

MEDICARE COMPLIANCE

Units of Service Are in Billing Limelight With Inhalation Treatment, Drug Audits

Billing for units of service is under the microscope, with auditors and payers reviewing drugs and other services. CMS recently limited hospital payment for inhalation treatment to one unit per patient encounter, a move that may have taken hospitals by surprise because it did not involve a change to CPT codes or a Medicare regulation. But it's another sign of the central role that units of service play in billing compliance and in CMS's efforts to keep Medicare spending under control.

Billing for units of service takes many forms. It's mostly seen on the outpatient side but sometimes affects reimbursement and payment rates on the inpatient side, says William Malm, senior data projects manager at Craneware.

A unit of service corresponds to the amount of a drug, therapy or other service described in a CPT or HCPCS code. Units of service are a big compliance risk in the world of outpatient drugs, including discarded doses. Hospitals and physicians report outpatient drugs with HCPCS codes, which specify the billable units based on the dose. Typical charge capture processes rely on the reporting of units administered, which is then cross-walked to a billable unit through some sort of system multiplier. If the HCPCS descriptor of a drug is 50 mg but 200 mg are administered to the patient, the hospital should bill four units. But conversion may not go smoothly, so Medicare auditors are all over this area (*RMC 4/2/12, p. 1*).

"If you buy four tires for your car, do you really want to see five on your bill?" says Malm, who is also a clinical practitioner at an Ohio trauma center.

Units of Service Attracting Attention

But he says units of service have been back-burnered at hospitals. "We had revenue integrity pretty well under control until the RACs, and then CFOs started moving funding away from clean claims to firefighting," he contends. "Once again, we see the HHS Office of Inspector General and recovery audit contractors and Medicare administrative contractors talking about units of service," Malm says.

With the inhalation therapy development, however, units of service may take a higher place on the risk-area

hierarchy. In January, the National Correct Coding Initiative (NCCI) coding policy manual proclaimed that CPT 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes, e.g., with an aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing device) should be used only one time per patient encounter instead of every time a patient receives an inhalation treatment during the encounter, Malm says.

That means hospitals can charge only one unit of service per patient encounter regardless of the number of times it's administered, usually by respiratory therapists and nurses, he says. The American Medical Association did not change the CPT code's definition; the significance lies in the fact that CMS uses NCCI. In other words, Medicare allows one unit of service per encounter, as of February, he says. This is relevant mostly on the outpatient side.

Change in Billing Is a 'Shocker'

"It has been quite a shocker," adds Denise Williams, senior vice president of revenue integrity services for Health Revenue Assurance Associates in Plantation, Fla.

Already many hospitals are getting claims "returned to provider" (RTP'd) or denied for units of inhalation treatment that exceed one per encounter, Malm says. When patients are in observation, their entire stay is one encounter, which means only one unit of 94640 should be billed to Medicare, according to NCCI. But CMS doesn't have a corresponding medically unlikely edit (MUE) to guarantee it will catch excessive units. It's up to hospitals to identify errors before dropping claims, according to Malm.

This is an operational challenge for hospitals, partly because Medicare and non-Medicare payers play by different rules, Williams says. "If you bill too many units, you could have a compliance problem," she says.

Malm sees the inhalation-treatment constraint as a reflection of the emerging risks around workload statistics. Some clinicians, such as respiratory therapists and nurses, are trying to keep their workload statistics high, billing as many CPT codes as they can to generate gross

revenue for the hospital and add value to their work, he says. For example, two units of service may be billed for CPR standby when a patient goes into cardiac arrest in the emergency room — one for the respiratory therapist and one for the emergency room — although it should be one unit of service. It hasn't gone unnoticed; commercial payers and CMS are recognizing patterns of behavior, such as clinicians charging for services inherent in care, he says.

Medications and medication waste are probably the top risk area in terms of units of service. A steady stream of OIG audits, for example, have identified Medicare overpayments to hospitals caused by reporting the incorrect units of services for various medications, such as chemotherapy drugs (e.g., Herceptin). More audits are planned, according to the 2014 OIG Work Plan, and hospitals may face RAC or MAC recoupment for "wasted" drugs. Homegrown data mining can help hospitals clear the debris and focus on drug claims that are at a higher risk of errors (*RMC 9/30/13, p. 1*).

Wasted Medications Are a Minefield

Wasted drugs seem to be top of mind in hospital compliance circles. Medicare allows hospitals to bill Medicare for leftover units in a single-use vial of medication if the wasted drugs are documented in the patient's medical record, Williams says. "It can't be documented somewhere in the pharmacy or on a log," she says. "[MACs] want easy access to validate this."

MACs may land on discarded drugs even if they don't start there, Williams says. They may be auditing the pharmacy for some other reason and find errors with units of service and then waste. "It doesn't matter if the drugs are separately payable or not. If the units were wrong, they counted it as an incorrect claim," she says. Data are very important to CMS and the industry because they inform future payment rates.

Documenting wasted drugs is easier said than done. "I don't know if there's a fully automated way to document it. Some facilities use wastage forms. They put the patient's information or label on the form, write how much wasn't used and put the form in the medical record," Williams says. She also has seen semi-automated versions. "Facilities want to find a way to put it in the medication administration record, but it isn't always easy and doesn't always happen. There has to be some kind of double check of what's going on the claim."

The bigger picture — converting drugs from doses to billable units — is a hot topic for auditors, and continues to be a challenge for hospitals. "Pharmacy systems are not built as billing systems. They are clinical dispensing systems — a patient-specific formulary for what the doctor ordered for the patient," Malm says. "The label [on

the drug] must be correct for what was dispensed, but it's hard to get it into billing language."

What Can Hospitals Do to Reduce Errors?

Here are questions that hospitals should consider in their journey to reduce errors for services reported to Medicare and commercial payers in billable units, according to Malm:

◆ *When the hospital puts in new charges or alters charges, does it test claims to ensure the number of units comes out correctly?* Is there a process to ensure the units of service are accurately represented? Multipliers in the charge description master should match the HCPCS code of the drug.

◆ *Does the hospital use the NCCI manual as its highest authority for units?* Are medically unlikely edits considered? Malm says the pharmacy and operating room are the highest risk areas. For example, the high-cost skin substitute Alloderm is billed per square centimeter. If the OR nurse documents that the physician used 50 square centimeters but the hospital mistakenly bills only one unit, which is one sheet of Alloderm, it will get paid for only one centimeter, not for 50 units. Each square centimeter equals one unit (*RMC 1/27/14, p. 1*).

◆ *Are hospitals keeping in mind that commercial payers still use hospital bill audit (HBA) methodology?* It's a method of contrasting the medical record against the itemized claim to find unallowable items, although it's primarily used on the inpatient side, Malm says. Medicare is also starting to look "in a backhanded way — through cost reports — at whether hospitals are saying they used more resources than they did."

◆ *When hospitals correct a problem, do they have "control points" to evaluate the ongoing effectiveness of the corrective action?*

◆ *Are hospitals aware of how computer systems — including new systems and upgrades — affect units of service?* A service may be billed automatically through documentation templates even when it exceeds the number of units allowed by that payer, Malm says.

Hospitals also lose money by reporting units of service wrong. If a patient is undergoing infusion over multiple hours in observation and the unit of service on the claim is one, the hospital is cheating itself, Malm says. "In observation I am getting extended care — hydration and antibiotics. Look at the records. Do I have sequential, concurrent, more than one line running? That is a quick way to find undercharges."

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