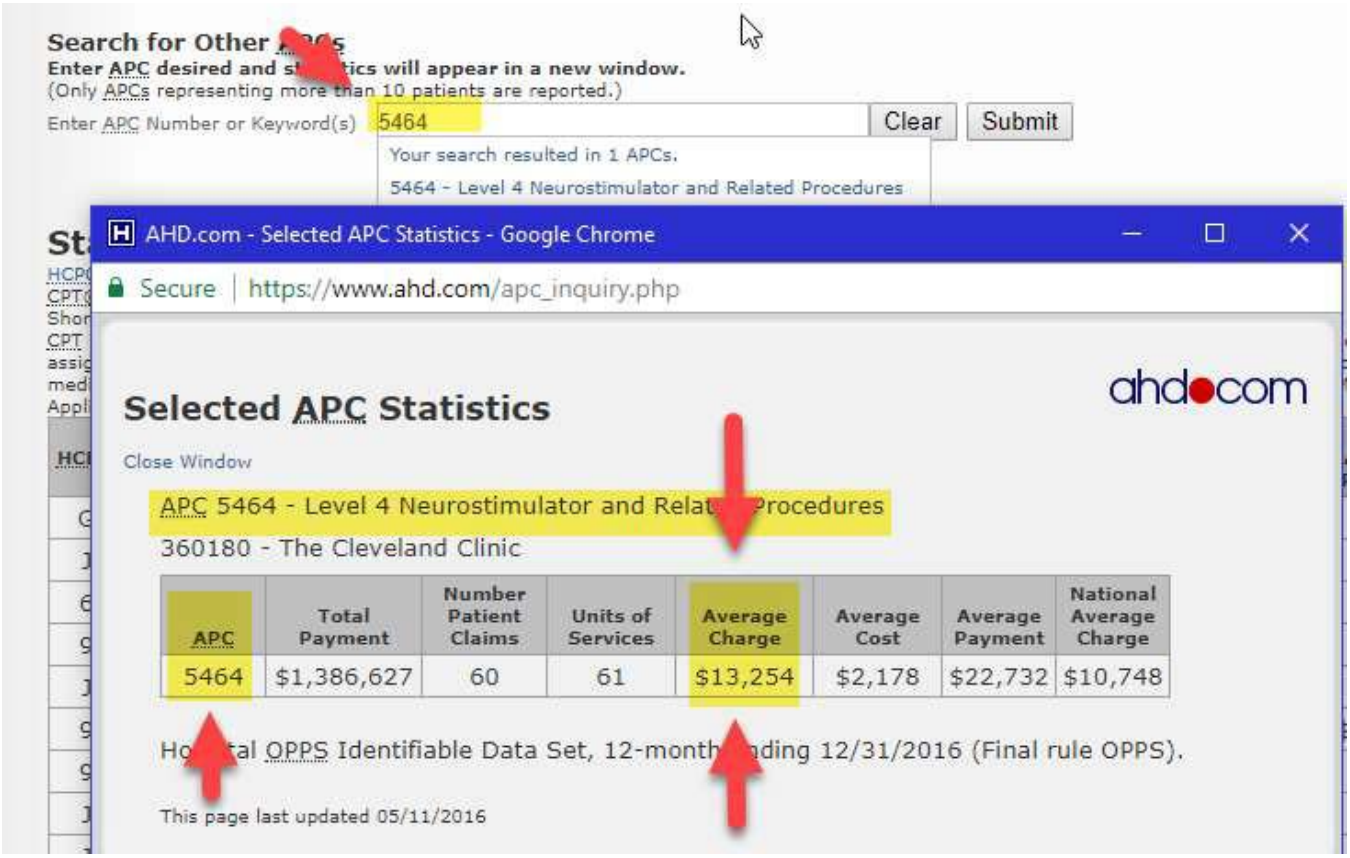
ICD-10 Diagnosis Codes

ICD-10 diagnosis codes / Definitions

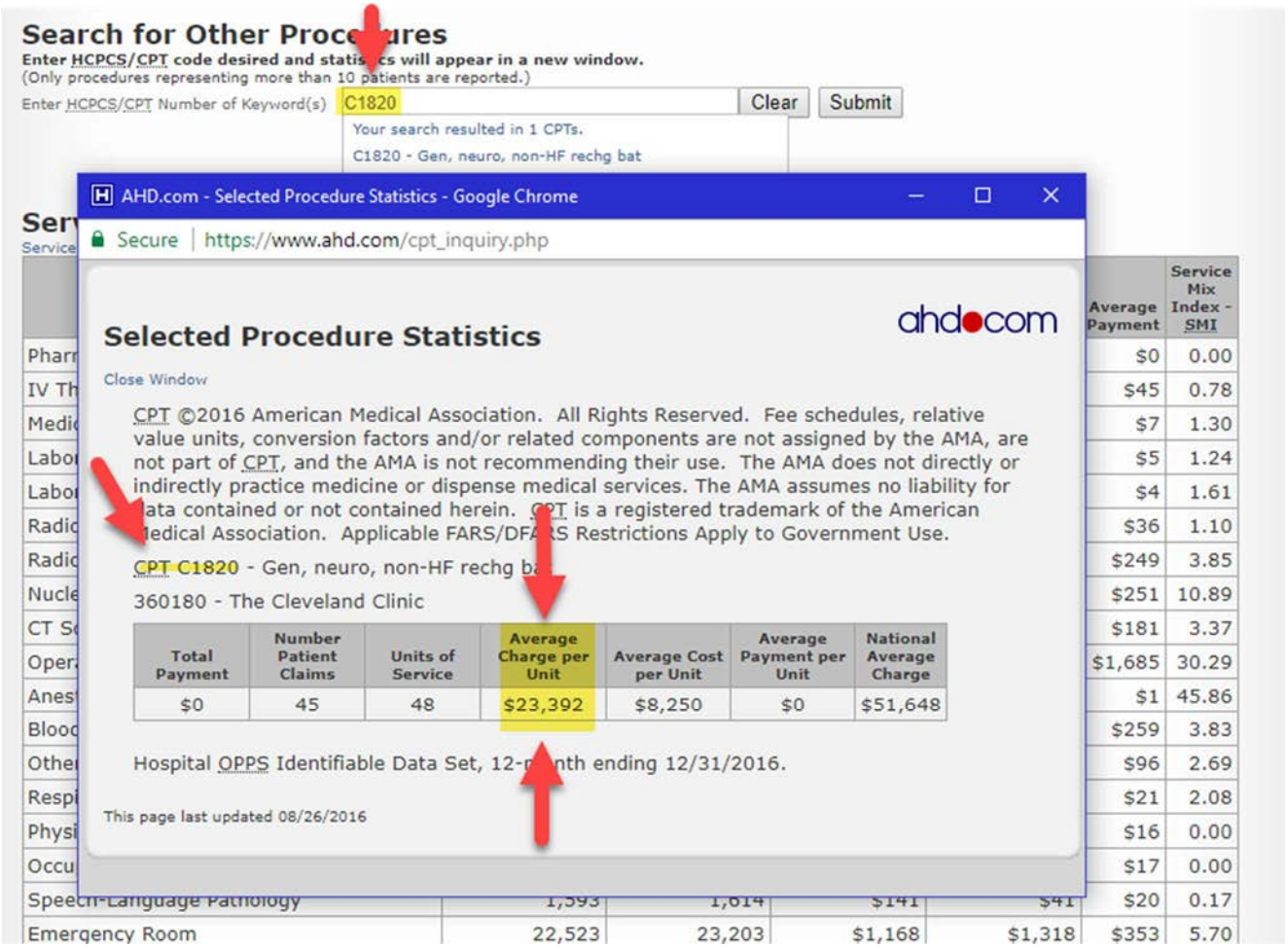
ICD-10 Code	ICD-10 Description	Total Payment	Number Patient Claims	Average Charge	Average Cost	Average Payment	Total Outlier Amount	National Average Charge
I10	Essential (primary) hypertension	$4,972,393	48,183	$368	$136	$103	$0	$729
C61	Malignant neoplasm of prostate	$4,294,830	9,684	$3,211	$916	$443	$1,486	$3,906
M0579	Rheu arthritis w rheu factor mult site w/o org/sys involv	$3,903,870	2,425	$6,807	$2,313	$1,610	$0	$4,546
I2510	Athscl heart disease of native coronary artery w/o ang pctrs	$3,723,391	11,252	$1,827	$420	$331	$856	$5,697
C9000	Multiple myeloma not having achieved remission	$3,561,800	3,338	$5,776	$1,896	$1,067	$0	$4,206
H3532	Exudative age-related macular degeneration	$3,505,344	3,888	$3,434	$1,424	$902	$0	$4,116
G35	Multiple sclerosis	$3,471,929	3,168	$4,624	$1,498	$1,096	$0	$6,588
I480	Paroxysmal atrial fibrillation	$2,488,475	9,452	$1,231	$353	$263	$10,416	$3,647
I4891	Unspecified atrial fibrillation	$2,428,697	12,930	$842	$258	$188	$4,375	$1,009
I481	Persistent atrial fibrillation	$2,112,691	3,502	$2,972	$808	$603	$0	$8,424
Z1211	Encounter for screening for malignant neoplasm of colon	$2,022,182	4,366	$2,025	$554	$463	$0	$4,571
M810	Age-related osteoporosis w/o current pathological fracture	$1,923,628	6,984	$1,240	$423	$275	$0	$1,428
Z23	Encounter for immunization	$1,876,128	20,018	$278	$106	$94	$0	$445
M170	Bilateral primary osteoarthritis of knee	$1,783,949	4,701	$1,318	$584	$379	$0	$1,488
C3490	Malignant neoplasm of unsp part of unsp bronchus or lung	$1,783,697	1,238	$7,384	$2,311	$1,441	$619	$4,919
C7951	Secondary malignant neoplasm of bone	$1,756,815	1,296	$5,960	$1,327	$1,356	$1,870	$7,537
Z4502	Encntr for adjust and mgmt of automatic implntbl card defib	$1,715,291	87	$56,986	$14,822	$19,716	$7,996	$22,692
E119	Type 2 diabetes mellitus without complications	$1,708,350	19,238	$358	$136	$89	$0	$452
C9002	Multiple myeloma in relapse	$1,702,389	613	$14,247	$4,633	$2,777	$0	$5,466

1. Scroll down to either the **"APC"** or **"CPT/HCPCS"** section.
2. The **APC** section is first, followed by the **CPT/HCPCS** section.
3. As with the inpatient (MS-DRG) information, there is an area following the table where a single APC, CPT, or HCPCS code may be entered.

4.Type the information needed in the box identified by **"Search for Other APCs"** and press enter. If the information is available (11 or more), the information for **APC 5464** will look like this:



5. If looking for the IPG either C1820 or C1767, enter the information in the box located below the CPT/HCPCS identified by **"Search for other Procedures"**, press enter, and if the information is available (11 or more), it will look like this:



Utilize the average charges.

The **facility charges** for the implantation of a rechargeable IPG non-high frequency at The Cleveland Clinic are:

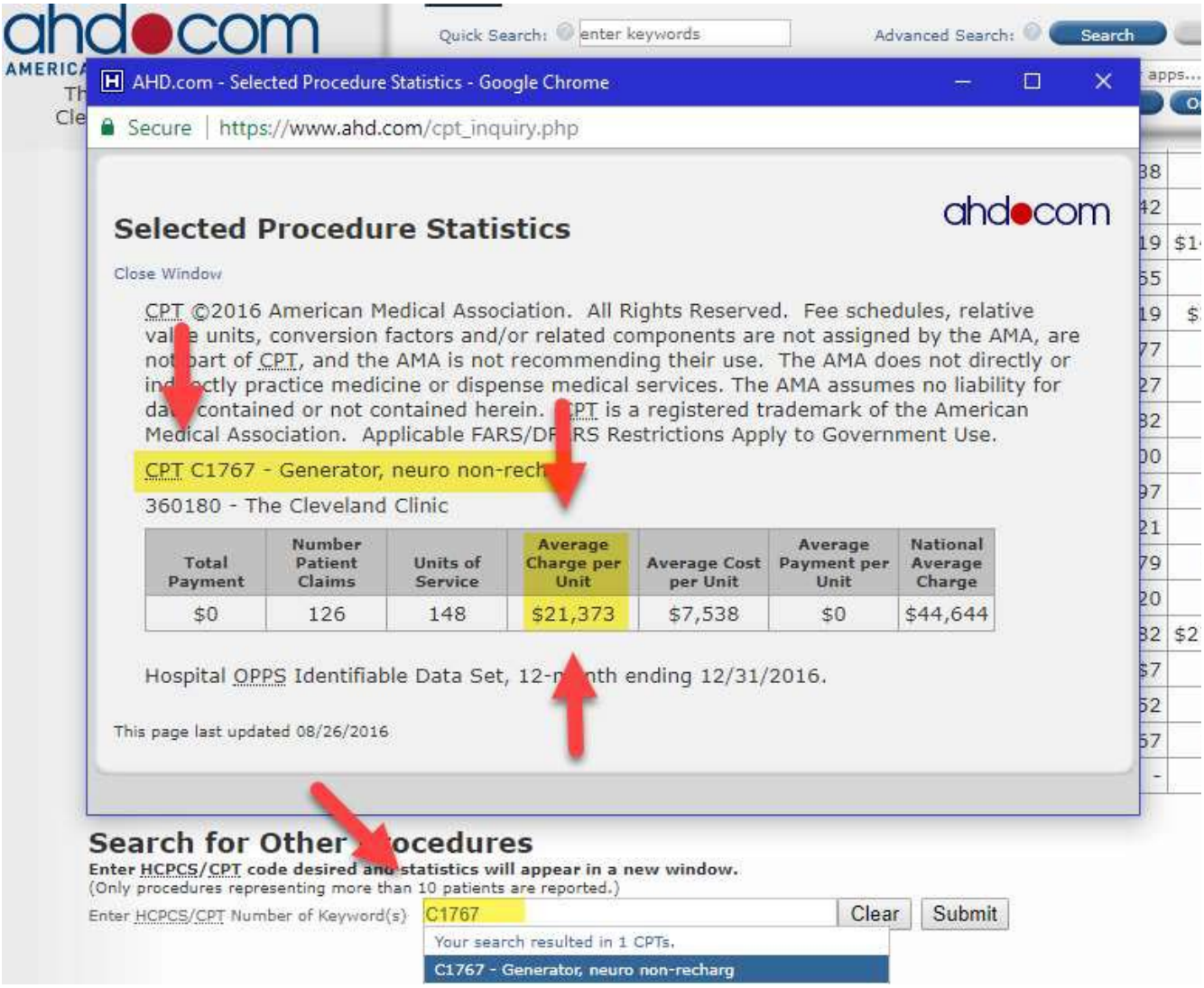
$13,254.00 + 23,392.00 = **$36,646.00**

OR

Utilize the average charges.

The **facility charges** for the implantation of a non-rechargeable IPG at The Cleveland Clinic are:

$13,254.00 + 21,373.00 = **$34,627.00**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Secure | https://www.ahd.com/cpt_inquiry.php
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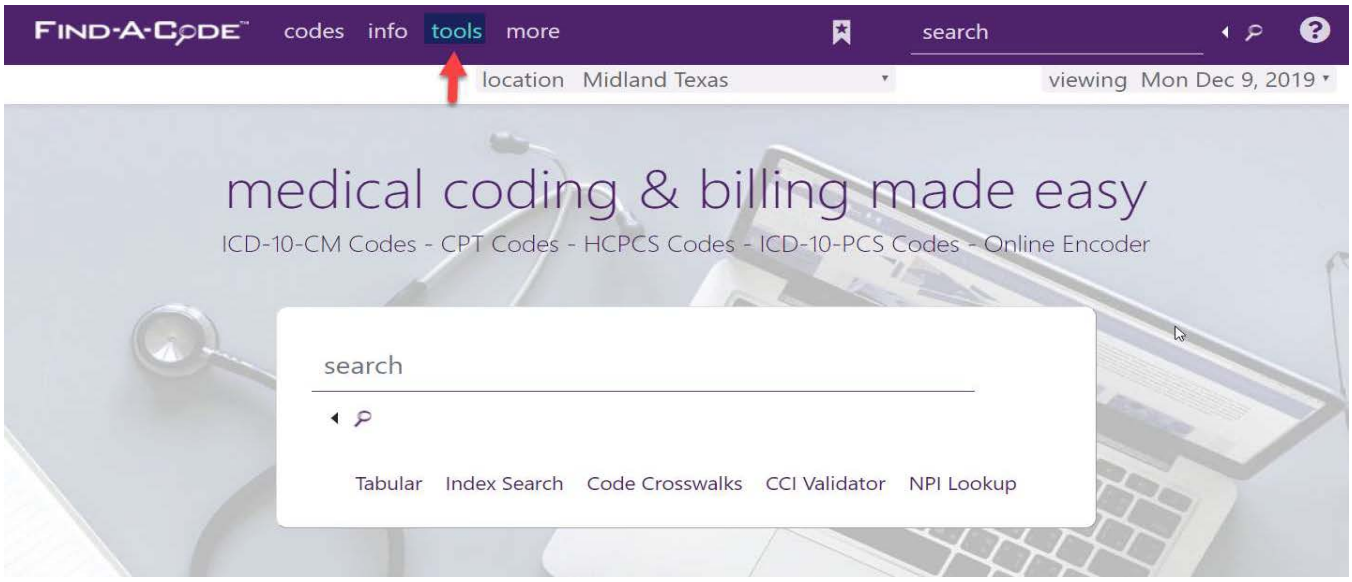
CPT C1767 - Generator, neuro non-rech
360180 - The Cleveland Clinic
Total Payment | Number Patient Claims | Units of Service | Average Charge per Unit | Average Cost per Unit | Average Payment per Unit | National Average Charge
$0 | 126 | 148 | $21,373 | $7,538 | $0 | $44,644
Hospital OPPS Identifiable Data Set, 12-month ending 12/31/2016.
This page last updated 08/26/2016
Search for Other Procedures
Enter HCPCS/CPT code desired and statistics will appear in a new window.
(Only procedures representing more than 10 patients are reported.)
Enter HCPCS/CPT Number of Keyword(s) C1767 Clear Submit
Your search resulted in 1 CPTs.
C1767 - Generator, neuro non-recharg

Utilizing Find-A-Code Pro Fee Calculator for UCR:

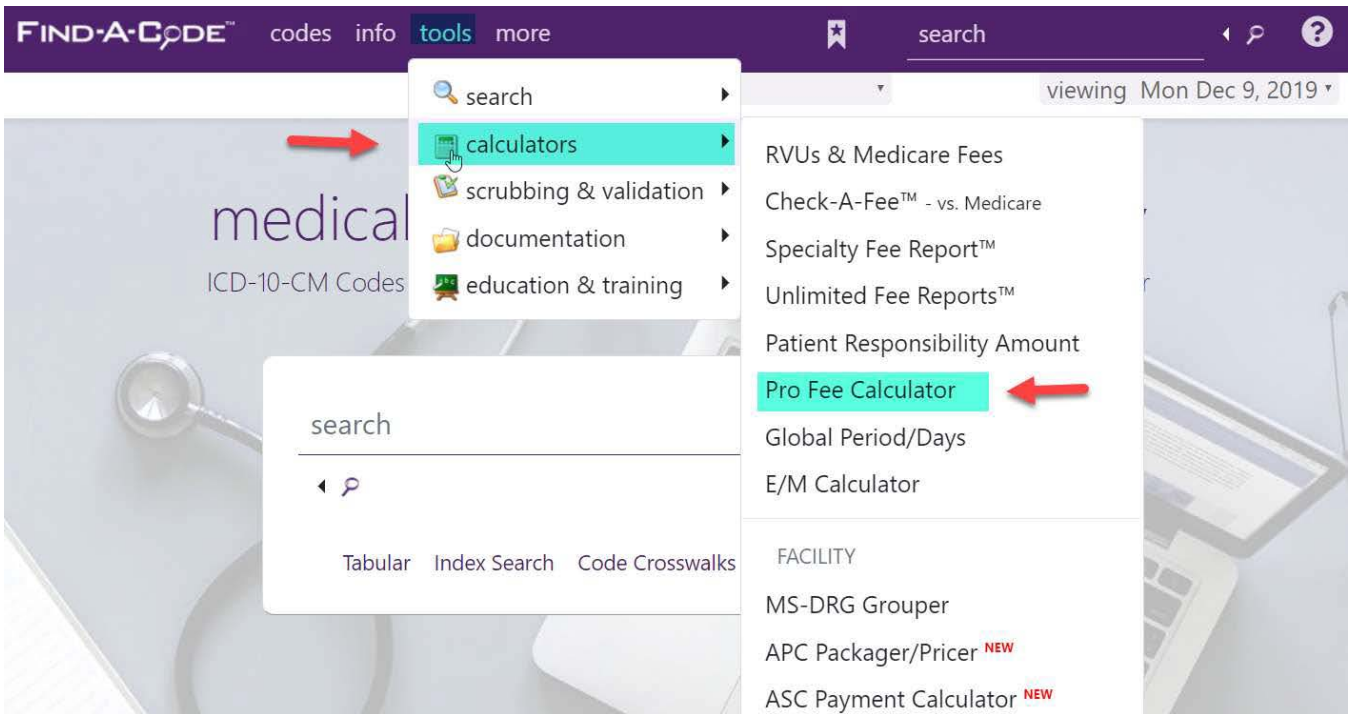
(The following information has been displayed with the permission of Find-A-Code)

The life care planner will need to have the UCR fee add on in addition to the base subscription. When using this service, the life care planner does not have to use the extensive formula requiring 3 different tables to obtain the VA Reasonable Data Charge professional fee. The Find-A-Code UCR = VA Reasonable Data Charges

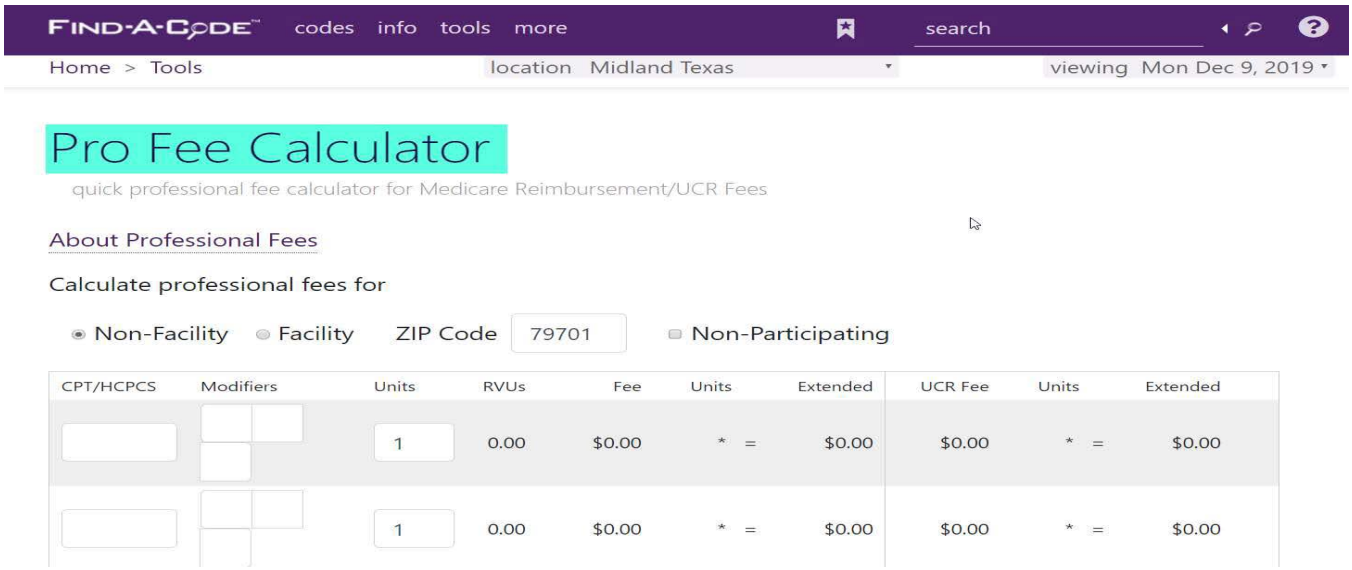
1. Go to tools



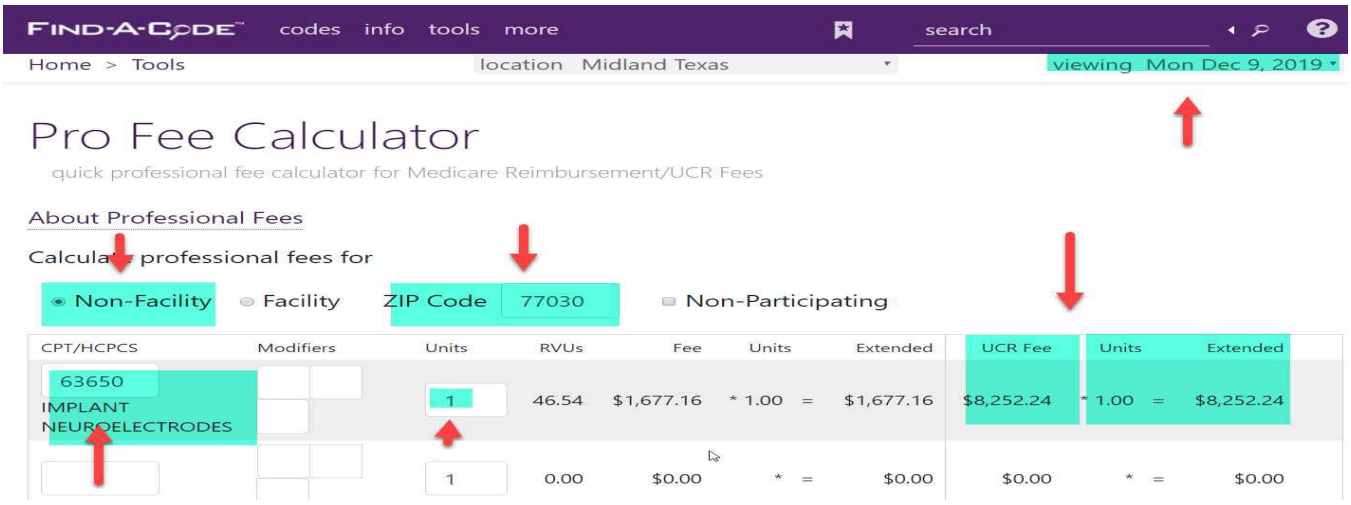
2. Click on “calculators”, then “Pro Fee Calculator”

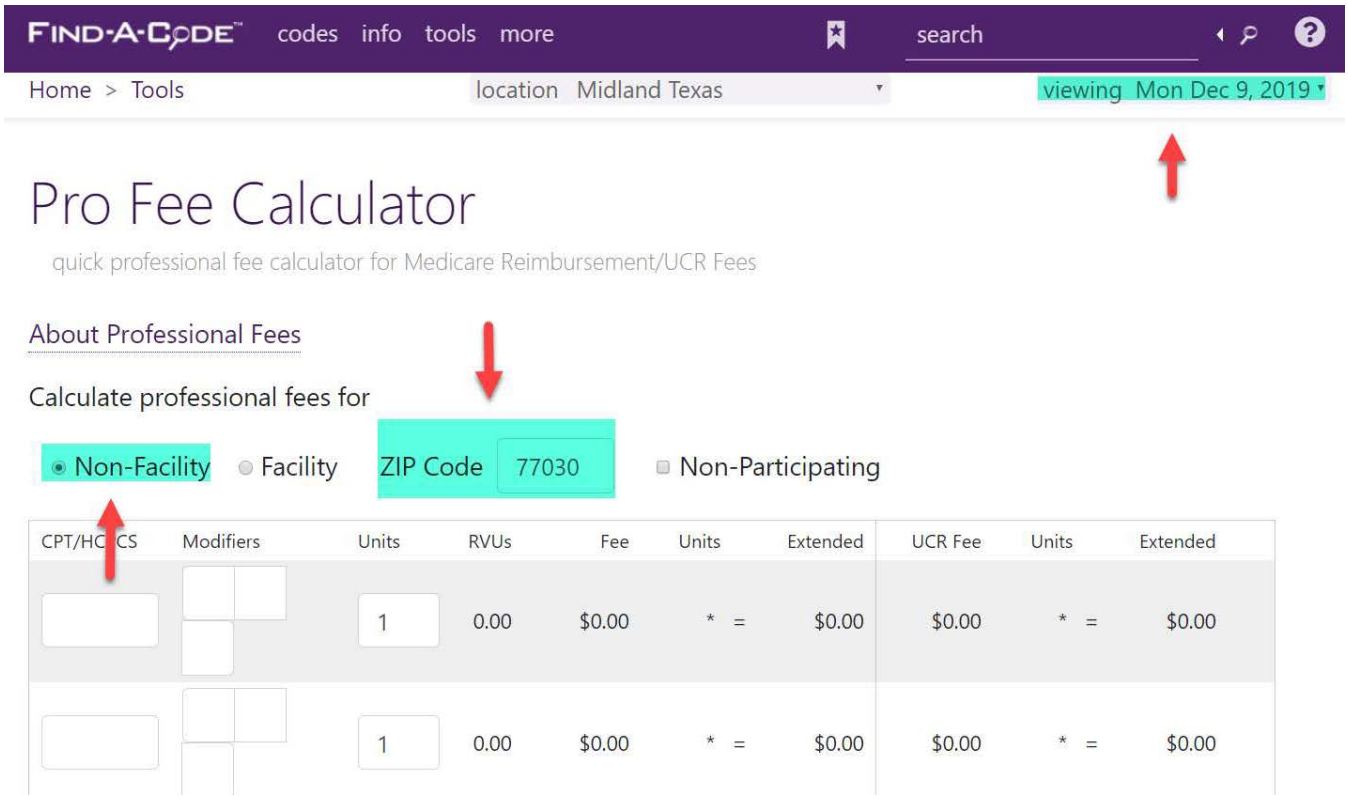


3. Pro Fee Calculator

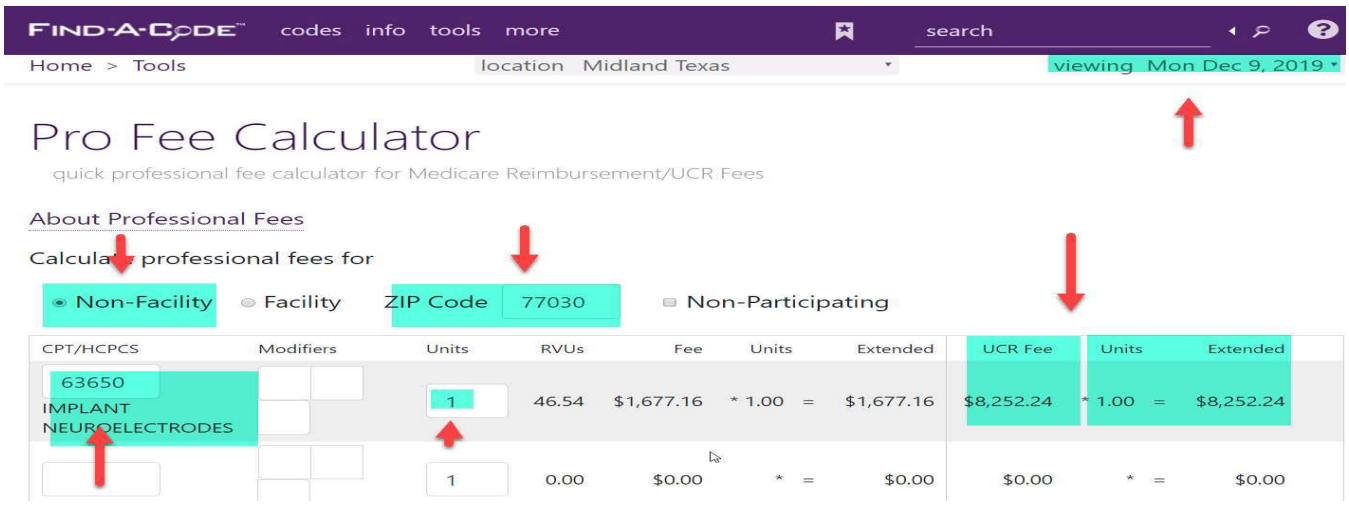


4. Make sure you **insert the zip code** of the geographic area needed
5. Choose if the procedure will be performed in a **facility or non-facility**
6. Make sure utilizing the **most recent information**

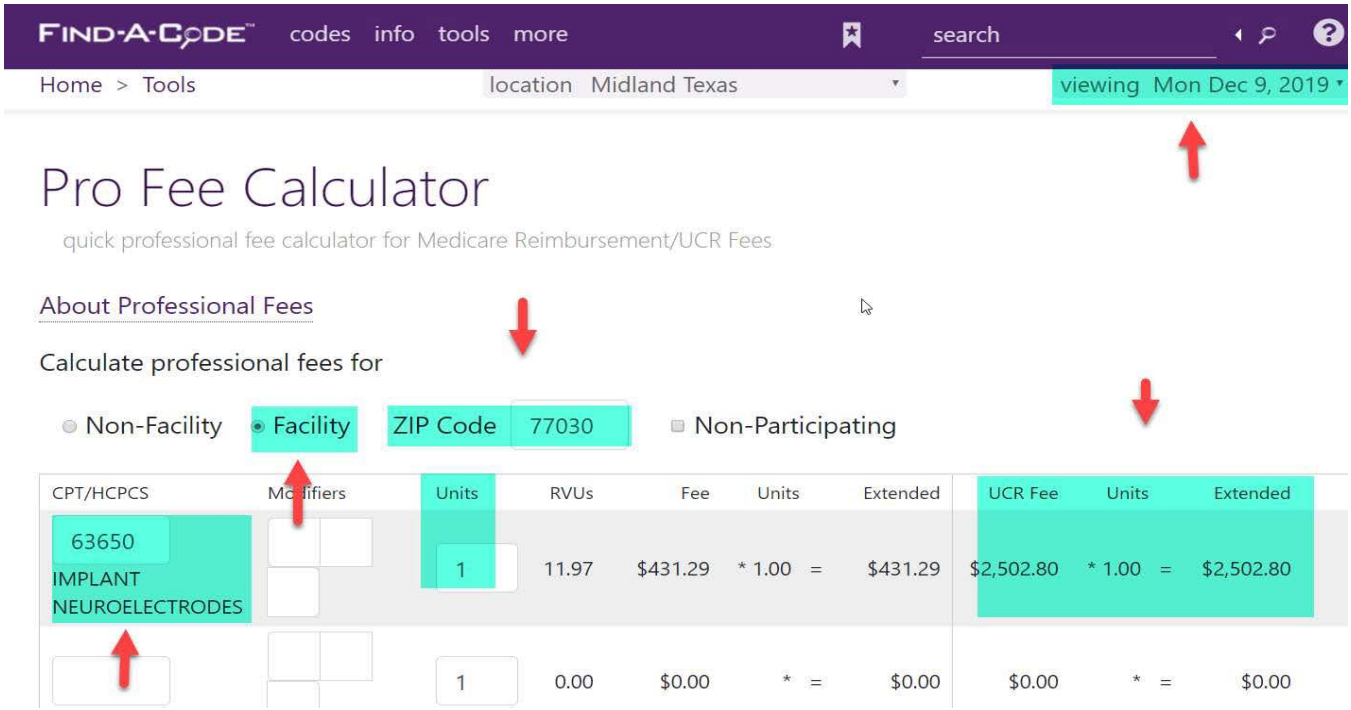




7. Zip code 77030 represents Houston, Texas
8. Viewing the most recent data as of the accessed (Dec. 9, 2019)
9. Procedure will be performed in non-facility place of service. *(it is important to note, the word facility does not represent facility charges but the charges for the physician/professional services performed in the facility)*
10. Will now input the CPT code 63650



11. The results indicate, the UCR charge for CPT 63650 performed in a non-facility place of service for 1 unit.
12. Will now change to facility



13. The results indicate, the UCR charge for CPT code 63650 performed in a facility place of service.
14. There is a significant difference in the UCR charge depending on where the procedure is performed.

The reason this specific CPT code has such a significant difference is due to the fact the RVUs for the non-facility include the cost of the trial stimulator (the equipment). This code represents the implantation of the trial lead for the SCS and the permanent implantation.

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38 C.F.R. (Code of Federal Regulations) 17.101, Collections or recovery by VA for medical care or services provided or furnished to a veteran for nonservice-connected disability.