uncovering pharmacy department risks and opportunities

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 Consider the extent of these challenges: outdated costs, improper mark-ups, invalid or missing Healthcare Common Procedure Coding System (HCPCS) codes or national drug codes (NDCs), unbilled items,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, darbepoetin alfa, ondansetron, and intravenous immune globulin are simply too intimidating. 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

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
> Billable 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.
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 underbilled; 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 package, 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 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 chargemaster) 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


**Audit Task** | **Reason**
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Develop a mapping of charge description master (CDM) service codes to national drug codes (NDCs) from the formulary, if not available | To facilitate proper billing, decision support, and ongoing audit and maintenance
Verify that all NDCs in the formulary are valid | To ensure proper compliance, billing, reimbursement, and reporting
Verify that all NDCs have a Healthcare Common Procedure Coding System (HCPCS) code assigned, if appropriate | To ensure that Medicare and other insurer reimbursement payable based on HCPCS codes are paid properly
Verify that HCPCS codes assigned are valid for NDCs and for reimbursement | To ensure proper compliance, billing, reimbursement, and reporting
Verify that billable units used by the hospital correlate with those published by an independent source | To reduce recovery audit contractor (RAC) and other audit exposure and ensure proper reimbursement levels
Verify that all cost information used in the formulary is current and complete for all items dispensed | To ensure the accuracy of the means used for determining proper pricing and reimbursement from payers paying on the basis of charges*
Verify that all items dispensed have a corresponding service code and are being billed | To uncover opportunities to recover lost revenue and improve cash flow
Verify that the pharmacy has a mechanism in place to routinely update the formulary for changing costs | To keep up with frequent cost changes and to address the impact of unit costs on the price billed
Verify that the mark-up factor or tiered mark-up factors are in line with market norms and are sufficient to cover labor, overhead, uncompensated care, and profit margin | To ensure that prices are in line with market norms but also sufficient to cover drug costs as adjusted for other revenue requirements
Determine whether current prices billed are optimum from both a reimbursement and a public relations standpoint | To fulfill fiduciary responsibility with an eye toward consumer awareness and regulatory initiatives
Verify that the billable units reflected on the bill are appropriate for the drug units and dosages dispensed | To reduce RAC and other audit exposure and obtain accurate reimbursement and electronic data
Verify that descriptions (and dosages) reflected on the bill correlate with those of the dispensed drugs and those reflected in the medical record | To ensure proper mapping between systems and proper reporting and reimbursement
Verify that all items purchased and dispensed have corresponding billing service codes | To reduce the likelihood of underbilling or lost charges
Compare current prices having assigned HCPCS codes with those charged by other hospitals in the market area | To identify material differences in pricing in an era of regulatory and consumer scrutiny
Verify that revenue codes are properly assigned based on the NDCs and HCPCS codes | 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

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* 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.

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/igo20109.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.

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/transmittals/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: “[I]f 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 28 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 to scan 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, shortfalls 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 prices 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

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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 primary source. 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 Drug 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 litigious 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.
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 markup factors and then applying them to the current WACs, AWPs, or actual acquisition costs in the benchmark database, adding a dispense 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 on page 87 provides a list of top audit areas that such an audit should consider and the reasons why. The exhibit on page 88 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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