Frequently Missed Items in Charge Capture: Focus on Pharmacy
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Disclaimer Statement

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Charge Capture Series

- June 2021 – Charge Capture focus on Supplies
- July 2021 – Charge Capture focus on Pharmacy
- August 2021 – Charge Capture – Getting Back After Covid
- September 2021 – Planning for 2022 charge capture
Agenda

Today we will cover:

▪ Review Charge Capture Process

▪ Identify points in the pharmacy process that can result in leakage

▪ Multipliers as a leading cause of inaccurate reimbursement

▪ Focus on the cost of providing pharmaceuticals

▪ Use of software to ensure all opportunities are reconciled

▪ *We will not be covering 340b due to the length of the presentation*
Objectives

Today we will cover:

▪ Be able to state why cost is now a relevant

▪ Understand potential lost areas such as CDM and Mapping concerns

▪ Be able to state why multipliers matter

▪ Understanding JW coding implications
Review of Charge Capture
Pharmacy Charge Capture Flow

Purchase and Inventory NDC

If 340B place in virtual inventory

Reconcile that item is new or replacement in Pharmacy Module

If new send to CDM to be added

Enter CDM number into data field in Pharmacy module (Meditech / Cerner) — EPIC uses shell

Map Pharmacy item to charge in CDM

Chargemaster

Change dispensing to billing units

Physician Order

Dispense

Charges placed on claim

BHI Scrubber

Claim to Payor for Reimbursement

Analyze Spend versus Charge

Is there a Discrepancy?

Root Cause Remediation
Source Authorities
Source Authority

- Can be CMS
  - Medicare
  - Medicaid
- Commercial Payer
  - Commercial payer guidelines
Authorities

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Pharmacy-Toolkits#self-auditing

PHARMACY TOOLKITS

The resources in these three toolkits will help pharmacy professionals make fewer mistakes, reduce the risk of audit, and save time.

- Pharmacy Self-Auditing Toolkit
- Pharmacy Prescribing and Billing Toolkit
- Off-Label Pharmaceutical Marketing Toolkit
Source for Chemo


CMS National Coverage Policy

*italicized font* - represents CMS national NCD language/wording copied directly from CMS Manuals or CMS Transmittals. Contractors are prohibited from changing national NCD language/wording.

CMS Pub. 100-02 *Medicare Benefit Policy Manual*, Chapter 15, Covered Medical and Other Health Services, Section 50, Drugs and Biologicals

CMS Pub. 100-04 *Medicare Claims Processing Manual*, Chapter 12, Physician/Nonphysician Practitioners, Section 30.5, Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions

CMS Pub. 100-04 *Medicare Claims Processing Manual*, Chapter 14, Ambulatory Surgical Centers, Section 10, General

CMS Pub. 100-04 *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, Section 90.2, Drugs, Biologicals, and Radiopharmaceuticals

CR 9749: August 24, 2016, CPT G0498: Chemo extend IV infusion with pump

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

This LCD addresses the coverage for chemotherapy agents based on the patient’s condition, the appropriateness of the dose and route of administration, based on the clinical condition, medical necessity and the standard of medical practice regarding the effectiveness of the drug for the diagnosis and condition.

Per this LCD, chemotherapy agents may be covered if reasonable and medical necessity is met

- **AND**
  - the drug is FDA approved

- **AND**
  - listed in the NCCN Clinical Practice Guidelines in Oncology (NCCN) with the specific ICD-10 diagnosis (that is being treated) for the drug/agent.
  - the chemotherapy agent must be listed Category 1 or 2A in NCCN,
  - the chemotherapy agent must be utilized per the NCCN Recommended Use (order or combination).
The Medicare program provides limited benefits for outpatient 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 patients who take them.

Generally, drugs and biologicals are covered only if all of the following requirements are met:

- They meet the definition of drugs or biologicals (see §50.1);
- They are of the type that are not usually self-administered. (see §50.2);
- They meet all the general requirements for coverage of items as incident to a physician’s services (see §§50.1 and 50.3);
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice (see §50.4);
- They are not excluded as noncovered immunizations (see §50.4.4.2); and
- They have not been determined by the FDA to be less than effective. (See §§50.4.4).
Medicare Part B does generally not cover drugs that can be self-administered, such as those in pill form, or are used for self-injection. However, the statute provides for the coverage of some self-administered drugs. Examples of self-administered drugs that are covered include blood-clotting factors, drugs used in immunosuppressive therapy, erythropoietin for dialysis patients, osteoporosis drugs for certain homebound patients, and certain oral cancer drugs. (See §110.3 for coverage of drugs, which are necessary to the effective use of Durable Medical Equipment (DME) or prosthetic devices.)
Benefit Before Payment

• For Federal programs the facility and/or physician must achieve a benefit category as determined by the Social Security Act
• For commercial payers they must meet Medicare and/or private payer guidelines
• All services must be medically necessary in order to achieve a benefit category
• All services must meet Incident to guidelines as described in Medicare policy
Why Cost Matters
“If you always do what you’ve always done, you’ll always get what you’ve always got.”

• The key takeaway is in 2021 charge capture strategies involve data and analytics and constant scrubbing
• They focus on cost AND reimbursement
Cost Per Capita is an International Healthcare KPI


- Pharmacy costs contribute significantly to the overall cost of care and is continuing to drive healthcare costs
- The following slides from the Kaiser Foundation and Peterson Center for Healthcare depict the rise in costs
- While these are 2019 figures this was published in 12/2020 therefore analytics are recent
Relative to the size of its economy, the U.S. spends a much greater amount on health care

GDP per capita and health consumption spending per capita, 2019 (U.S. dollars, PPP adjusted)
On average, other wealthy countries spend about half as much per person on health than the U.S.

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Consumption per Capita, U.S. dollars, PPP adjusted, 2019</th>
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</thead>
<tbody>
<tr>
<td>United States</td>
<td>$10,966</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$7,732</td>
</tr>
<tr>
<td>Germany</td>
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<td>Austria</td>
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<td>Sweden</td>
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<tr>
<td>Netherlands</td>
<td>$5,765</td>
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<td>Comparable Country Average</td>
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<tr>
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<td>$5,428</td>
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<tr>
<td>Canada</td>
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<tr>
<td>Japan</td>
<td>$4,823</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$4,653</td>
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</tbody>
</table>

Notes: U.S. value obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data • Get the data • PNG
# Drug Prices in Other Countries (Ways & Means Committee)

## Table 1. Descriptive Statistics on Prescription Drug Prices for Select Countries, 2018

<table>
<thead>
<tr>
<th>Country</th>
<th>Average</th>
<th>Min</th>
<th>Max</th>
<th>Pharmaceutical Spending per Capita(^{68})</th>
<th>Drugs Listed</th>
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<tr>
<td>Average</td>
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<tr>
<td>Average (excluding US)</td>
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<td>$0.08</td>
<td>$4,728.76</td>
<td>$625.73</td>
<td>59.9</td>
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</table>

**Sources and Notes:** Authors’ analysis of price data for 2018, collected from recognized price sources. Pharmaceutical spending per capita refers to the entire country of Canada and not specifically Ontario, Canada.
With more evolving analytics, cost accounting and supply chain / pharmacy chain metrics cost becomes a key constraint.

Many facilities are participating in value based contracting and therefore saving drive the overall reimbursement in cost sharing.

Charge capture is still paramount to prevent leakage but the change in motto to include cost management becomes a key driver.
Review: Implications of SAD and Medical Necessity
Overview of Medicare SAD

The Medicare program covers medications in different fashions based on the Medicare plan:

- Part A (aka – inpatient) – covered benefit
- Part B – only those medications that are not integral to a procedure and are not determined to be SAD are covered benefits
- Part D – based on the plan, formulary and fee schedules

In all of these Parts there is one rule that must be understood

- The service, procedure or medication must be a covered service and be medically necessary
- Therefore cannot be excluded from coverage
Generally, drugs and biologicals are covered only if all of the following requirements are met:

- They meet the definition of drugs or biologicals (see §50.1);
- They are of the type that are not usually self-administered. (see §50.2);
- They meet all the general requirements for coverage of items as incident to a physician’s services (see §§50.1 and 50.3);
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice (see §50.4);
- They are not excluded as noncovered immunizations (see §50.4.4.2); and
- They have not been determined by the FDA to be less than effective. (See §§50.4.4).
Incident To Criteria – BPM 15, § 50.3

50.3 - Incident To Requirements
(Rev. 1, 10-01-03)
B3-2049.3

In order to meet all the general requirements for coverage under the incident-to provision, an FDA approved drug or biological must:

- Be of a form that is not usually self-administered;
- Must be furnished by a physician; and
- Must be administered by the physician, or by auxiliary personnel employed by the physician and under the physician’s personal supervision.
What Constitutes Self Administered:

Usually:

- “usually self administered” = >50% of the Medicare beneficiaries can administer the drug by themselves

Evidence:

- Absent evidence to the contrary all drugs delivered intravenously are **NOT** usually self administered
- Absent evidence to the contrary presume all drugs delivered intramuscularly are **NOT** usually self administered
- Absent evidence to the contrary presume drugs delivered subcutaneously **ARE** self administered
- [BPM Ch 15, § 50.2]
- Based on this all oral, inhalation, rectal, topical, SQ, intradermal are SAD
Self Administered Definition

1. Administered: (How the drug enters the body)
   - Generally *only injectable drugs are eligible for coverage* under the incident to benefit
   - If there is more than one use for the drug then the Medicare *contractor must determine* whether the drug is self administered or non-self administered for each use
     - Ex: Med has both injectable and oral forms
     - Must weigh each indication
Determining Other Factors

Contractors (MACs) are instructed to consider factors that result in the Self-Administered Exclusions List:

- **Acute Condition**
  - Long term use – more likely to be SAD (Insulin)
  - Short term/emergent use – less likely to be SAD

- **Frequency of Administration**
  - More frequent – more likely to be SAD (Insulin)
  - Less frequent / one time use – less likely to be SAD
Integral = Supply (non-covered to covered)

“Certain drugs are so integral to a treatment or procedure that the treatment or procedure could not be performed without them. Because drugs are so clearly an integral component part of the procedure or treatment, they are packaged as supplies under the OPPS into the APC for the procedure or treatment. Consequently, payment for them is included within the APC payment for the procedure or treatment of which they are an integral part.

[A-02-129 p. 30]

If the facility CDM requires a line for cost accounting purposes, then it needs to be assigned to the packaged revenue center of 0250 so that all charges do roll into the procedure. These are considered integral supplies to the procedure.
Examples of when drugs are treated as supplies and hospitals should bill Medicare for the drug as a supply and should not separately bill the beneficiary.

✓ Sedatives administered to a patient while he or she is in the preoperative area being prepared for a procedure.

✓ Mydriatic drops instilled into the eye to dilate the pupils, anti-inflammatory drops, antibiotic drops/ointments, and ocular hypotensives that are administered to a patient immediately before, during, or immediately following an ophthalmic procedure. This does not refer to the patient’s eye drops that the patient uses pre- and postoperatively.

✓ Barium or low osmolar contrast media provided integral to a diagnostic imaging procedure.

✓ Topical solution used with photodynamic therapy furnished at the hospital to treat nonhyperkeratotic actinic keratosis lesions of the face or scalp.

✓ Antibiotic ointments such as bacitracin, placed on a wound or surgical incision at the completion of a procedure.
Medical Necessity

• While predominantly a Medicare action, most commercial payors also require some form of medical necessity for high-cost drugs

• Medical necessity derives its origin from Social Security Act
  • Sec. 1862. [42 U.S.C. 1395y]
  • (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
    • (1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,
Medical Necessity

• Medical Necessity must be achieved prior to the provision of the service
• If Medicare is likely to deny based on medical necessity guideline(s) then an ABN must be provided unless statutorily excluded service.
• ABN requirements are specified in 100.04 - Chapter 30 – Limitations on Liability
Commercial Payers

• Generally, a commercial payer will require an authorization for the drug and administration
  • May be a one-time authorization or
  • A plan of care authorization for “x” number of treatments
  • Physician authorization number may or may not cover the outpatient hospital authorization requirements
  • Many inpatient administrations also require prior-authorizations so it is important to have policies and procedures that govern these requirements.

• Both Medical Necessity and Authorizations tend to be managed by Patient Access in their module.
Multiple Modules
Multiple Challenges

What could go wrong?
Key Differentiator in Charge Capture

• One of the key differentiators in pharmacy charge capture is the number of modules and required mappings
  • Physician Ordering module
  • 340b virtual inventory
  • Pharmacy module
  • Pharmacy Dispensing – MAR (sometimes in one module)
  • Nursing Administration – EMR
  • Billing module

• All of these modules must be mapped from physician order to charge on claim with proper units
Mapping Challenges

• Mapping challenges are somewhat different between vendors
  • Example:
    • EPIC does not map 1:1 between pharmacy and billing but rather uses a “shell concept”
      • All like and kind items go into the shell
    • Meditech uses a 1:1 methodology between the PHA module and BAR billing module
    • Other vendors use a mix of 1:1 or one to many combinations
    • No matter what vendor mapping is a source of frequent charge errors
Billing Multiplier

- One of the challenges are converting an ordered dosage to the unit provided according to the NDC code and finally to the correct billing units on the claim
  
  - **Step One:** Ordered dosage
    - This is the amount of medication that the practitioner ordered
  
  - **Step Two:**
    - Confirm that the NDC matches what was used to create the dispensed dose
    - This confirmation will need to be made in the Pharmacy system as NDC in CDM are frequently outdated
Quick Review NDC

- National Drug Code (NDC) can be:
  - 10 digits
  - 11 digits (due to HIPAA concerns)
  - Three section format
    - Labeler – manufacturer, repackager …
      - 5 digits
    - The Product
      - 4 digits
    - Size of Package
      - 2 digits

- NDC determines the package size from which to convert to dispensed
Billing Multiplier
Lost Revenue

• **Step Three:**
  • Using the NDC convert it into the smallest mathematical unit

• **Step Four:**
  • Using the HCPCS Code billing description take the delivered dosage (smallest unit denominator) and the dispensed dosage (numerator)
  • Dispensed dosage / HCPCS Billing Units = Multiplier
#1 Pharmacy Error – Units of Service

• **Example Drug and Dosage:**
  - Ruxience™ - Rituximab
  - Supplied in either 100 mg or 500 mg vials
  - In pharmacy module the vial would be created
  - Once an order for the 420 mg (fictitious dosage) was created then the pharmacy would use 1 vial of 500 mg
  - The pharmacy would then dispense 42 cc of 500mg/50 cc vial and waste 8 cc
  - Nursing shows that 42cc was infused (96413 / 96415) over 4 hours
  - When the 420 mg comes through CDM it must be converted into billing units
    - Q5119 JA(iv admin) for 42 units and another line
    - Q5119 JW for 8 units
  - All of these conversions are done in the background and pose a real threat to appropriate charge capture
Compounding vs. Admixture

• Under the OPPS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug code (J9999 or J3490). In these situations, it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a specific HCPCS code has not been assigned.

Billing for Wastage
Novitas Billing Guidelines

• Two scenarios
  • Billing for medications never administered but provided
    • Example a chemotherapy mixed but patient is too ill to undergo the infusion
  • Billing for wastage from a single dose unit
    • [Link](https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00004990)

• Scenario #1:
  • “As described in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 17, Section 40.1, in addition to paying for the amount of drug that has been administered to a beneficiary, Medicare 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. Therefore, if no amount of the drug was administered to the patient, then no claim should be submitted.”
Novitas Billing Guidelines


- Scenario #2: JW Modifier
  - Can only be applied for medications that are provided in a single dose vial
    - Can a hospital charge for 'drug waste' when using a partial vial of a drug and there is no other patient scheduled for the same drug?
      - You are encouraged to schedule patients in a way that you can use the drug most efficiently. However, if you must discard the remainder of a single use vial after administering part of it to a Medicare patient, bill the amount of drug discarded along with the amount administered.
      - Effective January 1, 2017, you are required to report modifier JW with unused drugs or biologicals that are appropriately discarded. **You must document the discarded drug or biological in the patient's medical record.**
      - The JW modifier is only applied to the amount of drug or biological that is discarded.
      - **To clarify, coverage of discarded drugs applies only to single use vials.** Multi-use vials are not subject to payment for discarded amounts. When billing drug waste, it is expected that the medical record contains the name of the drug, dosage, route of administration, time and date given as well as the amount administered, and the amount wasted.
Charge Capture Interventions
Cost Interventions

• Software can now marry the cost to provide with the charge capture activities
• A lost charge still incurs a cost so continued focus on charge leakage is required
• Daily reconciliation of the cost metrics to the charge capture is one method to ensure that the cost of care is covered, to the extent it can, by reimbursement.
Calculators to Assist In Wastage and Billing Units

Enter 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 combination drugs containing more than one active ingredient within a single vial must be added together and the TOTAL amount of both drugs administered entered into the Dose Administered field. For example, the drug Vyxeos® is composed of two active ingredients, daunorubicin and cytarabine. Each vial of Vyxeos® 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 Dose Administered field in order to correctly calculate the billable units for this combination drug.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Dose Administered</th>
<th>Unit</th>
<th>Dose Wasted</th>
<th>Unit</th>
<th>Quantity</th>
<th>Drug Form</th>
<th>DOS</th>
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<tr>
<td>Q5119</td>
<td>42</td>
<td>mg</td>
<td>80</td>
<td>mg</td>
<td>1</td>
<td>Val</td>
<td>06/28/2021</td>
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Print Results | Print Code Details | Save View

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<tr>
<th>HCPCS</th>
<th>Billable Units</th>
<th>Wasted Units</th>
<th>Primary Drug Name</th>
<th>Long Description</th>
<th>Notes</th>
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<tr>
<td>Q5119</td>
<td>42</td>
<td>8</td>
<td>Rustice</td>
<td>Injection, rituximab-pvvr, b ...</td>
<td>Drug wastage ...</td>
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</tbody>
</table>
Charges Below Therapeutic Range

• Charge capture software is so sophisticated now that comparing billing units to therapeutic dosages are real-time

• Daily 837i or charges go through the processing scrubber and units more or less than expected are identified for review
  • These are essential edits to ensure that the claim has the correct units for correct reimbursement.
  • Undercharging units of service can result in significant reimbursement impact
Edits based on Individual Medication and Clinical Therapeutic ranges

| Drug Charge Below Therapeutic Dosage: Prothrombin Complex Concentrate |
| Drug Charge Below Therapeutic Dosage: Aripiprazole Extended Release |
| Drug Charge Below Therapeutic Dosage: OnabotulinumtoxinA |
| Drug Charge Below Therapeutic Dosage: Leucovorin |
| Drug Charge Below Therapeutic Dosage: Ceftaroline Fosamil |
| Drug Charge Below Therapeutic Dosage: Daptomycin |
### Hospital CPT/HCPCS

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<th>Code</th>
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<tbody>
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### Add condition

- **ALL**

### Net Quantity (Units of Service)

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### Patient Age

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</table>
Summation
Summation

- Of the four categories of what a facility can charge for Pharmaceuticals are:
  - Represent the largest overall cost
  - Very convoluted charging and math conversions to get the correct units on the claim
  - Are based on age, weight and multiple other factors
  - Requires 100% review daily of these charges
  - Creates an opportunity for enhancement in almost any facility
Questions?
Thank you!