Interview Questions for Charge Capture audits

What system(s) is(are) used for charge entry and documentation?

Who enters orders into the system?

Are any procedures performed without a written order? Or, are any tests performed differently than what is written on the order? In what situations? Are there protocols adopted by the medical staff approving this procedure? (Get evidence – meeting minutes, etc.)

Do you use a charge ticket? If so, please provide a copy. Who completes the charge ticket?

Who enters charges into the system? When do they enter the charges? If entered automatically, please explain.

Is there a backup person to enter charges?

Are charges reconciled to ensure that every patient was charged accurately? Who performs that function? Is there a backup person to do this?

Are there written policies/procedures for charge capture and/or reconciliation? If so, please provide a copy.

Do you have any concerns/issues with/about charge capture, charge entry or selection, chargemaster, charge reconciliation, late charges, etc.? Is there anything IA can do to help you resolve or escalate any issues?
Uncovering Pharmacy Department Risks and Opportunities

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At a Glance

To assess the risk a hospital faces from improper billing, coding, and pricing for pharmacy items, hospital finance leaders should perform an audit of the pharmacy department’s charge description master. The audit should look for inaccuracies with respect to:

- National drug codes
- Healthcare Common Procedure Coding System codes
- UB-04 revenue codes
- Browsable units
- Wholesale acquisition costs and average wholesale prices

Increased audit exposure, escalating drug costs, and declining reimbursement all give hospital finance leaders good cause to assess the risks and opportunities associated with their organizations’ pharmacy departments.

Hospital finance leaders may have a false sense of security where pharmacy revenue is concerned. Comprehensive analyses and audits may shatter this sense of comfort when they expose the challenges that contribute to making the pharmacy one of the most difficult departments to manage from a coding, compliance, reimbursement, and pricing standpoint. Consider the extent of these challenges: outdated costs, improper mark-ups, invalid or missing Healthcare Common Procedure Coding System (HCPCS) codes or national drug codes (NDCs), unbilled items, undocumented medical necessity, and improper descriptions and billable units.

Finance leaders have all too often given the pharmacy short shrift for many reasons. It could be that the line-item descriptions such as pegfilgrastim are unfamiliar, unspecified drug codes, and description and reimbursement information is critically important because this is too complicated. Or perhaps the conversion of package quantities from dosages to allowable billable units is simply too daunting. A hospital finance leader may have enjoyed a false comfort in knowing that pharmacy prices are often not included in the hospital’s charge description masters (CDMs), but instead are billed based on cost marked up by a factor to cover overhead, uncompensated care, and a profit margin. Or perhaps the finance leader has discounted the importance of pharmacy coding, compliance, and pricing based on the perception that pharmacy items are used primarily by hospital inpatients and most of the pricing for these items is based on prospectively set or negotiated all-inclusive rates.

Whatever the reason a finance leader has given this department little attention, a few things are certain. With gross revenue levels and cost increases in pharmaceutical and medical supplies exploding over the past decade, improper billing, coding, and pricing for pharmacy items can materially affect a hospital’s net revenue, even with a small change in payer mix. And let’s not forget, missing HCPCS codes, payable under Medicare, can result in lost reimbursement. Improper billable units and poor documentation for medical necessity are both targets for denials. The consequences for ignoring pharmacy department coding, compliance, pricing, and reimbursement responsibilities can be an onslaught of items that are unbilled, improperly billed, or undetected: revenue take-backs by payers; and even public relations nightmares.

Conducting a Pharmacy Department Audit

A hospital’s pharmacy system or CDM can easily contain tens of thousands of line items for the drugs dispensed each year. To perform an audit, the hospital’s finance leader should consider the use of a software program, spreadsheet program, or Access database to manipulate and analyze so many items efficiently and effectively.

Access to data from the hospital’s pharmacy CDM, formulary, and an external benchmark database will be required to perform the audit. The benchmark database should include the most current and comprehensive drug information providing all NDCs along with, at a minimum, the related primary and secondary HCPCS codes, revenue codes, billable units, reimbursement rates, wholesale acquisition costs (WACs), average wholesale prices (AWPs), and manufacturer names. By using the benchmark database as a basis for comparing the hospital’s pharmacy CDM, billing system, and formulary data, the audit can identify areas of risk and opportunity in the coding, compliance, and reimbursement area.

The audit should focus on accuracy in five key areas:

- NDCs
- HCPCS codes
- UB-04 revenue codes
- Billable units
- WACs or AWPs

NDC Accuracy

The NDCs are managed by the Food and Drug Administration (FDA). The NDC system is designed to provide drugs in the United States with a specific 11-digit number that describes the product. Originally created under Medicare to help identify drugs for reimbursement, the system has now gained more widespread usefulness. Data in the NDC system are updated quarterly (March, June, September, and December). The FDA requires firms to submit updated registered drug lists in June or December of each year (or sooner as new information about a drug becomes available to the firm).

NDCs identify drugs using 11-digit number divided into three segments. The first segment, assigned by the FDA, identifies the vendor (or labeler) involved with the manufacturing, packaging, or distribution of the drug. Product codes, listed in the second segment, comprise the generic entity, strength, and dosage form. The third segment, or package code, indicates the package size. The manufacturer assigns the second and third segments of the code for a given product.

The accuracy of the NDC is the foundation from which a hospital assigns HCPCS codes, revenue codes, billable units, descriptions, and prices. Maintaining accurate and updated NDC information is critically important because this information drives final payment and external audit risk. In fact, because of the specific, precise nature of a drug’s NDC, the Centers for Medicare & Medicaid Services (CMS) has adopted the NDC system as the primary driver in the development of its internal coding, billing, and payment crosswalks.

At a minimum, the audit initiative in this area should compare the NDCs in the hospital’s formulary with those in the benchmark database to determine whether the NDC is valid. Descriptions can also be compared at this time. If the hospital has a link or mapping between the NDCs in its formulary and the billing codes (service codes) used in its billing system or chargemaster, it will be necessary to update and maintain accurate mapping between the two systems to ensure that only current, accurate, and valid NDCs are in use and are properly mapped.

A concern for hospitals that have a relatively high utilization by Medicaid patients is that NDCs could affect Medicaid payments because Medicaid calculates drug rebates based upon what providers report. Another concern is the reporting of “static” NDCs that do not match the purchase records for the actual drug.

http://www.hfma.org/Templates/Print.aspx?id=26403

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dispensed, which could subject the hospital to increased potential audit risk and public relations problems.

If NDCs are improper or invalid, and if a hospital's pricing is based on the unit cost associated with those NDCs, the hospital's prices may not adequately represent the actual cost incurred by your organization for the drug purchased and dispensed. From a quality standpoint, bedside dispensing systems rely upon accurate NDCs to operate at peak efficiency.

**Typical audit findings.** A pharmacy CDM audit of the accuracy of NDCs often will find that 15 to 25 percent of NDCs in the formulary and linked systems are inactive or out-of-date. For example, the Medicaid program explicitly indicates that the NDC is found on the drug container (vial, bottle or tube). The NDC submitted to Medicaid must be the actual NDC on the package or container from which the medication was administered. Providers should not bill for one manufacturer's product and dispense another. It is considered to be a fraudulent billing practice to bill using an NDC other than the one administered. A disconnect between the NDC that providers report on the claim and the NDC that is actually dispensed therefore exposes the hospital to audit risk.

**HCPCS Accuracy**

Reporting accurate HCPCS codes is critical for correct and compliant outpatient reimbursement through Medicare and other payers. Although not all payers make payments based on the HCPCS codes, the safe scenario to ensure optimum reimbursement is also to ensure that every drug, as defined by the NDC, has a HCPCS code assigned when applicable for that NDC.

To identify missing, incorrectly assigned, and/or invalid HCPCS codes, the HCPCS codes assigned in a hospital's formulary (and if available in its charge master) should be compared with each assigned NDC in the benchmark database for the respective NDCs.

**Typical audit findings.** Often, the initial audit of the accuracy of HCPCS codes in the pharmacy CDM will find that 25 to 35 percent of codes are missing or invalid. To the extent that some of those codes represent ambulatory payment classification (APC) status indicator "K" codes payable separately by Medicare, an audit will have uncovered lost revenue or new incremental revenue. Conversely, if some items have been coded improperly for APC payments, the hospital may be at risk of, or during, an external audit.

**UB Revenue Coding Accuracy**

CMS's longstanding policy under the outpatient prospective payment system (OPPS) is to refrain from instructing hospitals on the appropriate revenue code to use to charge for specific services. CMS believes that this policy allows hospital flexibility in their billing and accounting systems and gives hospitals the autonomy they need to deal with the great variety of detail involved in creating a hospital CDM for multiple payers and to manage the accumulation of costs and charges for completing their Medicare hospital cost report.

CMS does not require hospitals to use revenue code 0636 (drugs requiring detailed coding) when billing for drugs and biologicals that have HCPCS codes, whether they are separately payable or packaged. However, the agency believes that this practice (i.e., use of revenue code 0636) would be consistent with National Uniform Billing Committee (NUBC) billing guidelines and would provide CMS with the most complete and detailed information for future rate setting.

Aside from Medicare, many other third-party payers use specific UB-04 revenue codes to identify high-cost drugs eligible for carve-out payments or increased reimbursement rates. In fact, the Illinois Workers' Compensation Commission (IWCC) provides additional "carve out" reimbursement beyond fee schedule payment established for services subject to their Hospital Outpatient Surgical Fee Schedule (HOSF). The policy will pay providers 65 percent of billed charges for drugs reported with UB-04 revenue code 636 along with the proper HCPCS code. (See www.iwcc.il.gov/pdf/0619.pdf for more information.)

In short, whether it is to identify drugs for payment purposes, coverage, or cost reporting, accurate and precise UB-04 revenue code reporting can have a significant impact on hospital revenue.

**Typical audit findings.** Because CMS gives providers wide latitude in reporting of UB-04 revenue codes, CDM audits invariably find that reporting practices differ substantially among hospitals. In some instances, hospitals have diligently assigned revenue codes to drugs based on the exact type of drug (for example, assigning revenue code 258 "IV solutions" to all IV solution products in the CDM). This practice, while time consuming, gives a hospital's claims data the highest level of granularity and can be very helpful in contract negotiations with payers. In other instances, the blanket application of the general revenue code 250 (pharmacy) to all items is used. A downside to this approach is that it can undermine a hospital's ability to differentiate drugs requiring detailed HCPCS coding or noncovered self-administered drugs at the claim level.

**Exhibit 1**

**Billable Unit Accuracy**

To receive proper payment under the Medicare OPPS, hospitals must report all HCPCS codes and charges for separately payable drugs in addition to reporting the applicable drug administration codes. Because CMS bases payment on the HCPCS code reported and the number of billable units, ensuring accuracy is critical for compliant payments. In fact, recovery audit contractors (RACs) continue to target billable units for drugs, making providers that do not pay close attention to this issue all the more vulnerable to improper payments. In the March 18, 2011, update of the hospital OPPS (Medicare Transmittal 2174, www.cms.gov/transmittal/downloads/R2174CP.pdf), CMS emphasizes, once again, the importance of billable units. The update elaborates as follows:

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4.

CMS goes on to caution providers and hospitals against billing the units based on how a drug is packaged, stored, or stocked. CMS offers the following example: "If the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, hospitals should bill 10 units, even though only 1 vial was administered." CMS also cautions that because a HCPCS short descriptor has only 26 characters, including spaces, it does not always fully describe the drug. "Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes," CMS advises.

Typical audit findings. Because payment is tied to each billed unit, RACs can easily target provider claims for outlier behavior and tie the reported units to improper payments. Pharmacy audits at various hospitals are likely to detect substantial differences in accuracy because some hospitals target only those drugs that are payable under the OPPS. By focusing only on payable items, these hospitals unwittingly create a "two-tiered" compliance policy. In effect, they are sending a message via their claim data that they will pay attention to billable unit accuracy only if there is payment tied to the HCPCS code that is reported. Curiously, this same effect does not occur when other ancillary departments (e.g., laboratory, physical therapy, and infusion therapy) have to report billed units based on the HCPCS code description.

WAC or AWP Accuracy

Unlike pricing in other departments that is determined by the finance department and that is hard coded into the CDM, pharmacy pricing is finalized by the provider on the patient bill based on the WAC, AWP, or actual acquisition cost. At this time, most pharmacy systems provide WACs and AWPs and the ability to mark-up the costs to cover overhead, uncompensated care, shortages from payers, and profit margins. Pharmacy directors often have full responsibility for setting pharmacy charges and operate their own CDMs with an entirely separate system tailored specifically to meet pharmacy department needs. Typically, the finance department provides one mark-up factor, or a set of mark-up factors based on the class of drugs, to the pharmacy for this purpose.

In many cases, however, pharmacies are using factors that they received many years ago, with the result that their mark-up factors no longer adequately reflect today's gross revenue requirements. Moreover, audits also are likely to find that the cost information used is also outdated or incomplete. In both of these instances, the result is improper pricing and reimbursement.

The best way to assess a pharmacy department's overall charge-to-cost mark-up factor is to compare it with other factors being used in the hospital's area and state. This effort is likely to detect wide variation in usage simply because many financial managers have overlooked pharmacy departments for so long, but using a regional or statewide median should provide an adequate and reasonable measure. This information can be obtained from CMS via the Medicare cost report database.

By identifying reasonable and up-to-date mark-up factors and then applying them to the current WACs, AWPs, or actual acquisition costs in the benchmark database, adding a dispens fee if applicable, hospitals can calculate new pharmacy prices and compare the results to those currently being calculated via the formulary system.

In addition, to ensure that the baseline pricing data are reliable, the audit should also compare the WACs or AWPs contained in the hospital's formulary with those reflected in the benchmark database. Moreover, by comparing the hospital's actual acquisition cost per unit with the WAC and AWP amounts, potential savings (overspending) can be uncovered.

Typical audit findings. Hospitals that are auditing the accuracy of WACs or AWPs in their pharmacy CDMs for the first time are likely to find that 20 percent or more of WAC or AWP data in the formulary is outdated or missing. Before adjusting or implementing the new prices, it is important that the gross and net revenue impact be determined to ensure that the hospital maintains or increases its net revenue in the pharmacy department.

For most hospitals, it is also important not to use actual acquisition costs, because, to the extent that a hospital has negotiated favorable pricing (either directly or through its group purchasing organization), it will want to realize the benefit of that lower cost by basing its prices on the standard WACs.

Be Proactive

A proactive approach to auditing a hospital's pharmacy coding, compliance and pricing could uncover unexpected incremental net revenue, or it could uncover outside auditor exposure. In either case, finance leaders are fulfilling their fiduciary responsibility in performing the audit to identify opportunities or risks. The exhibit above provides a list of top audit areas that such an audit should consider and the reasons why. The exhibit on page 68 provides a snapshot of an audit report flagging description, HCPCS, revenue code, and other discrepancies among the chargemaster, formulary, and benchmark database.

In today's financially challenging environment, hospitals can no longer afford to overlook lost revenue opportunities resulting from improper billing, coding, and pricing in the pharmacy. For finance leaders who have not yet directed their attention to the pharmacy, now is a good time to start.

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Footnote

a. The primary sources of AWPs are private drug data compendiums, with most pharmacies and third-party payers using First Data Bank or Medi-Span as their own information. Due to recent litigation over improper manipulation of the AWP, both First Data Bank and Medi-Span have announced decisions to cease the publication of AWPs for drugs no later than September of 2011. Other pricing compendiums—such as Gold Standard/Elsevier and Red Book Drum Reference—have pledged to continue publishing AWPs. The Department of Health and Human Services Office of Inspector General even recommended that Medicaid no longer use AWPs as a benchmark, and many retail pharmacies and drug wholesalers recognize the potentially inflated nature of AWPs. As a result, there is an emerging push in the industry to agree upon a new pharmacy reimbursement benchmark to eventually replace the AWP. Although nothing is decided now, prudent hospitals should begin evaluating their current pricing strategies and consider whether there are better alternatives to AWPs should it prove no longer to be a viable option.
<table>
<thead>
<tr>
<th>Audit Task</th>
<th>Reason</th>
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<tbody>
<tr>
<td>Develop a mapping of charge description master (CDM) service codes to national drug codes (NDCs) from the formulary, if not available</td>
<td>To facilitate proper billing, decision support, and ongoing audit and maintenance</td>
</tr>
<tr>
<td>Verify that all NDCs in the formulary are valid</td>
<td>To ensure proper compliance, billing, reimbursement, and reporting</td>
</tr>
<tr>
<td>Verify that all NDCs have a Healthcare Common Procedure Coding System (HCPCS) code assigned, if appropriate</td>
<td>To ensure that Medicare and other insurer reimbursement payable based on HCPCS codes are paid properly</td>
</tr>
<tr>
<td>Verify that HCPCS codes assigned are valid for NDCs and for reimbursement</td>
<td>To ensure proper compliance, billing, reimbursement, and reporting</td>
</tr>
<tr>
<td>Verify that billable units used by the hospital correlate with those published by an independent source</td>
<td>To reduce recovery audit contractor (RAC) and other audit exposure and ensure proper reimbursement levels</td>
</tr>
<tr>
<td>Verify that all cost information used in the formulary is current and complete for all items dispensed</td>
<td>To ensure the accuracy of the means used for determining proper pricing and reimbursement from payers paying on the basis of charges*</td>
</tr>
<tr>
<td>Verify that all items dispensed have a corresponding service code and are being billed</td>
<td>To uncover opportunities to recover lost revenue and improve cash flow</td>
</tr>
<tr>
<td>Verify that the pharmacy has a mechanism in place to routinely update the formulary for changing costs</td>
<td>To keep up with frequent cost changes and to address the impact of unit costs on the price billed</td>
</tr>
<tr>
<td>Determine whether current prices billed are optimum from both a reimbursement and a public relations standpoint</td>
<td>To fulfill fiduciary responsibility with an eye toward consumer awareness and regulatory initiatives</td>
</tr>
<tr>
<td>Verify that the billable units reflected on the bill are appropriate for the drug units and dosages dispensed</td>
<td>To reduce RAC and other audit exposure and obtain accurate reimbursement and electronic data</td>
</tr>
<tr>
<td>Verify that descriptions (and dosages) reflected on the bill correlate with those of the dispensed drugs and those reflected in the medical record</td>
<td>To ensure proper mapping between systems and proper reporting and reimbursement</td>
</tr>
<tr>
<td>Verify that all items purchased and dispensed have corresponding billing service codes</td>
<td>To reduce the likelihood of underbilling or lost charges</td>
</tr>
<tr>
<td>Compare current prices having assigned HCPCS codes with those charged by other hospitals in the market area</td>
<td>To identify material differences in pricing in an era of regulatory and consumer scrutiny</td>
</tr>
<tr>
<td>Verify that revenue codes are properly assigned based on the NDCs and HCPCS codes</td>
<td>To make appropriate use of revenue codes to distinguish high-cost drugs and for other reimbursement or carve-out provisions in payer agreements and to put them to proper use in classifying revenue for cost-report purposes and more</td>
</tr>
</tbody>
</table>

*Hospitals typically use the wholesale acquisition cost, but may also use the actual acquisition cost or average wholesale price. All of these cost amounts can be verified for accuracy against a benchmark database.
SAMPLE AUDIT PROGRAM FOR DEPARTMENTAL CDM REVIEW:

**Business Risk:** Incomplete or inaccurate chargemaster (CDM) fields may result in potential lost revenues.

**Desired or Established Control Procedures:** Data quality assessments of the Outpatient Oncology department CDM are regularly performed by department staff with involvement of the Reimbursement department.

**Description of Testing:** Obtain a copy of the current department CDM from Reimbursement. Using CAATs, compare CDM to Addendum B for completeness. Verify that payment rates per the CDM exceed charges for each CDM line. Compare chemo administration codes available (series 94600 series) built to those available per 2011 CPT. Inquire of department staff regarding any missing codes to determine if they should be added. Verify price and code consistency across Outpatient Oncology departments at the two facilities. If manually charged items are present on the department CDM, using CAATs test that manual charges were calculated properly.

**Sample Audit Tool for Charge Capture Process Audits**

**Department:**

**Objective:** To ensure appropriate charge capture and reconciliation processes are in place to minimize risk of inaccurate billing or lost revenue

**Audit Planning:**
- Review policies, procedures, and system manuals related to the charge capture process
- Review previous charge capture audits to understand key issues
- Interview key personnel involved in charge capture processes
- Interview persons responsible for technical aspects, including CDM maintenance, system updates, IT security, etc.
- Review key risk areas of charge capture processes, including:
  - CDM and charge screen maintenance
  - Charge tickets
  - Charge posting
  - Charge reconciliation
  - Charge capture tracking and reporting (late charge reports, nurse audit reports showing missed charge history, denial reports, departmental tracking of errors noted during reconciliation, etc.)
  - Patient access (charges posted to correct account)

Assess the charge capture process:
- Observe daily charge capture processes to identify risks or control gaps
- Compare actual processes with documented policies
- Ensure that the department has a reliable source to document all patients seen each day (schedule, log book, etc.)
- Ensure staff confirms patient identifiers and account numbers prior to treating the patient
- Ensure staff confirms patient account number prior to entering charges (post charges to correct accounts)
- Review departmental charge sheet for completeness and accuracy (compare to CDM, charge screens, etc.); should be updated at least annually
- Determine if medical record documentation is reviewed prior to entering charges, or if any comparison is made to documentation
- Determine if charges are entered timely (preferably same day)
- Determine if charge entry staff have trained back-ups in place

Assess the charge reconciliation process:
- Determine if there is a policy for timely reconciliation of charges
- Determine which staff reconcile charges & if there is a trained back up person in place
- Determine source document(s) used for reconciliation (master schedule, log book, etc.) against a daily charge posting report
- Ensure that all patients treated have a completed charge ticket
- Reconciliation should be performed the day following charge entry to ensure that all charges posted appropriately
- Observe process for correcting charges noted to be missing or incorrect during reconciliation process
- Reconciliation documentation should be signed or initialed and dated and kept for at least 90 days (or according to facility policy)
- Determine if department management conducts periodic checks to ensure that the reconciliation process is occurring as designed
- Verify the reconciliation equation:
  - Scheduled patients – no shows + unscheduled patients = number of charge tickets

SAMPLE OF POSSIBLE CAATS FOR CHARGE CAPTURE AUDITS

1 - Using ACL, filter transaction file for multiple initial codes on the same date of service. Search for multiple initial codes (same initial codes and different initial codes).

2 - Using ACL, filter transaction file for initial codes. Perform matched join with original transaction file to extract all charge line items (use patient ID as key). Filter results for encounters that appear to have initial and non-initial codes conflicting with the established initial code hierarchy for facilities.

3 - Using ACL, filter transaction file for chemotherapy administration code HCPCS series. Also, filter file for chemotherapy drug codes (J9000-J9999 series). Perform unmatched join (key of patient ID) on two sets of files. Review chemo admin charge capture exceptions for non-chemo drugs (MABs).
4 - Using ACL, filter transaction file for certain irrigation charges (HCPCS 96523). Review all charges for date of service for any other services reported in conjunction with this code, which is prohibited.

5 - Using ACL, filter transaction file for multiple blood transfusion service codes. Review final patient bills and medical records to determine if such codes were billed on different dates of service.

6 - Using ACL, filter transaction file for blood transfusion service codes. Also, filter file for blood products codes (P0000-P9999 series). Perform unmatched join (key of patient ID) on two sets of files.

7 - Using ACL, select sample of patient encounters with chemo drug administration add-on codes and validate time elapsed per the medical records supports chemo drug administration code(s).

8 - Using ACL, filter transaction file for multiple concurrent therapeutic infusion codes.

9 - Using ACL, IA performed a join of the ASP file to the formulary files (key of NDC) and exported the output into Excel.

10 - Using ACL, compare CDM to Addendum B for completeness.

Coding/Billing Glossary/Terminology/Acronyms

(ABN) Advance Beneficiary Notice – A CMS required form that Medicare patients sign indicating that a specific healthcare service ordered by a physician may be denied by Medicare for payment and the patient will accept responsibility for payment.

Acute Care – Acute care refers to necessary treatment of a disease for only a short period of time in which a patient is treated for brief but severe episode of illness. Many hospitals are acute care facilities with the goal of discharging the patient as soon as the patient is deemed healthy and stable, with appropriate discharge instructions. Acute care facilities generally offer inpatient and outpatient services.

(AMA) Against Medical Advice – The discharge status of patients who leave the hospital after signing a form that releases the hospital from responsibility, or who leave the hospital premises without notifying hospital personnel.

(APC) Ambulatory Payment Classification – A CMS/Medicare payment methodology classification system that is a part of the Outpatient Prospective Payment System (OPPS) and is used to group like services based upon clinical similarities and resources utilized. Please see OPPS for more detailed information.

Carrier – This term means the insurance company that will process enrollment applications (for both patients and for professional providers) and claims submitted by physicians, non-physician practitioners, and certain other ambulatory organizations.

(CC) Complication/Comorbidity – Coding term used in the acute care setting to mean a condition that leads to substantially increased hospital resource use such as intensive monitoring, expensive and technically complex services, and extensive care requiring a greater number of caregivers.

(CDM) Charge Description Master – This is normally used in an acute care hospital facility and is the detailed list of all available charge codes that may be applied to a patient's bill to capture services, medications and supplies provided during a patient encounter. May contain charge code, description, CPT/HCPCS codes, revenue codes, prices and some modifiers.
**CDMP Compliant Documentation Management Program** – Healthcare professionals who collaborate with medical staff to capture complete clinical data in the healthcare record to accurately reflect patient severity and complexity of care which results in more accurate case mix and appropriate reimbursement. BSHSI’s system-wide vendor for their CDMP Program is JA Thomas.

**Charge Integrity** – Completeness and accuracy of charges applied to patient bills.

**Charges** – Items applied to a patient bill to capture services rendered and supplies and/or medications provided during a patient encounter at either a healthcare facility or physician office. This term applies to both hospital as well as physician billing.

**CMI Case Mix Index** – This term is used by Acute Care Hospitals. It refers to the sum of all DRG relative weights, divided by the number of Medicare cases. A low CMI may denote DRG assignments that do not adequately reflect the resources used to treat Medicare patients.

**CPT Common Procedural Terminology** – Most hospital and physician procedures are represented by a CPT code of five unique digits. The CPT codes are updated annually, with new codes effective January 1st of each year.

**CPT Modifiers** – Modifiers are additional 2 digit codes added to a CPT code to indicate that a service was altered in some way but has not changed in its definition or code. Modifiers can also be used to indicate an anatomical location (i.e. LT or RT.)

**DRG Diagnosis Related Groups** – A payment methodology used to determine payment to hospitals for inpatient services as well as for quality of care, utilization, benchmarking, and outcomes analysis. The Diagnosis Related Group (DRG) system organizes ICD-9-CM diagnosis and procedure codes into a complex, comprehensive system of 999 groups that classify patients in groups that demonstrate similar consumption of hospital resources and length-of-stay patterns. One DRG is assigned to each inpatient stay. Diagnoses and procedures are designated by ICD-9-CM codes.

**EMTALA Emergency Medical Treatment & Labor Act** – Hospitals that offer emergency services are required to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay.

**Encounter Form** – In a physician practice this is used as a means for the provider of care (the physician or the non-physician provider) to indicate what services (CPT codes) were rendered and for what reasons (ICD-9-CM codes). The form can then be used as a way to enter the services into the billing system to produce a claim form.

**EOB Explanation of Benefits** – A written, detailed listing of medical service payments by a third party payer to inform beneficiary and provider of payment.

**False Claims Act** – The False Claims Act (31 U.S.C. § 3729–3733, also called the "Lincoln Law") is an American federal law which allows people who are not affiliated with the government to file actions against federal contractors claiming fraud against the government. The Act provides a legal tool to counteract fraudulent billings turned in to the Federal Government. The Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government.

**First-Listed Diagnosis** – In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis. When a patient presents for outpatient surgery, code the reason for the surgery as the first-listed diagnosis (reason for the encounter).
(FI) Fiscal Intermediary – Processes Medicare enrollment applications and claims submitted by most acute and non-acute health care organizations except physician practices, which are processed by Carriers.

Formulary – A listing of drugs providers may prescribe as dictated by the plan or Medicare.

Hard-coding – CPT/HCPCS codes that reside in the charge description master in an acute care setting and are applied to the patient’s bill by selecting that charge item (not coded by coders)

(HCPCS) Healthcare Common Procedural Coding System – Level I HCPCS refers to the codes found in the CPT manual describing work performed by professional providers. Level II HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies when used outside a physician’s office.

(HIPAA) Health Insurance Portability Accountability Act – Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers, and also addresses the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation’s health care system by encouraging the widespread use of electronic data interchange in the US health care system.

Home Care – Home health care consists of part-time, medically necessary skilled care provided in the patient’s home that is ordered by a physician. Patients are required to be “homebound” as a condition of eligibility for these services. Medicare has a unique set of billing regulations that pertain specifically to Home Care services.

Hospice – A service program, either inpatient or outpatient that offers palliative support, counseling, and daily resources to the terminally ill and their family members.

(ICD-9) International Classification of Diseases, 9th Revision – Official classification system of the World Health Organization that is used for classification of morbidity and mortality information for statistical purposes, and for the indexing of hospital records by disease and operations, for data storage and retrieval. ICD-10 is being used in some European countries and Canada with implementation planned for October 1, 2013 in the United States.

(IPPS) Inpatient Prospective Payment System – A system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. Please see DRG for more detailed information.

(JCAHO / TJC) Joint Commission on Accreditation of Healthcare Organizations (pronounced “jay-co”) / The Joint Commission – An independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards.

(LTC) Long Term Care – This term is used to describe a type of care that includes medical and non-medical care to people who have a chronic illness or disability. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living, or in nursing homes.
(MACs) Medicare Administrative Contractors – CMS claims payment contractors – fiscal intermediaries and carriers – have been replaced with new contract entities called MACs. MAC contracts will cover Part A and Part B services.

Medical Necessity – Services provided and billed must be clinically appropriate, reasonable and necessary for the prevention, diagnosis or treatment of disease, illness, or injury and in accordance with generally accepted standards of medical practice.

Medical Record – A legal document that is used to describe all services, items, and supplies that were billed or should have been billed by a facility or by a professional provider. The medical record may be handwritten, dictated, or a part of an electronic medical recording system.

(MIC) Medicaid Integrity Contractors – Medical claims contractors that audit Medicaid healthcare providers and Medicaid managed care organizations (MCOs). Unlike other CMS audit programs, the MIC audit appeals process is managed at the State level and varies from state to state and depending on the type of organization (healthcare provider, pharmacy, MCO, etc.), MIC auditors are not bound by limits on the number of claims records they can request in each audit, and the State, not the auditor, pursues the collection of any overpayments in accordance with State law.

(MPFS) Medicare Physician Fee Schedule – CMS uses the Medicare Physician Fee Schedule (MFS) to reimburse physician services based on CPT codes with wage-adjusted Relative Value Units (RVUs).

(MSP) Medicare Secondary Payer – Medicare Secondary Payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first.

(NCCI) National Correct Coding Initiative – A CMS program to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims.

Non-Acute – This term generally refers to ambulatory and outpatient clinics, dialysis centers, rehabilitation facilities, home health, schools, prisons, physicians’ offices, long-term care facilities, and assisted living environments.

Observation – Observation care provides a method of evaluation and treatment as an alternative to inpatient hospitalization. Medicare has specific requirements that must be met in order to bill for observation, including, but not limited to the reason (diagnosis) for the observation service. Observation stays are considered outpatients, even though the patient occupies a bed, may stay overnight, and may be located on an inpatient ward.

(OIG) Office of the Inspector General – The mission of the Office of Inspector General, as mandated by Public Law 95-452 (as amended), is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. The OIG’s duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components.

(OPPS) Outpatient Prospective Payment System – Payment system primarily for Medicare outpatient hospital services based on the ambulatory payment classification (APC) system, which divides outpatient services into similar procedure groupings. Each group (APC) is assigned a payment rate, which is wage adjusted by geographic area. Many incidental items and services such as anesthesia, certain drugs and supplies, etc. may be packaged into the APC payment for related procedures. More than one APC payment may be received per encounter, depending on the services rendered.

Overutilization – Services rendered by a provider more frequently than desired by insurance carriers.

Principal Diagnosis – That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
Peer Review – This term refers to the evaluation of a physician’s performance by his or her peers.

(POA) Present on Admission Indicator – Denotes a condition that is present at the time the order for inpatient admission occurs. The POA data will be used for measuring hospital performance, public reporting, and payment. This type of reporting makes it crucial for the physician to clearly indicate in the medical record all conditions that are present so it will not appear that a condition was first noted during the course of the patient’s hospital stay and not prior to admission (i.e. in the case of some type of infection.)

Pre-bill edits – Software editing packages that “scrub” insurance claim forms prior to their release by the facility or the professional provider to check for any errors that may cause a denial of payment. If an error is found by the edits, the claim is not released, but is reviewed to correct the error, or in some instances reverse or adjust the charge in question. The goal of these edits is to create a “clean” claim to be released. Some brand names used by BSHSI are Xactimed and MedAssets CCA products.

Provider – For professional billing this term refers to any qualified healthcare practitioner to include Physicians, Nurse Practitioners, Physician Assistants, and Residents when appropriate. In facility billing the term “provider” may also be used to indicate the hospital or other facility where services were rendered.

(RA) Remittance Advice – The RA explains the reimbursement decisions, including the reasons for denials, payments and adjustments of processed claims.

(RAC) Recovery Audit Contractor – CMS program using to detect and correct improper payments in the Medicare Fee For Service program. The RAC program’s goal is to ensure that correct payments are being made to providers and suppliers and, therefore, protect the Medicare Trust Fund.

Revenue Cycle – The complete process from the time the patient is pre-registered until the bill is paid in full. It includes patient registration/scheduling, charge entry and reconciliation, coding, billing (including pre-bill edit process), collection, follow-up, etc.

(RFV) Patient’s Reason for Visit – This is used for outpatient record coding where the reason for visit will be the presenting symptoms or complaints. Up to 3 may be listed on the UB claim form.

(RVU) Relative Value Unit – This is a value assigned to a procedure (CPT code) based on difficulty of the procedure to perform and time consumed used for computing the relative value study for physician payment.

(RW) Relative Weight – An assigned weight that is intended to reflect the relative resource consumption associated with each DRG. The higher the relative weight the greater the payment to the hospital. The relative weights are calculated by CMS and published in the final PPS rule.

Short Stays – This term generally refers to inpatient stays of 1 or 2 days. These “short stays” have become a focus of RAC audits.

(SNF) Skilled Nursing Facility – A health-care institution that meets federal criteria for Medicaid and Medicare reimbursement for nursing care including the supervision of the care of every patient by a physician, the employment full-time of at least one registered nurse, the maintenance of records concerning the care and condition of every patient, the availability of nursing care 24 hours a day, the presence of facilities for storing and dispensing drugs, the implementation of a utilization review plan, and overall financial planning including an annual operating budget and a 3-year capital expenditures program.

Soft-coding – CPT/HCPCS codes that are applied by the Health Information Management Team (the Coding staff), following a review of the medical record documentation, and not by selecting an item from
the charge description master where a code is automatically matched to the description of a service or supply. Surgical procedures are typically soft-coded.

**Transfer** – A situation in which a patient is transferred to another acute care hospital for related care.

**UHDDS** Uniform Hospital Discharge Data Set – UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No. 147), pp. 31038-40. Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc.).

**Workers Compensation** – Laws requiring employers to furnish care to employees injured on the job.

**SAMPLE PHARMACY AUDIT REPORT (excerpts):**

The Internal Audit Service has reviewed controls over certain data elements within the Pharmacy formularies.

The major objectives of the audit were to evaluate the risks and examine the effectiveness of internal controls related to the following areas:

- Review the accuracy of billable unit conversion factors.
- Ensure the completeness and accuracy of the Healthcare Common Procedure (HCPCS) code assignments to detect missing or invalid entries.
- Ensure revenue codes are properly assigned.
- Ensure consistent assignment of bill codes, revenue codes, and HCPCS codes for like medications within the various formularies.

The results of our review indicate that there are opportunities for control improvements within the following areas:

- **Conversion Factors and Charge Code Assignment:** Our review identified occurrences of errant conversion factors in addition to drugs that were either missing a HCPCS code or had the incorrect HCPCS code assigned. We recommend the Pharmacy perform an annual validation of the correctness of charge code assignment and the accuracy of conversion factors.

(Details:

Conversion factors convert dispense dosages to billable units for certain drugs. Pharmacy staff manually calculates and inputs these values into the facility level formulary within Meds Manager. The basis for these calculations includes strengths, dispense size, and the HCPCS dosage description. Providers are reimbursed for certain medications by reporting the appropriate HCPCS code and the quantity of billable units.}
Internal Audit recomputed the conversion factors for approximately 1,800 drugs. There were 80 conversion factor errors identified. Conversion factor errors may be attributed to incorrect HCPCS assignment, errant data elements associated with the drug, or mathematical errors. We noted that 25 drugs did not have the correct HCPCS code assigned which could result in the use of erroneous unit logic in the conversion factor calculation, in addition to reporting the incorrect HCPCS. There were also six drugs that had incorrect HCPCS assignments which did not result in conversion factor errors. Lastly, we identified eight drugs that had inconsistent conversion factors between facilities, which may be due to dispense size variances rather than calculation errors.

- **Continuous Quality Assurance of Formulary Data:** We produced a series of exception reports to evaluate the accuracy and consistency of revenue codes, bill codes, and HCPCS codes. The output is being reviewed by the Pharmacy. We recommend that Pharmacy work with the Reimbursement department to develop and utilize similar exception reports as part of their continuous data quality assurance efforts.

(Details:

During our review, we produced a series of exception reports to evaluate the accuracy and consistency of revenue codes, bill codes, and HCPCS codes.

- **Bill Code Consistency:** We produced a list of every instance in which the bill codes assigned to identical drugs differ across the three facilities. Bill code assignment determines the mark-up formula applied to calculate charges. We identified 22 drugs that are being reviewed by Pharmacy and Reimbursement.

- **Missing HCPCS:** We identified 508 drugs that may be missing a HCPCS code. Reimbursement reviewed a portion of the testing output noting that many of these drugs are considered self administered. RSFH has made operational decisions not to report HCPCS for these drugs. Management intends to review the remainder of this output.

- **Revenue Code Assignment:** National Uniform Billing Committee (NUBC) guidelines instruct providers to use revenue code 0636 when billing for drugs that have been assigned HCPCS codes. We produced a list of four drugs assigned HCPCS, but were not reported using revenue code 0636, and five drugs that were assigned 0636 revenue codes, but were missing HCPCS.

- **Revenue Code Consistency:** STAR Patient Accounting contains a table of formulary items that are considered self-administered (generally not covered under Medicare Parts A or B) and have revenue codes of 0250-0259. This table overwrites the revenue codes in Meds Manager. Our report compared the consistency of the revenue code assignment between this table and the formulary, and we identified nine discrepancies.)
### SAMPLE TEST MATRICES FOR INFUSION/TRANSFUSION/DRUG ADMINISTRATION AUDITS

<table>
<thead>
<tr>
<th>Business Risk</th>
<th>Established or Desired Control Procedures</th>
<th>Description of Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple initial administration codes are submitted resulting in billing delays, denials, rebills, and potential overpayments (RAC vulnerability).</td>
<td>Claims scrubber edits are designed and functioning properly to detect instances of multiple initial drug administration codes. Such edits are worked timely and not overridden.</td>
<td>Obtain transaction data file (6 months of line item charge data by patient with OP Onc department utilization). Using CAATs, filter transaction file for multiple initial codes on the same date of service. Search for multiple initial codes (same initial codes and different initial codes). Based on the output, review detail patient bills, EOBs/RAs, and medical records to determine if exceptions noted were coded with the appropriate modifier 59 and the medical records support the application of the modifiers. Inquire of department coding personnel and PFS regarding process of working claims edits and of any exceptions noted during testing.</td>
</tr>
<tr>
<td>Chemotherapy charges are not captured on claims in which chemotherapy administration codes on present (or vice versa) resulting in potential lost revenues.</td>
<td>Accumulated charges are reviewed by coding/PFS for completeness and accuracy (capture of all chemo and admin charges) prior to the release of final bills.</td>
<td>Using CAATs, filter transaction file for chemotherapy administration code HCPCS series. Also, filter file for chemotherapy drug codes (J9000-J9999 series). Perform unmatched join (key of patient ID) on two sets of files. Review chemo admin charge capture exceptions for non-chemo drugs based on the output, review detail patient bills, EOBs/RAs, and medical records to determine if exceptions noted were corrected. Inquire of department coding, pharmacy, and PFS personnel regarding reconciliation/review processes for charge capture and exceptions noted during testing.</td>
</tr>
</tbody>
</table>
Business Risk

Multiple blood transfusion service codes are submitted for the same date of service resulting in billing delays, denials, rebills, and potential overpayments (RAC vulnerability).

Blood transfusion/blood products charges are not captured on claims resulting in potential lost revenues.

Established or Desired Control Procedures

Claims scrubber edits are designed and functioning properly to detect instances of missing codes and multiple blood transfusion services on the same date of service. Edits are being worked timely and not overridden.

Accumulated charges are reviewed by coding/PFS for completeness and accuracy (capture of all chemo and admin charges) prior to the release of final bills.

Using CAATs, filter transaction file for multiple blood transfusion service codes. Review final patient bills and medical records to determine if such codes were billed on different dates of service.

Using CAATs, filter transaction file for blood transfusion service codes. Also, filter file for blood products codes (P0000-P9999 series). Perform unmatched join (key of patient ID) on two sets of files.

Based on the output, review detail patient bills, EOBs/RAs, and medical records to determine if exceptions noted were corrected. Inquire of department coding and PFS personnel regarding reconciliation/review processes for charge capture and exceptions noted during testing.

Description of Testing

Using CAATs, filter transaction file for multiple blood transfusion service codes. Review final patient bills and medical records to determine if such codes were billed on different dates of service.

Using CAATs, filter transaction file for blood transfusion service codes. Also, filter file for blood products codes (P0000-P9999 series). Perform unmatched join (key of patient ID) on two sets of files.

Based on the output, review detail patient bills, EOBs/RAs, and medical records to determine if exceptions noted were corrected. Inquire of department coding and PFS personnel regarding reconciliation/review processes for charge capture and exceptions noted during testing.

SAMPLE Pharmacy Audit Matrix

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<th>Business Risk</th>
<th>Established or Desired Control Procedures</th>
<th>Description of Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff may not perform duties in accordance with policy or policies may not exist.</td>
<td>Claims scrubber edits are designed and functioning properly to detect instances of missing codes and multiple blood transfusion services on the same date of service. Edits are being worked timely and not overridden.</td>
<td>Obtain the related policies and verify compliance. Policies to consider include: - Medication Administration Policy - Abbreviation policy - Policy Formation and approval process</td>
</tr>
<tr>
<td>The facilities may be billing incorrectly for Pegfilgrastim (a.k.a. Neulasta) &amp; Oxaliplatin; incorrect billing may result in overpayments with subsequent recoupment and/or investigation.</td>
<td>When billing for Pegfilgrastim, the correct number of multiples of 6 MG (or .06 ML) administered and not the number of MGs. Possibly Rev Cycle team monitoring Pegfilgrastim/ (Neulasta) &amp; Oxaliplatin.</td>
<td>1. Obtain an electronic file or accounts billed for Pegfilgrastim (a.k.a. Neulasta) &amp; Oxaliplatin; select a sample of 30 Medicare Outpatient patients per facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Review the Medication Administration Report (MAR) and compare to the bill;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For Pegfilgrastim: Ensure billing for the number of multiples of 6 MG administered rather than the number of MGs administered. HCPCS code J2505 is usually administered via a pre-filled syringe of .06 ML, which is the equivalent to 6 MG. For Oxaliplatin HCPCS code J9263 is for service units per 0.5 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Through inquiry and</td>
</tr>
</tbody>
</table>

CMS re: J2505 - MM4390.pdf

Compliance Watch re: Pegfilgrastim/Neulasta & Oxaliplatin (Coding, section #6 of the attached) - scan.jpg

Units of service conversion

Staff education provided and/or
formulas (for split dose administration) may be incorrect; generating over/under charging.

CDM structured to account for units of service conversion formulas.

observation, determine how conversion factors are updated in the Pharmacy system.

Compare a sample of drugs in Worx to the unit multipliers defined in the MedLearn databank, or other source where Pharmacy gets information on NDC# and/or J-Codes. (See CMS alert for Pegfilgrastim in #2 above).

The sample should include the following drugs:

Amiodarone 50MG/ML INJ 3ML
Rituximab 10MG/ML INJ 50ML
Alteplase 100MG INJ Vial
Pegfilgrastim 6MG/0.6ML INJ
Filgrastim 300MCG/ML 1.6 ML

J code drugs may not be billed with the correct revenue code.

J-Codes: relate to Permanent codes used to report injectable drugs that ordinarily cannot be self-administered; chemotherapy, immunosuppressive drugs and inhalation solutions as well as some orally administered drugs.

- Revenue code 250 (general classification);
  Revenue code 253 is to be used when dispensing drugs the patient is taking home and Revenue code 250 is to be used when billing for drugs used while the patient was in house

- Revenue code 637 is reserved for medication self-administered (SAD, self administered drugs)
- Revenue code 634, Erythropoietin (EPO) less than 10,000 units
- Revenue code 636, Drugs requiring detailed coding

Mark-ups may not be applied consistently to all drugs.

J drugs are often expensive and should have a 634 or 636 revenue code. Revenue Cycle personnel are aware and ensure the CDM is accurate.

HCFA-1450 (UB-04) revenue codes must be used to bill Medicare outpatient hospital facility services. In some instances, a HCPCS procedure code is required in addition to the revenue code for accurate claims processing.

1. Review the CDM to ensure that all drugs with J-codes are coded with a 636 revenue code, and that all drugs with a 636 revenue code also have a J-code. Utilize CAATs to complete where possible.

(All drugs with a 636 should have a J code and NO drugs with a 250 should have a J code!!)

Utilize CAATs to complete.

A mark-up policy is in place within the pharmacy departments and is being applied consistently to all drugs

1. Obtain copy of current mark-up policy.

2. Obtain electronic file of all pharmacy drugs purchased during 3/1/2009-8/31/2009 which include unit cost per drug. Sort by dollar value and select top 10 per unit cost drugs to test mark-
up.

3. Utilizing invoice and mark-up per policy, compare calculated charge to price/patient charge (may reside in Worx or in the CDM)