

Coding & Billing for Pharmacy: Issues & Answers

TELNET 2535 October 13, 2009 9:30-11 am EDT

Presented By:

Duane C. Abbey, Ph.D., CFP
Abbey & Abbey, Consultants, Inc.
Duane@aaciweb.com <http://www.aaciweb.com>
<http://www.APCNow.com> <http://www.HIPAAMaster.com>

Version 2.1 - 2009

Note © 1999-2009, Abbey & Abbey, Consultants, Inc.
CPT Codes – © 2008-2009 AMA

© 2007-2009 Abbey & Abbey, Consultants, Inc.

Slide # 1

Disclaimer

This workshop and other material provided are designed to provide accurate and authoritative information. The authors, presenters and sponsors have made every reasonable effort to ensure the accuracy of the information provided in this workshop material. However, all appropriate sources should be verified for the correct ICD-9-CM Codes, ICD-10-CM Diagnosis Codes, ICD-10-PCS Procedure Codes, CPT/HCPCS Codes and Revenue Center Codes. The user is ultimately responsible for correct coding and billing.

The author and presenters are not liable and make no guarantee or warranty, either expressed or implied, that the information compiled or presented is error-free. All users need to verify information with the Fiscal Intermediary, Carriers, other third party payers, and the various directives and memorandums issued by CMS, DOJ, OIG and associated state and federal governmental agencies. The user assumes all risk and liability with the use and/or misuse of this information.

© 2007-2009 Abbey & Abbey, Consultants, Inc.

Slide # 2

Presentation Faculty

Duane C. Abbey, Ph.D., CFP – Dr. Abbey is a healthcare consultant and educator with over 20 years of experience. He has worked with hospitals, clinics, physicians in various specialties, home health agencies and other health care providers.

His primary work is with optimizing reimbursement under various Prospective Payment Systems. He also works extensively with various compliance issues and performs chargemaster reviews along with coding and billing audits.

Dr. Abbey is the President of Abbey & Abbey, Consultants, Inc. A wide range of consulting services is provided across the country including charge master reviews, APC compliance reviews, in-service training, physician training, and coding and billing reviews.

Dr. Abbey is the author of eight books on health care, including:

- ***“Non-Physician Providers: Guide to Coding, Billing, and Reimbursement”***
- ***“Emergency Department: Coding, Billing and Reimbursement”***, and
- ***“Chargemasters: Strategies to Ensure Accurate Reimbursement and Compliance”***.

His most recent books, **“Compliance for Coding, Billing & Reimbursement A Systematic Approach to Developing a Comprehensive Program”** and **“Introduction to Healthcare Payment Systems”** are available from the Productivity Press a Division of Taylor and Francis..

Pharmacy Coding and Billing Introduction

- **Drugs – Coding, Billing and Reimbursement**
 - **Enormous Number And Type Of Drugs**
 - **Different Ways To Administer Drugs**
 - **Different Packaging For Drugs**
 - **Two Very Different Coding Systems For Drugs**
 - **Charge Capture Issues**
 - **Charges for pharmacy items are routinely missed at various levels.**
 - **Documentation Issues**
 - **Major audit area for billing versus what was documented.**
 - **Billing Issues**
 - **Multiple sets of requirements and idiosyncrasies from third-party payers.**
 - **Enormous Number Of Ways In Which Drugs Are Paid (Or Not Paid!)**

- ✓ **Note: We will look at drugs and pharmacy coding, billing and reimbursement first from the hospital perspective, secondly from the physician/clinic perspective and then for other types of healthcare providers. Medicare Part D is not addressed.**

Pharmacy Coding and Billing Objectives

- To review the provision of pharmacy items and various methods of administration.
- To discuss documentation issues and associated charge capture issues for drugs.
- To review National Drug Codes and Level II HCPCS codes and interfacing pharmacy systems to hospital billing systems.
- To assess different payment methodologies for pharmacy items.
- To discuss various compliance issues surrounding coding, billing and reimbursement for drugs.
- To discuss specialized issues such as chemotherapy services.
- To review current challenges with infusion centers.
- To briefly review medication management clinics.
 - Note: Coding and billing for drugs and pharmacy items is a major topic that involves many complexities. For this presentation, the main perspective is from that of a hospital or clinic as opposed to retail pharmacy billing. Even focusing on hospitals or clinics, there are many different third-party payers with differing payment mechanisms.

Pharmacy Coding and Billing Background

- Hospitals – UB-04 Claims
 - Revenue Codes
 - 025X Pharmacy Sequence
 - ✓ 0250 – General
 - ✓ 0251 – Generic Drugs
 - ✓ 0252 – Nongeneric Drugs
 - ✓ 0253 – Take-Home Drugs
 - ✓ 0254 – Drugs Incident to Other Diagnostic Services
 - ✓ 0255 – Drugs Incident to Radiology
 - ✓ 0256 – Experimental Drugs
 - ✓ 0257 – Nonprescription
 - ✓ 0258 – IV Solutions
 - ✓ 0259 – Other Pharmacy

Pharmacy Coding and Billing Background

- **Hospitals – UB-04 Claims**
 - **Revenue Codes**
 - **063X Pharmacy Sequence**
 - ✓ 0630 – Reserved → See 025X Sequence
 - ✓ 0631 – Single Source Drug
 - ✓ 0632 – Multiple Source Drug
 - ✓ 0633 – Restrictive Prescription
 - ✓ 0634 – EPO – Less Than 10,000 units
 - ✓ 0635 – EPO – 10,000 units or More
 - ✓ 0636 – Drugs Requiring Detailed Coding
 - ✓ 0637 – Self-Administrable Drugs
 - **Special**
 - ✓ 0343 – Nuclear Medicine - Diagnostic Radiopharmaceuticals
 - ✓ 0344 – Nuclear Medicine – Therapeutic Radiopharmaceuticals
 - ✓ Biologicals
 - ✓ Chemotherapy - Administration

Pharmacy Coding and Billing Background

- **Provider-Based Clinics**
 - **Provider-Based Is A Medicare Concept**
 - 42 CFR §413.65 + Related CFR Entries
 - **Physician-Based Freestanding Clinics**
 - Files only the 1500 claim form
 - ✓ Drugs go on the 1500
 - **Hospital-Owned Freestanding Clinics**
 - Files only the 1500 claim form
 - ✓ Drugs go on the 1500
 - **Provider-Based Clinics**
 - Files a 1500 claim form → Site-of-Service Reduction
 - Also files a UB-04 claim form → Paid under APCs
 - ✓ Drugs go on the UB-04
 - See special Medication Management Clinics discussion
 - **Significant Compliance Issues Surrounding Provider-Based Clinics**

Pharmacy Coding and Billing Background

- **APC Status Indicator Codes – Pharmacy/Drug Utilization**
 - **Addendum B for APCs provides a Status Indicator code for each of the HCPCS listed. HCPCS – C-Codes, J-Codes, Q-Codes**
 - **A – Fee Schedule Payment Outside OPPS**
 - **B – Not Recognized for OPPS**
 - **E – Not Paid Under Any Medicare Payment System**
 - **F – Reasonable Cost Payment – Not OPPS**
 - **G – Pass-Through Drugs and Biologicals**
 - **H – Pass-Through Device**
 - **K – Paid Under OPPS – Separate APC Payment**
 - **L – Influenza, Pneumococcal Pneumonia Vaccine – Cost Based**
 - **M – Not Billable, Not Payable Under APCs**
 - **N – Packaged – No Separate Payment**

Pharmacy Coding and Billing Background

- **Medicare ‘Integral-Part’ Concept**
 - **Medicare has discussed the concept of ‘integral-part’ in several *Federal Register* entries over the years. This concept is fuzzy as to whether this is a billing issue or a payment issue.**
 - **November 1, 2002 *Federal Register*, page 66767**
 - ***“Our policy is based on the premise that certain drugs are so integral to a treatment or procedure that the treatment or procedure could not be performed without them. Because such drugs are so clearly a component part of the procedure or treatment, we believe that they are more appropriately considered as supplies and should be packaged as supplies into the APC payment for the procedure or treatment. Moreover, the payment for packaged supplies is included in the APC payment for the procedure or treatment, so beneficiaries should not be separately billed for them.”***
 - **OK, what does this really mean?**
 - **Example – Ophthalmic drops used for cataract surgery. Generally self-administrable, but instead of billing with 0637, move to 0250 without a J-code. (Separately bill = separately charge + HCPCS)**

Pharmacy Coding and Billing Background

- **Self-Administrable Drugs**
 - **Social Security Act (SSA) does not allow payment for self-administrable drugs on the outpatient side.**
 - See §1861(2)(B)
 - **Alright, which drugs are self-administrable?**
 - Pills, Tablets, Liquids → Oral Medications
 - Suppositories
 - Certain Injectables ← Which ones?
 - **How do the MACs (FIs/Carriers) determine self-administrable?**
 - 50% Rule
 - **Hospital Billing - Outpatient**
 - Revenue Code 0637
 - Move to Non-Covered Column
 - Exception → Diabetic Coma – Insulin Injection
 - Unusual Requirements – HCPCS (A9270) and/or Modifier (“-GY”)
 - **Hospital Billing – Inpatient → Revenue Code 0250 (No HCPCS)**

Pharmacy Coding and Billing IV Solutions

- **IV Solutions**
 - RC=0258
 - Chargemasters → 10 to 40 Entries
 - Some may have J-Codes
 - Major Compliance Issue
 - If ‘stock item’, then not separately chargeable?
 - If pharmacy item, that is, ordered and dispensed then separately chargeable?
 - If there is a J-code, then separately billable?
 - Major Charge Issue
 - Check your chargemaster. How much do you charge for IV solutions? Typically - \$30.00 - \$60.00.
 - How much do these IV solutions cost? \$1.50 - \$3.00.
 - What is the markup? What kind of CCR (Cost-to-Charge Ratio) is generated? How does this fit into your overall pharmacy pricing structure?

Pharmacy Coding and Billing General Directions for Revenue Codes

- Inpatient Drug Coding/Billing
 - Revenue Code 0250 is generally used without HCPCS
- Outpatient Drug Coding/Billing
 - For drugs requiring (having?) separate identification (i.e., HCPCS J-Code), then use Revenue Code 0636 with the J-Code (or other HCPCS as appropriate)
 - For self-administrable drugs, use Revenue Code 0637 and replicate the charges in the non-covered column on the UB-04
 - The use of J-codes is not clear given that most of the self-administrable drugs don't have J-Codes.
 - HCPCS A9270 with the "-GY" modifier can be used if there is no J-Code as such. Check with your MAC as to the proper billing procedure.
 - Revenue Code 0250 can be used for integral-part drugs.
 - This appears to include self-administrable drugs that are routinely used for a given procedure.
 - The use of J-Codes with RC=0250 may be acceptable. ← Policy?

Pharmacy Coding and Billing General Directions for Revenue Codes

- Outpatient Drug Coding/Billing
 - Chargemaster Coordinators may want to use the APC Status Indicators to classify individual drugs for coding and billing purposes.
 - SI = "N" – Packaged Drugs
 - ✓ For Medicare, no separate payment, but may be payable for other third-party payers.
 - ✓ Policy Decisions → RC=0250 with no J-Codes, versus RC=0636 with J-Codes
 - SI = "B" "E" "M" – Generally Don't Code or Bill (Rare)
 - SI = "F" "G" "H" "K" "L" – Use RC=0636 with J-Codes
 - ✓ These are generally the categories for which there is separate payment for the drugs either on an APC basis (i.e., APC category) or on a pass-through basis (payment = charge * CCR)
 - Exceptional Situations
 - Insulin injection in ED for diabetic coma – RC=0637 + Additional Reporting Requirements
 - Vaccines/Toxoids and Immunizations

Pharmacy Coding and Billing Payment Processes

- Drug Payment Systems
 - Almost Every Imaginable System Is Used!
 - Sometimes drugs are paid separately, sometimes they are bundled.
 - Consider the Medicare Program
 - Hospital IP → Bundled into DRG (except hemophilia clotting factors → See RC=0636)
 - Hospital OP → APCs bundle some, pay others (See Status Indicators) – Generally a threshold - \$60.00
 - Skilled Nursing Facilities → Bundled Into PPS
 - Physicians → Paid through Drug/Biological Pricing File
 - Critical Access Hospital → Reasonable Cost
 - Special Drugs
 - Hepatitis B Vaccine, Pneumococcal/Flu Vaccine, EPO, Etc.
 - Typically, special billing and payment processes
 - AWP – Average Wholesale Price
 - ASP – Average Sales Price → See MMA 2003

Pharmacy Coding and Billing Payment Processes

- Drug Payment Systems
 - Average Sales Price – Medicare Process
 - The whole process of establishing the ASP for the Medicare Program is discussed at some length in Section 20.1 of Publication 100-04, Medicare Claims Processing manual
 - ✓ Section 20.1.1 – Online Pricing Files for ASP
 - ✓ Section 20.1.2 – ASP Payment Methodology
 - ✓ Section 20.1.3 – Exceptions to ASP Payment Methodology
 - ✓ Section 20.2 – Single Drug Pricer (SDP)
 - ✓ Section 20.3 – Calculation of Payment Allowance Limit for DMERC Drugs
 - ✓ Section 20.4 – Calculation of AWP
 - ✓ Section 20.5 – Detailed Procedures for Determining AWP
 - What about all the other third-party payers including the Medicaid Programs?

Pharmacy Coding and Billing HCPCS Level II J-Codes

- HCPCS – J-Codes for Pharmacy Items
 - What are they?
 - Where do they come from?
 - How often are they changed?
 - What is the format for J-Codes?
 - 5 Position Alphanumeric – J followed by 4 Digits
 - Are these the codes generally found in hospital billing computer systems? That is, in a chargemaster of some sort.
 - Do J-Codes include the units of the drug?
 - This creates multiple problems – See pharmacy related P&Ps – partial dosage, single use vials, discarded drugs
 - Why is there such a problem interfacing pharmacy computer systems to the hospital's main billing system?
 - Lisinopril – J-Code??
- HCPCS – Other Codes
 - C-Codes
 - Q-Codes → LOCMs/HOCMs

Pharmacy Coding and Billing National Drug Codes - NDCs

- National Drug Codes
 - What are they?
 - Where do they come from?
 - How often are they changed?
 - What is the format for NDCs?
 - 11 Digits, 3 Segments (Vendor, Product, Package)
 - 4-4-2, 5-3-2, or 5-4-1 ← What would a programmer think?
 - What's are the fuss about 10-digits versus 11-digits?
 - Are these the codes generally found in pharmacy computer systems?
 - Why is there such a problem interfacing pharmacy computer systems to the hospital's main billing system?
 - Why didn't we convert to NDCs in lieu of the HCPCS J-Codes?
 - Do NDCs include the units of the drug?
 - What references and/or systems are available concerning drugs?
 - Lookup, Cross References, NDC to J-Codes
 - Example: Lisinopril Tablets – 60505-0186-*0 (10 Mg, 100, Oral, Bottle)

Pharmacy Coding and Billing National Drug Codes - NDCs

- National Drug Codes
 - Converting from 10-digits to 11-digit format (One Way)

10-Digit Format	10-Digit Example	11-Digit Format	11-Digit Example	11-Digit Conversion
4-4-2	1234-1234-12	5-4-2	12345-1234-12	01234-1234-12
5-3-2	12345-123-12	5-4-2	12345-1234-12	12345-0123-12
5-4-1	12345-1234-1	5-4-2	12345-1234-12	12345-1234-01

- Is this conversion process difficult? See “*” also.

Pharmacy Coding and Billing National Drug Codes - NDCs

- Converting NDCs to HCPCS J-Codes (See Current NDC to HCPCS Crosswalk)
 - NDC Information
 - Drug
 - Units
 - Quantity
 - HCPCS J-Codes
 - Single Code for Drug Including Units – Must indicate quantity per dosage in the code for that which was administered.
 - Example 1
 - NDC = 00002-7623-01 (11-Digits)
 - NDC – Per Vial – 500 mg
 - Dosage – 200 mg
 - NDC Units – 200 mg/500 mg = 0.40
 - J-Code – J9305 per 10 mg
 - Report J9305 with 20 Units

Pharmacy Coding and Billing National Drug Codes - NDCs

- **Converting NDCs to HCPCS J-Codes**
 - **Example 2**
 - NDC = 00002-8971-01 (11-Digits)
 - NDC – 250 mcg/ml
 - Dosage – 750 mcg
 - NDC Units – $750 \text{ mcg} / 250 \text{ mcg} = 3.00$
 - J-Code – J3310 per 10 mcg
 - Report J3310 with 75 Units
 - **Example 3**
 - NDC 00004-1946-01 (11-Digit)
 - NDC – 5 mg/ml
 - Dosage – 15 mg
 - NDC Units – $15 \text{ mg} / 5 \text{ mg} = 3.00$
 - J-Code – J2250 per 1 mg
 - Report J2250 with 15 Units
 - **Exercise → Set up a programming formula to make this calculation.**

Pharmacy Coding and Billing National Drug Codes - NDCs

- **NDCs – Units of Measure (UOMs)**
 - You may be required to report units of measure with the NDC code under some very specific circumstances. See various Medicaid drug rebate programs.
 - Note: Be certain to follow any specific instructions given to you by your state Medicaid program.
 - **Units**
 - F2 = International Unit → Reconstituted Powder, Each Vial
 - GR=Gram → Ointments, Creams, Etc. – Usually Retail Pharmacy
 - ML = Milliliter → Vial/Liquid – Most Common
 - UN = Unit (Each) → Factor VIII-Antihemophilic Factors
 - **Report the Amount Administered**
 - Will this fit nicely into the HCPCS units?
 - Are there any challenges in reporting the units?

Pharmacy Coding and Billing National Drug Codes - NDCs

- UOM Examples
 - 4 mg Zofran IV Administered
 - Zofran 2 mg/ml → Liquid
 - J2405 - Ondansetron hydrochloride, per 1 mg
 - ✓ Units = 4, 4 mg per 1 mg HCPCS units
 - NDC – Units = 2
 - ✓ 2, 2 ml vials
 - ✓ Report “ML2”
 - 1 gram of Rocephin IM
 - Rocephin 500 mg vial – Powder
 - J0696 Ceftriaxone sodium, per 250 mg
 - ✓ Units = 4 (4 * 250 mg = 1,000 mg = 1 gram)
 - NDC – Units = 2
 - ✓ 2, 500 mg vials
 - ✓ Report “UN2”
- Specific Reporting Requirements – May Vary!
 - UB-04 – FL43 → N4 (Positions 1 & 2); NDC (5-4-2); UOM Qualifier (F2 or GR or ML or UN); Unit Quantity with Floating Decimal with up to 3 digits to the right of the decimal point.

Pharmacy Coding and Billing NDCs to HCPCS – Computer Interfaces

- Pharmacy System Interface to Hospital Billing System
 - Process Flow – Pharmacy System to Hospital Billing System
 - What information does the pharmacy system provide?
 - NDC
 - NDC Units ← Amount Dispensed (?)
 - ✓ In Example 1 – 500 mg Vial – Single Use Vial? Multi-Use Vial?
 - ✓ Only 100 mg used as dosage to patient
 - Does the pharmacy system have the dosage??
 - Hospital Billing System – Through Chargemaster
 - Dosage information??
 - NDC → Selects J-Code
 - Dosage → Units for J-Code
 - ✓ Questions: What about charging for the whole vial if this is a single-use vial? If multi-use vial, 100 mg patient 1, 200 mg patient 2, 100 mg patient 3, how is patient 3 billed?
 - How is this supposed to work?
 - Do we have problems in this area?

Pharmacy Coding and Billing Special Billing Requirements

- **Multiuse, Single-Use Vials and the “-JW” Modifier**
 - Transmittal 1478, March 14, 2008, provides interesting guidance on billing for multiuse and single-use vials when there is some portion of the drug discarded.
 - The “-JW” modifier is used only for single-use vials when there is some portion discarded.
 - Use this modifier only if instructed or otherwise required.
 - **Example 1 - A provider schedules three Medicare patients to receive Botulinum Toxin Type A on the same day within the designated shelf life of the product. Currently, Botox is available only in a 100-unit size. Once Botox is reconstituted, it has a shelf life of only four hours. Often, a patient receives less than a 100 unit dose. The provider administers 30 units to each of the three patients. The remaining 10 units that must be discarded are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the provider had to discard 10 units at that point.**

Pharmacy Coding and Billing Special Billing Requirements

- **Multiuse, Single-Use Vials and the “-JW” Modifier**
 - **Example 2 - A provider administers 15 units of Botulinum Toxin Type A to a Medicare patient, and it is not practical to schedule another patient who requires Botulinum Toxin. The remaining 85 units are discarded. For example, the provider may have only one patient who requires Botulinum Toxin, or the patient requiring treatment may be previously unknown to the provider, thereby precluding consideration of the treatment modality in scheduling the new patient. The provider bills for 100 units on behalf of the patient and Medicare pays for 100 units.**
 - These two examples from the Transmittal do provide reasonably clear guidance.
 - From an auditing/compliance perspective, there can be questions.
 - How do we know the last patient was the Medicare patient if there was a multi-use vial?
 - Can we use the same billing technique for other third-party payers?

Pharmacy Coding and Billing Special Billing Requirements

- **State Medicaid Program Requirements**
 - **DRA 2005 Mandates Collection of Coding & Utilization Data**
 - **Must Use NDCs**
 - **Anticipate Variations in Requirement Between States**
 - **Typical Approach**
 - Valid 11-digit NDC Code
 - Report all Drugs Including Combinations of Over-the-Counter and Prescription
 - Revenue Code Sequences – 025X and 063X
 - Report NDC in FL #43, Description for Line Item
 - ✓ Units and/or Unit Measurement May Be Included
 - HCPCS J-Code As Usual
 - Number of Units in Service Units
 - Note that there are variations between state Medicaid programs. Be certain to follow the specific guidelines for you state or states.
 - In some sense, this process will eventually be expanded to all pharmacy items for all third-party payers.

Pharmacy Coding and Billing Charging and Charge Structures

- **Hospitals through the chargemaster tend to price supply items and pharmacy items on a tiered approach.**
 - **One of the most commonly used approaches is a tiered charging mechanism based on acquisition cost.**
 - Items less than \$20.00, multiply by 3.50
 - Items between \$21.00 and \$75.00, multiply by 3.00
 - Items between \$76.00 and \$200.00, multiply by 2.50
 - Items between \$201.00 and \$1,000.00, multiply by 2.00
 - Items above \$1,001.00 multiply by 1.50
 - From a transparent pricing approach, this process makes some sense.
 - However, given the fact that the Medicare program takes our charges and translates them back into what they, Medicare, thinks our costs are, this tiered pricing arrangement leads to what is called 'charge compression'.

Pharmacy Coding and Billing Charging and Charge Structures

- Pricing Separately Billable Pharmacy Items
 - OK, so is there anything wrong with such a tiered approach?
 - Answer – The Cost-to-Charge Ratio (CCR) is skewed.
 - See Calculations on Next Slide
 - Background
 - The Medicare Program requires hospitals to have a charge structure that is uniformly based on costs.
 - ✓ This is a cost report issue.
 - ✓ In theory, hospitals should adopt a charge formula that uses a single multiplying factor. Example: Multiply by 2.75 or 1.80 or ??.
 - CMS uses the CCR to convert charges on the claims back into what they, CMS, thinks the costs to the hospital actually were.

Pharmacy Coding and Billing Charging and Charge Structures

- Pricing Separately Billable Pharmacy Items
 - For items which use the 3.50 multiplying factor the CCR is:
 - Charge = $3.50 * \text{Cost}$
 - Cost/Charge = $1/3.50 = 0.285$
 - For items which use the 1.50 multiplying factor the CCR is:
 - Charge = $1.50 * \text{Cost}$
 - Cost/Charge = $1/1.50 = 0.667$
 - Overall, the supply CCR will be someplace in between, but most likely will be skewed downward because of the volume of less expensive pharmacy items.
 - CMS will then under estimate the cost of separately billable drugs, that is the more expensive drugs.

Pharmacy Coding and Billing Charging and Charge Structures

- **Overhead and Handling Charges for Drugs**
 - CMS has discussed this issue at some length in FR entries.
 - “In addition, we understand that because hospital charges for drugs are adjusted to cost by a single CCR, but hospitals continue to apply differential markups to their charges for low and high cost drugs and biologicals, the result is an overestimation of costs for less expensive drugs and an underestimation of costs for more expensive drugs. In order to more accurately identify costs for drugs, we proposed to split the current single drug cost center into two standard cost centers on the Medicare cost report. By creating two standard cost centers (one for Drugs With High Overhead Cost Charged to Patients, the other for Drugs With Low Overhead Cost Charged to Patients), we believed that the resulting CCRs would provide a more accurate ASP-based estimate for those drugs that are separately paid, as each individual drug charge would be subject to a more accurate CCR, depending on whether the drug was classified by the hospital as having high or low overhead costs.” (73 FR 68654) – November 18, 2008
 - Basically, break out 0636 in a separate CCR. What about 0258?

Pharmacy Coding and Billing Chemotherapy

- **Chemotherapy Considerations**
 - As a general rule, the expensive chemotherapy drugs are separately payable.
 - Chemotherapy services can be provided:
 - Freestanding Physician-Based Operations → RBRVS Payment,
 - Hospital-Owned Freestanding → RBRVS Payment, or
 - Provider-Based Operations → APC Payment.
 - Which organizational structuring provides the greatest reimbursement?
 - Drug Reimbursement
 - ✓ ASP+% → Possible different percentage
 - Administration Reimbursement
 - ✓ APCs
 - ✓ RBRVS
 - Special Drug Programs → For instance, see 340B
 - Special Requirements
 - Possibly Significant Increases In Reimbursement

Pharmacy Coding and Billing Radiopharmaceuticals

- Radiopharmaceuticals
 - In CY2008, CMS began packaging diagnostic radiopharmaceuticals into the associated procedures.
 - Hospital must still charge appropriately → At least cost divided by appropriate CCR.
 - Proper reporting of units can also be an issue.
 - There is a great deal of variability in hospital costs for these nuclear medicine services due to the relatively high cost of the associated radiopharmaceuticals.
 - The best way to handle this is to pay for the radiopharmaceuticals on a pass-through basis (payment = cost * CCR)
 - However, CMS wants to bundled.
 - ✓ “We [CMS] understand that by packaging payment for a range of products such as diagnostic radiopharmaceuticals, payment for the associated nuclear medicine procedure may be more or less than the hospital’s cost for these services in a given case. (73 FR 68546) November 18, 2008 *Federal Register*.

Pharmacy Coding and Billing Take-Home Drugs

- Take-Home Drugs
 - Drugs that are provided to patients on a take-home basis are generally self-administrable and not separately payable under the Medicare Program.
 - As usual, there are some exceptions. See Transmittal 882, March 3, 2006
 - *All hospitals, including critical access hospitals (CAHs), bill the appropriate DMERC for take-home supplies of oral anti-cancer drugs, oral anti-emetic drugs and multi-day supplies of immunosuppressive drugs, as well as the associated supplying fees. All inhalation drugs and the associated dispensing fees are also*
 - *Claims for these take-home drugs are billed on the NCPDP, a HIPAA-compliant telecommunication format specifically designed for drug billing. All entities billing on the NCPDP use the NDC for the particular drug being billed, and list units as multiples of the quantity represented by the NDC. billed to the DMERC.*

Pharmacy Coding and Billing Take-Home Drugs

➤ Take-Home Drugs

▪ Exceptional Cases

- *When beneficiaries come to a hospital outpatient department and have an encounter with a physician or mid-level professional (e.g., a physician assistant or nurse practitioner) during which one or more specimens are collected for laboratory work, treatment is monitored (including anti-cancer drugs, either oral or infused), and a drug is administered, this is considered an outpatient visit. Only when more than a single day's supply of a drug is dispensed to the beneficiary for take home use are the drugs so dispensed to be billed to the appropriate DMERC.*

▪ Notes:

- For CAH's, this is one area in which payment is not cost based.
- The DMERC is billed. Usually DMERC's are billed on the 1500 claims form. In this case, a special claim process is required.

▪ What about other take-home drugs?

- See RC=253, J-Codes or A9270 along with the "-GY" modifier – The patient is responsible for payment.

Pharmacy Coding and Billing Infusion Centers

➤ Infusion Centers

- Hospital service areas dedicated to providing a variety of drug administration services have become quite popular. Many hospitals provide chemotherapy services along with various types of injections, infusions and even blood transfusions. Specialized nursing staff provides these services.

• Organizational Structuring

- ✓ Provider-Based versus Freestanding
- ✓ Off-Campus vs. On-Campus vs. In-Hospital

• Physician Orders and Medical Necessity

- Documentation Systems
- Drug Charge Reconciliation
- Pharmacy Interface

Pharmacy Coding and Billing Medication Management Clinics

- **Medication Management Clinics Under Medicare APCs**
 - Hospitals often develop what are called 'Medical Management Clinics'. While different medications can be managed, Coumadin is one of the primary drugs.
 - A pharmacist, nurse or other qualified person performs a test and then adjusts the medication level for the individual.
 - For provider-based clinics, that is, hospital-based clinics, charges are made for:
 - Low-Level E/M Visit – Generally a 99211, and
 - The test itself.
 - Community physicians must order the tests and the results of the tests are communicated back to the physician.
 - These services can be provided inside hospital pharmacies.
 - There are a number of compliance issues involving documentation and services provided.
 - See Veritus Medicare Services Provider Notice 03-145 dated December 2, 2003 for more information.

Pharmacy Coding and Billing Auditing and Compliance Issues

- **Pharmacy Related Compliance and Auditing Issues**
 - **Charge Capture**
 - Charge capture audits for pharmacy items are common.
 - While the provision of a drug may be clinically documented, sometimes there is no charge for the drug.
 - **Date Inconsistencies**
 - Date Dispensed versus Date Administered (versus Date Ordered)
 - This may be a systemic problem that repeatedly occurs.
 - **Correct Units**
 - See Pharmacy System interface to Hospital Billing System
 - See also policies and procedures on drug wastage billing.
 - **Drug Dispensing Machines – Computer Interface**
 - **Documentation Issues**
 - Drug administration documentation forms
 - Anesthesiology drug reporting
 - Injection/Infusion Coding – Correlation to Drugs Reported

Pharmacy Coding and Billing Pharmacy Auditing – Tools & Information

- **Auditors Working with Drug Reviews Need Tools and Information**
 - **Tools**
 - NDC and J-Code Listings and Crosswalks
 - Crosswalk Listings of Brand Name and Generic Drugs
 - ✓ Some drugs as documented in the record can have numerous equivalents
 - Mapping of NDCs into J-Codes
 - **Drug Utilization Policies and Procedures**
 - **Pharmacy System to Hospital Billing System Interface**
 - Chargemasters from both systems?
 - Programming for the interface (algorithms used).
 - **Charge and Payment Information As Appropriate**
 - AWP, ASP, ??
 - **Special Payment Information → Rebates, 340B, Others**

Pharmacy Coding and Billing Exercises

- **Exercise 1 – Conscious Sedation**
 - **Sylvia, the Chargemaster Coordinator at the Apex Medical Center, has been working with several clinical areas concerning coding and billing for conscious sedation and the associated drugs (generally Versed and Fentanyl). With the introduction of the bulls-eye notation “o” there has been confusion over billing in this area.**
 - **Sylvia understands that conscious sedation can be separately reported (i.e., separately billed) when there is no annotation. However, to simplify the whole billing process she has decided to bundle the conscious sedation charges for all procedures.**
 - **Does this mean that the Versed and Fentanyl (and/or other drugs) should also be bundled? Or should these drugs just be reported without HCPCS under Revenue Code 250 on outpatient claims?**
 - **However, there seems to be a problem because Versed and/or Fentanyl are sometimes used (particularly in the ED) as analgesics having nothing to do with conscious sedation.**
 - **What would you recommend to Sylvia concerning addressing this situation?**

Pharmacy Coding and Billing Exercises

- **Exercise 2 – Surgical Drugs and Injections**
 - Charge auditing staff, including clinical area personnel, are having difficulty properly correlating the number of drugs charged with the proper coding for injections and infusions. It appears that some drugs that are injected and/or infused have no corresponding procedure charged.
 - One area in which this occurs is outpatient surgery. There is often a pre-surgery antibiotic provided and then some injections after the surgery as well. No injection codes appear relative to the drugs.
 - Sylvia, the Chargemaster Coordinator, is indicating that the Medicare program does not allow these operative injections to be separately billed. Thus, there will be no such correlation.
 - Is this correct? If not, what would you suggest that the Apex Medical Center do in order to be better able to correlate drugs with injections?

Pharmacy Coding and Billing Exercises

- **Exercise 3 – Anesthesiology Drugs**
 - The Apex Medical Center currently codes and charges for anesthesia drugs and gases. Sometimes there is a J-Code and other times note. There has been some discussion about developing a blanket, time-based charges for technical component anesthesiology that would include all the drugs. The anesthesia drugs are documented on the anesthesia form. However, the anesthesiologist also seems to be documenting other drugs/injections performed during the surgical procedure.
 - Discuss how you would suggest approaching this situation?
 - Will there be any problem relative to pharmacy dispensing these drugs and invoking a charge?

Pharmacy Coding and Billing Exercises

- **Exercise 4 – Drug Reconciliation Audit**
 - During a recent audit of 100 outpatient surgical cases, it was found that for several very common drugs, the units were consistently, incorrectly underreported on the claims. The pharmacy information, the drug administration and documentation all appear to be in good order.
 - What, most likely, is happening in this case?

Pharmacy Coding and Billing Exercises

- **Exercise 5 – IV Solutions**
 - Sylvia, the Chargemaster Coordinator, has decided to change the policy on charging for IV solutions. Currently, AMC charges for every IV solution used with an average charge of \$40.00. Her new plan involves:
 - IV solutions that are simply stock items on the Medical/Surgical floors, including the operating suites, will not be charged separately.
 - IV solutions that are specifically ordered through the pharmacy will be separately charged with a J-Code (that is, separately billed).
 - The charges for the separately billed IV solutions will be at three times the acquisition cost.
 - ✓ Do you think this process will work?
 - ✓ Will Sylvia have any problems implementing this new policy?

Pharmacy Coding and Billing Exercises

- **Exercise 6 – Infusion Center**
 - The Apex Medical Center has a very active Infusion Center located in a separate building on the hospital's campus. Chemotherapy, infusions, blood transfusions and associated services are provided at this facility. Physicians routinely send patients to have various services. Nursing staff is very fastidious about properly reporting services, drugs administered and methods of administration. While physicians may visit the Infusion Center from time-to-time, generally no physicians are at the center, as such.
 - Do you see any problem with this type of arrangement?

Pharmacy Coding and Billing Summary and Conclusion

- **Coding And Billing For Drugs And Pharmacy Items Can Be Quite Complex.**
- **Numerous Payment Processes Including Many Drugs That Are Packaged Into Associated Services.**
 - **Expensive Drugs Tend To Be Separately Paid**
- **Two Major Coding Systems For Drugs –**
 - **Level II HCPCS**
 - **National Drug Codes – NDCs**
- **NDCs Were Originally Mandated Under The HIPAA Administrative Simplification**
- **Medicaid Programs Are Now Requiring NDC Reporting**
- **Many Problem Areas**
 - **Proper Charge Capture**
 - **Proper Billing – Number of Units**
 - **Pharmacy System to Billing System Interfaces**
 - **Proper Use of Revenue Codes**
 - **Proper Charges and Development of Cost-to-Charge Ratios (CCRs)**