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Keeping with the Code: Medicare Reimbursement Starts with Drug Coding Compliance

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Given the scale and complexity of the Medicare system, outpatient drug billing can be complicated. Incomplete medical records, errors in drug dosage reporting, and a lack of attention to the nuances of the Healthcare Common Procedure Coding System (HCPCS) are just a few factors that contribute to incorrect claims—particularly for outpatient drugs.

In 2014 the Office of Inspector General (OIG), housed within the Department of Health and Human Services, will review Medicare outpatient drug claims to identify incorrect coding and overbilling. This month the OIG is expected to set forth a work plan detailing the projects to be audited and addressed within the fiscal year.

To prepare for the upcoming audits and avoid the consequences and penalties associated with incorrect billing and overpayments, providers should improve their understanding of the billing guidelines and establish an internal auditing process for complying with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS).

The Healthcare Common Procedure Coding System

Applying appropriate HCPCS codes to each drug requires careful attention. To qualify for Medicare coverage, the drug must be considered necessary to diagnose or treat a medical condition and must meet the accepted standards of medical practice.

For example, drugs and biologicals are covered by Medicare only if they aren't self-administered, excluded as immunizations, or determined by the Food and Drug Administration to be less than effective. Additionally, they must meet all general requirements for coverage of items as incident to a physician's services.

When billing Medicare for drugs and biologicals, health care providers must remember to report:

- Charges for all drugs, biologicals, and radiopharmaceuticals, regardless if paid or packaged
- Correct HCPCS codes
- Separate codes if two or more drugs or biologicals are mixed together
- Correct dosage and quantity, depending on the HCPCS description

Throughout the billing process, as with any expenditure, it's important to use the appropriate revenue code as well. Billing entities should carefully review all documents so that units reported in the HCPCS are consistent with the actual quantity used. For example, an entity shouldn't bill for the full amount of a drug in one vial if it has been split between two or more patients.

If a drug does not have a valid HCPCS code, NOC (not otherwise classified) codes can be reported.

Avoiding Coding Errors

Care providers must have a medication administration record (MAR) that documents a full history pertinent to the indications and medical necessity for administering a drug to receive payment from CMS. Determining and documenting medical necessity is a critical element of the process. If medical necessity can't be substantiated, the health care provider risks being denied payment from Medicare and will be forced to write off the expense—even if the drug is billed accurately. Health care providers can protect themselves against this risk by including in their MARs:

- Name of medication
- Dosage
- Time given
- Route of administration
- Patient's reaction (effects, side effects)
- Name of person who administered medication

If a scheduled medication isn't administered, the omission of the medication should be recorded. Or, if the full dosage isn't used, the specific dosage administered should be recorded along with the amount of medication discarded. Using a "JW" modifier identifies unused drugs and biologicals. When unused amounts are recorded properly and discarded appropriately, Medicare will cover the amount discarded.

Review your coding with the following guidelines in mind:

- The number of units reported should be accurate and supported by the medical administration records.
- Billing should be based on the dosage specified in the HCPCS code and should specify minimum dosage codes.
- Errors and overpayments to Medicare should be reported and reconciled immediately.

The results from past reviews of CMS by the OIG offer helpful insight into common drug billing issues. Frequent errors include:

- Incorrect units of service
- No documentation of drug administration to support charge
- Off-label drug use not approved by Medicare
- Incorrect HCPCS code
- Incomplete documentation
- Lack of medical necessity per National Drug Code (NDC) to support charge

Some drugs are more vulnerable to coding errors than others. For example, previous OIG reviews indicate that chemotherapy drugs are frequently coded incorrectly. Developing a stringent plan can help to avoid coding errors.

Plan Ahead to Achieve Compliance

The following steps can help your organization code the drugs it bills to Medicare appropriately: First, implement a charge master system that includes the HCPCS codes and accompanying descriptions. Second, check HCPCS codes against the pharmacy vending system; the pharmacy description should match the official HCPCS description. Finally, develop an internal process to audit how well your organization is maintaining compliance with Medicare billing procedures. To make the most of your audit, consider reviewing:

- High-dollar drugs
- High-volume drugs
- Units of drugs with an NDC—they should match the HCPCS code on the claim
- Drugs billed with modifier JW
- Drugs packaged in multiuse vials

A more thorough review should also include:

- Complete orders
- Correct drug dispensed
- Correct HCPCS for drug ordered and administered
- Dispensed inventory against charges
- Drug claim denials

We Can Help

An effective self-audit of billing compliance requires smooth and structured collaboration across departments, systems, and staff. It also requires a method of checks and balances and steady communication among all participants.

Your Moss Adams health care professional can help you avoid the consequences of incorrect billing by assessing the strength of your billing audit process and developing internal processes to help your drug claims comply with CMS regulations.

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