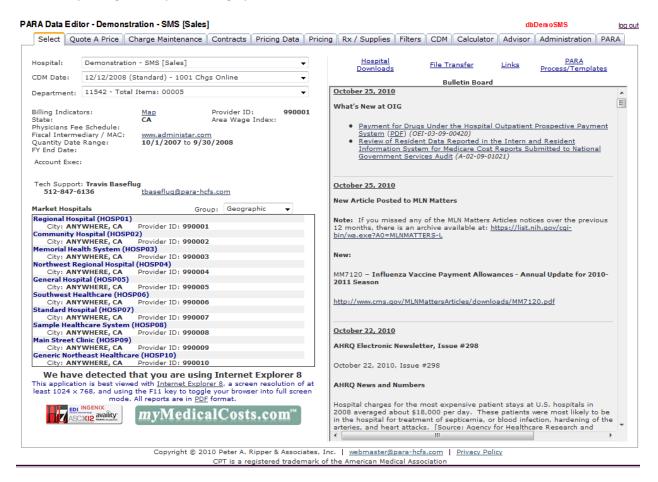
The **PARA** charge master audit process utilizes the **PARA Data Editor (PDE)** to create a series of focused screens and reports utilized by the **PARA HIM Coding Staff** to identify and correct charge master errors, compliance issues, and missing charges.

The **PARA Data Editor** is the main tool used for the review; the **PDE** is available 24/7 to all Hospital Users.

There are 7 phases to the PARA Charge Master Comprehensive Review process:

- 1. Checking Invalid HCPCS and Revenue Codes
- 2. Checking Line Items for Charge Compliance and Modifiers
- 3. Checking Valid Code Assignment
- 4. Claim review
- 5. Interactive discussions with Managers (on-site or web meetings)
- 6. Checking pricing internally and against fee schedule and pricing data
- 7. Reporting and implementing updates



Deliverables

- 1. Complete desk review of the charge master line items with quantity prior to on-site interviews to identify items that need further discussion with Department Managers.
- Interactive discussion (on-site or web meetings) with each revenue generating Department
 Manager to review each active charge line item for correct codes, descriptions, pricing and
 reimbursement.
- 3. Claim review of 100 detail itemized and UB04 outpatient claims to identify missing charges, compliance problems and billing issues.
- 4. Quarterly updates to the charge master to keep current with Medicare coding regulations.
- 5. **PARA** shall provide support throughout the term of the contract for all coding, billing compliance questions via telephone conference calls, email, or the PDE.
- 6. **PARA** shall review and approval all charge master changes using the Charge Maintenance tab functionality in the PDE.

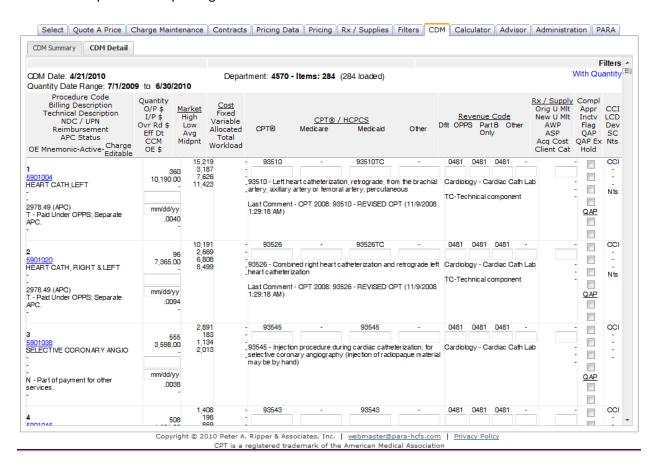
Timeline

1 11111	eiiie	_								
			Week Number							
	Process	Period after receipt of data by PARA	1	2	3	4	5	6	7	8
1.	Engagement	N/A								
2.	Processing of initial data set by PARA	2 weeks								
3.	Review of charge master - desk audit	2 weeks								
4.	Review of claims	2 weeks								
5.	Departmental Meetings	1 week								
6.	Final charge master review	3 weeks								
7.	Implementation	1 week								

All queries in the **PDE CDM tab** are color coded:

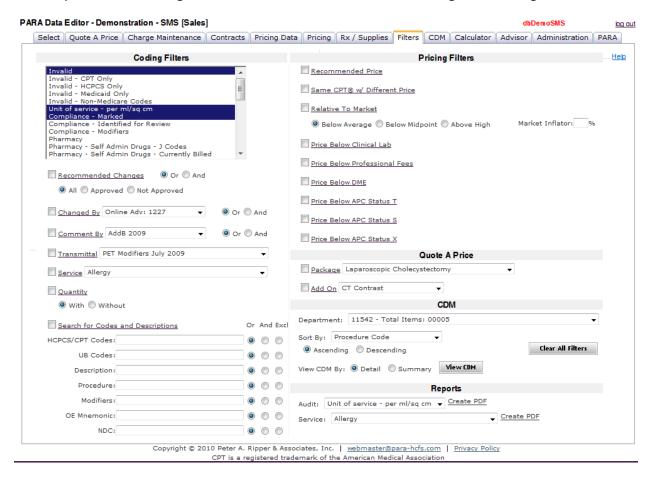
- 1. Red Invalid code
- Blue Code, procedure number, NDC, OE mnemonic or description which matches the filter query
- 3. Green PARA / Hospital recommended changes
- 4. <u>Purple</u> PARA advisory recommended changes, to be reviewed by Hospital prior to implementation

The detail **CDM Tab** allows **PARA** and the Hospital User a view of all data tables tied to the charge items for a "one stop" all encompassing review.



Phase I - Coding Review

The first portion of the charge master audit will be a review of issues using the following filters:



- Invalid This filter will list each line item which has an incorrect code.
 The codes will be listed in "red", with any recommended changes displaying in green.
- 2. <u>Unit of service per ml/sq cm</u> This filter will find all items in the charge master which should be billed using a unit of service identified in the HCPCS code. The User will need to review each line and determine if the charge is correct per unit of service, or the correct units of service have been entered into the billing system to adjust the units on the UB04. The hospital units of service adjusted will be displayed in the PDE CDM tab for the filtered items.
- 3. <u>Pharmacy Self Admin Drugs J Codes</u> This filter is based on the Medicare list of SAD J coded drugs. The filter will allow the User to review each line, verify the code is correct, update the code, and then to be sure the line is coded to be billed to the Patient under the SAD rules.

Phase I - Coding Review (continued)

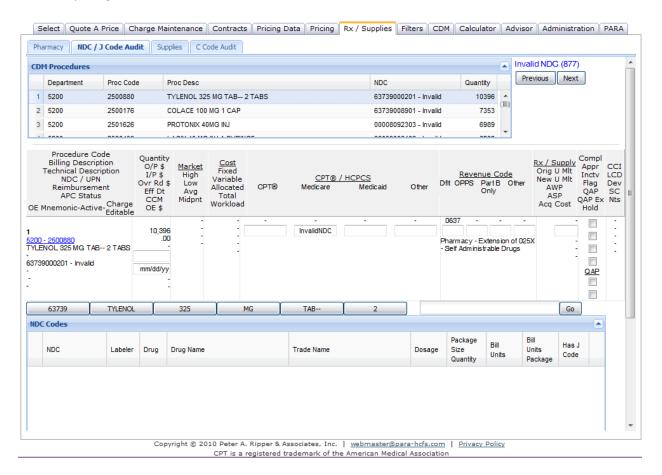
- 4. Pharmacy Self Admin Drugs Identified for review This is a "keyword" search filter to display the lines in the charge master which appear to be SAD and are not coded correctly in the system. The User can then review the line items and assign the correct code for billing.
- 5. <u>DME OPPS Exempt ID for Review</u> This "keyword" filter will identify all line items in the charge master which may be billed using a DME code and the 0274 revenue code. The User will be able to create a report to be reviewed by Materials to determine the correct "L" code to be applied.
- 6. **Consistency** In some of the more complex patient accounting systems there are opportunities to maintain a number of different "third party indicators", all of the "indicators" are mapped to a code type (CPT, Medicare, Medicaid, Workers Comp, or Other), within the **PARA PDE**. This filter will assist the User in making sure the codes and segments within a code type are internally consistent. This filter allows the User to identify the "background" codes which are different from the main upfront displayed codes and make corrections.
- 7. <u>Blood</u> Review of blood charges to be sure that the Hospital does not incur a blood deductible for products billed using the 038X rev code series.
- 8. <u>ED, Urgent Care, Provider Based Clinics, and Nursing Procedures</u> Review of the department charges to be sure the hospital is billing for the technical portion of physician procedures, and all separately billable nursing procedures are charged and coded.
- 9. <u>Radiology Interventional Procedures</u> Review the imaging departments to be sure all surgical procedures are coded and charged.
- 10. <u>Implants</u> PARA reviews all line items which contain key words in the charge description to be sure the implant revenue codes are assigned correctly.

Phase I - Coding Review (continued)

<u>Pharmacy J code and Unit of Service Review</u> – This review utilizes the CMS National Drug Code (NDC) to HCPCS J code audit file.

PARA processes the Pharmacy clinical NDC data table into the PDE and then audits the currently assigned J codes and unit of service.

The **PDE NDC / J Code Audit sub-tab** is utilized for this review; **PARA** will identify all invalid NDC codes, incorrectly assigned J codes, and incorrect units of service.



Phase II - Review of Line Items for Charge Compliance and Modifiers

- Compliance Identified for Review The compliance ID for review filter is driven by the
 "Wheatland's" Medicare billable item PDF. This document can be found in the Hospital
 Downloads section of the PDE Select tab. The filter will search the charge master for
 compliance keywords and identify the items which should not be billed to the Program.
- Compliance Modifiers With the focus on modifiers, this filter and review allows the User to review all modifiers "hard coded" in the charge master to be absolutely sure the auto application of the modifier is correct.

Medicare Chargeable Items List

The determination regarding whether a service, supply or equipment is chargeable is based upon:

- The Kansas Fiscal Intermediary's (FI) interpretation and application of existing Medicare laws and regulations or CMS manuals and other instructions regarding coverage, charging and billing.
- Absent specific regulatory or CMS guidance, a provider survey to determine the common or
 established classification of an item or service as routine and not separately chargeable or
 separately chargeable as an ancillary item wherein 40% or more of responding providers
 made a separate ancillary charge for a particular item or service.

Some items on the chargeable items list were based upon surveys conducted by the Kansas Hospital Association. Survey results were reviewed by a committee of hospital representatives and the Kansas Fiscal Intermediary.

The first survey to determine "common and established" charging practices in Kansas was performed in 1997. In December 1998, the FI published M-K Letter 99-1 containing the results of the survey. A second survey was performed in 2006.

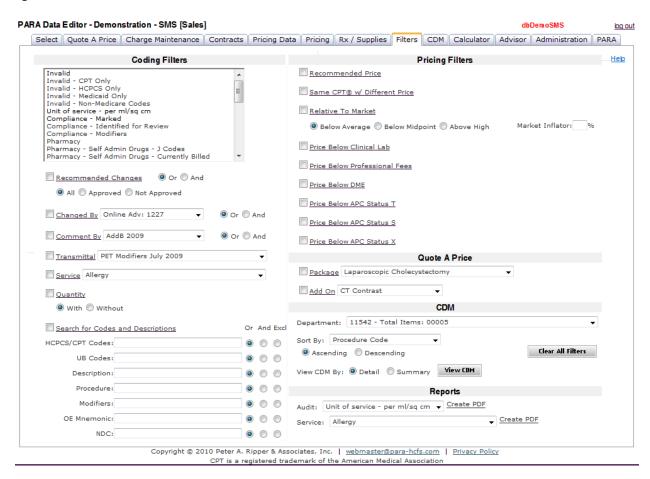
This list is not all-inclusive.

The authoritative source for reliance on a survey to determine charging practices by hospitals in the state of Kansas is the following citation from the Provider Reimbursement Manual (PRM) 15-1, Chapter 22, Section 2203 Provider Charge Structure as Basis for Apportionment.⁽¹⁾

The authoritative sources for classifying a service, supply or equipment as routine or ancillary are PRM 15-1, Section 2202.6 Routine Services and Section 2202.8 Ancillary Services. (Note: CMS responded to the Kansas FI, on August 24, 2006, and is in agreement with this source. Nursing services to patients in the routine rooms are part of the routine room and board charge.)

Phase III - Coding Validation and Usage

The third portion of the charge master review is to identify items which are coded incorrectly, but the code is a valid code, or if the service assigned to the code is inconsistent with other services assigned to the same code. The process utilized for this review will be contained in the **Audit Report** section on the right side of the **Filters Tab**.



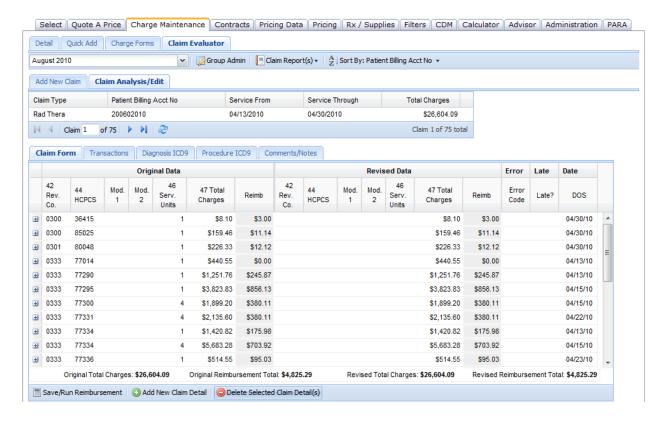
The service line filters and audit reports are based on CPT/HCPCS codes contained in the CMS Addendum B, each of the codes are tied to a service line, in some cases a single code can be tied to several service lines. By listing the codes in CPT/HCPCS code sequence the codes are grouped together and allow a fast and efficient review. The **Service Line Filters** and **Audit Reports** can be utilized to identify any codes which are not currently contained in the charge master or where codes, prices or usage is incorrect.

The **Service Line Filters** and **Audit Reports** are very useful for multi-hospital groups to tie similar codes across different hospitals and departments, for consistent coding, charge descriptions and pricing.

Phase IV - Claim Review

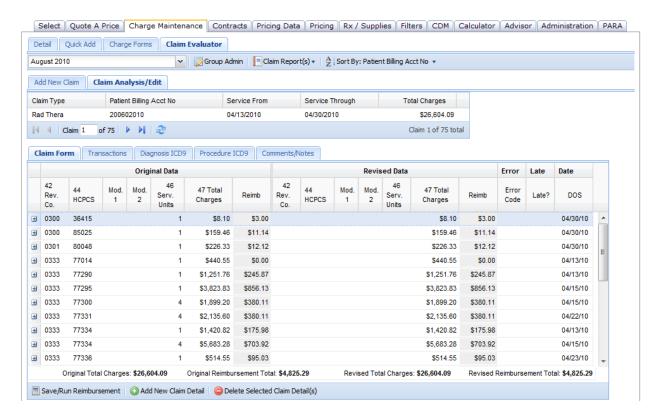
PARA will review a minimum of 100 Medicare Outpatient claims to identify system, charge process capture issues, coding and compliance errors. The review will identify missing codes, charges, inappropriate modifier usage, missing or incorrect pharmacy codes and multipliers.

The PARA Data Editor Claim Evaluator sub tab is utilized in this review.

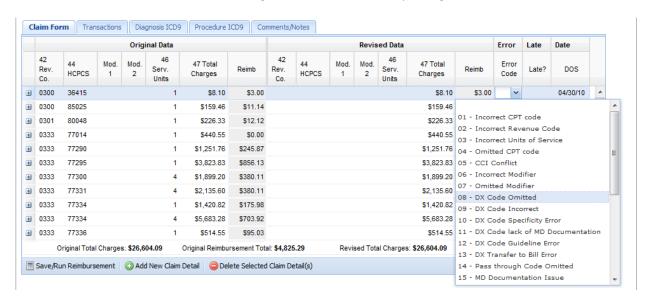


Phase IV - Claim Review (continued)

If the claims are "built" in the **PARA** system utilizing the transaction data set on file, the detail transactions are available for access and review.



Each of the "corrections" to a claim is assigned a error code for reporting.



Phase IV - Claim Review (continued)

The number of claims and supporting documentation for each type of claim is noted in the table below.

Outpatient Claim Type	Description	Minimum Number of Claims	Supporting Documents
Interventional Radiology	Breast Biopsy, Cyst Aspiration, Percutaneous Biopsy, Pain Injections	8	Radiology Report
Pacemaker	Initial Placement and Replacements	4	Cath Lab/Surgical Report and HIM abstract if performed in surgery
Cath Lab	Left Heart, Combo Left & Right Heart, Stent Placement	6	Cath Lab Report
Angiography	Stent Placement, Aortogram with runoff, Declot Fistula, Dialysis Fistula	8	Procedure Report
Surgical	Include claims from simple to complex surgeries, multiple procedures, bilateral and unilateral services	8	Surgical Report and HIM Abstract Worksheet
Chemotherapy	Multiple infusions, hydration, clinical visits, injections	4	Nursing Notes
Observation	Emergency Room observation admits, direct admit from a physician office	4	Physician Notes, orders and Nursing Notes
Emergency Room	Critical care, surgical procedures, blood transfusion, IV infusions, injections	5	Physician and Nursing Notes, transcribed dictation, radiology reports, ER level assignment form
Blood Transfusion	If not available as standalone claims, provide claims from other areas i.e., ER	3	Nursing Notes
Rehab – PT, OT, Speech	Claims from each modality with evaluation and therapy charges	4	Therapist notes

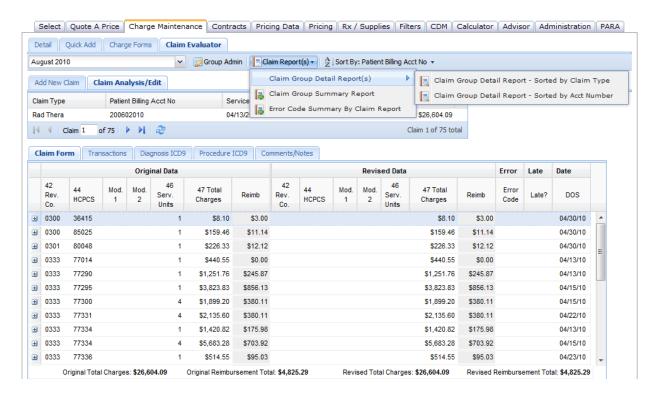
Phase IV - Claim Review (continued)

Number of claims by type and supporting documentation (continued)

Outpatient Claim Type	Description	Minimum Number of Claims	Supporting Documents
Diagnostic Imaging	Claims from each: Radiology, CT, Nuclear Medicine, Mammography, MRI, Ultrasound	12	Radiology Reports
Wound Care	Include 2 claims from each: new office visit, recurring visit, graft, debridement, hyperbaric oxygen therapy	6	Nursing Notes
Clinical Lab	Multiple tests on a single claim	4	Lab Information System listing
IV Infusions	Hydrations, Infusions and Injections	6	Nursing Notes
OB Outpatient, Labor check	Non Stress tests, monitoring, IV Therapy	4	Nursing Notes
Smoking Cessation	Complete course of care	2	Procedure Notes
Medical Nutritional Therapy	Diabetes self management training	4	Procedure Notes
Sleep Lab	Complete overnight study, CPAP titration, home studies	4	Procedure Notes
Pulmonary Rehab	Complete course of care	2	Procedure Notes
Cardiac Rehab	Complete course of care	2	Procedure Notes
	Total Minimum Number of Claims	100	

Phase IV - Claim Review (continued)

There are several reports which can be generated ad hoc by the User, with two different sort options.



The reports present all data elements, corrections and descriptions, in Detail or Summary view.



Phase IV - Claim Review (continued)

PARA will accept the claims in a number of formats:

- 1. Submission of claims from an electronic 837 file import (recommended method)
- 2. Submission of claims from an account header and transaction file, in addition to submitting the diagnosis ICD-9 and the billing HIM assigned HCPCS information and claims data, either in a data table or hard copy (paper) format
- 3. Submission of claims in hard copy (paper) format, extra charge to be billed for the keying of the claims

<u>DE-IDENTIFY THE CLAIMS</u>. PARA will use the patient control or account number in box #3 on the UB04 for the identifier.

Provide claims billed to Medicare, the review is based on Medicare billing guidelines.

Each claim needs to include the UB04 and Itemized Bill.

PARA will review the claims and produce a list of medical records and the portion of the record required for additional review. This will preclude the Provider from having to copy or scan many pages of records which may not be required.

Mail the paper portion of the claim review to:

Claim Review PARA Attn: Peter A. Ripper 4801 East Copa De Oro Drive Anaheim, CA 92807

The data tables submitted for the claim review should be transmitted using the **PARA** secure file transfer process, the link is pasted below.

https://apps.para-hcfs.com/pde/documents/PARA FileTransferUserGuide.pdf

If you have questions, please contact your Account Executive at (800) 999-3332.

Phase V- Interactive Discussion with Managers

PARA will conduct either **on-site or web meetings** for all interactive discussions with Department Managers to review all active charge line items for correct coding and descriptions, additional coding/charging opportunities, and hospital specific goals.

	<u>Memorandum</u>				
То:	Directors and Department Managers				
From:					
Re:	PARA On-site Visit				
Date:					
	ned the services of PARA Healthcare Financial Services, a hospital financial consulting sist us in the review of our Charge Description Master, billing and charge compliance.				
The review will charge capture	focused on CPT/HCPCS codes, Medicare APCs, compliance with billing regulations, and pricing.				
Peter Ripper, of PARA will be conducting on-site meetings with each Revenue Department Manager to review all charging, coding, compliance and billing issues.					
	of my Staff will also be attending the meetings.				
Peter is schedu	lled to be here on (Date) and (Date) to perform the on-site portion of the review. This				

engagement may require one or more meetings with you. The first set of meetings will be held in the (Conference Room Name) and will run from (Beginning Time) to (End Time).

I have attached a list of departments and the amount of time Peter has estimated for the first meeting, based on each Department's complexity.

Please review the list and e-mail me with several times that you would be available. As you will see the Business Office will be the first meeting scheduled, the Department meetings will follow.

To prepare yourself for the meeting, please review your charges and codes, if you would like a charge listing from the PARA system, email Mary at mmcdonnell@para-hcfs.com with your department G/L numbers. Mary will assign you a login to the PARA system and give you access to the PARA Data Editor user's manual.

Phase V- Interactive Discussion with Managers (continued)

Memorandum (continued)

Please bring the following to your meeting; these items will assist Peter in understanding your charge process.

- Any charge sheets or process that you may utilize
- Copies of any claims, bills or regulations that are of a concern
- Pricing worksheets or schedules (pharmacy and materials)

Additionally, please be prepared to discuss any coding, compliance and pricing issues that are of concern.

Please invite any member of your Staff to attend the meeting that is involved in the charge process.

Phase V- Interactive Discussion with Managers (continued)

Memorandum (continued)

Date

Department Meetings - Time Requirements (in hours)

Department	Hrs
Business Office	
First meeting of the visit	1
 Review of current issues – this will help frame the remainder of the meetings 	
Cardiology – EEG, EKG, Echocardiography, Cardiac Rehab	1
Emergency Room - Trauma	1
Inpatient Daily Hospital Services	1
Labor and Delivery	1
Laboratory – Pathology – Blood Bank	1.5
Materials – Medical /Surgical Supplies	1
Outpatient / Ambulatory Nursing Services	1
Pharmacy	1
Radiology – Diagnostic, Ultra Sound, MRI, CT, Nuclear Med, Fluoroscopy, Mammography, Interventional Procedures	2
Rehab Services – Physical Therapy, Occupational Therapy, Speech	1
Respiratory Therapy / Pulmonary Function / Sleep Lab	1
Surgical Services – Operating Room	1
Women's Center	1
Please add any additional Departments	1

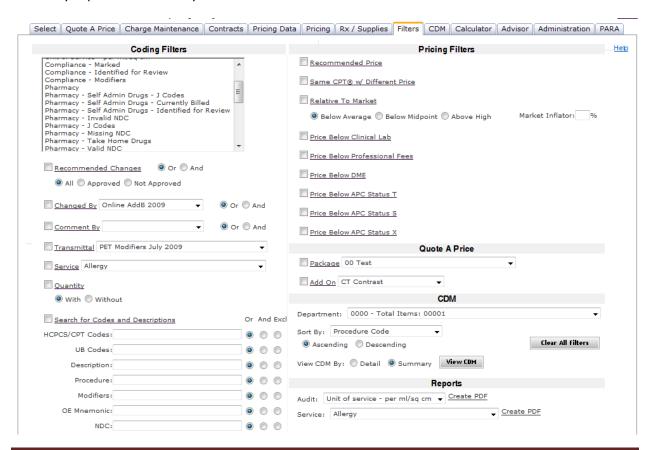
Phase VI - Checking Pricing Internally and Against Fee Schedule and Pricing Data

The **Filters Tab** within the **PDE** contains a number of different views/filters to review prices against various fee schedules and pricing data extracted from Medicare claim data.

The available pricing filters are as follows:

- 1. Same CPT with a different price
- 2. Below Market average market price
- 3. Below 85th percentile market price
- 4. Above market high price
- 5. Price below clinical lab fee schedule
- 6. Price below Professional Fee schedule
- 7. Price below DME fee schedule
- 8. Price below APC Status T
- 9. Price below APC Status S
- 10. Price below APC Status X

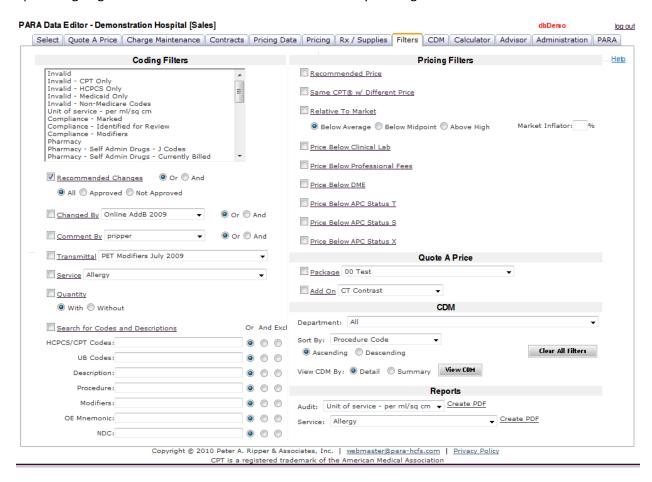
The market pricing filters contain the most current peer market pricing data available, the market prices are always up to date for every User within the **PDE**.



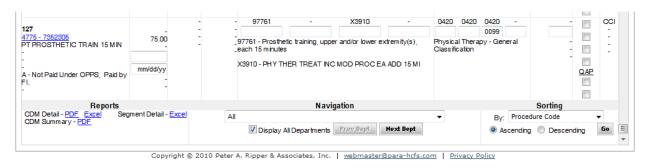
Phase VII - Reporting and Implementing Updates

There are a number of different reporting filters available; the User can "build" a report using a number of filters, with logic to include, exclude or "find" exact matches.

Upon assigning a filter the User will then create the CDM by clicking on the CDM tab.



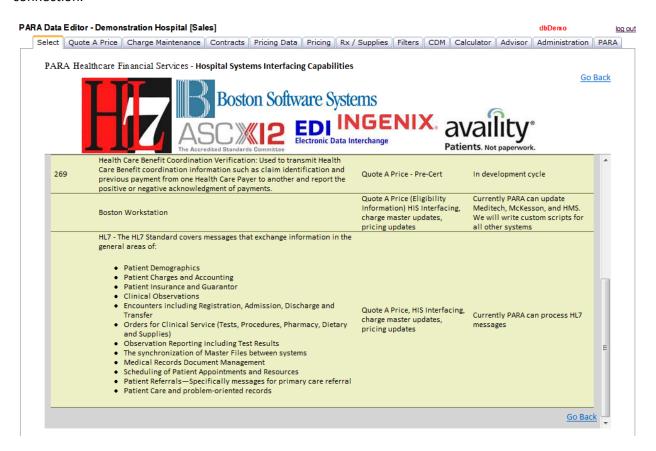
The User then has options on how the report is to be sorted (procedure code, HCPCS / CPT code, gross revenue, charge description) and reported (PDF or Excel) in summary view or detail view.



Phase VII- Reporting and Implementing Updates (continued)

The User also has options on how the codes are to be implemented within the hospital information system.

PARA provides a service to update the codes and prices using Boston Workstation, utilizing a VPN connection.



PARA can also format a file for hospital upload with the specific header and trailer data elements assigned within the file.