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CLIENT APPRECIATION WEEK

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Pharmacy

Identifying and Solving Problems in the Revenue Cycle

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Disclaimer Statement

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Agenda

- Review Source Authorities for Pharmacy
- We will review the revenue cycle, the pharmacy solutions (i.e. Willow), pharmacy team impacts and the charge capture process.
- We will examine the CDM and multiplier as a root cause of leakage.
- Examine the impact of prior authorization and audit on the ultimate reimbursement
- Understanding clinical dosages
- Review some complexities like JW modifier and post claim submission audits by the payors.

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Objectives

- Participant will understand the use of a multiplier
- Participant will understand steps to audit a pharmacy claim
- Participant will be able to state why carve outs and prior authorizations are important
- Participant will be able to state the elements of the audit cycle and their importance

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Pharmacy Revenue Cycle

A Leading Source of Lost, but Earned, Revenue

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Overview

- Pharmacy has a very disparate revenue cycle that models supply revenue cycle.
- It requires that the correct medication (NDC) be converted into a dispensed dosage and then further change to include a HCPCS billing code and dose.
- We will cover the steps in the revenue cycle as well as the importance of the NDC
- We will review the importance of Self Administered Medications
- Provide Guidance on the JW modifier
- Cover charge capture concerns for pharmacy
- Create a template audit to review the “purchase or spend file aga
and usage”

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Source Authorities

Source Authorities Include:

- FDA – Landing Page: https://www.fda.gov/drugs
  - NDC Lookup - https://www.fda.gov/drugs/drug-approvals-and-databases/national-drug-code-directory
- 340b - https://www.hrsa.gov/opa/program-requirements/index.html
- Self Administered Medications:
  - IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, Section 50.2, Determining Self-Administration of Drug or Biological
  - Transmittal 123, CR 6950 dated April 30, 2010
  - Noridian (MAC) - https://med.noridianmedicare.com/web/jeb/policies/sads
- JW Modifier - https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

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Pharmacy Charge Capture Complexities

- Pharmacy is a particular charge capture concern as the medication is based upon a physician ordered dosage and that matches the dispensing dosage
- However, billing units are based on HCPCS code descriptions and not dispensing units
- NDC numbers are very specific to the drug, dosage, and manufacturer and with purchases can change frequently in the inventory
  - NDC number is key to the HCPCS coding required for billing
- If your facility uses EPIC the concept of “shells” that makes it somewhat difficult to reconcile specific purchases to charged items
- Wastage and credits can be difficult if charged on dispensing instead of administration
- Modifier -JW is difficult to operationalize

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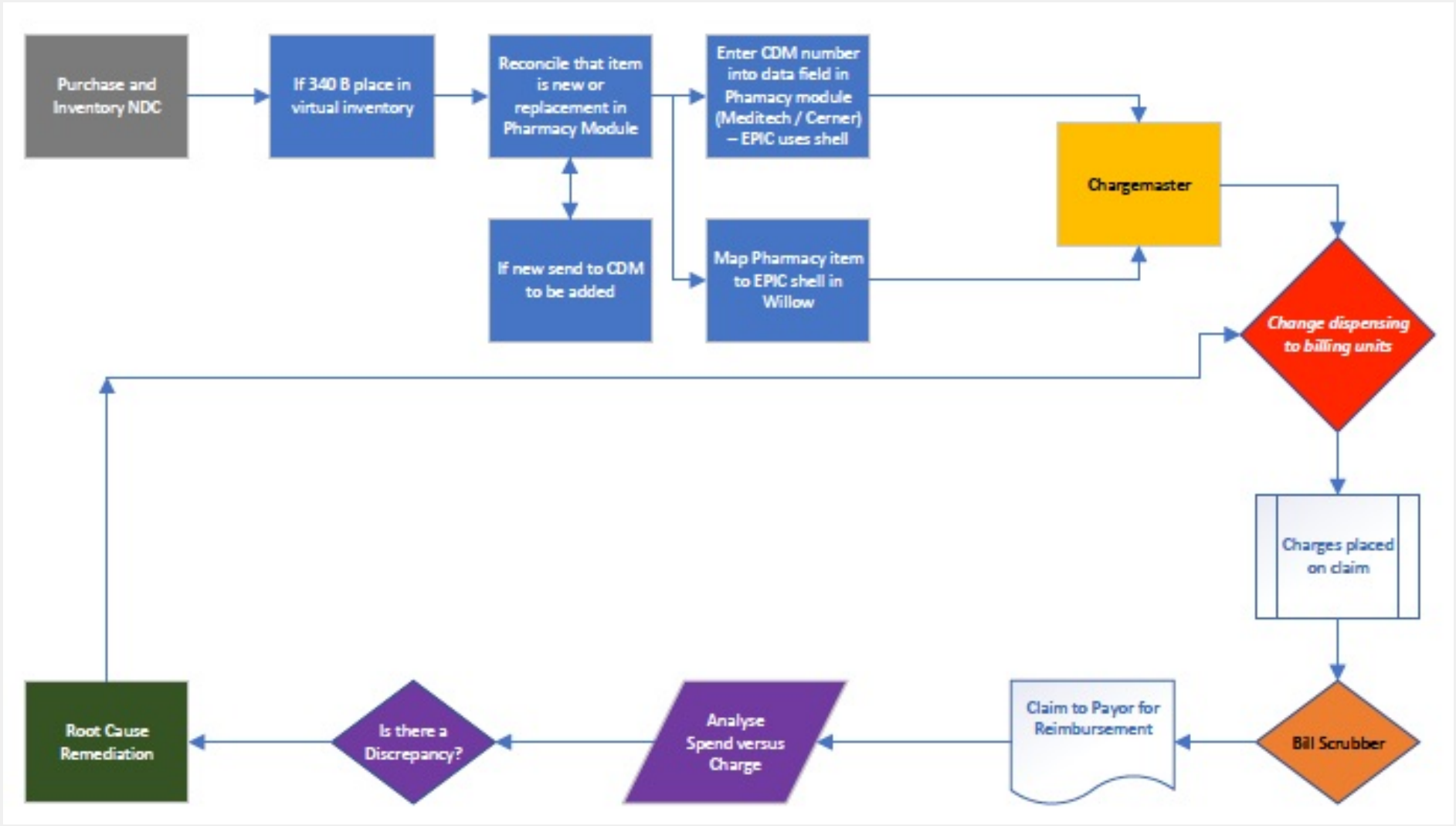
Pharmacy Revenue Cycle



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Understanding the NDC

National Drug Code (NDC) consists of:

- “Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs” (FDA)
- Either a ten or 11 digit code
- Defined for 11 digits in a 5-4-2 layout
  - First 5 digits is the labeler code
    - Code is assigned by the FDA
  - Second 4 digits is the product code
  - Final 2 digits is the package code
- Therefore, every manufacture and medication and package size has it’s own NDC
- Billing may require that the NDC on the vial or medication be represented on the claim – if so this is the NDC of what was actually administered and not a default NDC.

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NDC and Drug Rebates

NDC billing requirement to ensure that the correct drug is captured for rebates requires that the actual medication administered be the only NDC submitted and not an alternative.

- Most payors have similar statements to this effect. One example is from Amerigroup
  - https://provider.amerigroup.com/docs/gpp/WAWA_CAID_PU_NDCFAQ.pdf

If I am not sure which NDC was used, can I pick another NDC under outpatient drug claims and bill with it?
No, the NDC submitted to us must be the actual NDC on the package or container from which the medication was administered.

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NDC and Drug Rebates

Why do I have to bill with national drug codes (NDCs) in addition to HCPCS/CPT/revenue codes?

- The PPACA includes provisions about state collection of data for the purpose of collecting Medicaid drug rebates from drug manufacturers for outpatient-administered drugs from managed care claims. Because there are often several NDCs linked to a single HCPCS, CPT or revenue code, CMS deems the use of NDCs critical to correctly identify the drug and manufacturer to enable invoicing and collection of rebates.

- NDC numbers become a critical element in the 340B program as well.
  - Due to the complexity of 340B we will not be covering that in this seminar

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Understanding Self Administered Medications

Overview:

- “The Medicare program provides limited benefits for outpatient prescription drugs. The program covers drugs that are furnished "incident-to" a physician's service provided that the drugs are not "usually self-administered" by the patient. Section 112 of the Benefits, Improvements & Protection Act of 2000 (BIPA), amended §§1861(s)(2)(A) and 1861(s)(2)(B) of the Social Security Act (SSA) to redefine this exclusion. The prior statutory language referred to those drugs "which cannot be self-administered by the patient." Implementation of the BIPA provision requires interpretation of the phrase "not usually self-administered" by the patient.
- CMS has defined "not usually self-administered" by the patient, according to how the Medicare population as a whole uses the drug, not how an individual patient or physician may choose to use a particular drug.
- CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, §50.2, Determining Self-Administration of Drug or Biological.”
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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Requirements to be SAD Medication

Determining if SAD or Not

- Administered
  - "The term "administered" refers only to the physical process by which the drug enters the patient's body. It does not refer to whether the process is supervised by a medical professional (for example, to observe proper technique or side-effects of the drug)." [100-02, Ch 15, Section 50.2]
- Usually
  - "For the purposes of applying this exclusion, the term ***"usually" means more than 50 percent of the time for all Medicare beneficiaries who use the drug***. Therefore, if a drug is self-administered by more than 50 percent of Medicare beneficiaries, the drug is excluded from coverage and the A/B MAC (A), (B), or (HHH) may not make any Medicare payment for it." [100-02, Ch 15, Section 50.2]
    - 1. Absent evidence to the contrary, presume that drugs delivered intravenously ***are not usually self-administered*** by the patient.
    - 2. Absent evidence to the contrary, presume that drugs delivered by intramuscular injection ***are not usually self-administered*** by the patient.

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Requirements to be SAD Medication

Determining if SAD or Not

- Usually
  - 3. Absent evidence to the contrary, presume that drugs delivered by subcutaneous injection ***are self-administered by the patient***.
    - **A. Acute Condition** - Is the condition for which the drug is used an acute condition? If so, it is ***less likely that a patient would self-administer the drug***. If the condition were longer term, it would be more likely that the patient would self-administer the drug.
    - **B. Frequency of Administration** - How often is the injection given? For example, if the drug is administered once per month, it is less likely to be self- administered by the patient. However, ***if it is administered once or more per week, it is likely that the drug is self-administered by the patient***.

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Billing for SAD (or Not ?)

Billing:

- All payers, with the exception of a very few, require the use of Revenue Code 0637
  - Use HCPCS Code A9270 – non covered item or service
  - Some Medicaid groups want these in Revenue Code 0259 but the majority want 0637
- Should we bill these to the patient?
- Do they know they might be billed for these as an outpatient / observation?
  - Medicare notifies each beneficiary through the “Medicare and You – 2021” section 2 that these drugs are not covered and will not be covered by the Program
  - https://www.medicare.gov/Pubs/pdf/10050-Medicare-and-You.pdf

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Billing for SAD (or Not?)

Is it unlawful if we don't bill the patient? Our patients react negatively to these on their statements?

- SAD are a very problematic area as frequently the charge to dispense is in excess of what the patient can obtain it at a local retail pharmacy
- Strategy: If billing these make sure they are charged in line with what a local retail pharmacy might charge
  - OIG Guidance: https://oig.hhs.gov/compliance/alerts/guidance/policy-10302015.pdf
  - …hospitals will not be subject to OIG administrative sanctions if they discount or waive amounts that Medicare beneficiaries owe for Noncovered SADs (including Noncovered SADs that may be covered under Medicare Part D) the beneficiaries receive in outpatient settings, subject to the following conditions: • This Policy Statement applies only to discounts on, or waivers of, amounts Medicare beneficiaries owe for Noncovered SADs that the beneficiaries receive for ingestion or administration in outpatient settings;
  - There are criteria that must be achieved to meet the letter of intent of this policy

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Billing for SAD (or Not?)

Is it unlawful if we don't bill the patient? Our patients react negatively to these on their statements?

- OIG Guidance
  - Hospitals must uniformly apply their policies regarding discounts or waivers on Noncovered SADs (e.g., without regard to a beneficiary's diagnosis or type of treatment);
  - Hospitals must not market or advertise the discounts or waivers; and
  - Hospitals must not claim the discounted or waived amounts as bad debt or otherwise shift the burden of these costs to the Medicare or Medicaid programs, other payers, or individuals.
  - Nothing in this Policy Statement requires hospitals to discount or waive amounts owed by Medicare beneficiaries for Noncovered SADs that the beneficiaries receive in outpatient settings

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JW another complexity

Source Authority:

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
  - 40 - Discarded Drugs and Biologicals
  - FAQ: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf
  - FAQ discusses the specifics and provides guidance regarding the implementation (2016)
- JW Modifier:
  - The JW modifier is a Healthcare Common Procedure Coding System (HCPCS) Level II modifier used on a Medicare Part B drug claim to report the amount of drug or biological (hereafter referred to as drug) that is discarded and eligible for payment under the discarded drug policy. The modifier shall only be used for drugs in single dose or single use packaging.

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JW another complexity

- Part B also pays for the amount of drug that has been discarded, up to the amount that is indicated on the vial or package label. The discarded drug amount is the amount of a single use vial or other single use package that remains after administering a dose/quantity of the drug to a Medicare beneficiary.
- Effective January 1, 2017, the modifier must be used in order to obtain payment for a discarded amount of drug in single dose or single use packaging under the Medicare discarded drug policy. The modifier is not required if no discarded drug is being billed to any payer.
- The JW modifier does not apply to drugs or biologicals administered in a Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC). Drugs and biologicals administered in RHCs and FQHCs are generally not separately payable under Part B
- The modifier policy applies to all separately payable Part B drugs that are designated as single-use or single dose on the FDA-approved label or package insert. Accordingly, use of the modifier is not appropriate for drugs that are from multiple dose vials or packages
- The JW modifier must not be used to report overfill wastage
- CMS does not use fractional billing units to pay for Part B drugs. Therefore, the JW modifier should not be used when the actual dose of the drug administered is less than the HCPCS billing unit.

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JW another complexity

- Claims for drugs furnished on or after January 1, 2017 containing billing for discarded drugs that do not use the JW modifier correctly may be subject to review.
- The drug discarded should be billed on a separate line with the JW modifier. The unit field should reflect the amount of drug discarded
- The JW modifier requirement applies to all separately payable drugs assigned status indicators G (Pass-Through Drugs and Biologicals) or K (Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals) under the OPPS for which there is an unused or discarded amount. Eligible and participating 340B providers are not exempt from reporting the JW modifier

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How to Determine If JW Is The Correct Choice

Choosing JW

- Select all status indicators G and K within Addendum B or within the toolkit
- Subdivide this between Single Dose and Multi-Dose
- Only Choose the Single Dose with SI= G or K
- Make a list of those G or K that are also single dose

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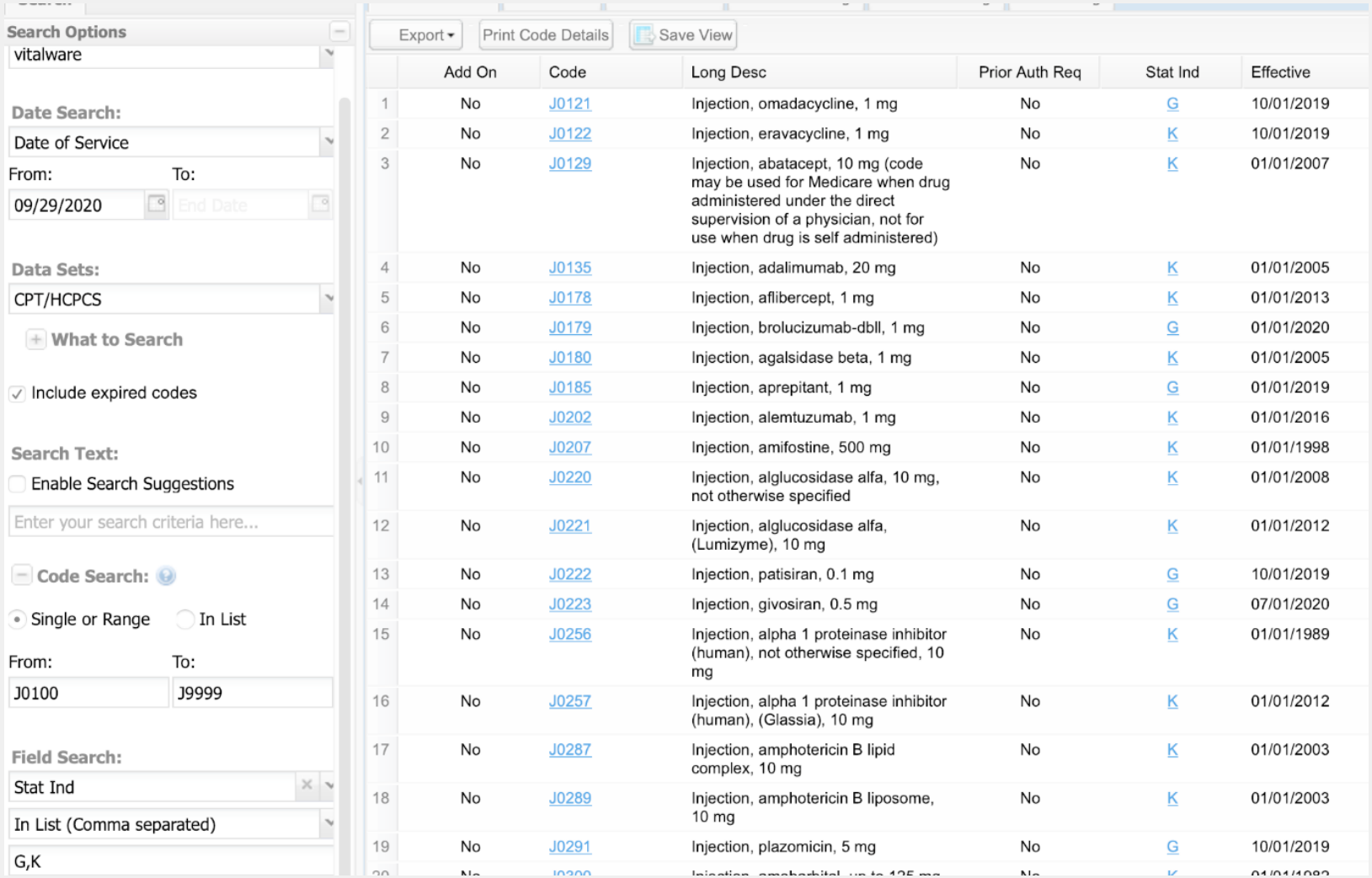
Use VitalKnowledge – Sort G or K



	Add On	Code	Long Desc	Prior Auth Req	Stat Ind	Effective
1	No	J0121	Injection, omadacycline, 1 mg	No	G	10/01/2019
2	No	J0122	Injection, eravacycline, 1 mg	No	K	10/01/2019
3	No	J0129	Injection, abatacept, 10 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	No	K	01/01/2007
4	No	J0135	Injection, adalimumab, 20 mg	No	K	01/01/2005
5	No	J0178	Injection, aflibercept, 1 mg	No	K	01/01/2013
6	No	J0179	Injection, brolucizumab-dbll, 1 mg	No	G	01/01/2020
7	No	J0180	Injection, agalsidase beta, 1 mg	No	K	01/01/2005
8	No	J0185	Injection, aprepitant, 1 mg	No	G	01/01/2019
9	No	J0202	Injection, alemtuzumab, 1 mg	No	K	01/01/2016
10	No	J0207	Injection, amifostine, 500 mg	No	K	01/01/1998
11	No	J0220	Injection, alglucosidase alfa, 10 mg, not otherwise specified	No	K	01/01/2008
12	No	J0221	Injection, alglucosidase alfa, (Lumizyme), 10 mg	No	K	01/01/2012
13	No	J0222	Injection, patisiran, 0.1 mg	No	G	10/01/2019
14	No	J0223	Injection, givosiran, 0.5 mg	No	G	07/01/2020
15	No	J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg	No	K	01/01/1989
16	No	J0257	Injection, alpha 1 proteinase inhibitor (human), (Glassia), 10 mg	No	K	01/01/2012
17	No	J0287	Injection, amphotericin B lipid complex, 10 mg	No	K	01/01/2003
18	No	J0289	Injection, amphotericin B liposome, 10 mg	No	K	01/01/2003
19	No	J0291	Injection, plazomicin, 5 mg	No	G	10/01/2019

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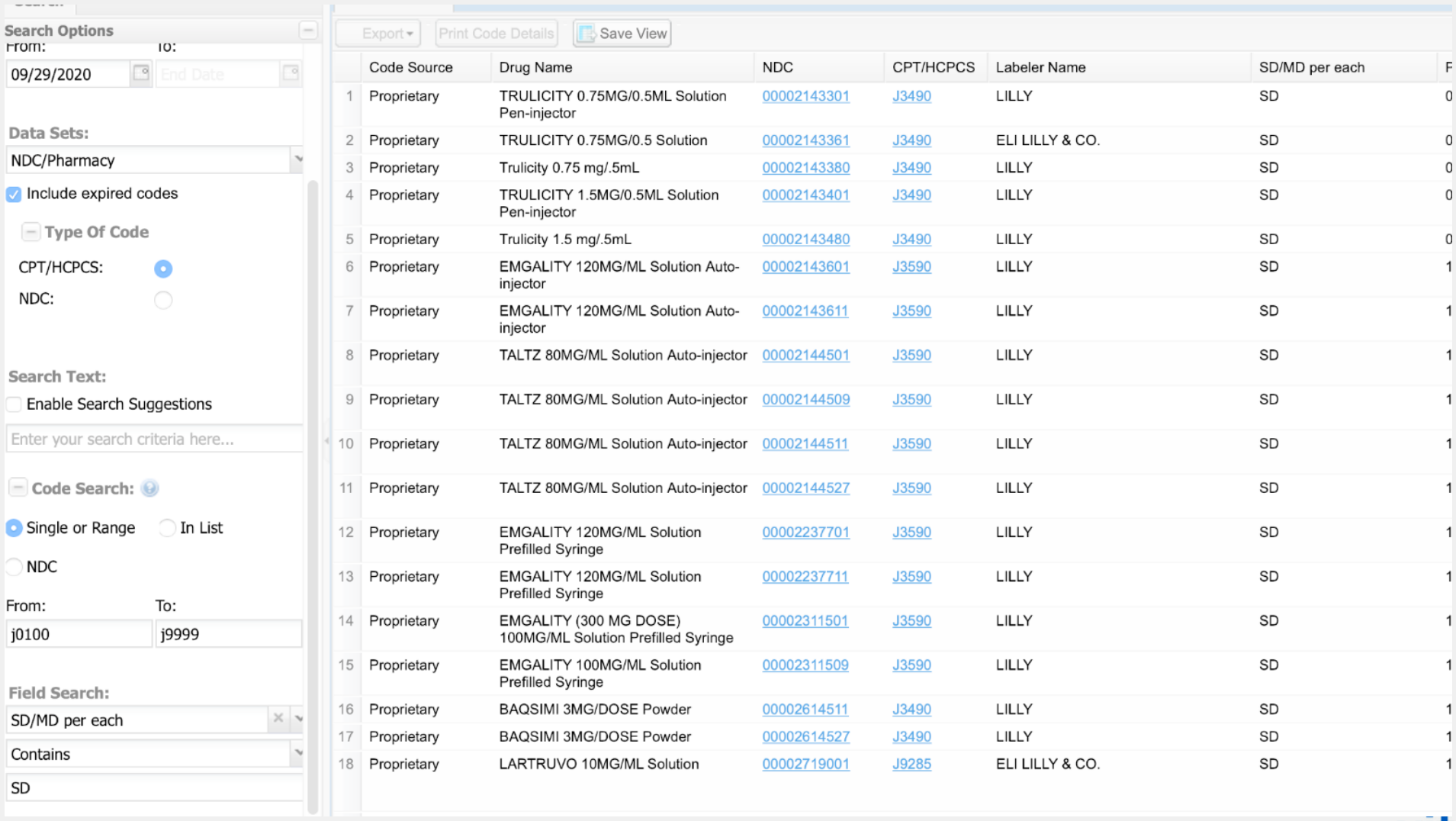
Single or Multiple Dose (Look for SD)



	Code Source	Drug Name	NDC	CPT/HCPCS	Labeler Name	SD/MD per each	F
1	Proprietary	TRULICITY 0.75MG/0.5ML Solution Pen-injector	00002143301	J3490	LILLY	SD	0
2	Proprietary	TRULICITY 0.75MG/0.5 Solution	00002143361	J3490	ELI LILLY & CO.	SD	0
3	Proprietary	Trulicity 0.75 mg/.5mL	00002143380	J3490	LILLY	SD	0
4	Proprietary	TRULICITY 1.5MG/0.5ML Solution Pen-injector	00002143401	J3490	LILLY	SD	0
5	Proprietary	Trulicity 1.5 mg/.5mL	00002143480	J3490	LILLY	SD	0
6	Proprietary	EMGALITY 120MG/ML Solution Auto-injector	00002143601	J3590	LILLY	SD	1
7	Proprietary	EMGALITY 120MG/ML Solution Auto-injector	00002143611	J3590	LILLY	SD	1
8	Proprietary	TALTZ 80MG/ML Solution Auto-injector	00002144501	J3590	LILLY	SD	1
9	Proprietary	TALTZ 80MG/ML Solution Auto-injector	00002144509	J3590	LILLY	SD	1
10	Proprietary	TALTZ 80MG/ML Solution Auto-injector	00002144511	J3590	LILLY	SD	1
11	Proprietary	TALTZ 80MG/ML Solution Auto-injector	00002144527	J3590	LILLY	SD	1
12	Proprietary	EMGALITY 120MG/ML Solution Prefilled Syringe	00002237701	J3590	LILLY	SD	1
13	Proprietary	EMGALITY 120MG/ML Solution Prefilled Syringe	00002237711	J3590	LILLY	SD	1
14	Proprietary	EMGALITY (300 MG DOSE) 100MG/ML Solution Prefilled Syringe	00002311501	J3590	LILLY	SD	1
15	Proprietary	EMGALITY 100MG/ML Solution Prefilled Syringe	00002311509	J3590	LILLY	SD	1
16	Proprietary	BAQSIMI 3MG/DOSE Powder	00002614511	J3490	LILLY	SD	1
17	Proprietary	BAQSIMI 3MG/DOSE Powder	00002614527	J3490	LILLY	SD	1
18	Proprietary	LARTRUVO 10MG/ML Solution	00002719001	J9285	ELI LILLY & CO.	SD	1

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Billing Unit Conversion – Another Complexity

Billing Unit Conversion:

- In terms of charge leakage, the pharmacy billing unit conversion is the number one cause of large dollar losses.
- Most consulting firms, specializing in charge capture, look to Pharmacy as the place to go to find untapped charge capture leakage
- The concern is around changing an NDC ordered dosage to an NDC dispensed dosage to an NDC administered dosage and then over to a dosage that is based upon a HCPCS Code Description.
  - Requires math to perform a conversion
  - This is even more complicated when trying to implement the JW modifier for single dose medication wastage.

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Converting Dispensed to Billable Units

The key to maintaining charge integrity with pharmacy is in the conversion of the ordered, dispensed, and administered dosage to billing units

- Example: MD order is for Zofran 4mg and Morphine 2mg IV
- Package is 2mg/ml and the vial is 2ml (4mg total)
- J2405 – Ondansetron per 1 mg
  - *Conversion is 4mg delivered and 4mg needs to be charged and this is per 1mg*
  - *Conversion factor is therefore 4*
- Morphine is J2270 which is morphine up to 10mg – therefore it would be a unit of 1 as 2mg is less than 10mg
  - *Note: If you use one syringe multiple times it is still only 1 unit (not recommended)*

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Overcoming the Complexities

The key is to ensure that the NDC on the shelf has the correct HCPCS code at the time of purchase.

- Many facilities use a “category system” where all NDCs with the same HCPCS code are placed into one category or “shell”
- These categories then require a specific equation to take from the NDC dispensing units to the specific billing units
  - *This conversion factor is the #1 reason for failed pharmacy charge capture*

Some software systems have a low and high dosage range to capture billing units that are too low or too high for the average adult

Ensuring a flawless charge capture would require several audit steps

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Pharmacy Software

Success with Vitalware Solutions

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Essential Toolkit for Pharmacy

Software:

- Most facilities are using some sort of software to ensure they are charging for their purchased /spend file
- Many vendors have imbedded pharmacy software to manage the actual order, dispensing and medication safety
  - EPIC – Willow
  - Cerner – PharmNet
  - Meditech – PHA
  - All of these only manage the pharmacy component and generally does not charge for the medication until dispensing / administration is documented
  - After the charge is “created” there is an algorhythm or mathematical calculation that changes the dispensed/administered unit into the HCPCS billable unit of service

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Sort Your Revenue and Usage

Importance of Revenue and Usage

- When reviewing the CDM and the Pharmacy Module and the billable unit conversion start with:
  - High Acquisition Cost Medications
  - High Volume Medications
- Look at key departments:
  - Infusion Centres
  - Rheumatology
  - Chemotherapy Centres
- Manually do the math to convert one vial to billable units

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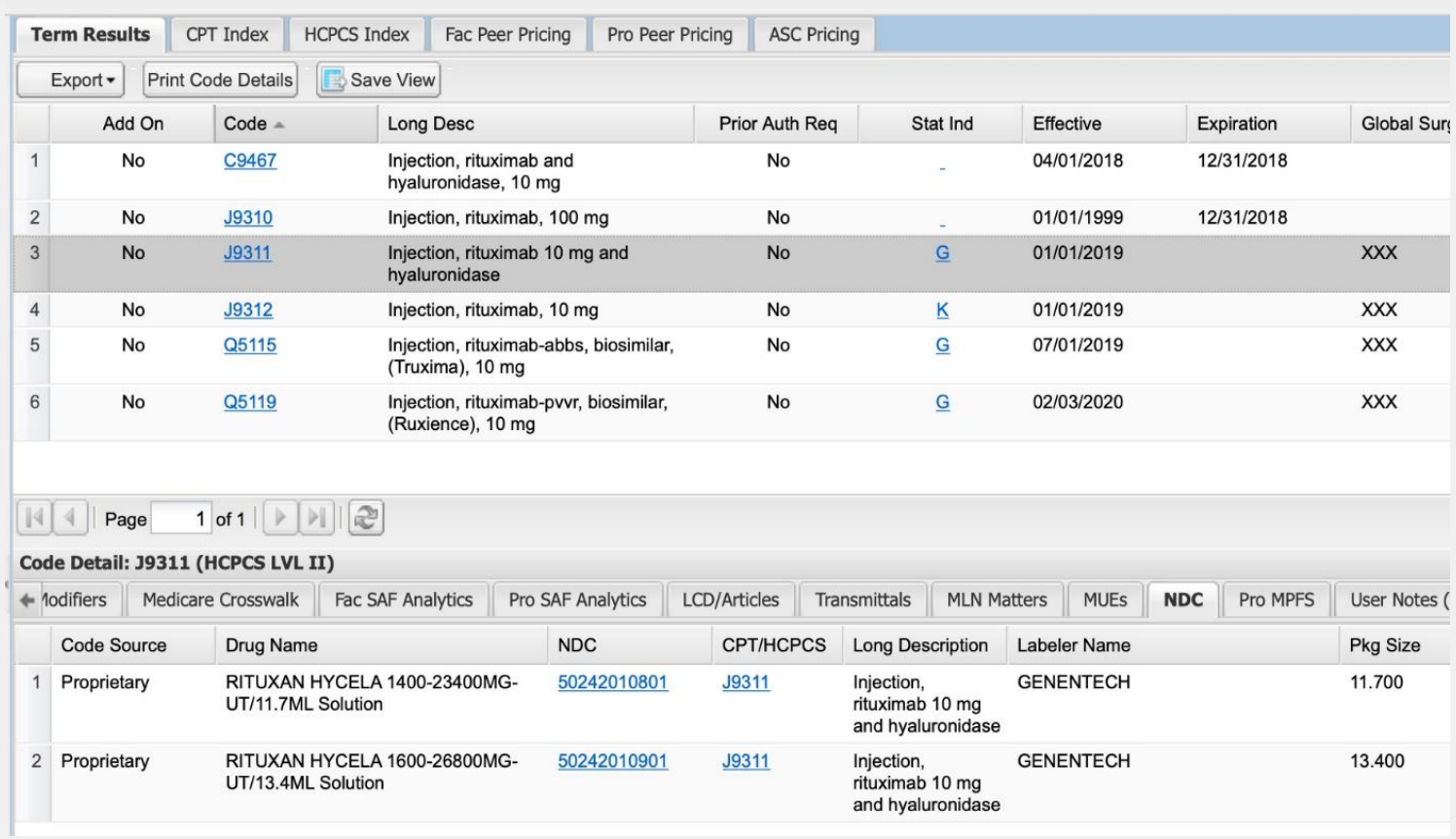
Step 1 – Confirm the NDC to HCPCS Code Map

NDC to HCPCS code map:

- Software should allow you to enter the NDC and find the most appropriate HCPCS code



Term Results | CPT Index | HCPCS Index | Fac Peer Pricing | Pro Peer Pricing | ASC Pricing

Export | Print Code Details | Save View

	Add On	Code	Long Desc	Prior Auth Req	Stat Ind	Effective	Expiration	Global Surg
1	No	C9467	Injection, rituximab and hyaluronidase, 10 mg	No		04/01/2018	12/31/2018	
2	No	J9310	Injection, rituximab, 100 mg	No		01/01/1999	12/31/2018	
3	No	J9311	Injection, rituximab 10 mg and hyaluronidase	No	G	01/01/2019		XXX
4	No	J9312	Injection, rituximab, 10 mg	No	K	01/01/2019		XXX
5	No	Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	No	G	07/01/2019		XXX
6	No	Q5119	Injection, rituximab-pvvr, biosimilar, (Ruxience), 10 mg	No	G	02/03/2020		XXX

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Code Detail: J9311 (HCPCS LVL II)

Modifiers | Medicare Crosswalk | Fac SAF Analytics | Pro SAF Analytics | LCD/Articles | Transmittals | MLN Matters | MUEs | **NDC** | Pro MPFS | User Notes (

	Code Source	Drug Name	NDC	CPT/HCPCS	Long Description	Labeler Name	Pkg Size
1	Proprietary	RITUXAN HYCELA 1400-23400MG-UT/11.7ML Solution	50242010801	J9311	Injection, rituximab 10 mg and hyaluronidase	GENENTECH	11.700
2	Proprietary	RITUXAN HYCELA 1600-26800MG-UT/13.4ML Solution	50242010901	J9311	Injection, rituximab 10 mg and hyaluronidase	GENENTECH	13.400

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Step 2 – Review Revenue and Usage Against Spend File

Revenue and Usage can be telling:

- Take a copy of the spend file from 60 days prior (2 months prior)
- Review the charge revenue and usage
- Deduct the spend from the revenue and usage
  - Then deduct amount still in inventory
- What is the difference
  - Large gaps in the amounts can signify lost charges or overcharges at a high level

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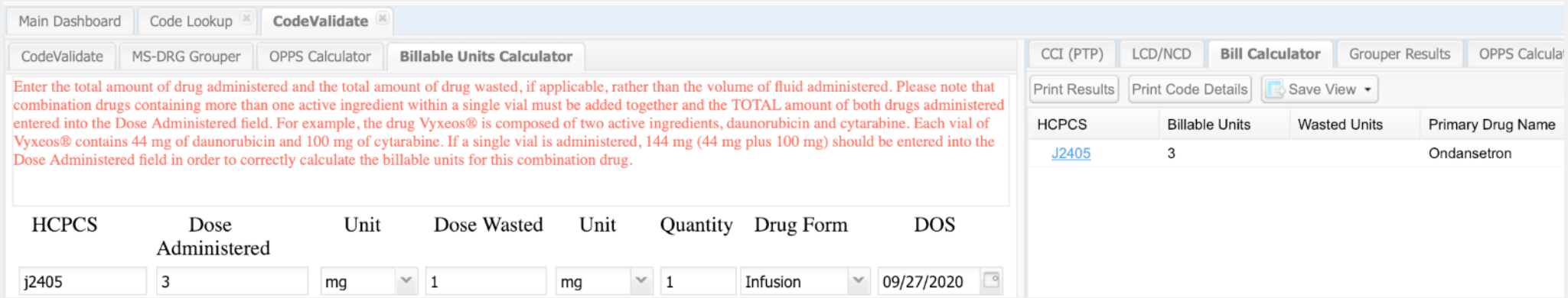
Step 3 – Use an embedded calculator

Calculator:

- Ordered and Administered 3mg of Ondansetron
- Vial contains 2mg/ml and is 2ml = 4mg

- Billing HCPCS J2405 is per 1 mg
- 3mg administered and 1 mg wasted
- HCPCS is SI=N therefore JW does not apply



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Step 2 – J9153

	Add On	Code	Long Desc	Prior Auth Req	Stat Ind
1	No	J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	No	G

Page 1 of 1

Code Detail: J9153 (HCPCS LVL II)

Code Detail | Revision History | APC Info | ASC Info | Rev Codes | Modifiers | Medicare Crosswalk

Code:	J9153
Code Type:	HCPCS LVL II
Long Description:	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine
Short Description:	Inj daunorubicin, cytarabine
Effective Date:	01/01/2019
Deleted Date:	N/A
Stat Ind:	G
Status Ind Desc:	Pass-Through Drugs and Biologicals Paid under OPPS; separate APC payment.

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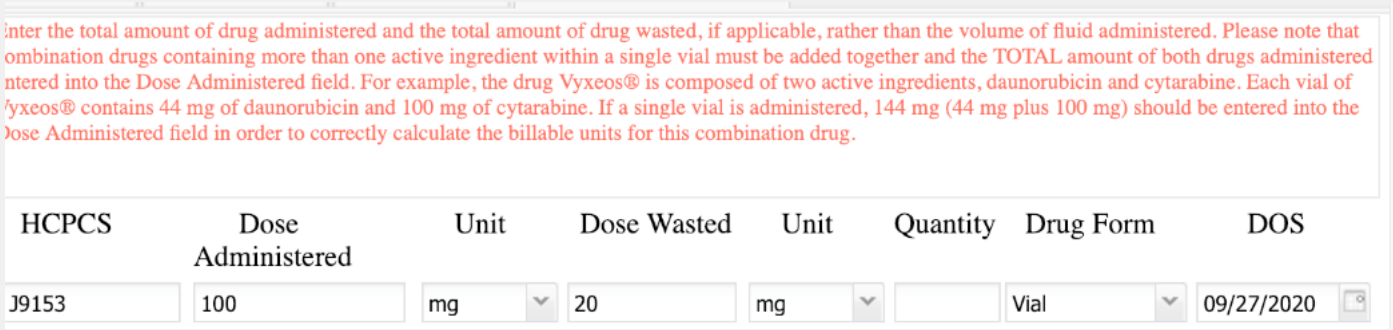
Step 3 - Calculations

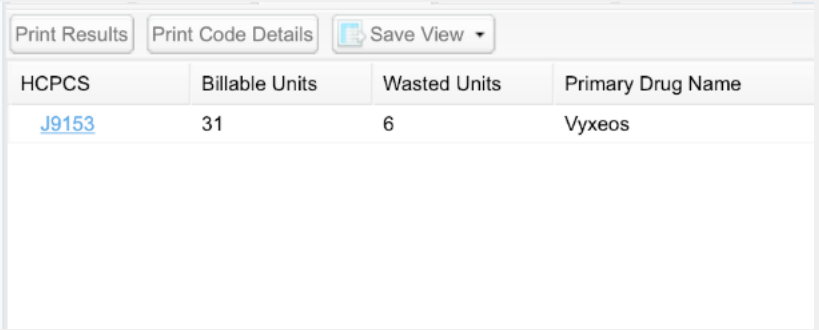
J9153 – Ordered 100 mg and comes in single dose vials, SI=G

- Wasted 20 mg
- Billable units were 31 and wastage was 6 units (Need JW modifier)



nter the total amount of drug administered and the total amount of drug wasted, if applicable, rather than the volume of fluid administered. Please note that ombination drugs containing more than one active ingredient within a single vial must be added together and the TOTAL amount of both drugs administered ntered into the Dose Administered field. For example, the drug Vyxeos® is composed of two active ingredients, daunorubicin and cytarabine. Each vial of yxeos® contains 44 mg of daunorubicin and 100 mg of cytarabine. If a single vial is administered, 144 mg (44 mg plus 100 mg) should be entered into the ose Administered field in order to correctly calculate the billable units for this combination drug.

HCPCS	Dose Administered	Unit	Dose Wasted	Unit	Quantity	Drug Form	DOS
J9153	100	mg	20	mg		Vial	09/27/2020



Print Results | Print Code Details | Save View

HCPCS	Billable Units	Wasted Units	Primary Drug Name
J9153	31	6	Vyxeos

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Audit to Prevent Lost Charges

Another Tool to Defend Against Lost Revenue

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Real Time Charge Edit is Key

Charge Capture Edits

- Two locations:
  - Pre-bill itemized charges
  - 837i – post bill charges
- Pre-bill allows for correction of charges prior to claim submission
- 837i allows for correction of charges in two locations:
  - 837 created from the system but ***before the scrubber*** and claim submission
  - 837i ***after the scrubber*** and sent as a claim to the payor
    - Would require rebilling the claim to make the adjustment

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Pharmacy Pre-Bill Edits

Because high dollar drugs such as chemotherapy and highly complex biologics need chemotherapy administration charges a prebill edit should be created.

Ex: 96413 (trigger) must have one of the following targets in the charges:

- https://med.noridianmedicare.com/documents/10546/12461373/Chemotherapy+Administration
- J9100, J9120, J9179 etc..... There are many drugs that would be a potential choice
- If the drug does not appear in the charges, then potentially the drug was missed or the incorrect infusion charge was present
- Either way it will either result in a lost charge or a denial for medical necessity/coding

Pre-bill edits are used to "illuminate" when a code pair is not present in the charges but should be to ensure a clean claim

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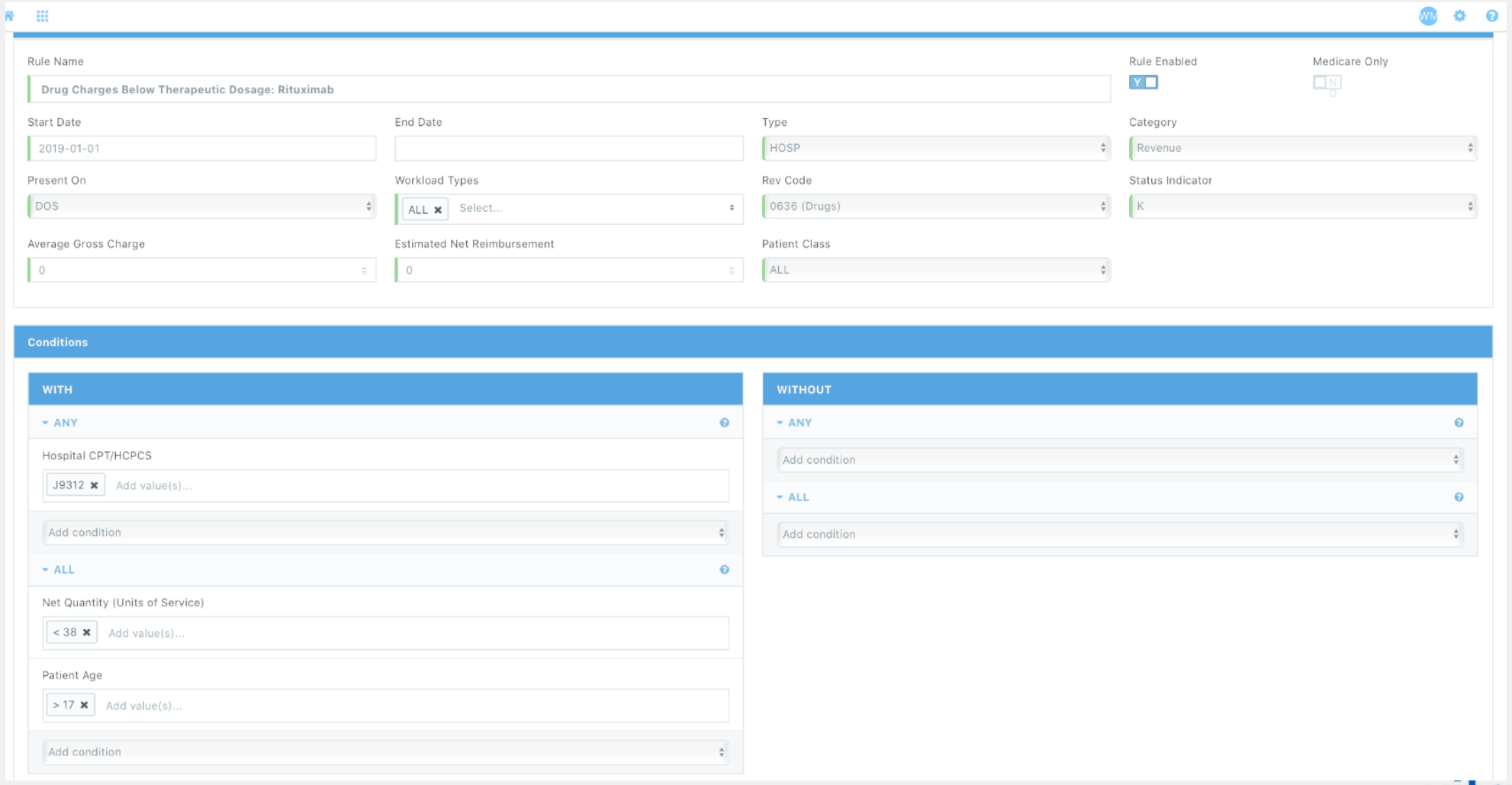
Example Drug Below Threshold Rule



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Vaccine Examples

2758361	Missing Administration: Oral Vaccine	HOSP
2758362	Missing Administration: Oral Vaccine	PHYS
2758363	Missing Administration: Oral Vaccine - Pro Fee	PHYS
2758367	Missing Administration: Intranasal Flu Vaccine	HOSP
2758368	Missing Administration: Intranasal Flu Vaccine	PHYS
2758369	Missing Drug: Intranasal or Oral Vaccine	HOSP
2758370	Missing Intranasal Flu Vaccine	PHYS
2758371	Missing Administration: Flu Vaccine	HOSP
2758372	Missing Administration: Flu Vaccine	PHYS
2758373	Missing Administration: Pneumococcal Vaccine	HOSP
2758374	Missing Drug: Pneumococcal Vaccine	HOSP
3380880	Unlisted CPT Code Review: Immune Globulin or Vaccine	HOSP

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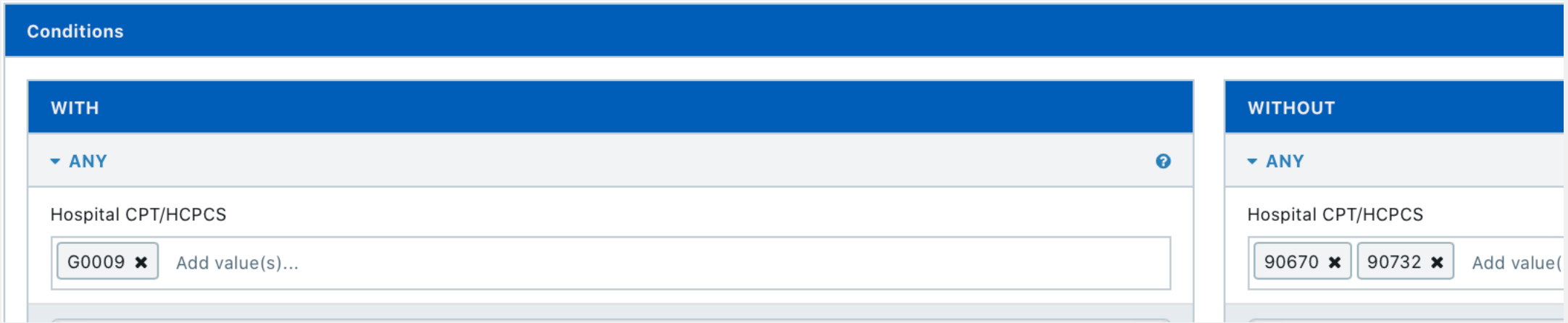
Pre-Bill Edits

Pre-Bill Edits:

- Previous slides indicate the way pre-bill edits operate
- Generally a trigger (either a medication or an administration) and a target (administration and target)
- Vaccine: Trigger G0009 and Target (Missing on claim 90670 or 90732)



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Pre-Bill Edit Advantages / Disadvantages

Advantages:

- Software can provide minimally acceptable dosage thresholds (either below threshold or above threshold)
  - The ability to identify drugs by threshold allows for easy identification of a charge capture issue
  - Drug threshold also allows for immediate remediation of conversion factors in billed units (if the billed unit conversion occurs at the time of charge)
  - Allows for comparison of administered NDC to the actual HCPCS code

Disadvantages:

- May have multiple drug charges for same medication that would exceed the MUE on a single date of service that would not be caught
- Billing units below threshold may not yet be calculated at the charge level and need to wait for the 837 to be created for scrub

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837 Before Scrubber

Advantages:

- Provides time for correction of the claim prior to claim going into scrubber
- Allows for definitive measure of below and above therapeutic ranges
- Allows for detection of billing units above or below expected thresholds / MUE
- Still time to put a bill hold on the claim to remediate any concerns

Disadvantages:

- Last minute work to fix charges
- Late charges may still be in play
- May have a higher volume caught in the 837 pre-scrub edits to work

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837i – Post Bill

Advantages:

- Everything is on the claim
  - Will still be missing late charges that didn't hit the claim or lost charges
  - Easy to identify targets and triggers
  - Easy to identify drug units below or above threshold

Disadvantages:

- Will require rebilling as claim has been submitted to the payor and/or paid by the payor
- Rebilling required for lost charges and they may be below the threshold to rebill – slow charge leakage over time
- Uses 837i/UB-04 which does not have any detail behind the charge such as CDM number, description etc.
- Charges can be rolled according to revenue code on inpatient claims

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Real Time Versus Post Bill Manual Audits

Real Time:

- HFMA states that 1-5% of net bottom line revenue is lost to charge capture
- Real time itemized charge review will encompass 100% of all charges for pharmacy
- Targets / Triggers can identify procedures in which medications might have been used or missed
- Real time review of administration to medication association to identify lost charge
- Therapeutic thresholds are taken into account and billing unit disparity is easily identified as under/ overcharge
- Ability to catch lost revenue in pharmacy before the claim times out

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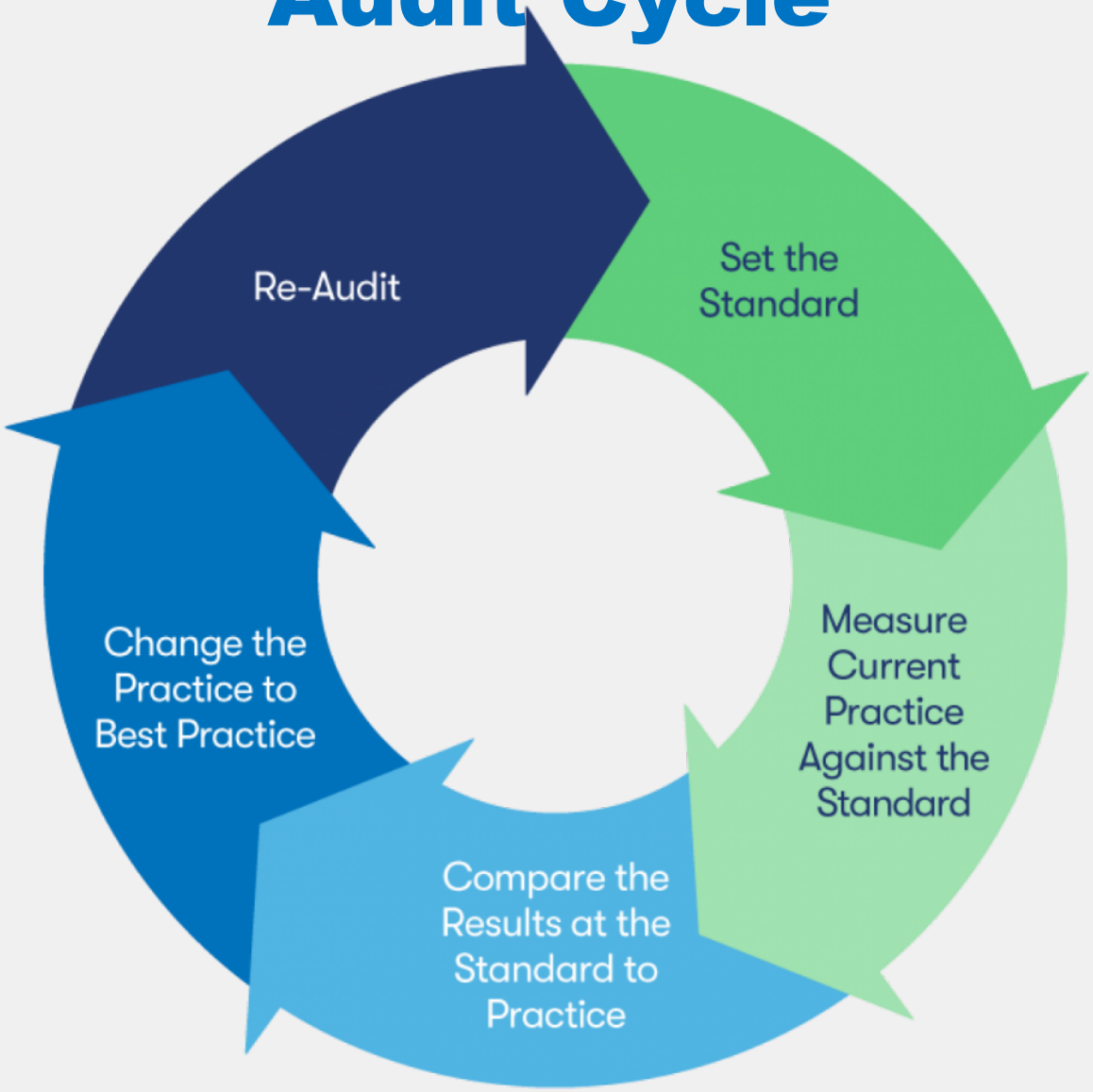
Audit Cycle



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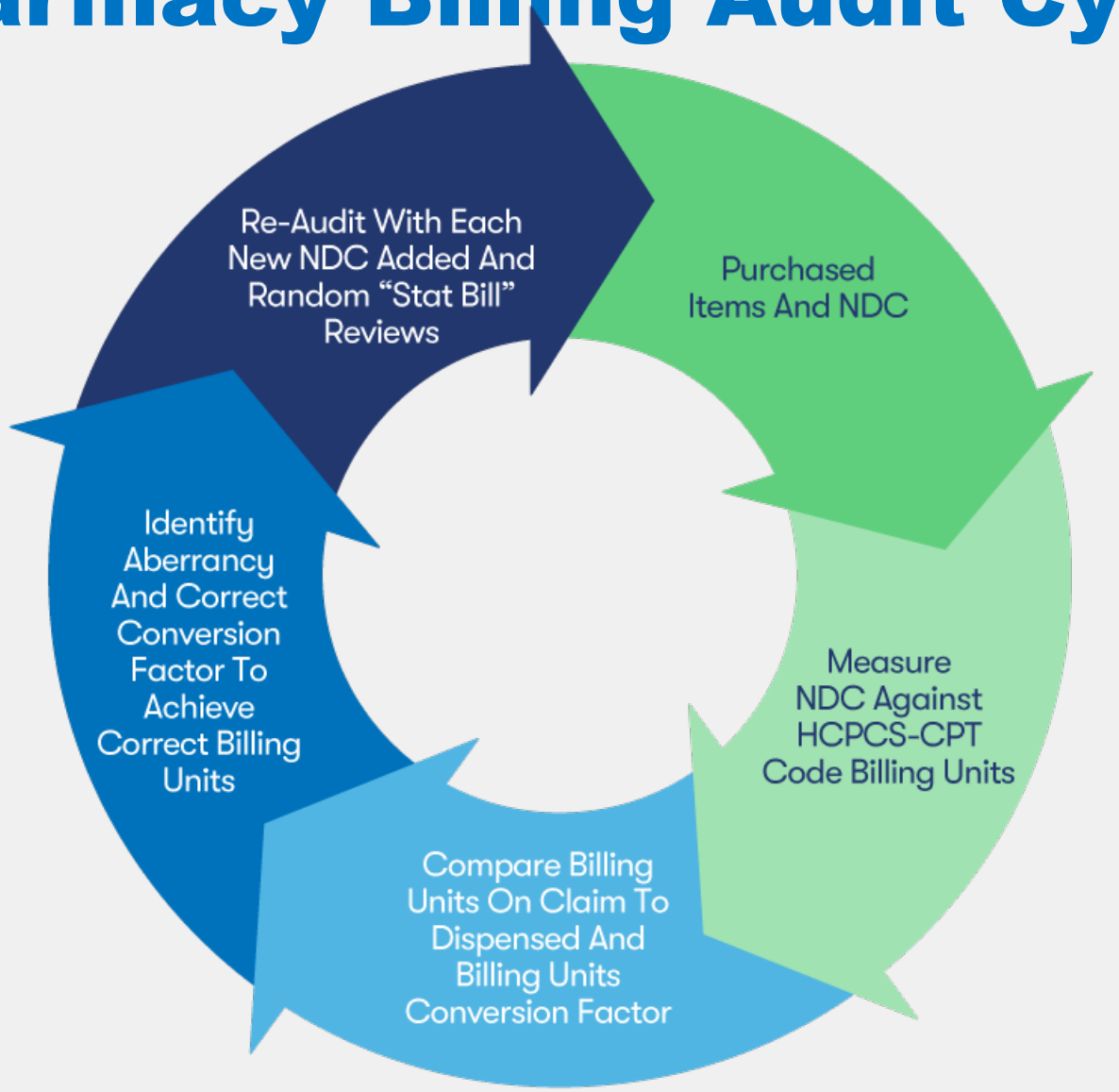
Pharmacy Billing Audit Cycle



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Benefits and Methodology for Auditing

Benefits:

- Allows for identification of under / overcharges
- Allows for identification of a “pattern of behaviour” that might otherwise be missed
- Demonstrates charging inaccuracies in high dollar drugs
- Allows for determination of wastage and application of JW modifier.
- Required as part of a robust compliance plan
- Increases patient satisfaction as they get charges for meds given and at the correct charge
- Essential with a new charge or system updates to detect inaccuracies
- Breaks down silos between pharmacy and revenue cycle to provide a more comprehensive revenue integrity programme.

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Selection Process Must Be Focused

Considerations:

- Going to audit the “universe” of the population being examined?
- What would be the correct amount of records to review?
- What if you are a facility with seasonal variability?
- Is the audit for compliance and require statistical reliability and precision?
- Are you trying to determine “patterns of behaviour”?
- Any other consideration that will likely result in a specific selection process

Will selection be by software, such as charge capture or claims review that reviews 100% of charges / claims, or will it be a manual selection.

- Easiest manual method is the “nth selection” process for randomisation to ensure adequate sample
- Say you want to audit 100 records (universe) then you can take the digits in the month you are auditing and select every one of those digits until 100 records are selected
  - Month = October, Select every 10th registration record until you get 100 records over 12 months

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Compare Results Against Standards

Manual:

- For example you wish to review Rituximab administrations in the Rheumatology Department.
  - Would select random records (nth selection) and compare the documentation against the standard and determine if the medication was billed as ordered and there is an administration charge
- Another example is reviewing vaccinations to ensure that the patient is receiving the vaccinations per medical guidance
  - Select a portion of patients who were identified as requiring the vaccine
  - Compare the identified patients against those that actually received the vaccine per protocol noting any aberrancies.
- Once the results of the comparison between the stated benchmark and the chart findings is determined then a hypothesis or determination on next steps can occur
  - If no problem is found then no need to pursue further steps

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Changing the Process

Audit Findings:

- Negative or Null findings in the sample move to Step 5 – Re-audit
- Positive Findings:
  - Is there an identified singular aberrancy or are there multiple findings
  - Goal is to get back to root cause and remediate the errors
  - Goal is NOT to just continue to audit and find the same error over and over

Remediation of Positive Findings & / or Patterns of Behaviour

- Most facilities employ Six Sigma remediation teams
- Many certified auditors are also Six Sigma certified

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Six Sigma – “Why…Why…Why…Why…Why”

One of the easiest audit remediation techniques is the Six Sigma “5 Why” pattern

Initial step is to write down the finding from the audit

- Then ask “why” is that a finding and determine an answer
- Then ask “why” is that answer occurring and repeat 5 times.
- Generally at the end of the process a true result is found.

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Six Sigma – “Why…Why…Why…Why…Why”

Example you note that a unit of 1 is found on IV contrast that should be billed by the Millilitre (ML)/cc

Why is only one unit of contrast on the claim

- Because it is auto charged at time of injection

Why was charged but not in the correct amount – auto charging

- Because the charge fires based on the activation of the injector

Why was the wrong units assigned at the time of the injector usage

- Because it is set up in RIS to flow to the CDM

Why did this error occur…

- Because the math behind the mapping from RIS to CDM did not charge by the cc

Why was the math wrong

- Failed to audit after originating the charge and mapping in the system

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Remediate The Issue

Once the root cause is found, it is time to remediate the issue

- Corrective action plans are put in place but frequently fail because the staff focuses on the “next fire” and things revert back to original state
- Ensure the remediation is written so that step 5 – the re-audit can occur
- Re-audit at regular intervals such as every month for 3 months then every 2 months etc….
  - Did the remediation work ?
  - Are there further changes that need to occur based on the stated goal or benchmark?

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Audit Inventory to Charges

Simple audit of purchased to charged over a 90-day period can illuminate charge capture concerns

- Step 1: Start with the purchased quantity and convert that to billing units
- Step 2: Account for the inventory on a specific day that it was purchased
- Step 3: Using revenue and usage, review the charge units for the drug over 90 days (general time frame for complete turnover)
- Step 4: Determine the delta between purchased and charged
  - What is the difference?
  - Is it due to wastage ?
  - Is it due to items charged but with the wrong conversion multiplier?
  - Is it due to failure to return medications for credit?
  - Determine root cause

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Summation

Putting the Pieces Together

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Pharmacy Revenue Cycle

Source Authority

Complexities

- JW Modifier
- SAD medications
- Billing Units

Importance of ongoing real time or near real time review of charges

- Use of software
  - Pre-Bill
  - Post-Bill

Importance of random auditing

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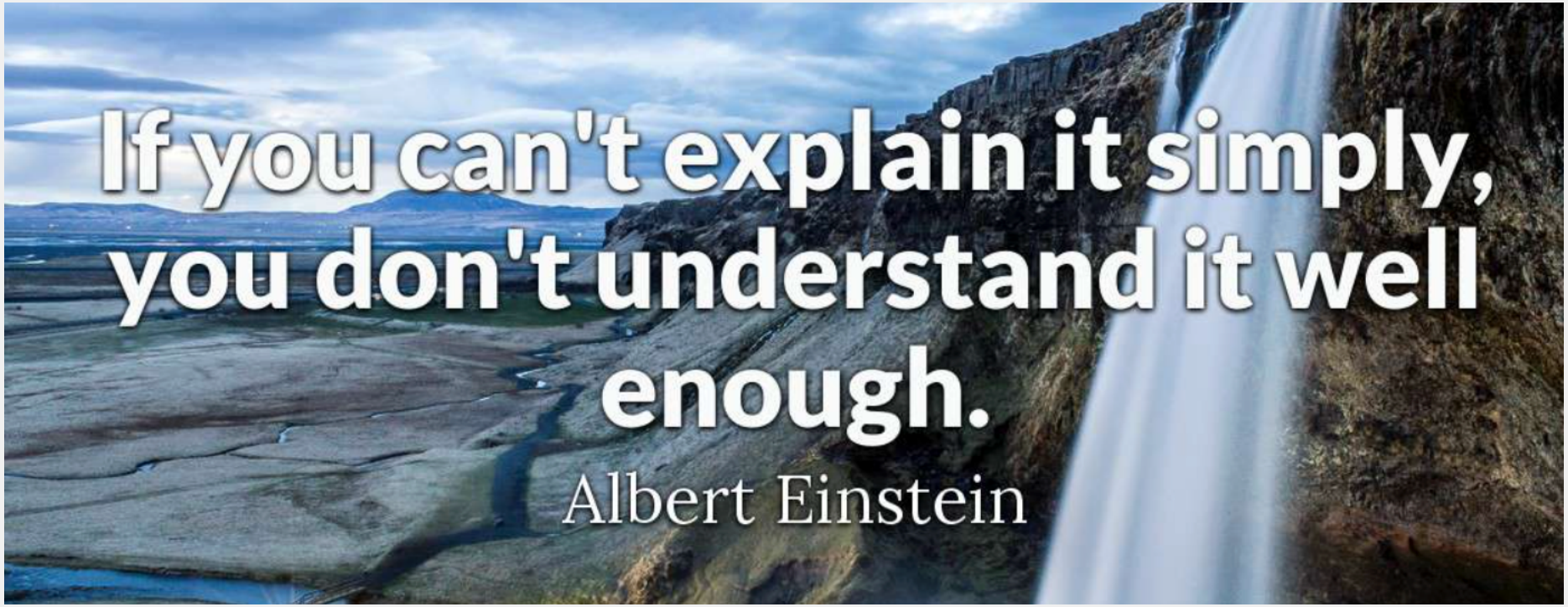
Pharmacy Must Be Broken Down into Simple Elements



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Questions?

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CLIENT APPRECIATION WEEK