The PARA Data Editor (PDE)

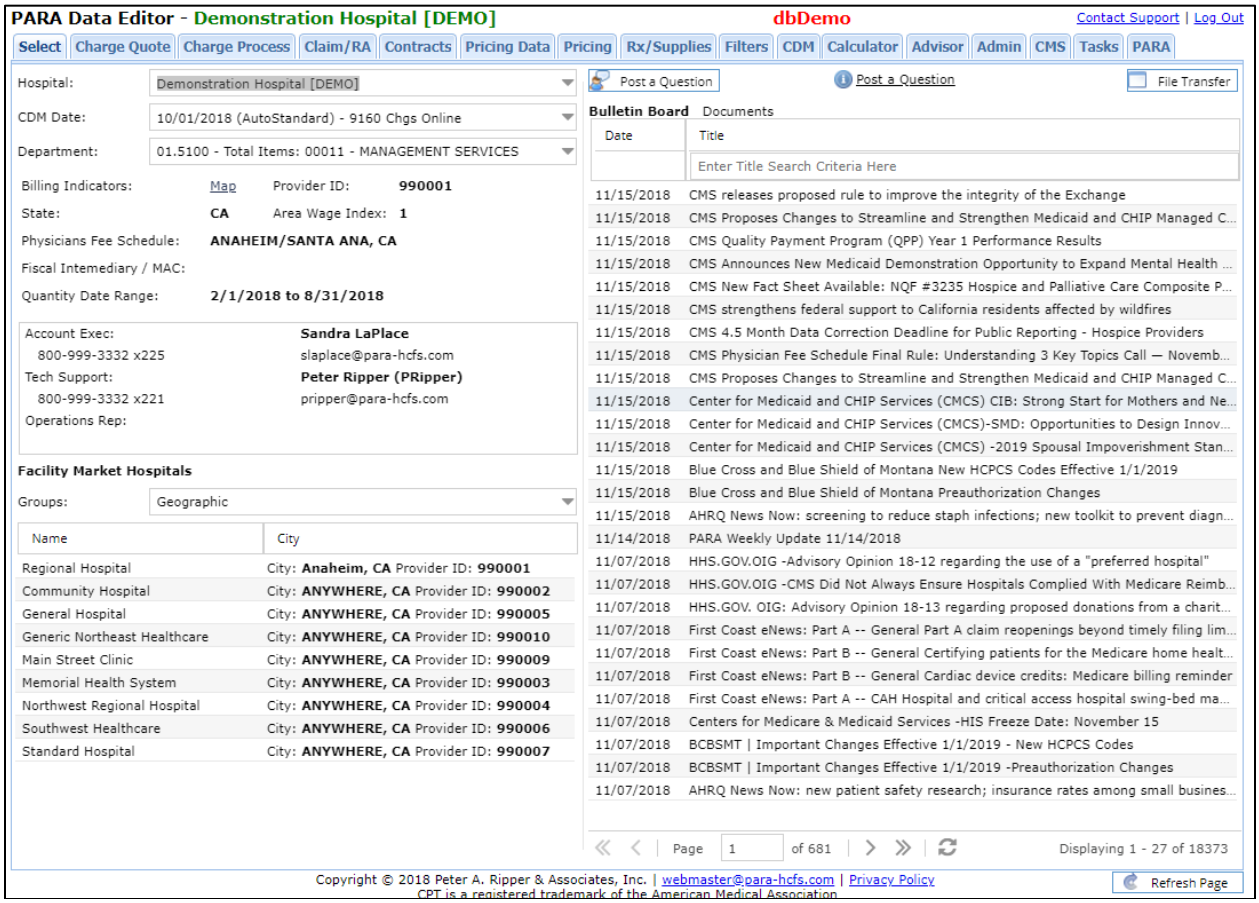


Table of Contents

INTRODUCTION **4**

Select Tab **5**

Charge Quote **7**
Share of Cost/Charge Quote – Create a Quote 8
Share of Cost Step 2: Coverage Check – Advance Beneficiary Notice (ABN) 21
Share of Cost Step 3: Quote Creation – Customized Letters 24
Share of Cost Step 4: Eligibility Verification 25
Existing Quotes 29
Administration – Ratios and Discounts 30
Administration – Letters 31
Administration – Packages 32
Administration – ABN Checker 34
Administration – Payers 35

Charge Process **36**
Charge Process (continued) - Quick Add Form 42

Claim/RA Management **43**
837 Claims 44
835 Remit – Pending Review 45
835 Payer Mapping 46
835 Remit – Marked For Review 47
835 Remit – Finalized 48
837 Settlement Modeling 49
837 Payer Mapping 50

Contracts **51**
Reimbursement Method Detail 52
Stop Loss 53
AddB 54

Pricing Data **55**

Pricing **58**

RX/Supplies – Pharmacy **61**
Rx/Supplies Tab - Supplies 62

Filters **63**

CDM Tab **66**
CDM Tab – Procedure Detail 67
CDM Tab – CDM Summary 68

Calculator **69**

Advisor Tab **74**

Administration Tab **75**
Administration Tab – My Profile 76
Administration Tab – Add New User 78
Administration Tab - Access 79
Administration Tab - Workflow 80
Administration Tab - Contacts 81
Administration Tab - Hospital 82
Administration Tab – Rx/Supplies 83
Administration Tab – Pricing 85
Administration Tab – Projects 86
Administration Tab – Docs 87
Administration Tab – Widget Administration 88
Administration Tab – Department Map 89
Administration Tab – File Transfer Log 90

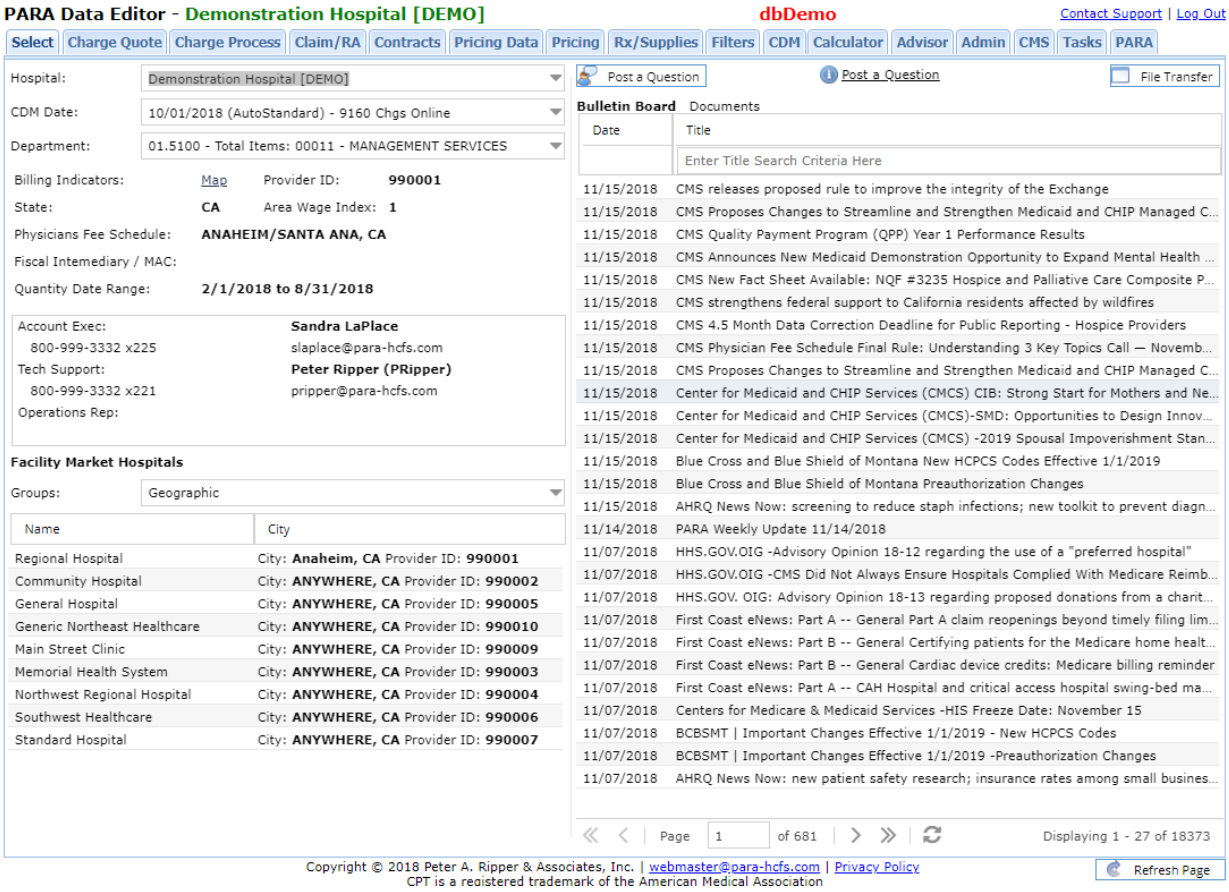
CMS Tab **91**

Tasks Tab **92**

Introduction

The **PARA Data Editor (PDE)** encompasses a complete suite of essential applications that will streamline the multiple functions necessary to maintain a clean, up-to-date Charge Description Master (CDM). It also features our Charge Quote tool, which enables the User to provide quotations to patients who are seeking the best possible price for their healthcare needs. All of these functions are contained within a single web-based application, so there is no need for expensive, difficult to upgrade and maintain software programs to be installed or custom built.

Select Tab



The **PARA Data Editor** provides an easy to use web portal designed to optimize a multitude of functions and streamline the hospital's efforts to maintain a compliant Charge Master. The tool allows hospital staff access to the most current News and Notices available for all healthcare entities, and is constantly being updated to reflect the most current and accurate data available. Each client hospital's individual indicators are maintained within the **PDE**, so that such factors as Billing Indicators, Area Wage Indices, and Fee Schedules are incorporated into all calculations performed by the **PDE**.

To log into the **PDE**, a **PARA** staff member will have to create a User ID and password for you. Once this has been done, access your web browser and visit the website www.para-hcfs.com. On the Introductory page, in the middle column under the header "**What We Do**" you will see the first section is labeled "**The Charge Description Master**" and the second section is labeled "**The PARA Data Editor**". Click on the "**PARA Data Editor**" link, and that will direct you to the User login page.

Once you have logged into the **PDE**, the first thing you will see is an End User License Agreement. This Agreement is only necessary to accept once a year, so in your subsequent sessions in the **PDE** it will no longer appear. Once you have accepted the terms, you will be redirected to the Main Page of the **PDE** for your facility. The name of your facility will appear in

Select Tab (continued)

the "Hospital" box on the upper left. If you are part of a hospital system, the drop-down menu on this box should be active, allowing you to choose between your facilities. This page also lists all of the hospitals currently included within your market peer group, your Account and Support representatives, a Bulletin Board that contain information and notices pertinent to the healthcare community and recent updates to the **PDE** itself, and numerous downloads for your convenience.

Charge Quote

The Charge Quote tool allows the User to provide the patient with their share of cost prior to services being rendered. In today's highly competitive healthcare market, patients are becoming far more sophisticated when it comes to getting the most value for their money. The **PARA Data Editor** provides the User with the most comprehensive system to not only quote patient liability on individual services, but on packaged services as well. For any surgical or diagnostic procedures that require multiple charges in addition to the primary procedure (e.g., add-on procedures, anesthesia, drugs, and supplies) these services can be bundled into a single order set. In addition, the User can load the details of their Payor Contracts, which allows the User to quote the most accurate price possible. Charge Quote also allows the User to design and produce custom patient letters, quote summaries, and Advance Beneficiary Notices that can be mailed or emailed to the patient and the Departments. Charge Quote provides an easy-to-use tool for the hospital to exhibit pricing transparency, and gives the facility the ability to give patients the information they need without installing additional expensive software applications.

The Charge Quote tab also features Eligibility Verification, so policy validation, deductible, and coinsurance can be verified in a real-time transaction for even more accuracy in determining the patient's out of pocket cost.

Share of Cost/Charge Quote – Create a Quote

Creating a quote is a four-step process:

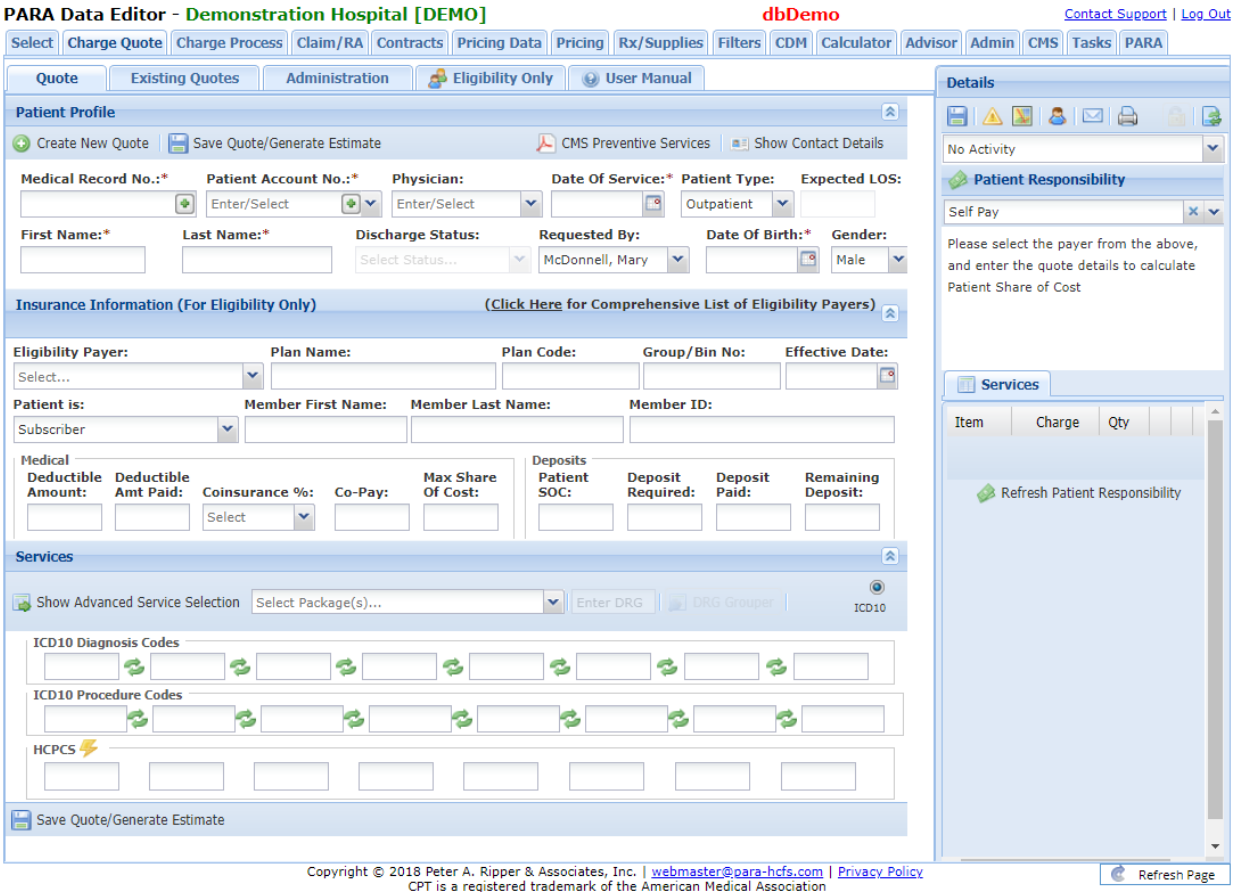
- **Create the quote** – Enter the patient demographic information, insurance information, and the services that will be provided by the hospital. The initial Patient responsibility will be determined by the services selected and the Patient's deductible and coinsurance as entered by the User interview with the patient.

- **Check Medical Necessity Coverage** – If the Patient has Medicare, Users can check for coverage under Medicare medical necessity policies and produce an Advance Beneficiary Notice, if needed. Procedure codes (HCPCS/CPT®) which may be subject to Medicare National and Local Coverage Determinations (LCD/NCDs) are checked against the specific diagnosis codes entered by the User. If the Patient diagnosis is not covered under the LCD/NCD, the cost of the service may become patient responsibility and an ABN is necessary. The ABN can be automatically completed within the Coverage check feature using the cost assigned by the Administrator (current charge, Medicare-equivalent reimbursement, or other calculation.)

- **Revise Total** – once coverage has been checked and an ABN completed, the patient total will be revised to include any non-covered items that will become the Patient's responsibility. The system offers Users the option to print a patient letter which includes their entire estimated out of pocket cost.

- **Eligibility Verification** – the Patient's insurance coverage may be verified before the quote is finalized for insurers which offer online eligibility verification. This helps hospitals identify lapses in coverage which may result in the full amount falling to Patient liability.

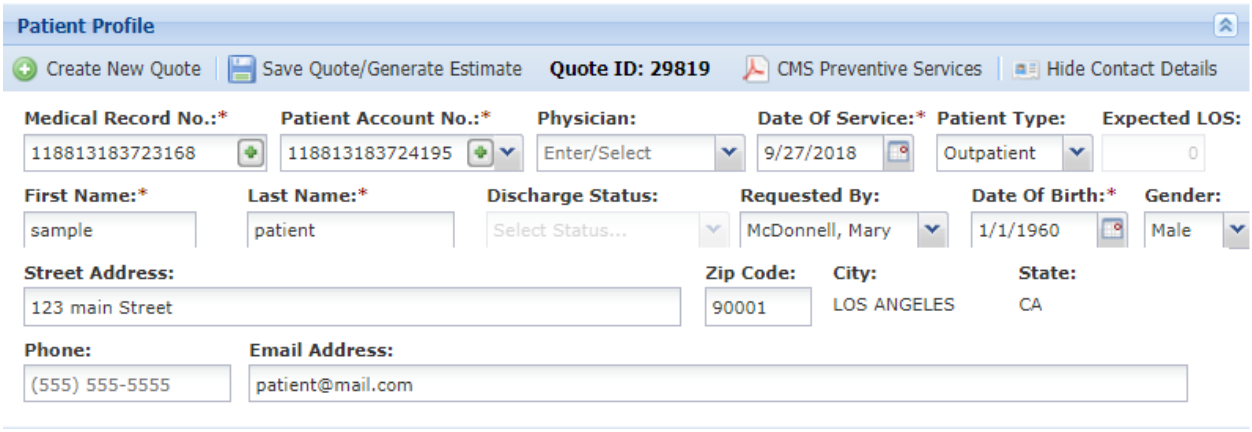
Share of Cost/Charge Quote – Step 1: Create a Quote



The Quote tab is divided into four sections:

- **Patient Profile** – Patient demographic information, Patient type, LOS and Discharge Status
- **Insurance Information** – Insurance company, plan, and Deductible/Coinsurance information
- **Services** – medical services that will be provided to the Patient
- **Details** – function icons, Payer selection, Patient responsibility totals, and list of services in the quote

Share of Cost/Charge Quote Step 1: Quote Creation – Patient Profile



Complete the information in the Patient Profile section; required fields are denoted with a red asterisk (*). To expand the view to add Patient address, phone, and email, click on the Show Contact Details icon in the upper right corner of the section.

- **Medical Record Number and Patient Account Number (*required fields*) -** If your facility chooses not to enter their internal record and account numbers, clicking on the green plus sign at the end of the box will auto-fill the field with a randomly-assigned unique number

- **Physician -** A physician name can be manually entered or a list of Physicians may be made available in the drop-down menu if added by the system Administrator.

- **Date of Service (*required field*) -** A date may be manually entered in the MM/DD/YYYY format, or selected from the Calendar by clicking the icon

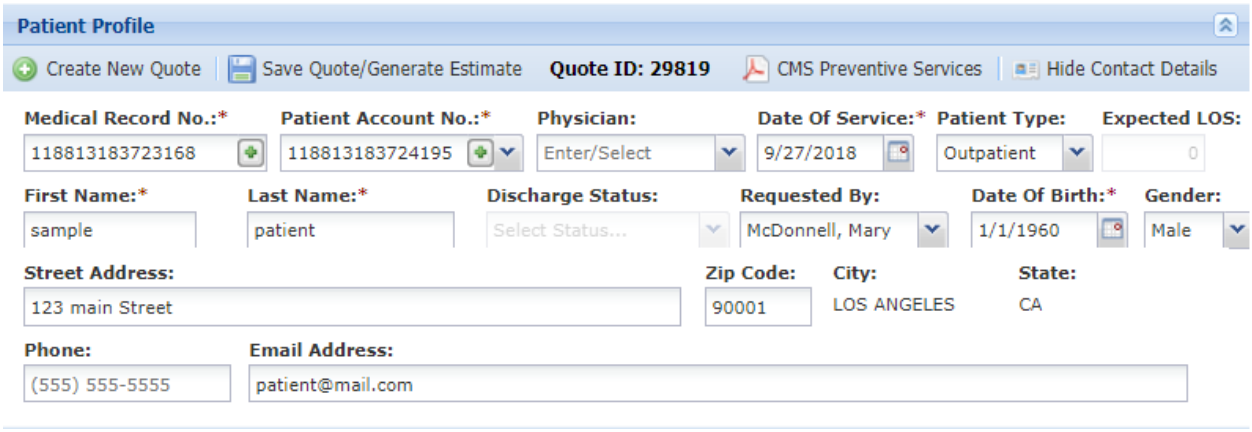
- **Patient Type -** Select Inpatient or Outpatient from the available drop-down

- **Expected LOS -** This field is only required if utilizing the DRG group when preparing an Inpatient quote. Manually enter a date, or select from a pop-up calendar

- **Patient First Name (*required field*)**

- **Patient Last Name (*required field*)**

Share of Cost/Charge Quote Step 1: Quote Creation – Patient Profile

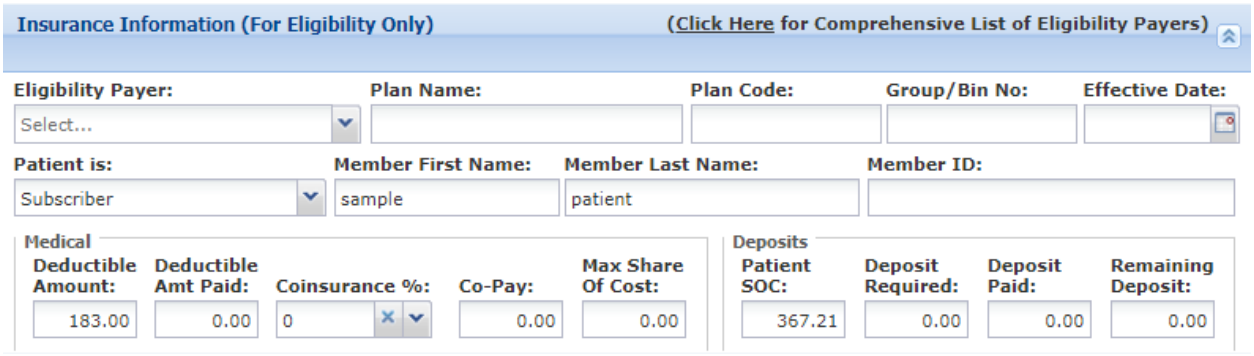


- **Discharge Status -** This field is only required for preparing an Inpatient Quote. Select a DC status from the drop-down menu:

01 – Home or Self-care	43 – Fed Hospital
02 – disch/trans to another S/T hosp	50 – Hospice-home
03 – disch/trans to SNF	51 – Hospice-medical facility
04 – disch/trans to ICF	61 – Swing bed
05 – disch/trans to another type facility	62 – Rehab fac/unit
06 – Care of home health service	63 – LTC hospital
07 – Left against medical advice	64 – Nursing facility Medicaid certified
20 – Died	65 – Psych hospital/unit
21 – Court/law enforcement	66 – Critical Access Hospital
30 – Still a patient	70 – Other institution

- **Date of Birth (*required field*) -** Enter the date manually or use the pop-up calendar
- **Gender -** Select from the drop-down menu
- **Street Address**
- **Zip Code -** The City and State will auto-fill based on the zip code entered
- **Phone –** this field is not preformatted, the User may enter parentheses and/or hyphens manually
- **Email Address -** The Quote letter can be emailed to the Patient through our secure email process

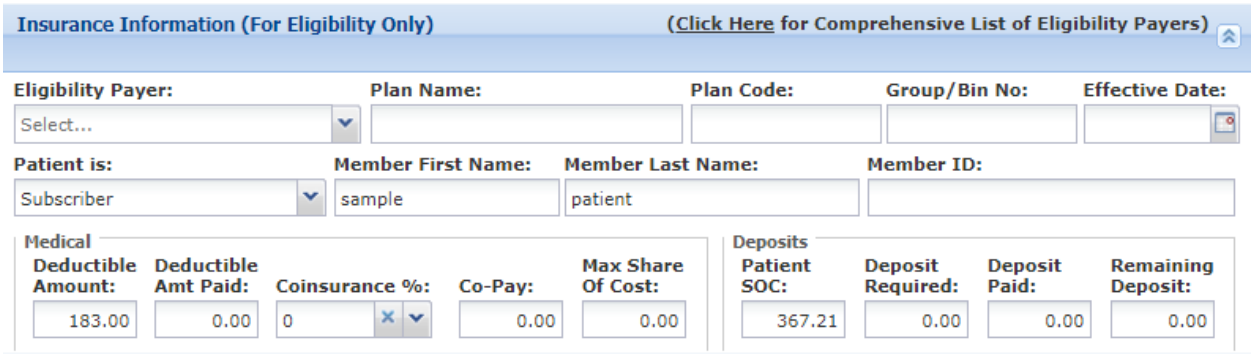
Share of Cost/Charge Quote Step 1: Quote Creation – Insurance Information



The following fields are available in the Insurance Information section. The top two rows affect the Eligibility Enquiry only; the bottom row (the financial fields) are incorporated into the quote.

- **Insurance Company -** Select a company from the drop-down menu
- **Plan Name -** Enter the plan name (if applicable)
- **Plan Code -** Enter the plan code from the Insurance card (if applicable)
- **Group/Bin Number -** Enter the group or Bin number from the Insurance card (if applicable)
- **Effective Date -** Enter the effective date of coverage if available
- **Patient Is -** The field will default to “Subscriber” - use the drop-down menu to select “Dependent” or “Spouse” if applicable
- **Member First Name -** Will auto-fill from Patient Profile, can be manually edited if the Patient is not the Insured
- **Member Last Name -** Will Auto-fill from Patient Profile, can be manually edited if the Patient is not the Insured
- **Member ID -** Enter the ID number from the Insurance card

Share of Cost/Charge Quote Step 1: Quote Creation – Insurance Information



Medical Deductible Fields:

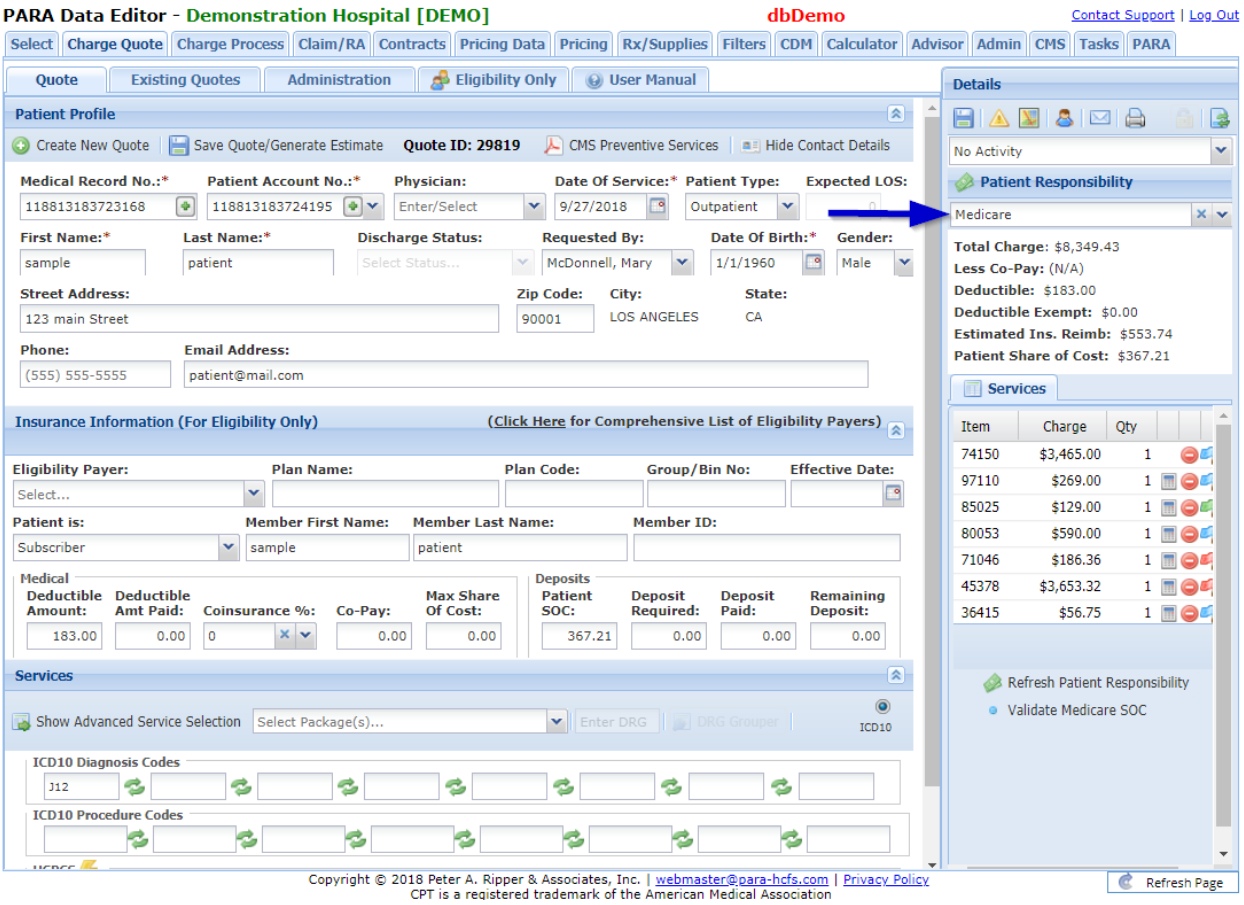
- **Deductible Amount –** the Patient's total yearly deductible amount
- **Deductible Amount Paid –** how much of that amount has been met so far in the calendar year
- **Coinsurance % -** the percentage the Patient is required to pay after insurance reimbursement
- **Office Co-Pay –** the out-of-pocket amount due at the time of service
- **Max Share of Cost (Out of Pocket) –** the maximum amount the Patient will be required to pay

Deposit Fields:

- **Patient SOC -** the Patient's share of cost calculates in this field, based on the services selected
- **Deposit Required –** Some facilities require a deposit for Self-Pay Services, such as surgeries
- **Deposit Paid –** the amount of the deposit that has already been received
- **Remaining Deposit –** the amount of the deposit still to be paid

Once all of the applicable information has been entered in the Patient Profile and Insurance Information fields, services can be selected for the quote.

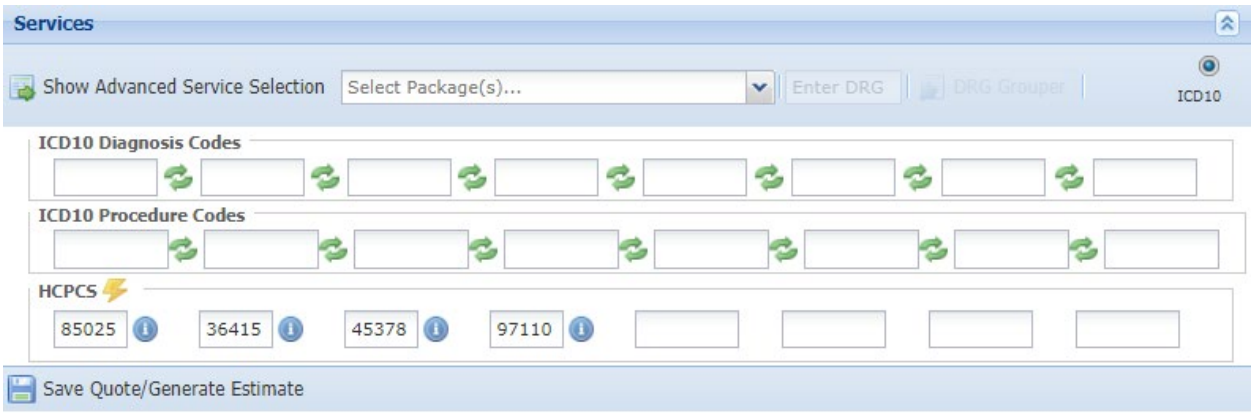
Share of Cost/Charge Quote Step 1: Quote Creation – Payer Selection



The Payer is selected from the drop-down menu available in the Patient Responsibility section, indicated above by the blue arrow. All of the Payers for which terms have been loaded will appear in the drop-down, and the User selects the appropriate one.

Please note-the Advance Beneficiary Notice (ABN) checker requires Medicare to be the selected payer.

Share of Cost Step 1: Quote Creation – Service Selection

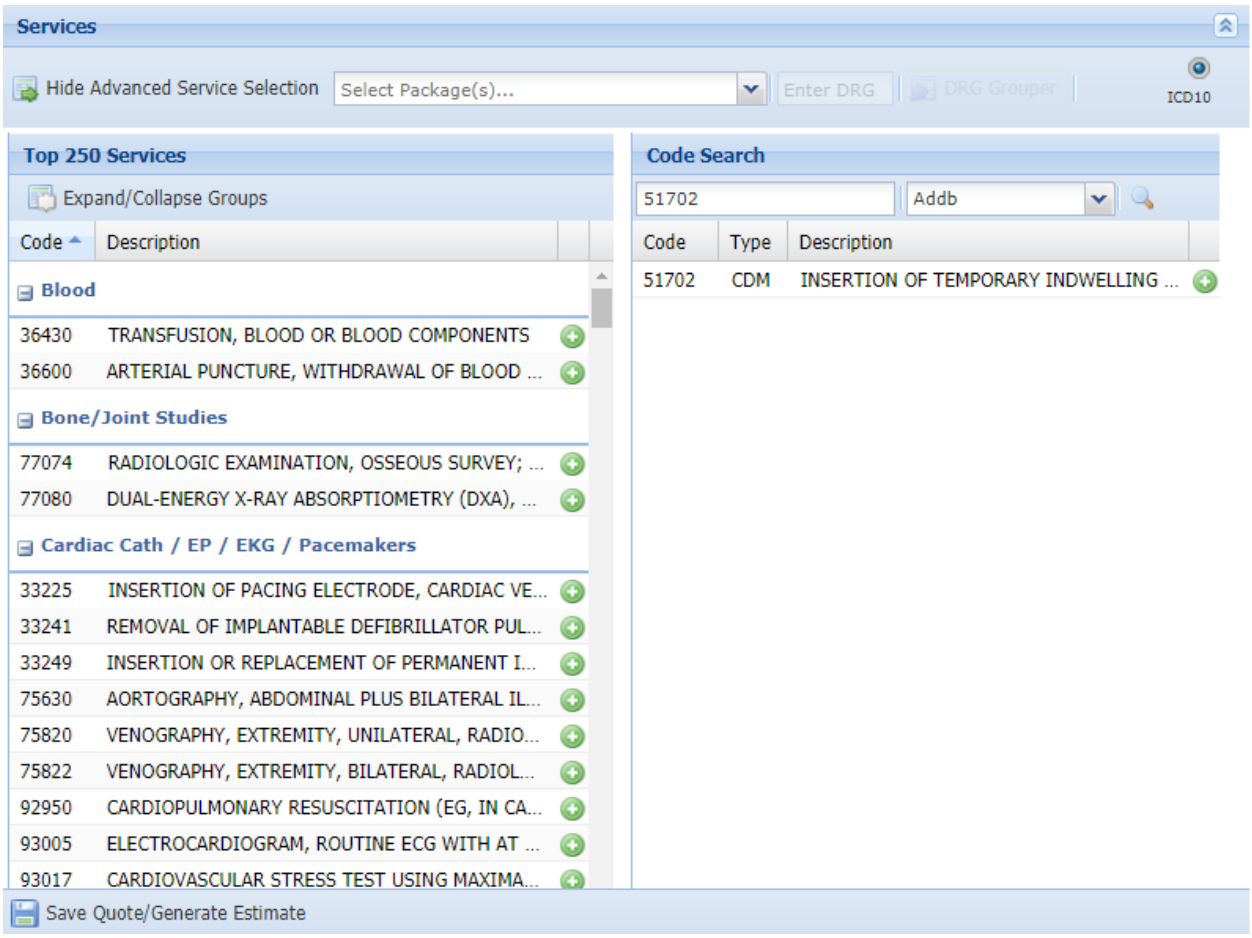


The following fields are available under Service Selection:

- **ICD-10 Diagnosis Codes -** Enter the diagnosis codes **without decimals** **(*Note: an ICD-10 Diagnosis code is required to utilize the ABN function within the Quoting tool).** If there is no Diagnosis code available, this field can be left blank.
- **ICD-10 Procedure Codes -** Enter the procedure codes (if available to the User)
- **HCPCS -** Enter the five digit CPT® or HCPCS codes

With each entry, a pop-up will appear with a complete description of the code entered, and the code will be added to the Quote Detail on the right side of the screen. If the User does not have the code information, the User can search for the codes (see next example).

Share of Cost Step 1: Quote Creation – Service Selection

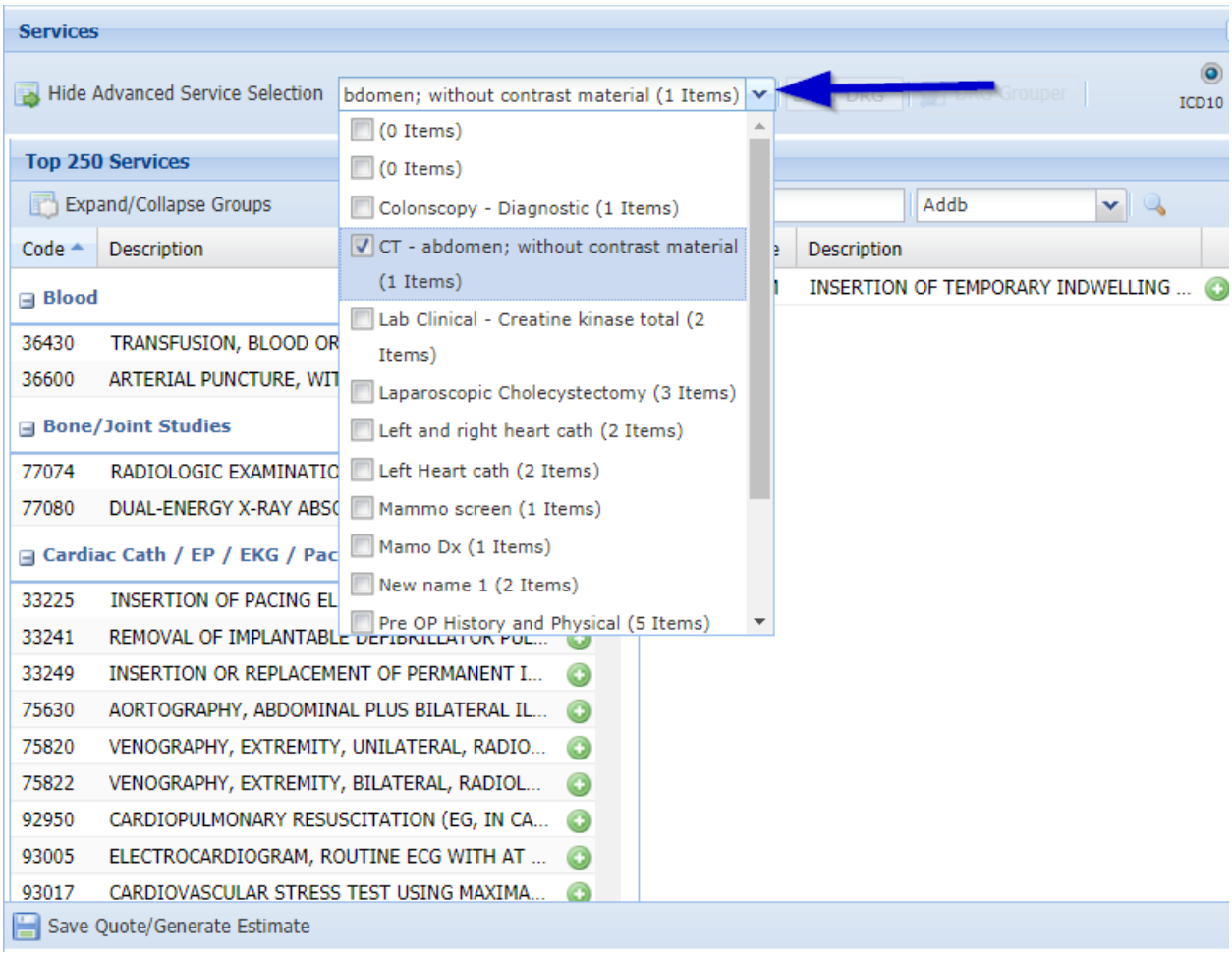


The User has several options to search for services. To search for items based on HCPCS code, Charge Number, or keyword, click on Show Advanced Service Selection directly above the ICD-10 Diagnosis Code fields. This will cause the expanded pane above to appear.

On the left, the top 200 services (by volume) have been grouped by type of service. To select one of these items, click on the green button beside it and it will be added to the quote.

On the right, the User can search for a specific code or keyword within the AddB (Medicare's list of CPT®/HCPCS codes), by CDM item number within the Charge master, or in the Professional Fee Database for Physician services. By clicking the plus (+) sign next to an item in the code search section, Peer Market Data and the full description can be viewed. To add this item to the quote, click on the green button adjacent to the line.

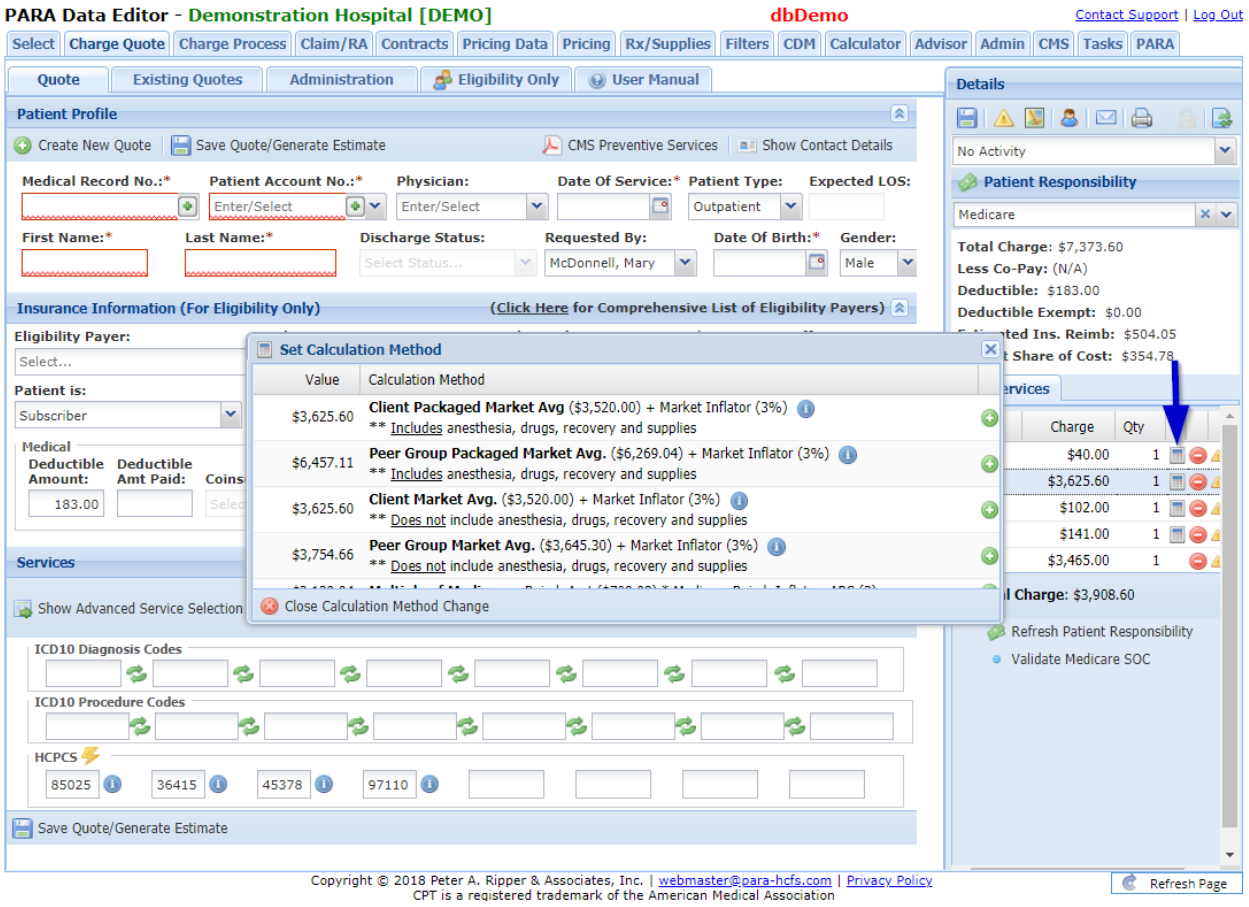
Share of Cost Step 1: Quote Creation – Service Selection



The facility also has the option to create customized packages, which can include all of the services tied to a procedure. Surgery time, recovery time, supplies, and drugs can all be included in the package, so the User will not have to search the entire Charge master for individual items.

Clicking on the drop-down arrow in the Packages field will display the available packages, with the number of individual items included in the package. To add a package to a quote, click in the box next to the package name in the drop-down. All the items will load into the quote, and are highlighted in green within the quote listing.

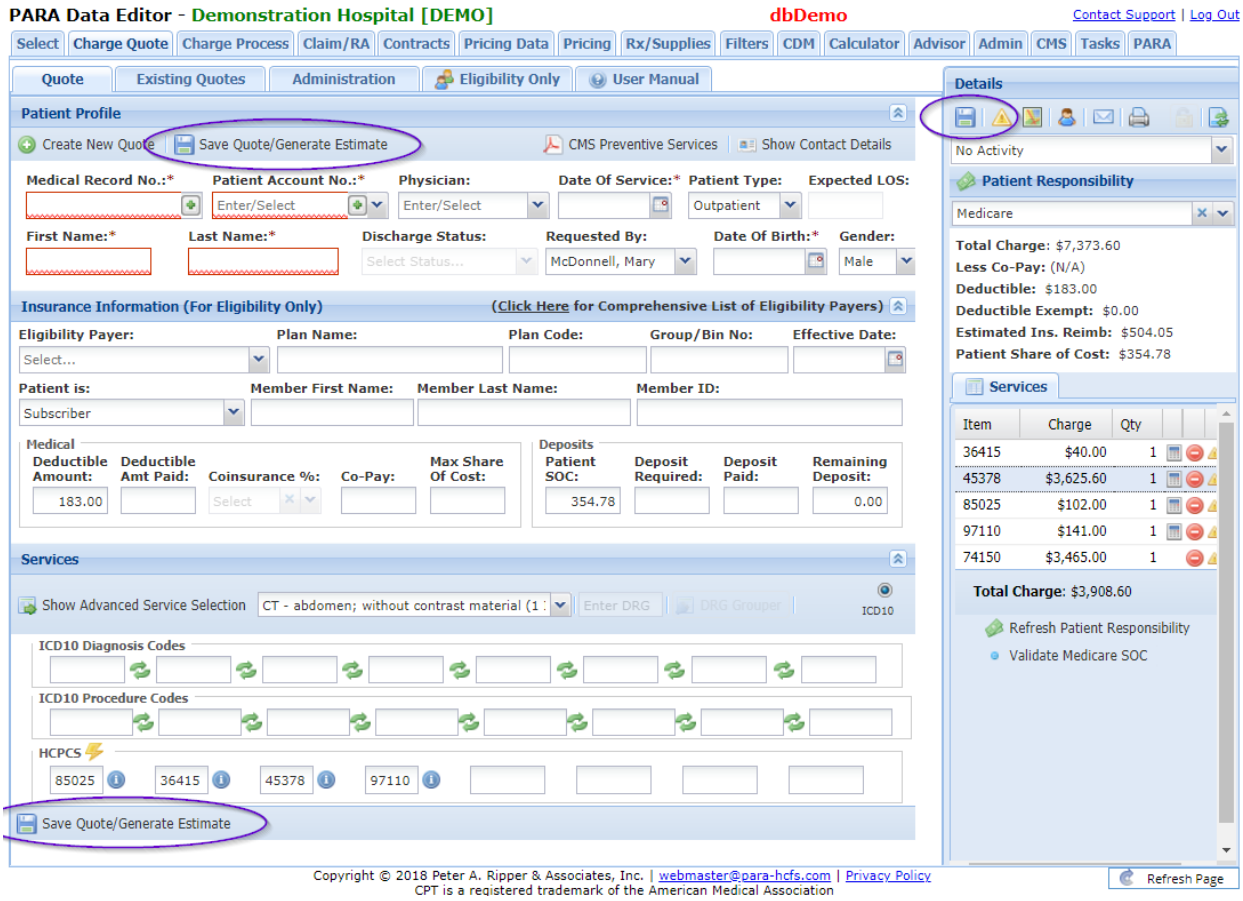
Share of Cost Step 1: Quote Creation – Service Selection



To display the price Calculation method for an item in the quote, click on the Calculator icon next to the item in the quote service list. The pop-up above will display, allowing the User to change the calculation method if desired.

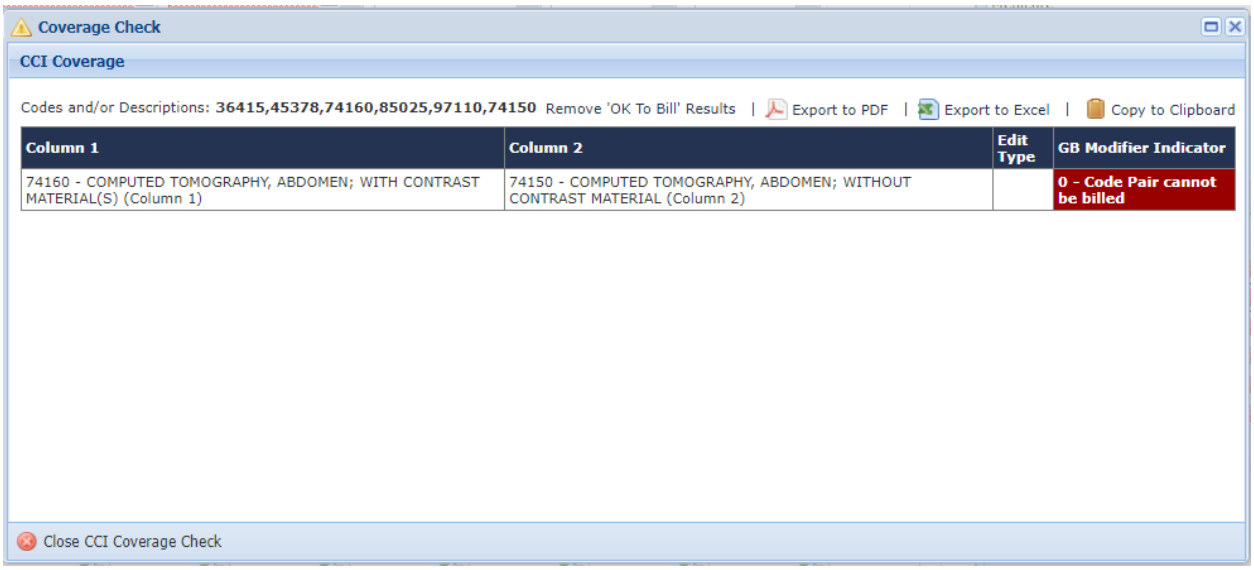
To remove a line item from the quote, click on the red button at the far right of the item in the quote list. **Please note, if an item within a package (highlighted in green) is selected for deletion, all of the items in the package will be deleted.**

Share of Cost Step 1: Quote Creation – Saving your Quote



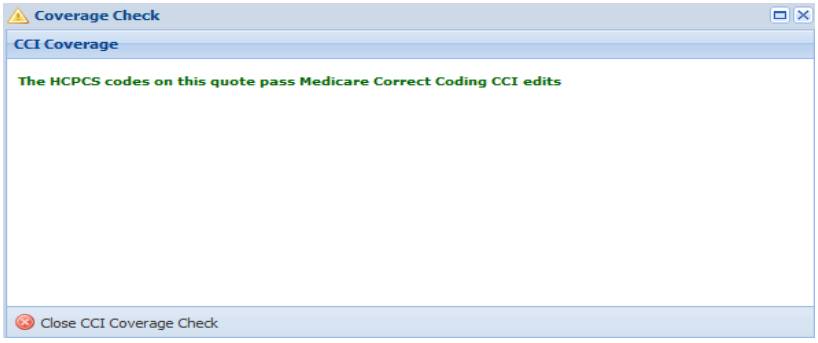
The quote must be saved before CCI edits and Eligibility can be checked. There are several locations (circled in purple above) where the User can save.

Share of Cost Step 1: Quote Creation – Correct Coding Initiative Edits (CCI)



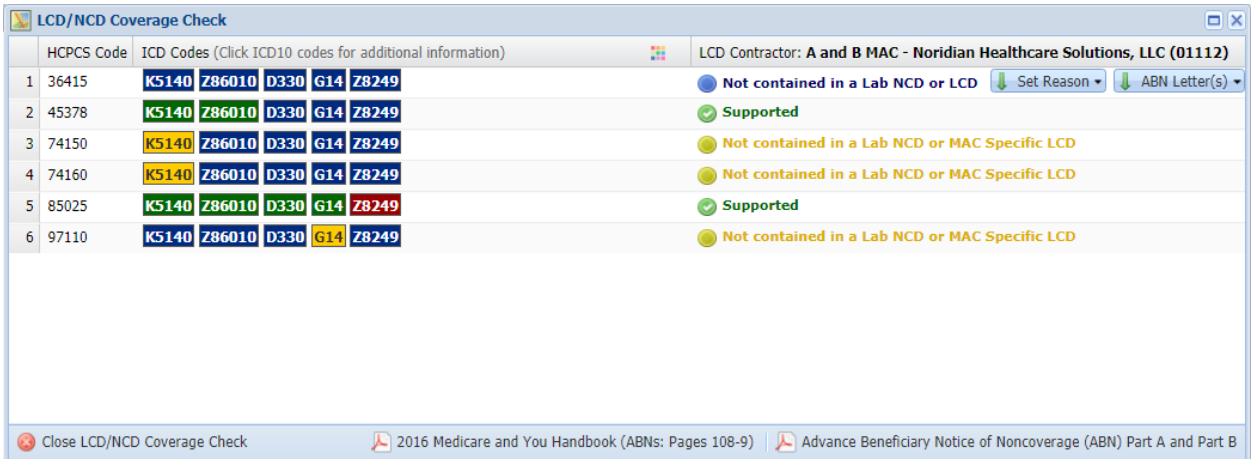
Medicare Correct Coding Initiative (CCI) Edits can be checked to ensure that all codes on the quote, and subsequently the claim, are billable together on the same encounter. Above the Patient Responsibility Summary, click on the icon. A pop-up window will display any coding conflicts, so the User can remove one or more of the conflicting services from the quote, or note that a modifier will be necessary for claim submission.

If there are no conflicts within the codes, the following message will appear in the pop-up:



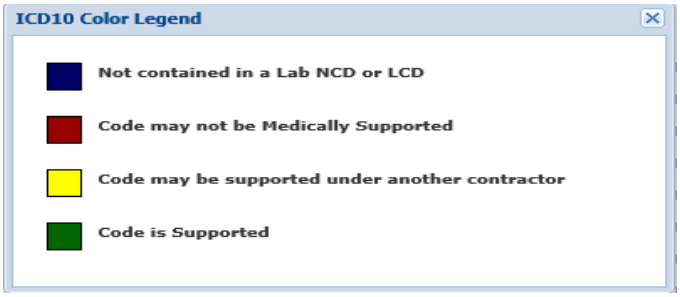
Share of Cost Step 2: Coverage Check – Advance Beneficiary Notice (ABN)

***Note: at least one ICD-10 Diagnosis code is required to utilize the ABN function within the Quoting tool.**



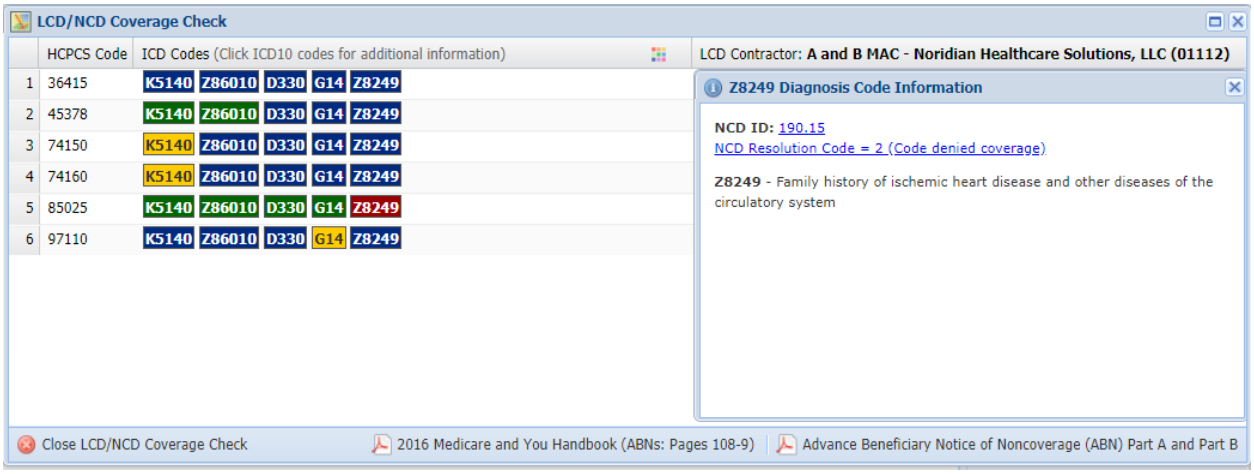
The Advance Beneficiary Notice (ABN) tool within Charge Quote/Share of Cost will allow the User to determine whether the services are supported for Medical Necessity by the diagnosis codes supplied. This coverage determination is geared specifically to your FI/MAC Contractor, and also supplies information from other Medicare contractors which may inform the determination.

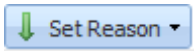
There is a color legend available within the window by clicking the icon :



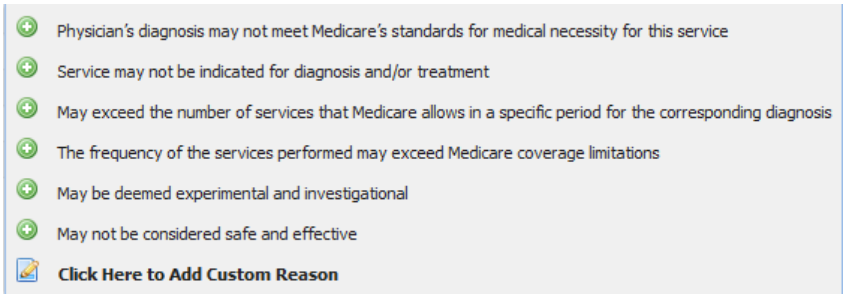
Share of Cost Step 2: Coverage Check – Advance Beneficiary Notice (ABN)

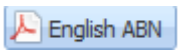
LCD/NCD Details for each of the ICD9 codes are available by clicking on the code:

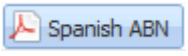


When printing an ABN, the reason for non-coverage may be selected from the 

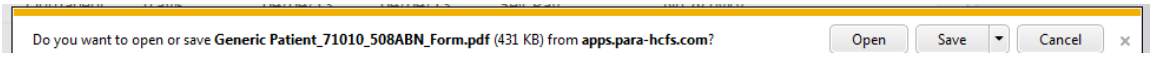
drop-down; if no reason is selected, the first reason is the default ("Physician's diagnosis may not meet Medicare's standards for medical necessity for this service"):



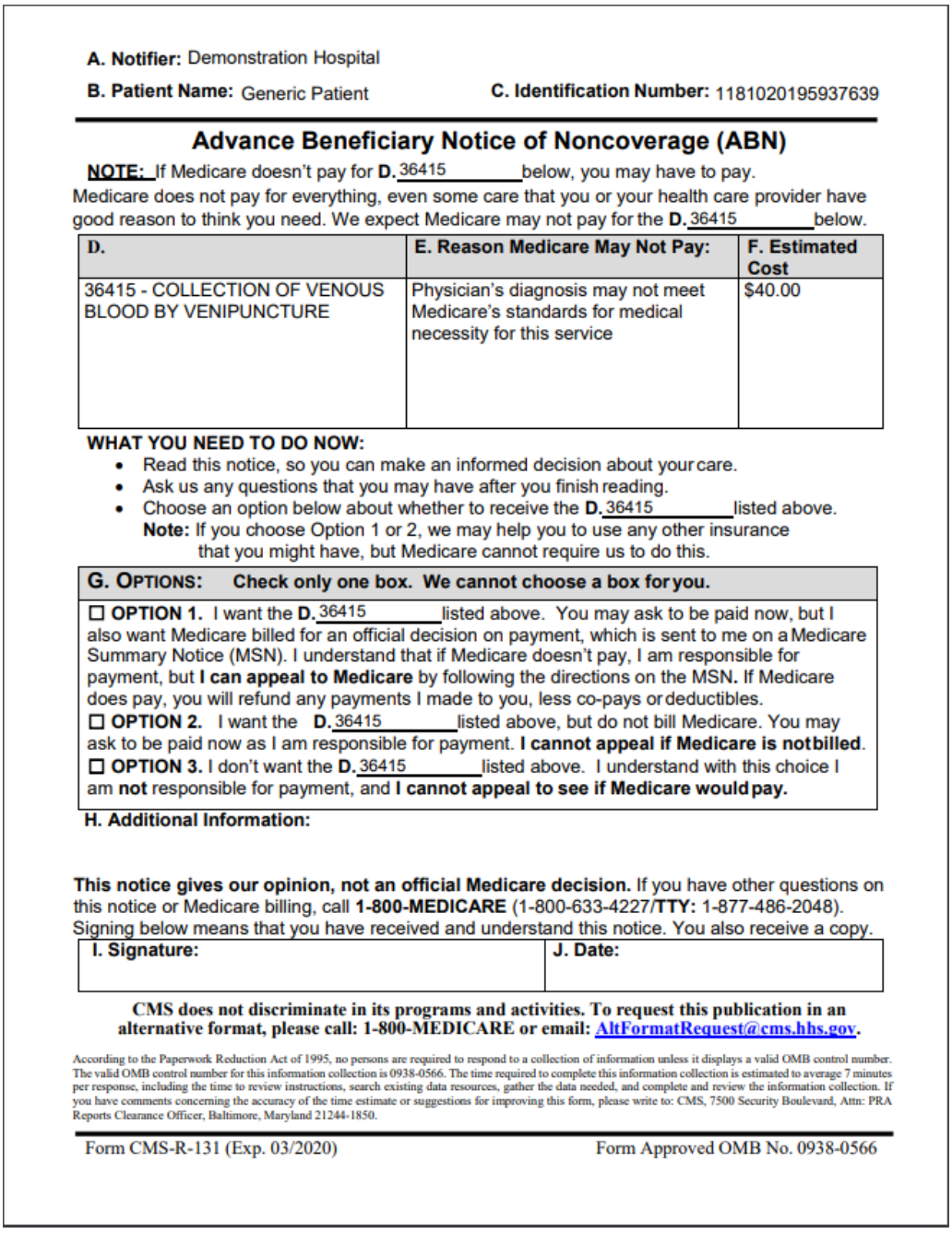
To Produce the ABN, click the 

or 

button in the Coverage Check window. The current Medicare standard ABN document may be opened by clicking "Open" when the prompt appears at the bottom of the web page:



Share of Cost Step 2: Coverage Check – Advance Beneficiary Notice (ABN)



A. Notifier: Demonstration Hospital

B. Patient Name: Generic Patient **C. Identification Number:** 1181020195937639

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** 36415 below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** 36415 below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
36415 - COLLECTION OF VENOUS BLOOD BY VENIPUNCTURE	Physician's diagnosis may not meet Medicare's standards for medical necessity for this service	$40.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** 36415 listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** 36415 listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** 36415 listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** 36415 listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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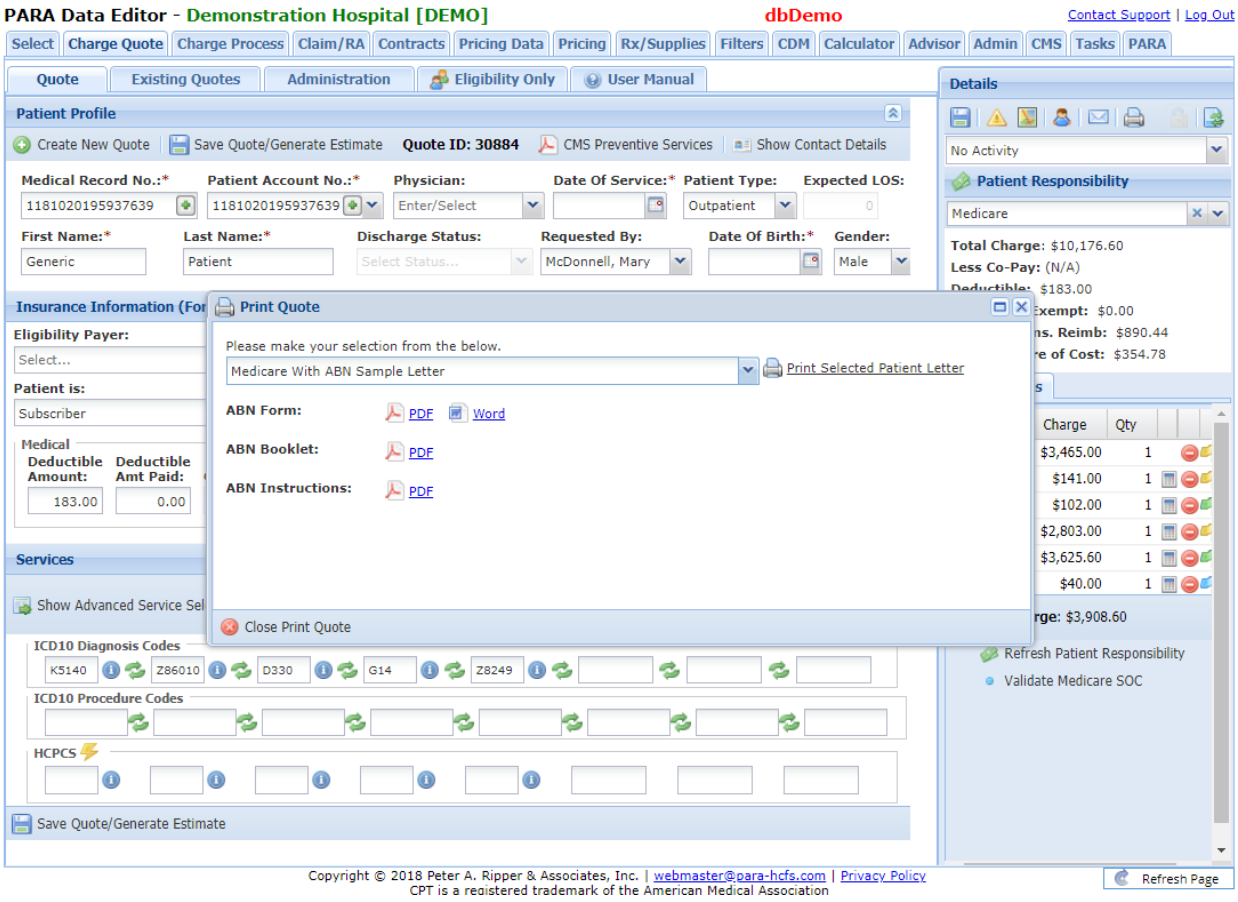
Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

To support staff in explaining ABNs to Patients, hyperlinks to the ABN pages of the 2016 beneficiary manual "Medicare and You" and to a brochure publication produced by CMS are available at the bottom of the page.

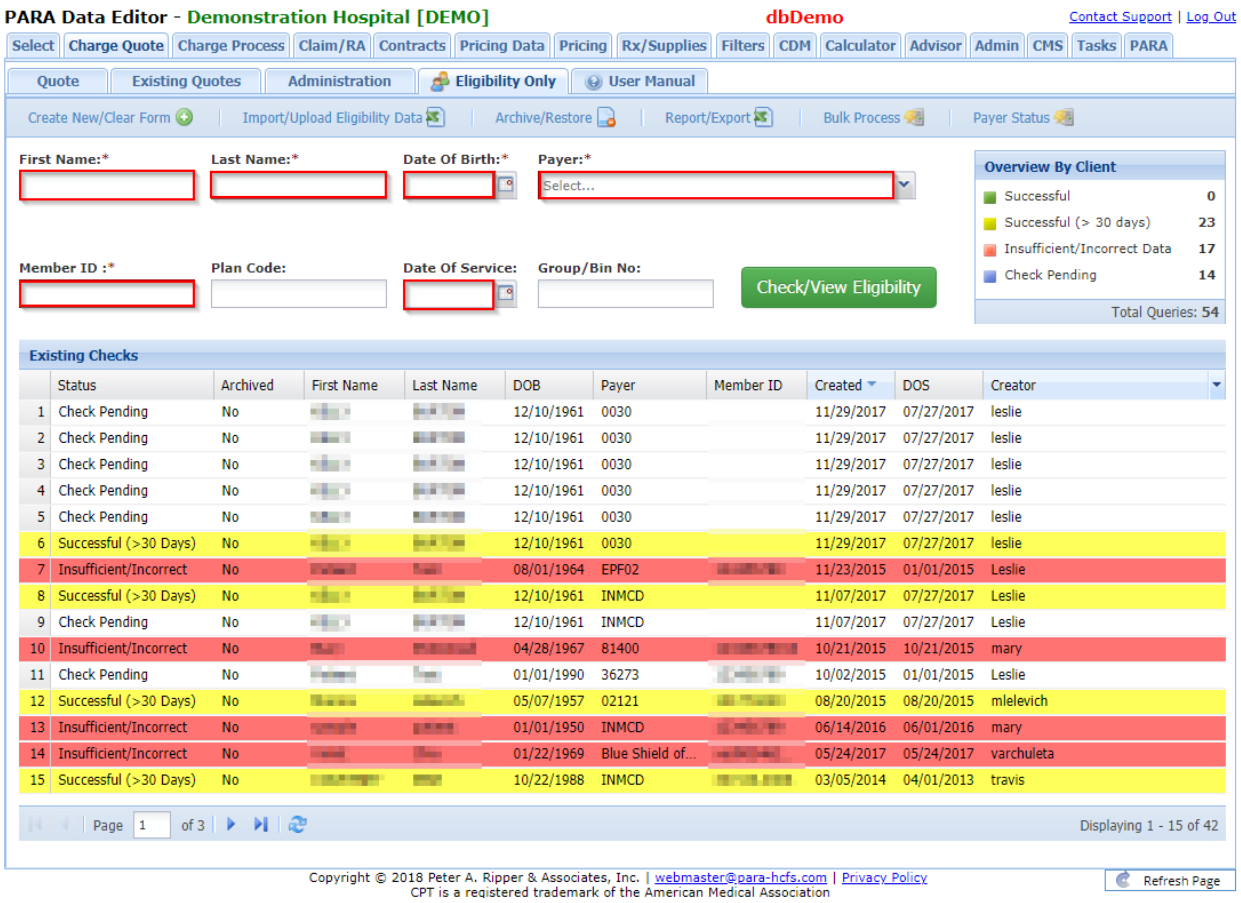
2013 Medicare and You Handbook (ABNs: Pages 108-9) | Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B

Share of Cost Step 3: Quote Creation – Customized Letters

A customized letter can be sent to the Patient, with the details of the quote just created. To select a letter, click on the icon. A pup-up menu will appear, allowing the User to select one of the current letter templates. The services selected, and Patient information will appear in the letter automatically. If there is an email address for the Patient on file, they will receive an email with a secure link embedded within to allow the Patient to view the letter. A copy of the letter is not sent to the Patient, the link directs them to a secure site on a **PARA** server when the letter can be viewed.



Share of Cost Step 4: Eligibility Verification



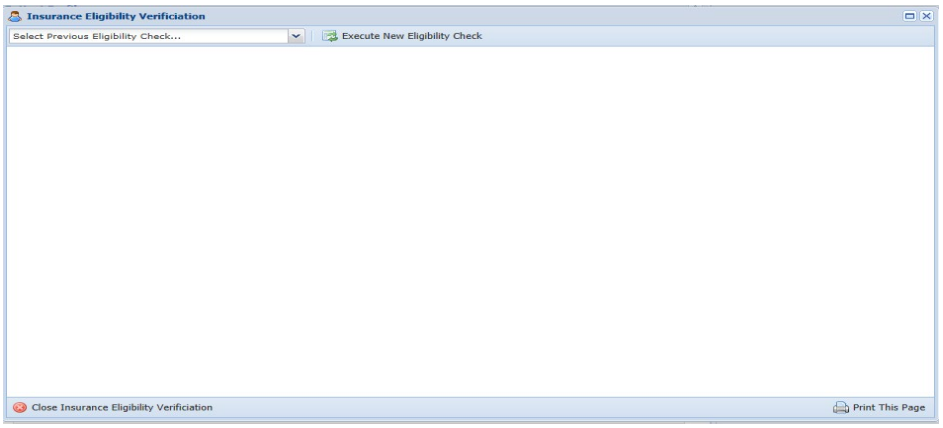
Available within the Share of Cost Charge Quote tool is **PARA**'s Eligibility Verification process. This process can be used in conjunction with building a quote, or by itself as a standalone tool. The screenshot above is of the "Eligibility Only" option, which requires only the following fields (outlined in **red**):

Patient First Name
Patient Last Name
Patient Date of Birth
Payer (selected from the available options in the drop-down menu)
Member ID
Date of Service

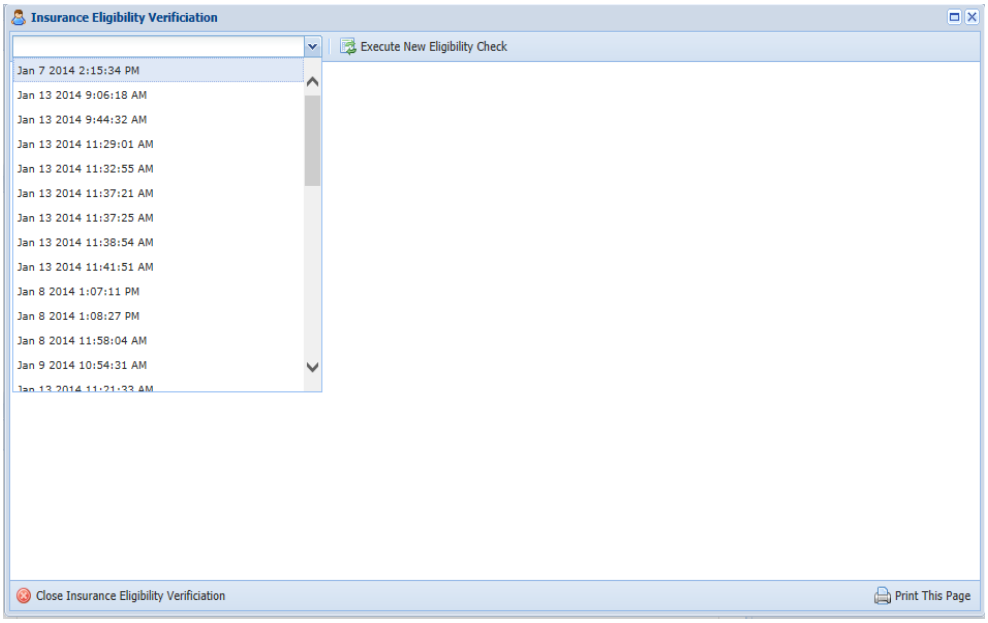
The remaining fields, Plan Code, Date of Service, and Group/Bin Number are optional.

Share of Cost Step 4: Eligibility Verification – Executing Query

When the necessary fields are complete, click on the Check/View Eligibility icon, and a blank Eligibility screen will appear:



If an Eligibility query has been performed previously, the query results are available from the drop-down menu in the upper left corner:

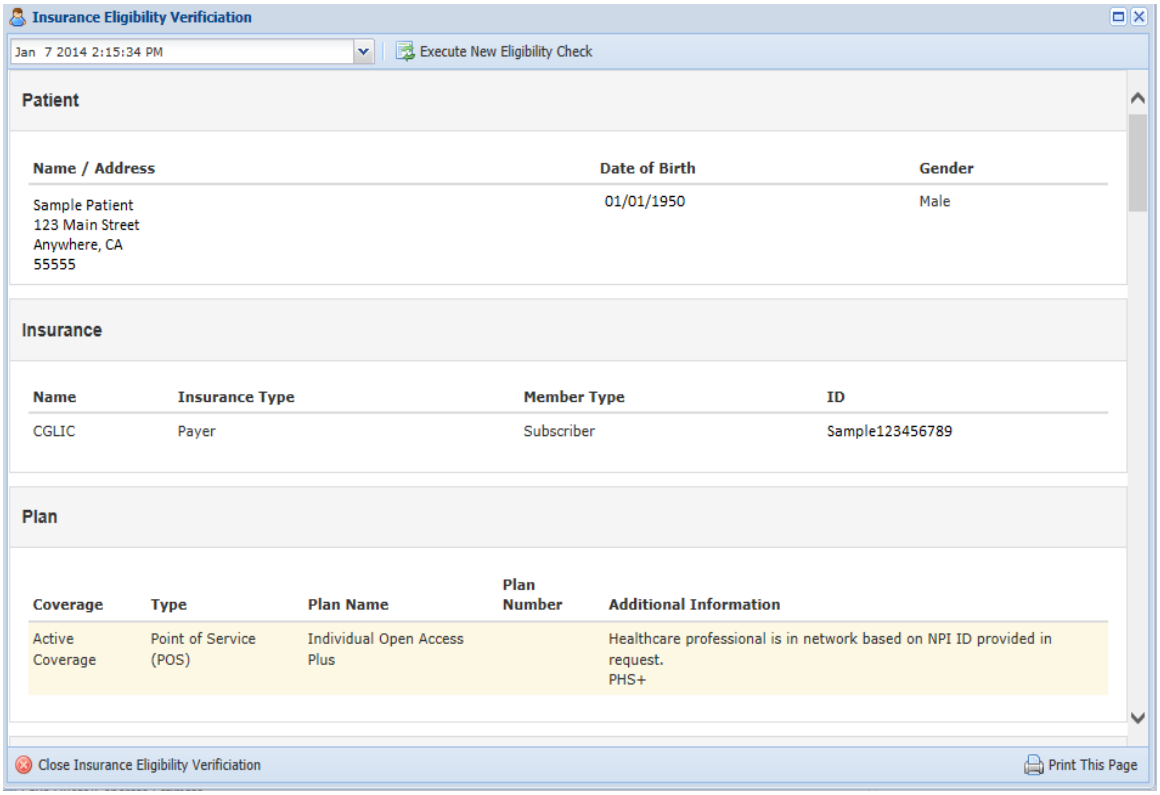


Simply click on one of the previous queries to view the results. To start a new query, click on the "**Execute New Eligibility Check**" link.

The query can take up to 1-2 minutes to run-most returns are received within a few moments.

Share of Cost Step 4: Eligibility Verification - Eligibility Return

The response on a query will appear on the screen in the pop-up window:



The information on the return is dictated by the payer, and can range from minimal data to extremely comprehensive. The results can be exported by clicking the "**Print this Page**" icon in the lower right –hand corner.

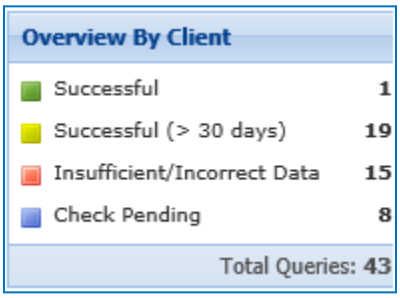
Share of Cost Step 4: Eligibility Verification – Previous Checks

Existing Checks

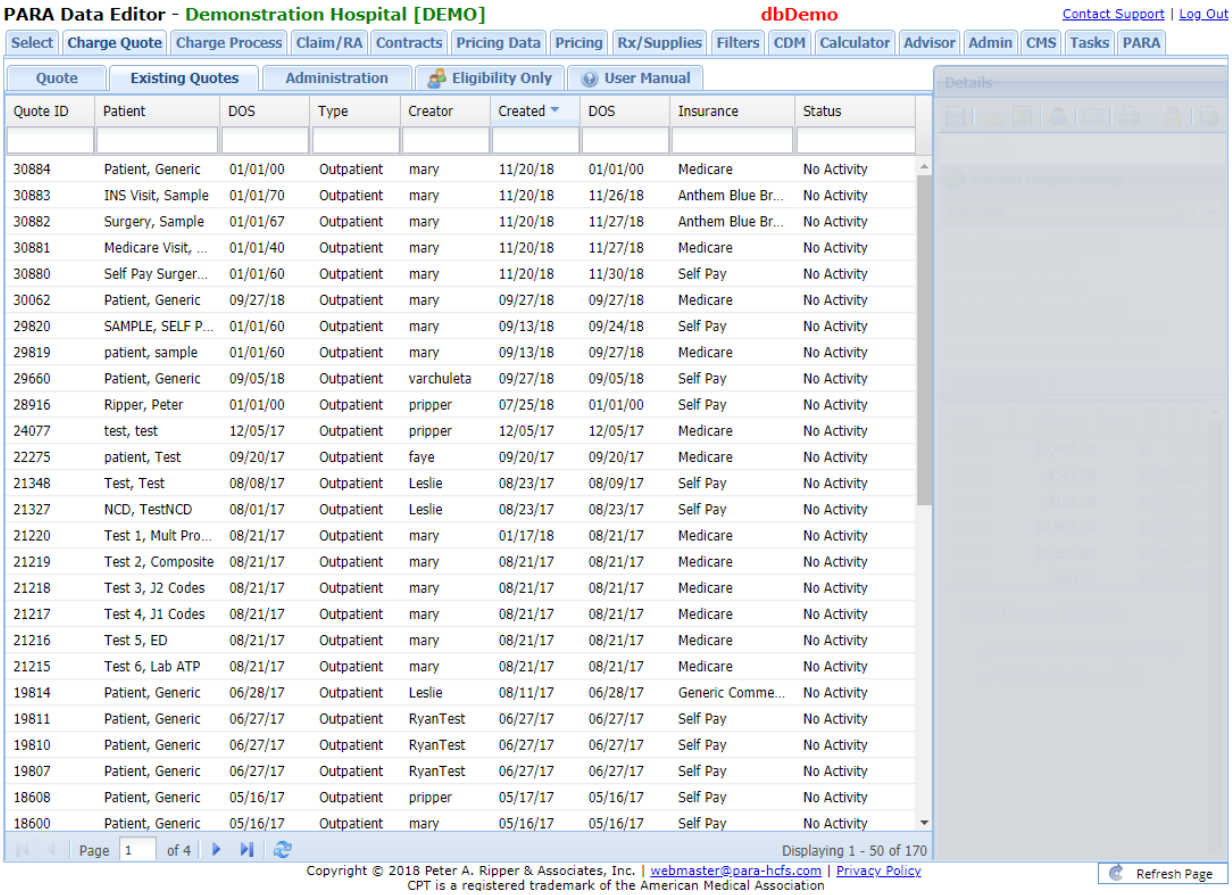
	Status	Archived	First Name	Last Name	DOB	Payer	Member ID	Created	DOS	Creator
1	Check Pending	No			12/10/1961	0030		11/29/2017	07/27/2017	leslie
2	Check Pending	No			12/10/1961	0030		11/29/2017	07/27/2017	leslie
3	Check Pending	No			12/10/1961	0030		11/29/2017	07/27/2017	leslie
4	Check Pending	No			12/10/1961	0030		11/29/2017	07/27/2017	leslie
5	Check Pending	No			12/10/1961	0030		11/29/2017	07/27/2017	leslie
6	Successful (>30 Days)	No			12/10/1961	0030		11/29/2017	07/27/2017	leslie
7	Insufficient/Incorrect	No			08/01/1964	EPF02		11/23/2015	01/01/2015	Leslie
8	Successful (>30 Days)	No			12/10/1961	INMCD		11/07/2017	07/27/2017	Leslie
9	Check Pending	No			12/10/1961	INMCD		11/07/2017	07/27/2017	Leslie
10	Insufficient/Incorrect	No			04/28/1967	81400		10/21/2015	10/21/2015	mary
11	Check Pending	No			01/01/1990	36273		10/02/2015	01/01/2015	Leslie
12	Successful (>30 Days)	No			05/07/1957	02121		08/20/2015	08/20/2015	mlelevich
13	Insufficient/Incorrect	No			01/01/1950	INMCD		06/14/2016	06/01/2016	mary
14	Insufficient/Incorrect	No			01/22/1969	Blue Shield of...		05/24/2017	05/24/2017	varchuleta
15	Successful (>30 Days)	No			10/22/1988	INMCD		03/05/2014	04/01/2013	travis

Page 1 of 3 Displaying 1 - 15 of 42

The tool will store previous checks indefinitely. Previous checks and their status can be viewed in the Eligibility screen, color coded to indicate the age and result of the check:



Existing Quotes

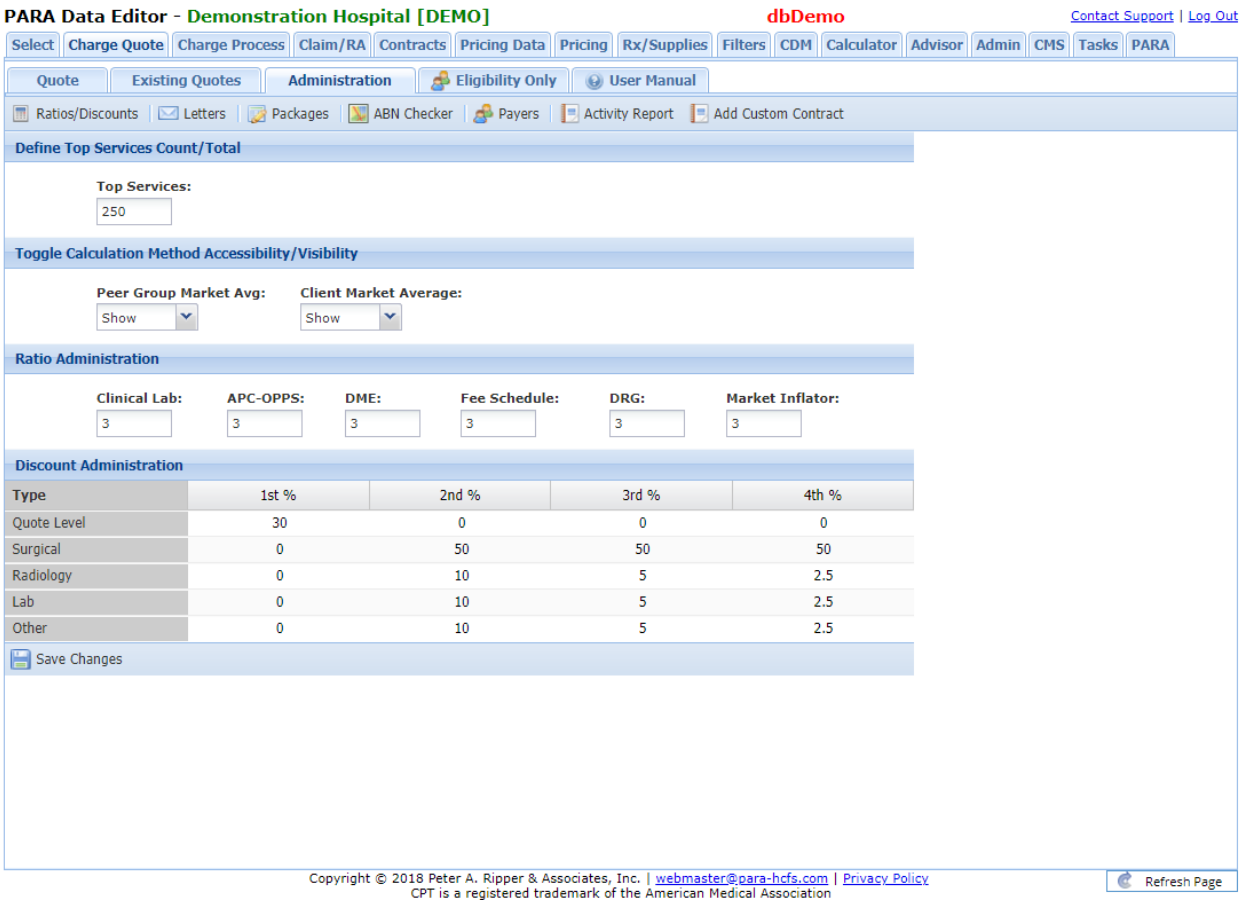


Existing quotes are stored within the tool. They can be grouped and sorted by any of the column headers:

- Quote ID
- DOB
- Type
- Creator
- Created Date
- Date of Service
- Insurance
- Status

To view an existing quote, click on the quote within this list and then click on the Quote tab. The selected quote and all its details will appear.

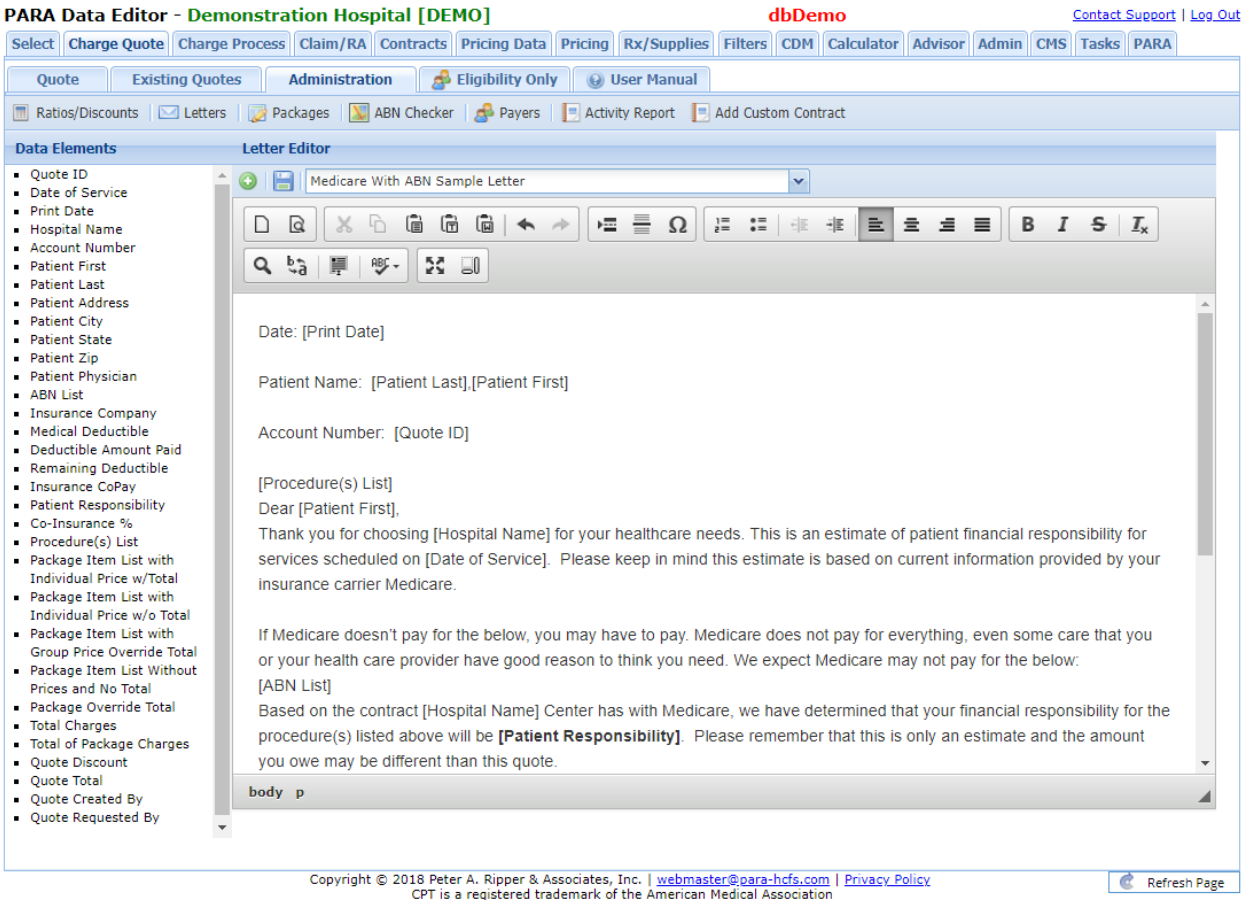
Administration – Ratios and Discounts



Ratios can be set in this tab to calculate quote amounts based on Medicare Fee Schedules. Self Pay or Prompt Pay discounts can also be set, as well as discounts for multiple procedures in the same medical encounter.

To set ratios or discounts, enter the number is whole numbers in the appropriate filed, then click the Save Changes icon.

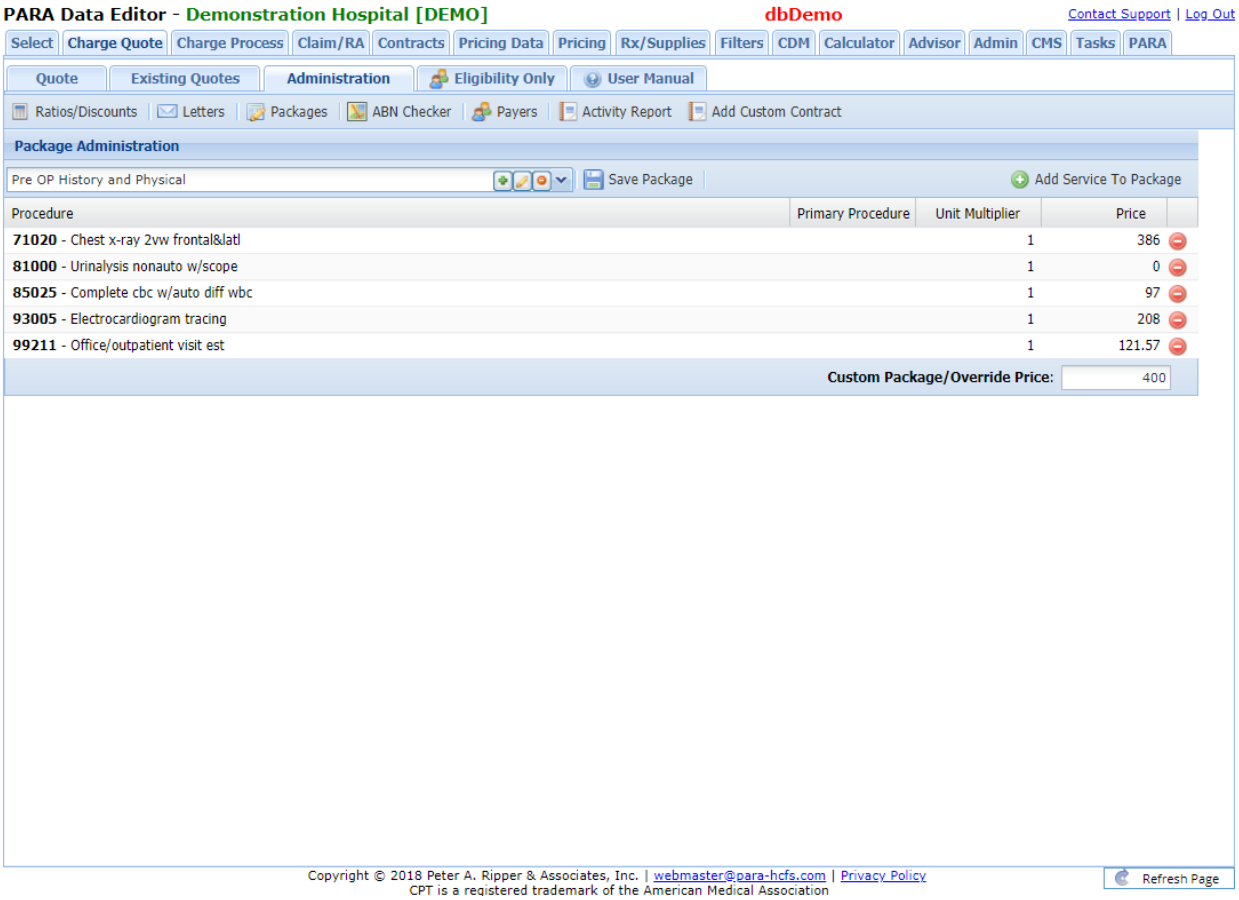
Administration – Letters



Administrative Users can create numerous letter templates, in multiple languages, and select what data points from the quote are listed in the letter. The facility logo can also be uploaded so the letter appears on the hospital letterhead.

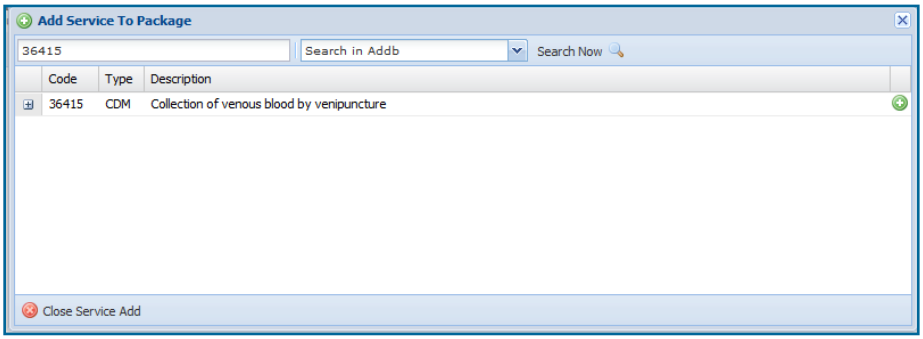
The letters are updates in a Word formatted screen, so the User can copy and paste from an existing file, or type the verbiage as needed.

Administration – Packages



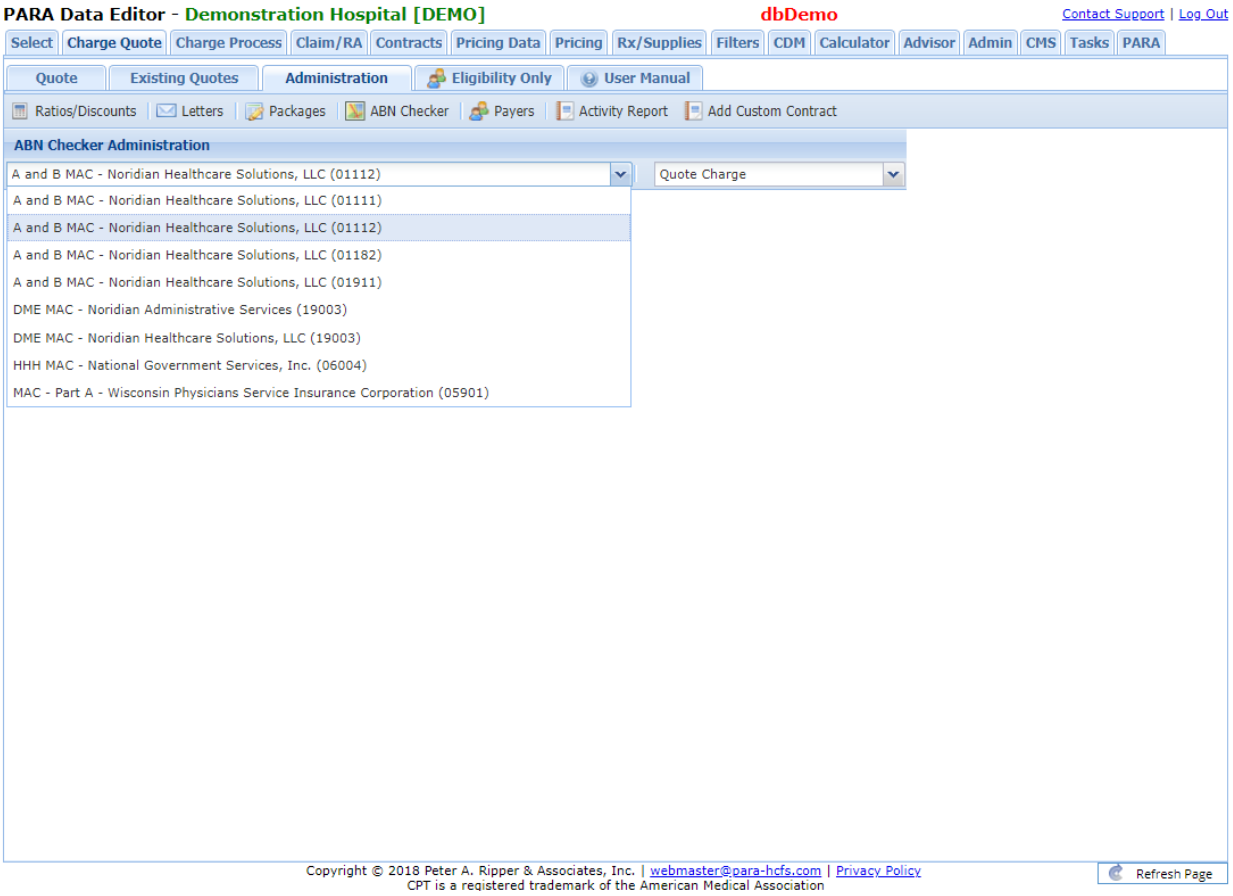
Packages can be created and edited within this section. The icons beside the package name in the drop down allow the User to add a new package, edit the name of an existing package, or delete a package.

Administration – Packages



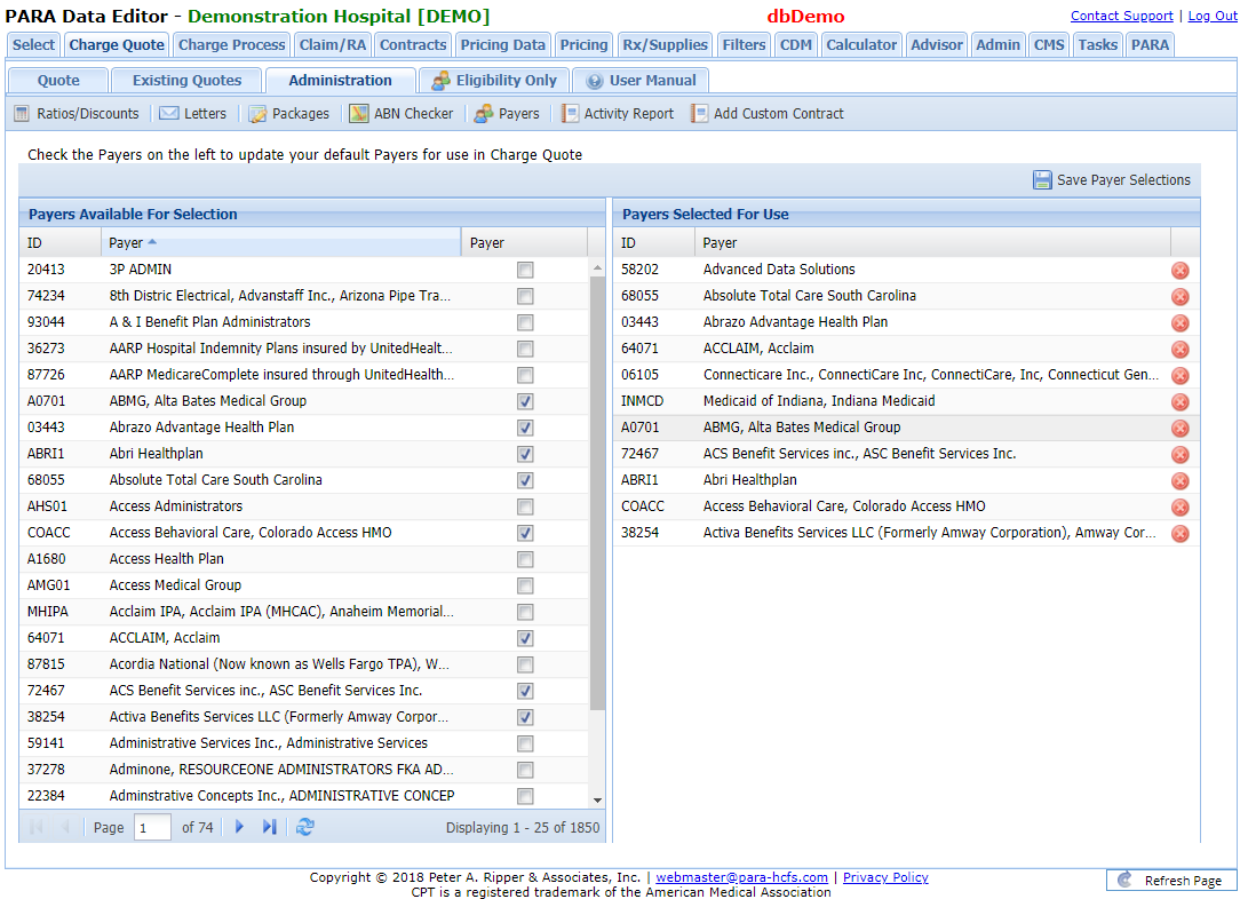
To add services to a package, select an existing package or create a new one. Choose the package from the drop-down, then select the Add Service To Package button. The pop-up that appears allows the User to search services in the same way as in the quote-by CPT® within the AddB, or by CDM number in the Charge master. Just click the green plus icon next to the service in the window to add to the package, and save your changes Save Package.

Administration – ABN Checker



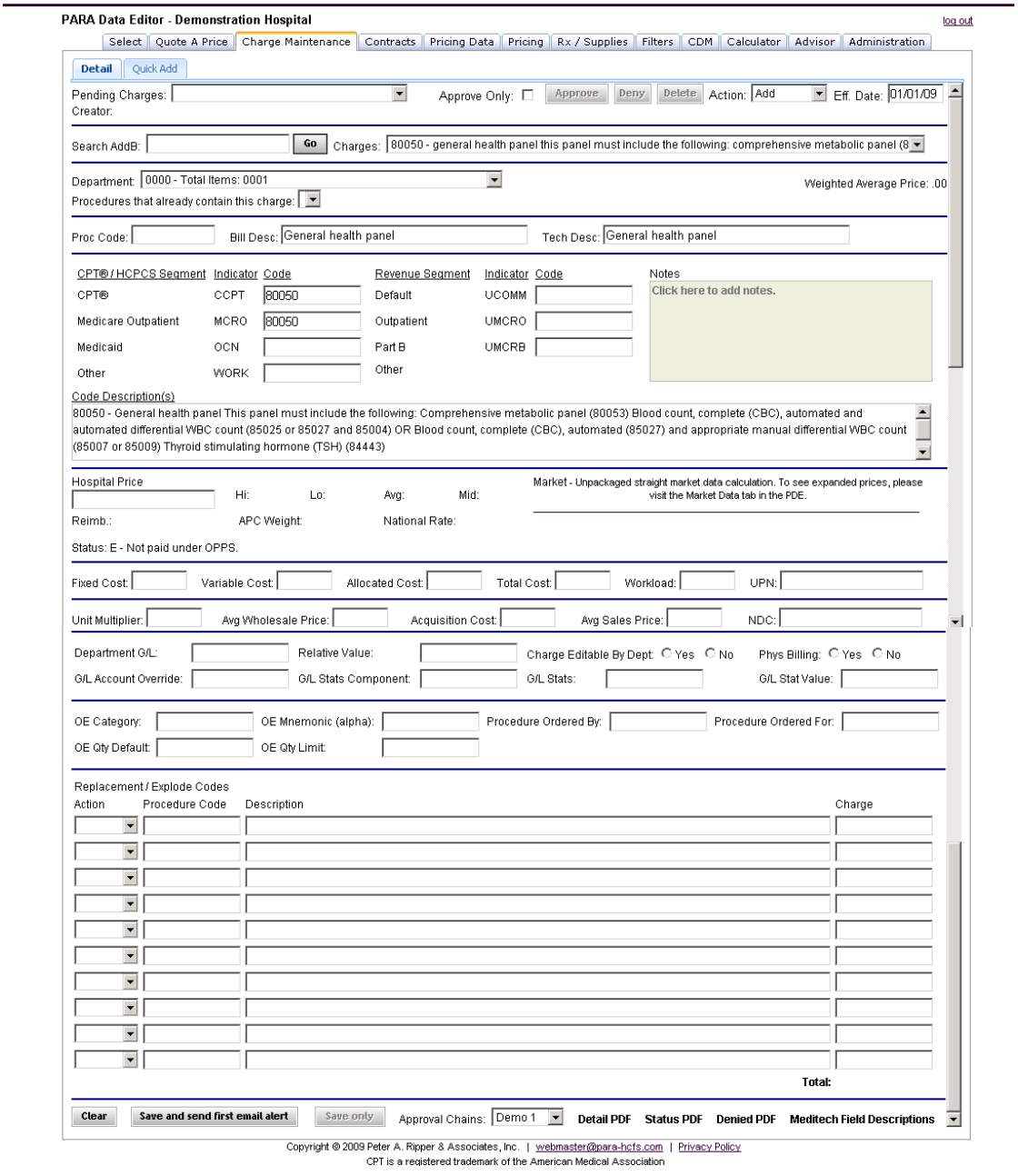
The hospital-specific Contractor is selected here, as is the indicator to determine the amount that will auto-fill in the ABN for the estimated cost. The hospital can choose the Quote Charge amount, which will be the hospital's price for the item, or the Medicare Reimbursement amount.

Administration – Payers



The list of payers available for Eligibility verification is extensive, so facilities have the option to filter the list to only those they check on a regular basis.

Charge Process



The Charge Process Function within the **PDE** allows the User greater control over additions and deletions to their Charge Master. Any requested changes can be routed electronically through a specific chain of approval, and will report any possible duplication of any items, which can then be researched before they are added to the CDM.

Charge Process (continued)

This allows the User to spend less time requesting, researching, and adding new items to the Charge Master.

There are two options available within the Charge Process tab – the Detail Entry Form, which includes all the data necessary to add a procedure to the Charge Master. The request can then be emailed to the appropriate party through approval chains that have been set up by the User.

The following are descriptions of each field in this Form:

- **Pending Charges** – this field utilizes a drop-down menu so that the User can request that new items be added to the CDM. If a request has been received by an individual with approval rights, they can use this function to approve requests and forward to the next person in the approval chain, by clicking the "Approve" button.

- **Approve Only** – this radio button acts as a filter to view only those items the User is responsible for approving

- **Action** – select an option from the drop-down menu, to add, change, inactivate, or reactivate the item you are working on

- **Effective Date** – the date the item is to be implemented

- **Search AddB** – to locate an item, you can enter a code, keyword, or partial code to search the Addendum B code table. When the information is entered, click "**Go**".

- **Charges** – this field will contain the search results. It will show any items with the code attached, individually and items in which the code is included in the description (e.g., Laboratory Panels)

- **Department** – Select the Department from which the charge update is to be retrieved from or added to the file

- **Weighted Average Price** – if an item is already contained within the CDM, the averaged price for all occurrences with quantity will produce a number in this field

- **Procedures that already contain this charge** – if the item already exists within the CDM, the items will appear here

- **Proc Code** – if creating a new item, the new procedure code can be entered here, either by the requestor or an individual farther up the approval chain. If updating an item, the existing procedure code should be entered here

- **Bill Desc** – this field displays the CPT®/HCPCS short description. This field can be modified by the user to reflect preferences in charge description format

Charge Process (continued)

- **Tech Desc** – can be used in the same way as the "Bill Desc" field
- **CPT®/HCPCS Segment** – these fields display standard code segments.
- **Indicator** – these are hospital-defined code segments
- **Code** – these fields will automatically fill with any suggested codes for the item, and can be manually changed to accommodate any payor-exclusive codes, such as Worker's Comp
- **Revenue Segment** – hospital-defined code segments, and follows the same format as CPT®/HCPCS code segments, with defined indicators and editable code fields
- **Notes** – any notes the User chooses to enter on the specific line item being edited can be entered here
- **Code Description** – this field displays the full CPT®/HCPCS code description
- **Hospital Price** – the User can enter the standard (default) price for the item in this field. Any additional prices for the item should be entered in the "**Notes**" field
- **Hi, Lo, Avg, Mid** – any available market data from the Peer Market group for this code will be summarized here showing the low, average, midpoint, and high prices
- **Reimb** – the assigned reimbursement rate, from the applicable Fee Schedule, will appear here
- **APC Weight** – the CMS assigned APC weight (if applicable)
- **National Rate** – the national reimbursement rate for the default code
- **Market Data** – the facilities included in your Peer Market group, with the specific price for the item from each facility
- **Status** – the current OPPS status of the code will appear in this field

Supply Item Fields – these items are used specifically for supplies

- **Fixed Cost** – the fixed cost of the item, without efficiency or overhead adjustments
- **Variable Cost** – the additional costs to be added to the fixed cost for each incremental use of the item

Charge Process (continued)

- **Allocated Cost** – the additional cost allocated from non-revenue departments, to be added to the fixed cost for each additional use
- **Total Cost** – the total cost, with all adjustments added to final product
- **Workload** – the basic workload unit assigned to the item, as defined by the hospital
- **UPN** – the Unit Product Number, for stock tracking

Pharmacy Fields – these are used specifically for Pharmacy items

- **Unit Multiplier** – the pharmacy unit multiplier to adjust the claim, to update the J code dose to match the dose received by the patient
- **Avg Wholesale Price** – enter the Average Wholesale Price of the pharmacy item
- **Acquisition Cost** – enter the Acquisition Cost of the pharmacy item
- **Avg Sales Price** – this field displays the average national sales price from the CMS table
- **NDC** – enter the National Drug Code for the item. You can search for a possible J code from this field.

General Ledger Fields – these fields are not required, but can be used if desired

- **Department G/L** – enter the department general ledger number to which the charge and revenue are to assigned
- **Relative Value** – enter the workload value of the charge, as determined by the Cost Accounting department
- **Charge Editable by Dept** – select the appropriate option, "**yes**" or "**no**", for zero price items that will have a price assigned based on the cost of the item
- **Phys Billing** – select "**yes**" or "**no**" to create a Physician Billing form on this charge item
- **G/L Account Override** – DO NOT USE
- **G/L Stats Component** – enter the appropriate component as determined by the hospital
- **G/L Stats** – enter the appropriate value, as determined by the hospital

Charge Process (continued)

- **G/L Stat Value** – enter the appropriate value, as determined by the hospital

Order Entry Fields – also not required, can be used if desired for the Meditech system

- **OE Category** – enter the department, or the division of a department
- **OE Mnemonic** – for the alpha code designating the procedure. This code must be unique within the category
- **Procedure Ordered By** – Determines if the item can be ordered by the care area, department, or both
- **Procedure Ordered For** – determines if the item can be ordered for a patient, department, or both
- **OE Qty Default** – enter the standard quantity for the item
- **OE Qty Limit** – enter the maximum limit of the quantity the item can be charged

Replacement/Exploding Codes

- **Action** – use the drop-down menu to select the appropriate action
- **Procedure Code** – displays the procedure code or allows the User to enter a new replacement code for the selected item
- **Description** – displays the charge description of the replacement procedure code entered or linked to the selected item
- **Charge –** displays the default charge for the replacement procedure code

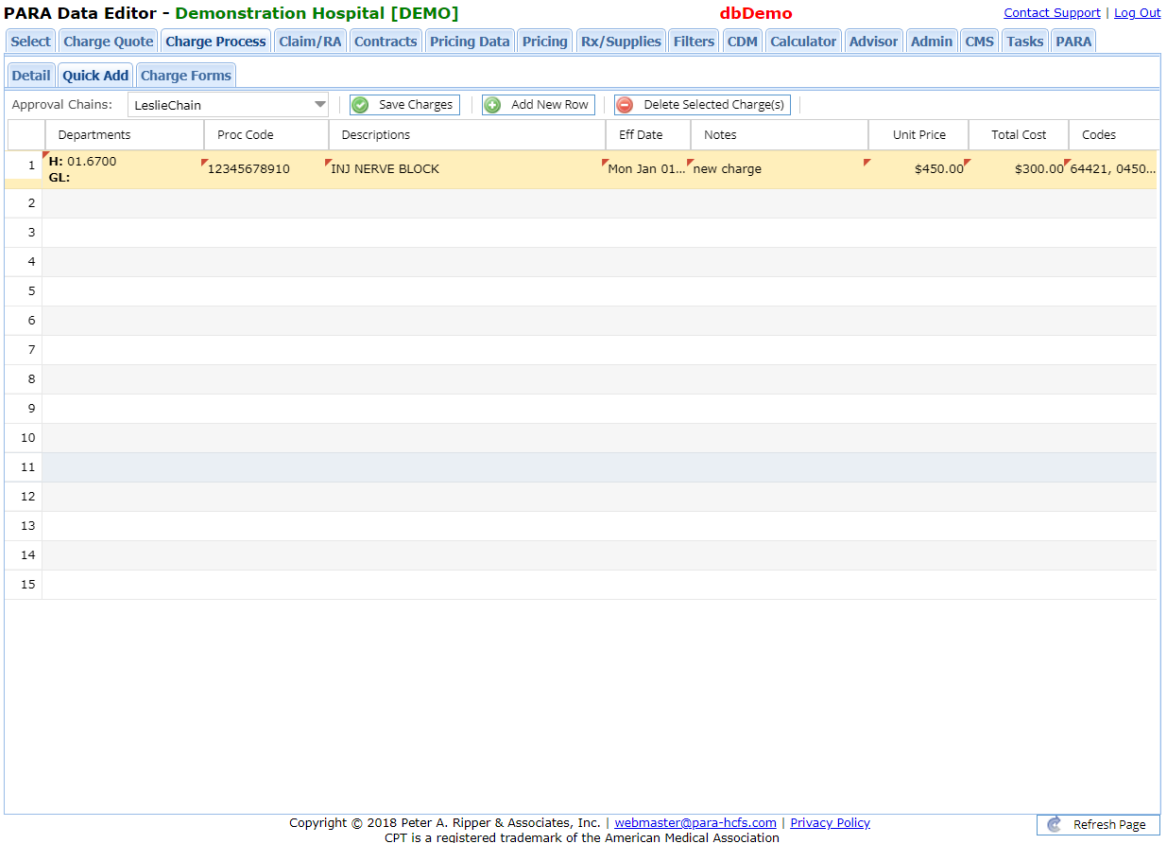
Action Buttons

- **Clear –** this button will clear all fields on the Charge Process tab
- **Save and Send First Email Alert –** when new items or changes have been entered, this button will save the page and send an email to the next person in the selected approval chain
- **Save Only –** if the User does not finish the item, and wants to return later, this button will save the changes but will not generate an email to the next person in the approval chain

Charge Process (continued)

- **Approval Chains –** Select the appropriate approval chain to be assigned to this charge
- **Detail PDF –** this button will produce a PDF report with all of the detail changes
- **Status PDF –** this report will show a complete listing of all open Charge Process items, and the status of the item in the approval chain
- **Meditech Field Descriptions –** for the User's reference, this pop-up will detail each of the fields in the Charge Process tab, the type of data the field contains, the format each data type needs, the accepted values if the field can be updated by the User, and the type of action required

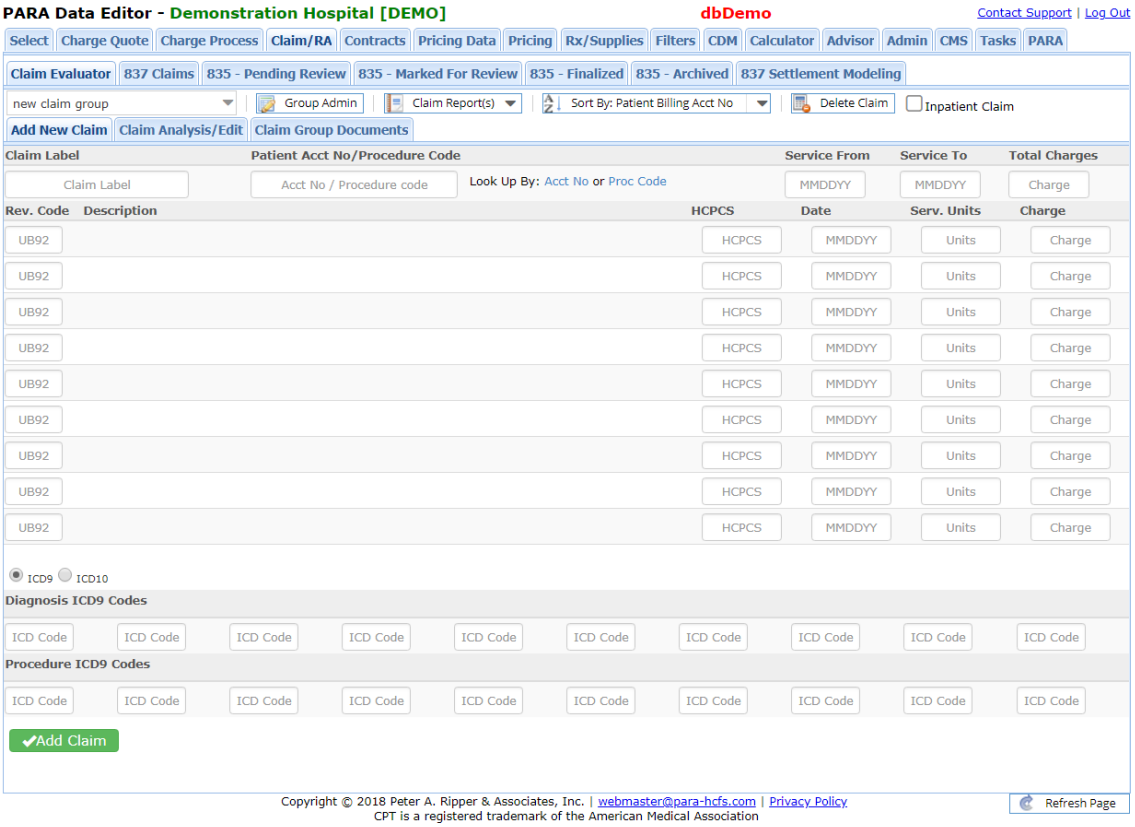
Charge Process (continued) - Quick Add Form



The Quick Add Form allows the User to add items to the CDM in a basic format, when items need to be added as soon as possible or simply do not require the same level of detail. After an Approval Chain is selected, as each field is clicked a popup window will appear for the User to enter the appropriate information. The fields included are:

- **Departments** – Hospital Department and G/L Department numbers
- **Procedure Code** – the individual facility procedure number or charge code
- **Descriptions** – options for the Billing and Technical Descriptions can be entered
- **Effective Date**
- **Notes** – any necessary notes on the item can be entered in text format, for review by others in the approval chain
- **Unit Price**
- **Total Cost**
- **Codes** – the popup will display fields that correspond to the hospital's Billing Indicator Fields. CPT®, HCPCS, Medicaid, Other, and Revenue Codes, as well as Unit Multipliers, can be entered.

Claim/RA Management



Hospitals can upload 835 and 837 files and use the **PDE** to review claims, manage denials, and analyze reimbursement patterns within a single program. Denials can be reviewed by Patient Name, Account Number, or by Denial Code. The electronic picture of your 835 file is formatted in a way that is easy to read and process, taking the challenge out of correcting and resubmitting denied claims.

Also available is a choice of charts, which display your selected denial codes in bar, pie, or line chart format.

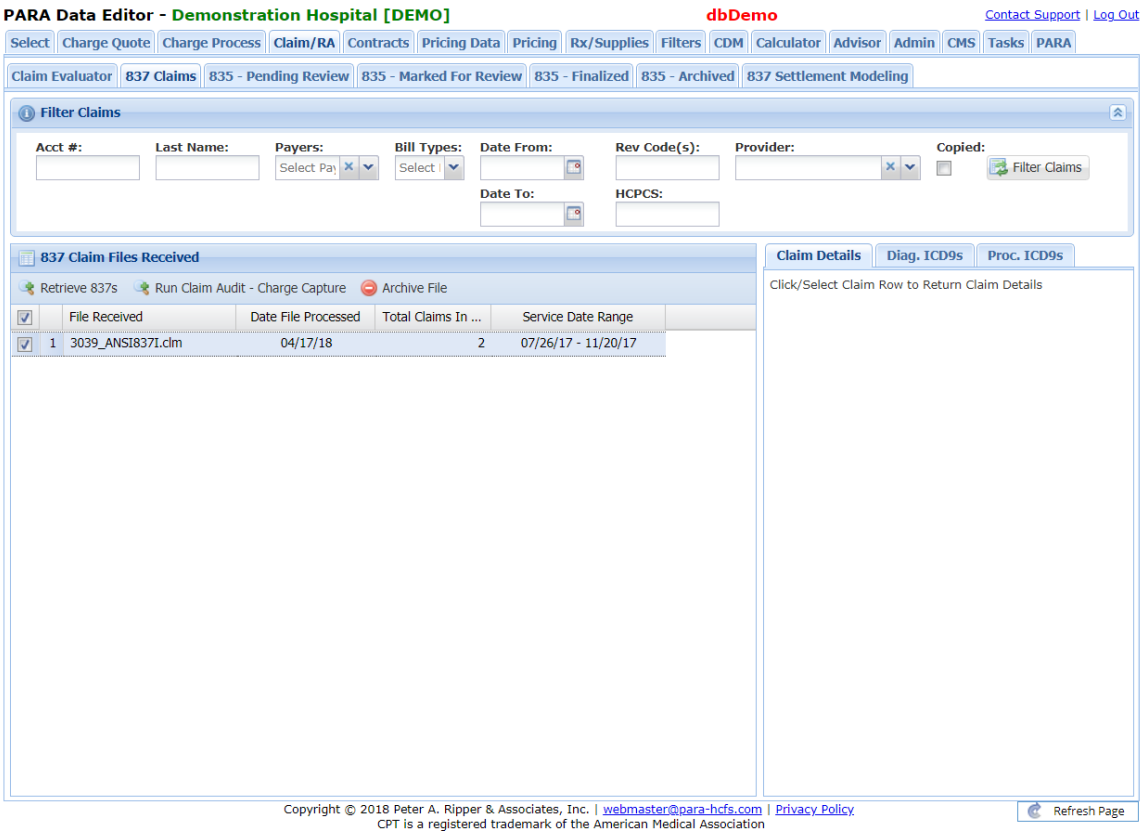
The Claim/RA tab within the **PDE** will assist Users to:

- **Identify denials for corrective rebilling and collection**
- **Data mine paid claims for claim resubmission due to retroactive changes in regulations**
- **Report to management billing/charge process issues impacting billing efficiency and reimbursement**

Claim/RA Management Sub-Tabs

The sub-tabs within the Claim/RA module include:

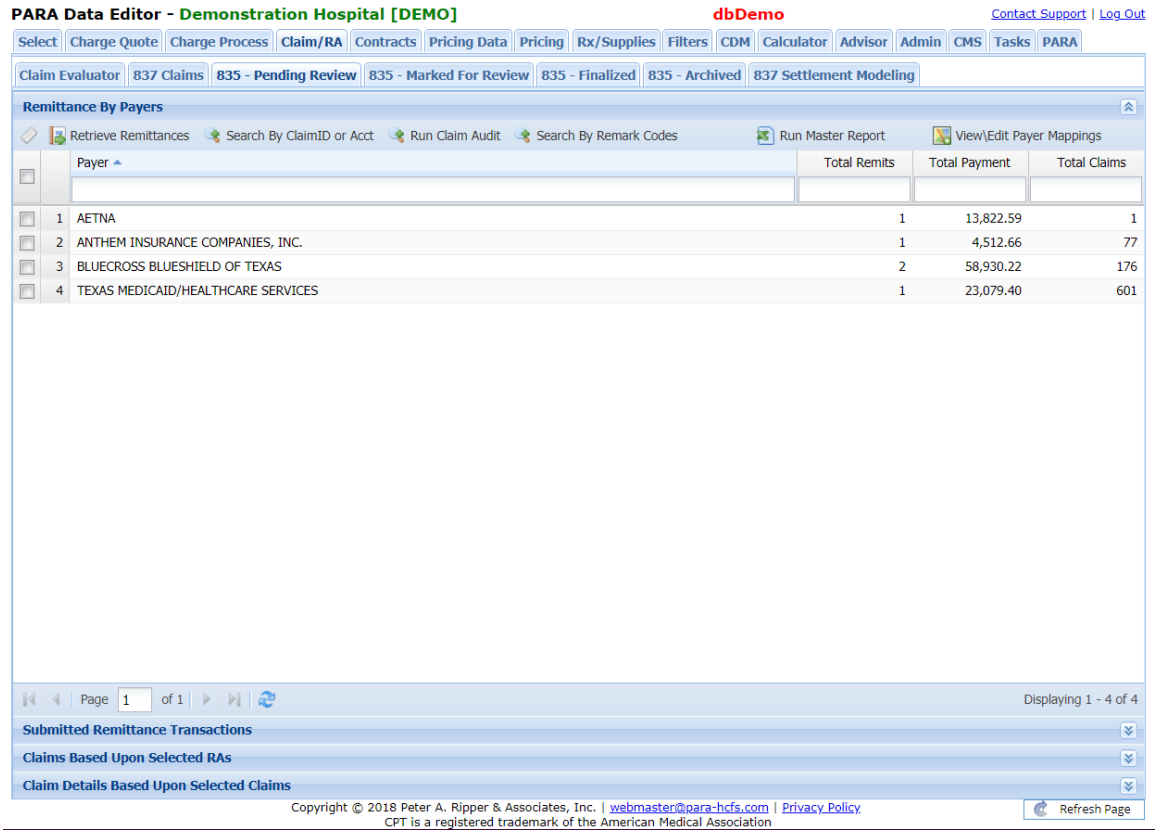
837 Claims



Claims can be selected by Payer, Bill Type, a date range, or specific Revenue or HCPCS codes to isolate for specific review. The claim details can then be displayed, including diagnostic and Procedural ICD-10 codes.

Claim/RA Management Sub-Tabs (continued)

835 Remit – Pending Review



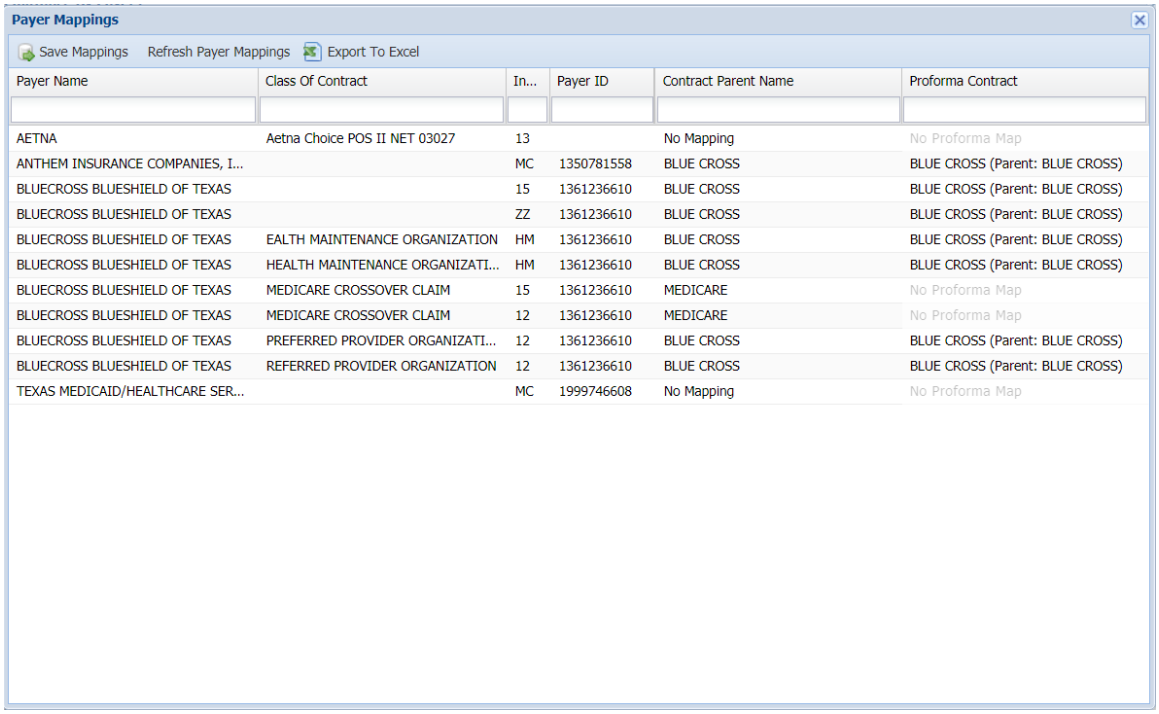
Details from Selected R/As can be filtered based on denial codes or claim details.

Once filtered, details can be exported in Excel format and assigned to Follow-up staff for review and resolution. The User can also generate charts (Bar, Line, or Pie format) based on reason codes or group codes.

This tab also allows selection of remittances for the Reimbursement Analysis functions. Users can view/edit payer mappings for the reimbursement analysis to ensure claims are settled under the correct terms, and run the Reconciliation Report package to view all claims in the remit by Reconciled, Non-Reconciled, and Un-reconcilable status.

Claim/RA Management Sub-Tabs (continued)

835 Payer Mapping

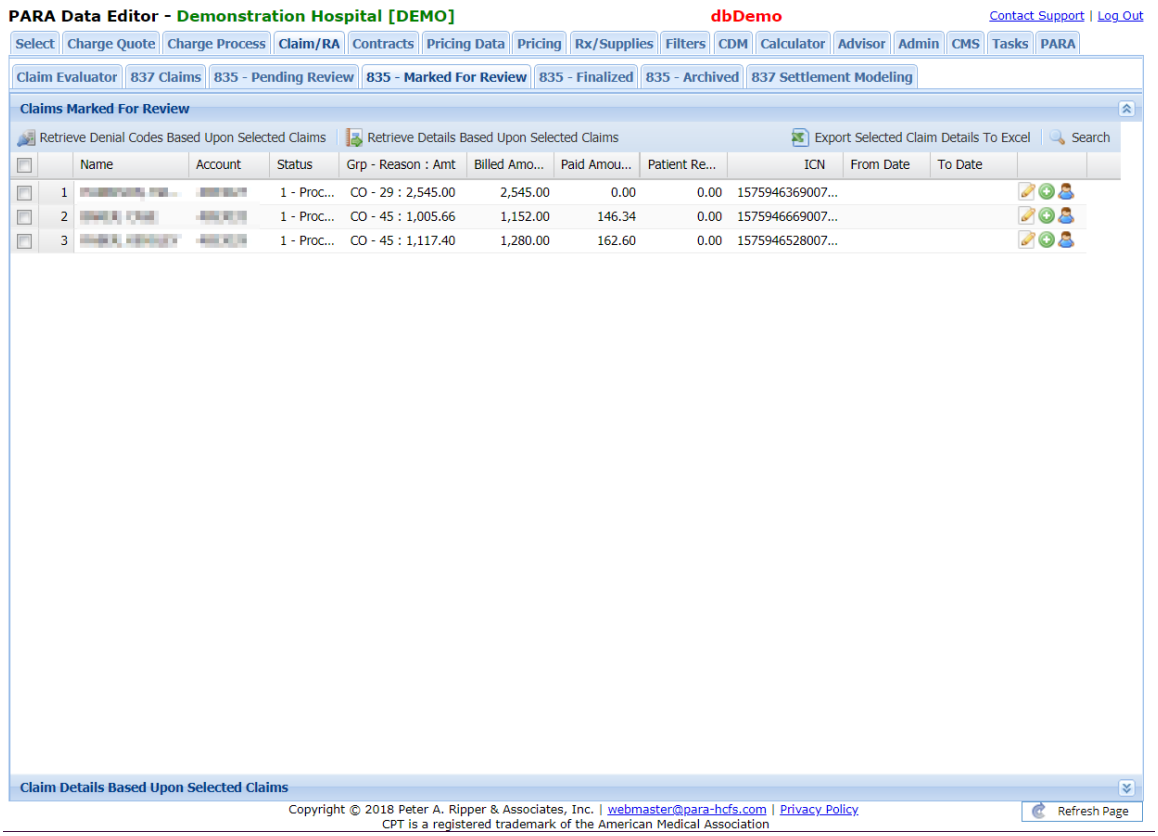


Payer Name	Class Of Contract	In...	Payer ID	Contract Parent Name	Proforma Contract
AETNA	Aetna Choice POS II NET 03027	13		No Mapping	No Proforma Map
ANTHEM INSURANCE COMPANIES, I...		MC	1350781558	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS		15	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS		ZZ	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS	EALTH MAINTENANCE ORGANIZATION	HM	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS	HEALTH MAINTENANCE ORGANIZATI...	HM	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS	MEDICARE CROSSOVER CLAIM	15	1361236610	MEDICARE	No Proforma Map
BLUECROSS BLUESHIELD OF TEXAS	MEDICARE CROSSOVER CLAIM	12	1361236610	MEDICARE	No Proforma Map
BLUECROSS BLUESHIELD OF TEXAS	PREFERRED PROVIDER ORGANIZATI...	12	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS	REFERRED PROVIDER ORGANIZATION	12	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
TEXAS MEDICAID/HEALTHCARE SER...		MC	1999746608	No Mapping	No Proforma Map

Payers from the remit are mapped to the parent contracts within the **PDE** Contracts tab to settle against the specific terms loaded for that parent. If a pro forma analysis is being performed, the pro forma parent can be mapped as well.

Claim/RA Management Sub-Tabs (continued)

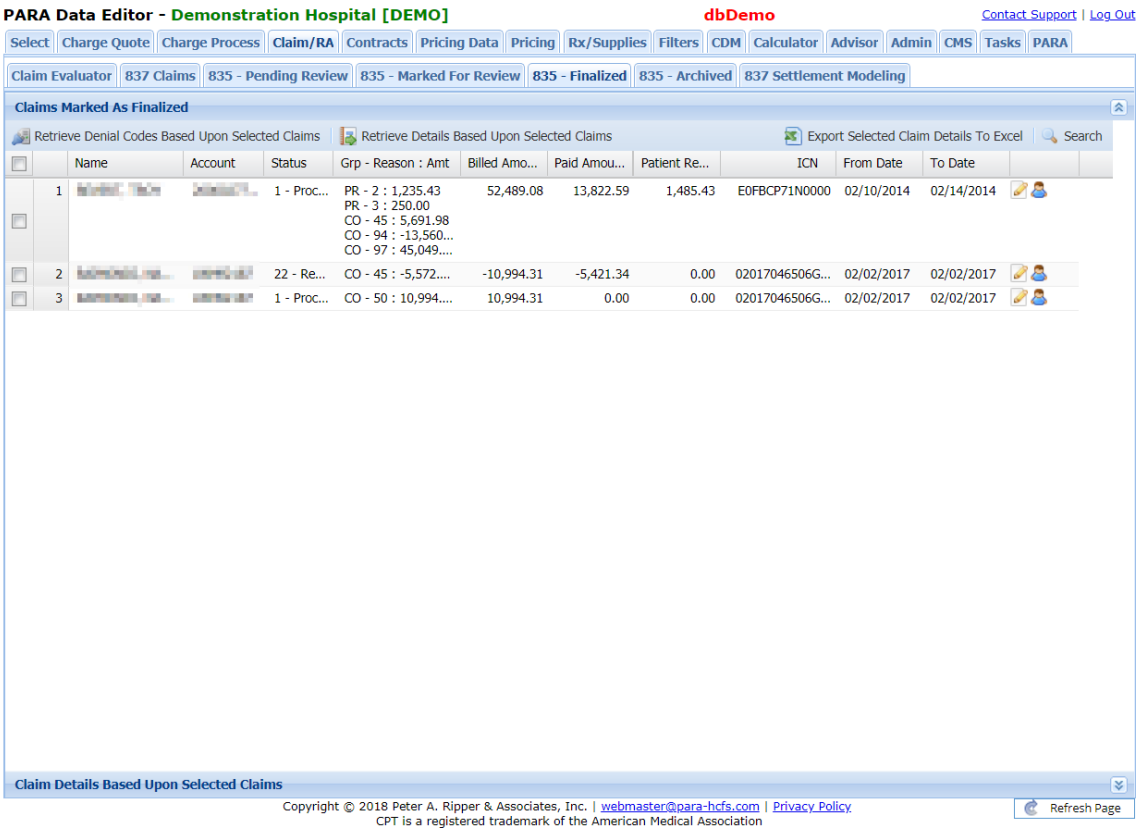
835 Remit – Marked For Review



Specific claims within a remittance can be marked for review, and are then able to be viewed in the Marked for Review tab.

Claim/RA Management Sub-Tabs (continued)

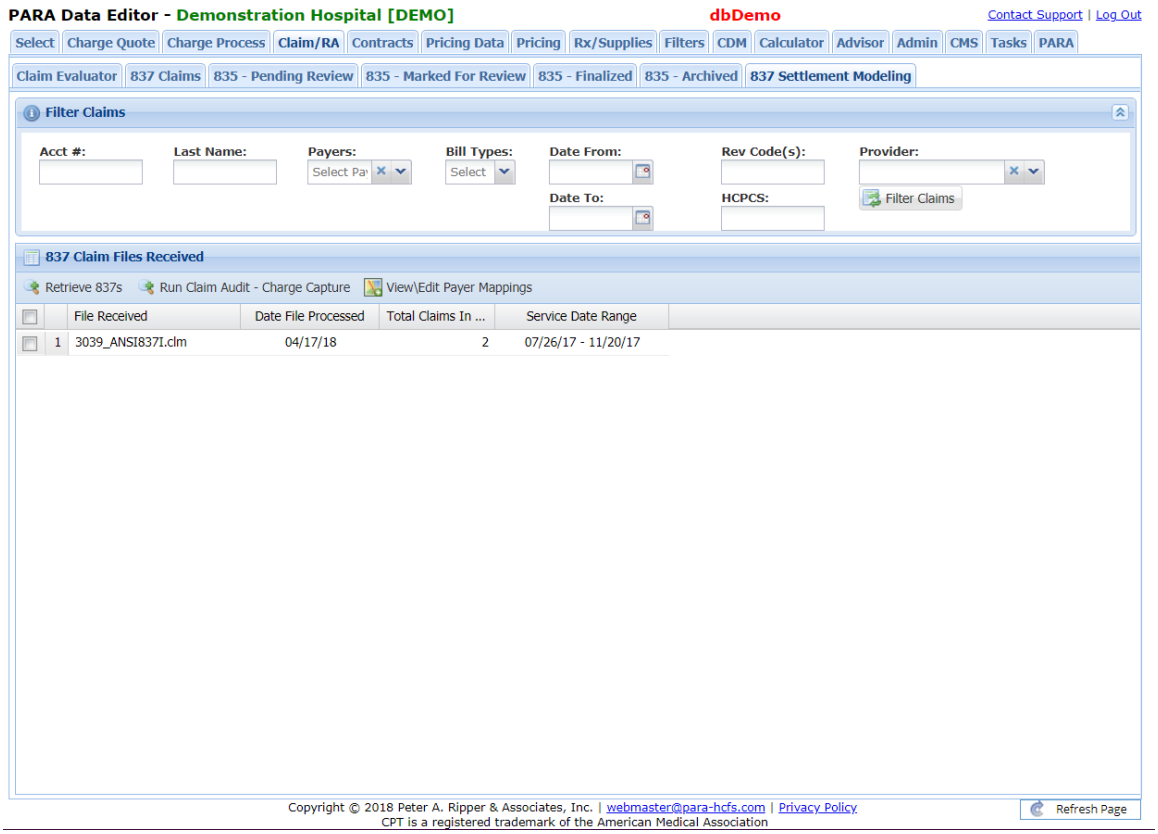
835 Remit – Finalized



Once a marked claim has been worked (appealed, re-billed, etc.) it can be marked within the Marked For Review tab and it will be transferred to the Finalized tab.

Claim/RA Management Sub-Tabs (continued)

837 Settlement Modeling

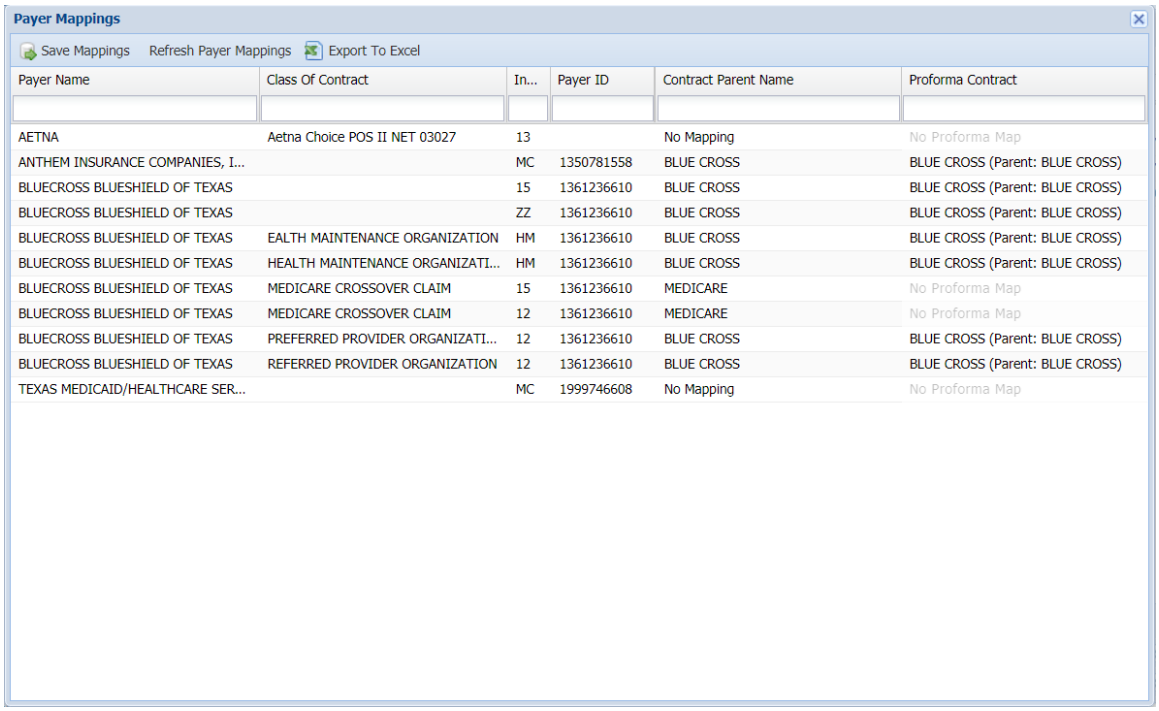


837 claim files can be searched on a variety of data points, including:

- Account number/Claim ID
- Last Name
- Payer
- Bill Type
- Date Range
- Revenue Code
- HCPCS code
- Physician Provider

Claim/RA Management Sub-Tabs (continued)

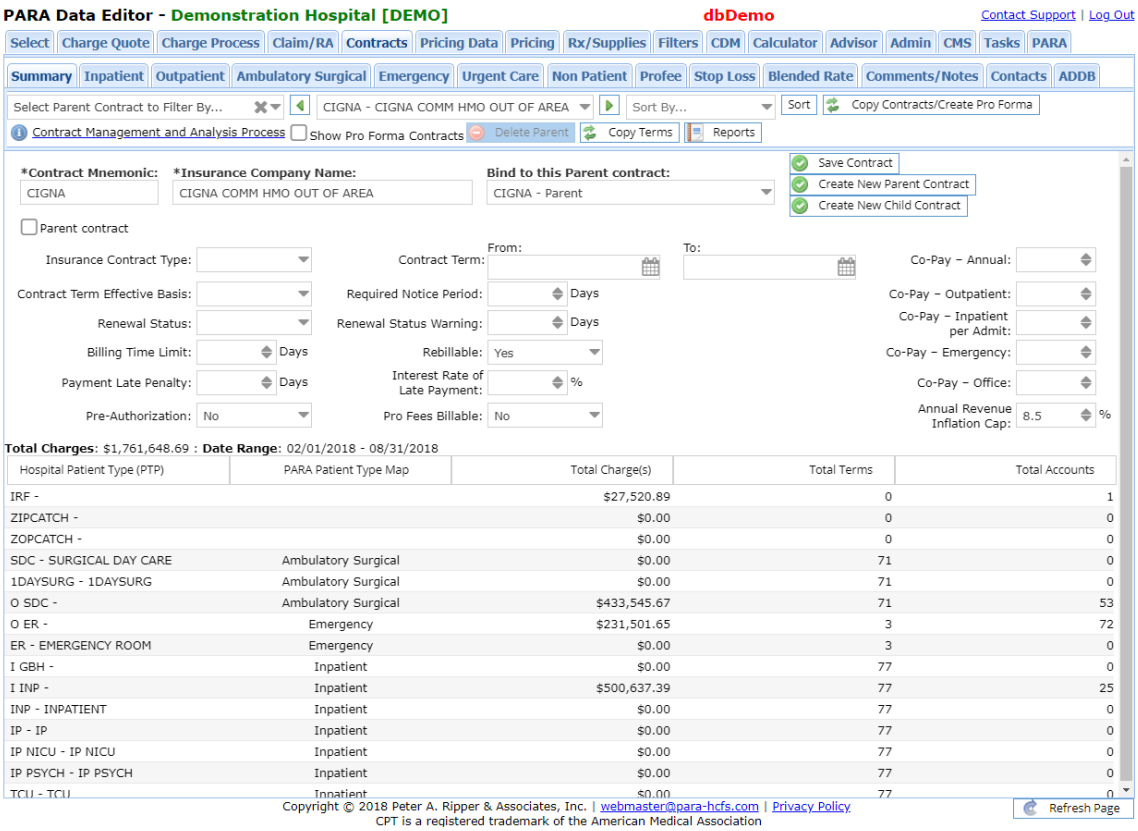
837 Payer Mapping



Payer Name	Class Of Contract	In...	Payer ID	Contract Parent Name	Proforma Contract
AETNA	Aetna Choice POS II NET 03027	13		No Mapping	No Proforma Map
ANTHEM INSURANCE COMPANIES, I...		MC	1350781558	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS		15	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS		ZZ	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS	EALTH MAINTENANCE ORGANIZATION	HM	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS	HEALTH MAINTENANCE ORGANIZATI...	HM	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS	MEDICARE CROSSOVER CLAIM	15	1361236610	MEDICARE	No Proforma Map
BLUECROSS BLUESHIELD OF TEXAS	MEDICARE CROSSOVER CLAIM	12	1361236610	MEDICARE	No Proforma Map
BLUECROSS BLUESHIELD OF TEXAS	PREFERRED PROVIDER ORGANIZATI...	12	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
BLUECROSS BLUESHIELD OF TEXAS	REFERRED PROVIDER ORGANIZATION	12	1361236610	BLUE CROSS	BLUE CROSS (Parent: BLUE CROSS)
TEXAS MEDICAID/HEALTHCARE SER...		MC	1999746608	No Mapping	No Proforma Map

As with the 835 Remit files, the 837s can be mapped to specific payer and pro forma terms for settlement.

Contracts

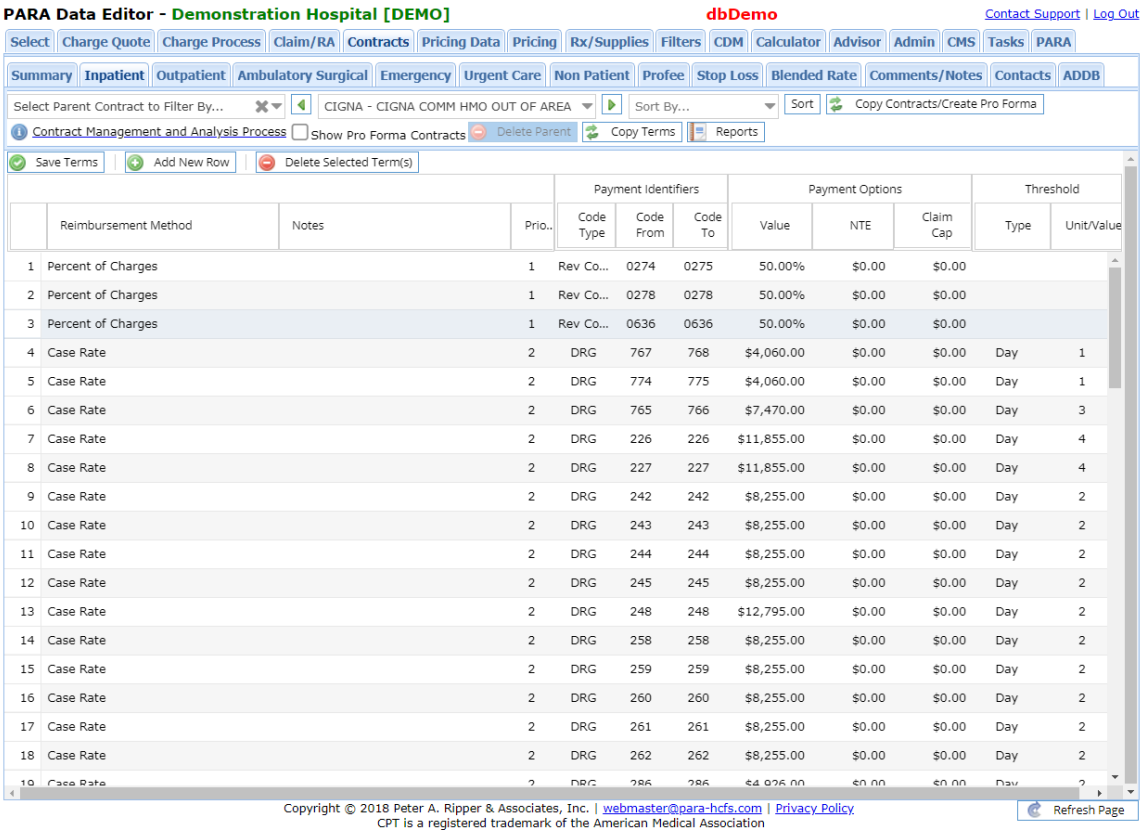


The **PDE** also allows the User to load the details of all their Payor Contracts, which are then incorporated into the Charge Quote, Claim/RA Analysis and Pricing functions. Non-covered services and contracted payment rates are mapped into Charge Quote, so that any possible coverage issues are immediately apparent to the User, and can be dealt with accordingly. This benefits the facility in having fewer hours spent on billing and follow-up of claims, as possible coverage issues are apparent prior to services being rendered.

The Contract screens can include all parameters of each contract, from percentage of billed charges to flat case rates for individual procedures or DRGs, as well as specific contract terms such as billing window dates, interest rates, late payment penalties, and any other items specific to that payer. Sub tabs, for individual patient types, can accommodate the multiple variations of payer rates. Other tabs also contain Stoploss parameters, Blended Rates, Comments/Notes, Contacts within the Health Plan, as well as a complete listing of items in the Addendum B allows the User to enter data on non-covered items, specific payment rates, and individual copayment amounts.

Contracts Sub-Tabs

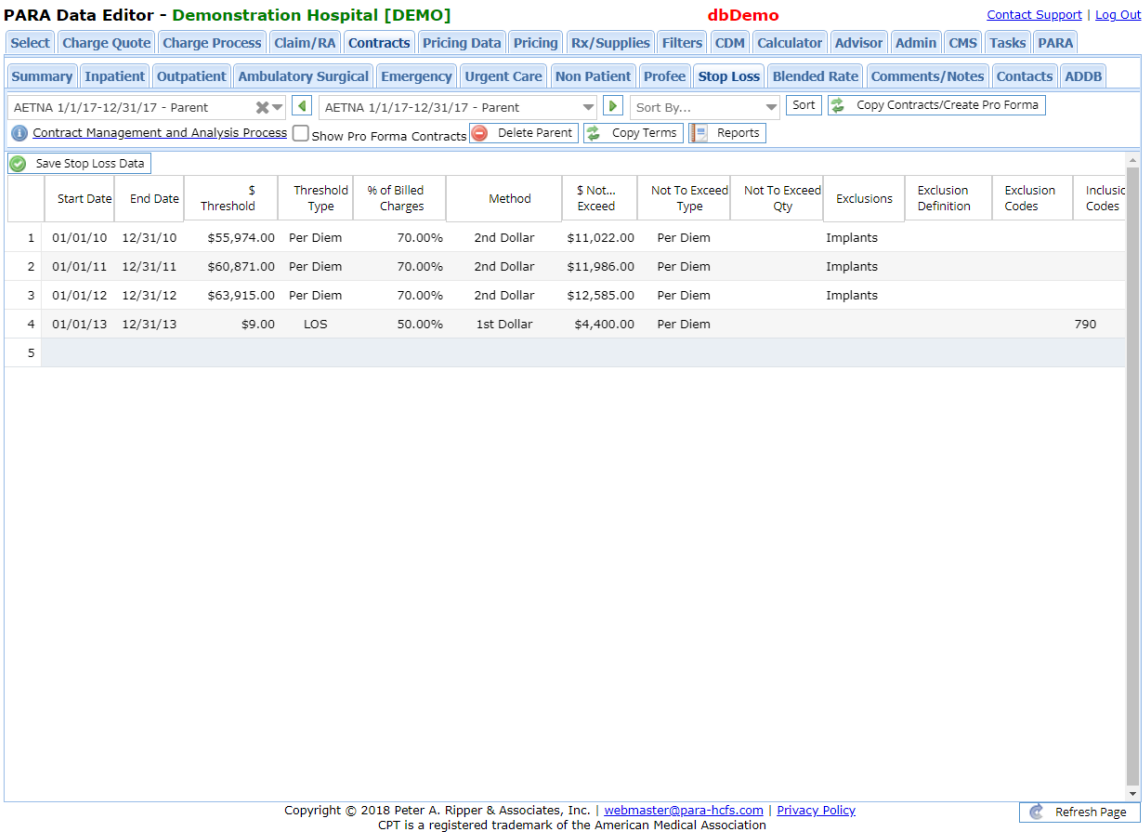
Reimbursement Method Detail



The Reimbursement Detail tabs, separated by patient type, can accommodate multiple methods of reimbursement. If the services are identified by HCPCS code, revenue code, or DRG, it can also incorporate claim caps and not to exceed (NTE) limitations.

Contracts Sub-Tabs (continued)

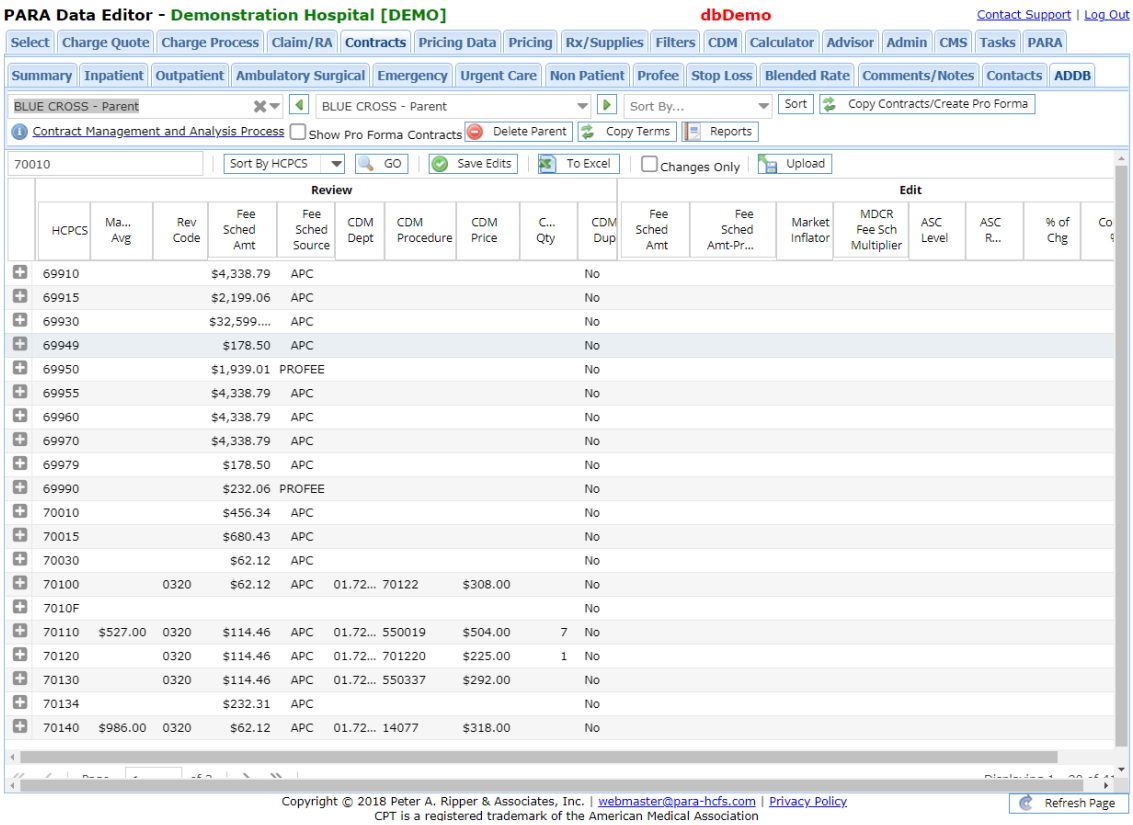
Stop Loss



Stop Loss terms are also incorporated, including thresholds, exclusions, reimbursement method, and not to exceed limitations.

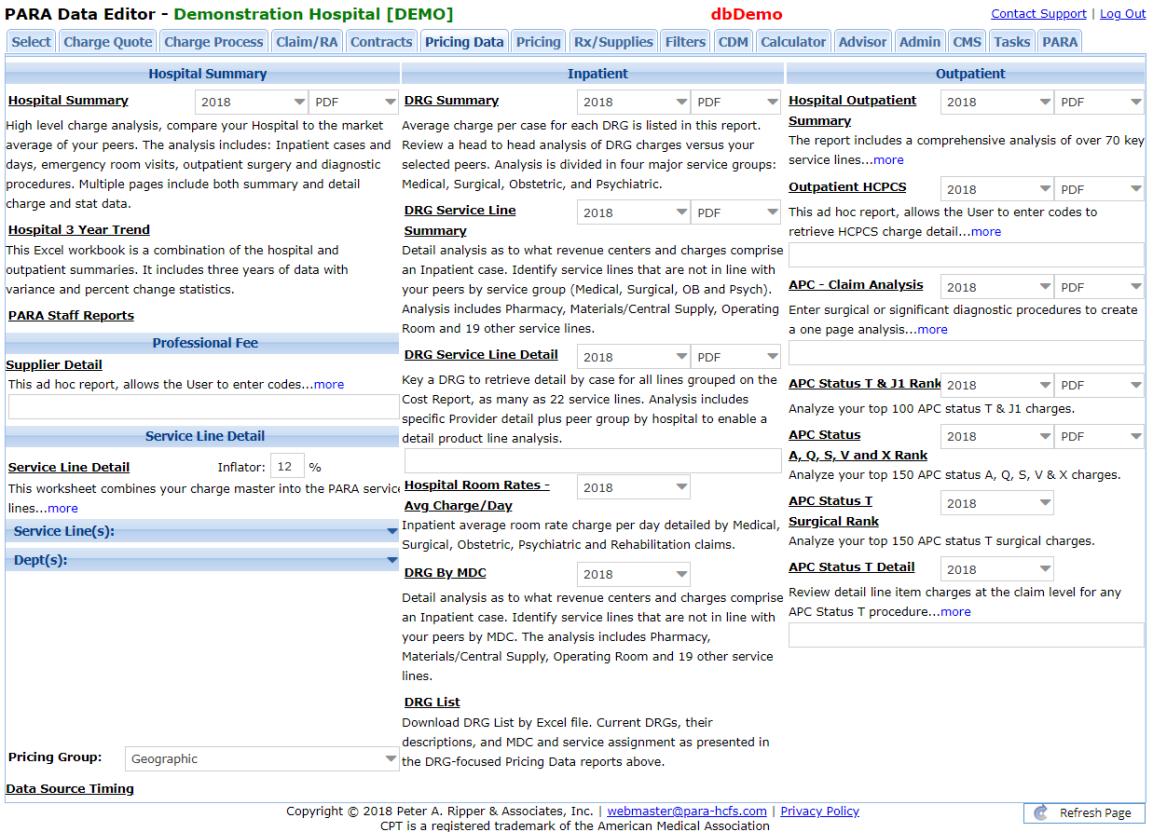
Contracts Sub-Tabs (continued)

AddB



If items are reimbursed under a contract-specific fee schedule, those rates are also tracked within a copy of the current quarter Addendum B, which is also linked to the hospital's Charge Master file.

Pricing Data



Current Market Data can be an invaluable tool in determining appropriate pricing for various procedures. Our Market Data is the most current available, and can provide the User with information on their closest competitors, in order to position their facility strategically within their chosen market. Data can be reviewed for both Inpatient DRGs and Outpatient HCPCS/CPT® codes, as well as a summary of the hospital's current overall position within their market. The data can also be viewed for the previous year, as well as the most current year available. A number of our reports allow the User to select the full year of statistics, or isolate the fourth quarter of the current year, to eliminate any anomalies that may appear due to mid-year pricing changes. A new feature in the **PDE** allows the User to select specific hospitals to include in a designated market group. The hospital's standard geographic market is created when the client data is loaded into the **PDE**. Organizational and Service-related markets can be created, based on the User's needs. The User then selects the applicable market, and the appropriate report.

The following reports, for any of the available markets, can be accessed through this tab:

- **Hospital Summary Report** – this report includes several Inpatient and Outpatient measures, to give an overall view of how your hospital compares to your peers.

- **Hospital 3 Year Trend** – This report compares the changes in the Inpatient and Outpatient Summary measures over a three year period.

Pricing Data (continued)

- **Comprehensive CDM Summary** – this excel report will display all items in the Charge Master, summarized by Department, and will link all available market data to the individual line items.

- **DRG Summary** - compares the hospital to its peers on all reported DRGs, and includes the number of cases as well as average case rates.

- **DRG Service Line Summary** - examines the revenue centers that contribute to an Inpatient case.

- **DRG Service Line Detail** - can be utilized to look at individual DRGs by entering a DRG into the text box below, and then clicking on the underlined report name to produce the report.

- **Hospital Room Rates-Average Charge/Day** – this report displays the average charge per day for each of the room rate types.

- **DRG By MDC** – Another way to view your Inpatient Data, grouped by Major Diagnostic Category. This report displays the totals by Service Line, grouped by MDC. A complete list of the DRGs that comprise an MDC are at the end of the report.

- **DRG List** – for Users' reference, there is a complete list of current DRGs, the full desciptions, and the MDC to which each is grouped.

- **Hospital Outpatient Summary** – compares the service lines that comprise an Outpatient case.

- **Outpatient HCPCS** – can produce instant Market Data on a particular HCPCS or CPT® code. Enter the code into the search box, and click on the underlined report title. The report produced will provide the code information, the current reimbursement rate, market rates for each of your peer hospitals for all of the service areas that reported the code (i.e., ED, OP), details on the individual code as well as the packaged rates billed, and any data available from non-hospital providers.

- **APC Status T Claim Analysis** – this report examines claims nation-wide for the APC Status T procedures. All services included on claim for the Status T item are compared, with the number of claims and the percentile value displayed.

- **APC Status T Rank** – a complete list of the top 100 (by volume) Status T procedures, with number of claims, client average charge, peer market average charge, and percentage of difference displayed. This report can be exported in either PDF or Excel format.

- **APC Status A, Q, S,V, and X** – procedures under these APC payment status indicators are also available, and can be exported in PDF or Excel format.

- **APC Status T Surgical Rank** – a listing of the top 50 Surgical APC Status T charges.

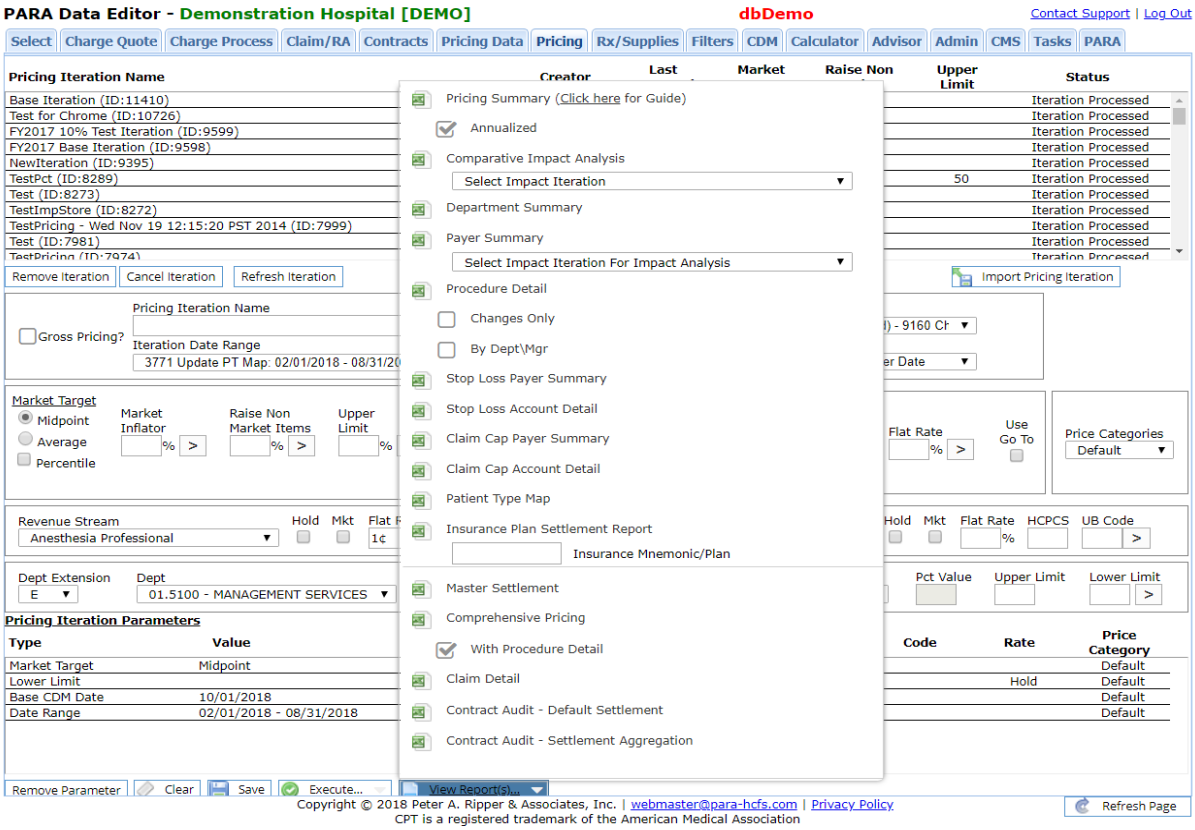
Pricing Data (continued)

- **Status T Detail** – this report compares facilities on Outpatient Surgical Services, by all line items that appear on a claim.

- **Service Line Detail** – this report includes data for all procedures within a particular service line, based on the CPT® code groups, and shows market data not only for your hospital peers but all of the applicable data from non-hospital providers. This data is provided not only for items within your charge master, but all other codes within the service line as well. This report can be adjusted to show specific service types, or specific departments at the User's discretion.

- **Supplier Detail** – Charge data from the 1500 form file, as well as Physician Fee Schedule reimbursement rates, displayed over a three year period.

Pricing



If **PARA** has produced any Pricing Iterations for the hospital, those iterations can be quickly accessed through the Pricing tab. The iterations can viewed at the Grand Summary level, or at the Department Summary level. **PARA**'s Pricing Program can assist a hospital in achieving optimal reimbursement, by positioning the hospital's pricing within their market.

Users can also create their own Pricing Iterations, from simple parameters such as moving items to the Market Average or Midpoint with a specific limit to increases, to complex iterations that move specific department or revenue streams different amounts, raise or lower to market targets, hold certain items or departments, or any other parameters you choose.

You can select the pre-set parameters from any of our standard iterations, including just removing compliance items, targeting your Peer Market average or midpoint with or without moving non-market (items with no HCPCS/CPT® code attached), or other options. To set your own custom parameters, name your iteration and select a date range and CDM date. Determine your market target, the appropriate inflation factor, what percentage (if any) to raise non-market items, the maximum percentage to which you wish to limit line item increases, and whether or not to lower any high prices. To have these parameters set to your iteration, just fill in the data, and be sure to hit the ">" box next to the field. More complex parameters, such as holding items with a specific modifier, flat rate increases, particular price categories or revenue

Pricing (continued)

streams, or certain departments can all be done in this tab. Just set your parameters and click on "**Execute**". The results can be viewed via a number of reports.

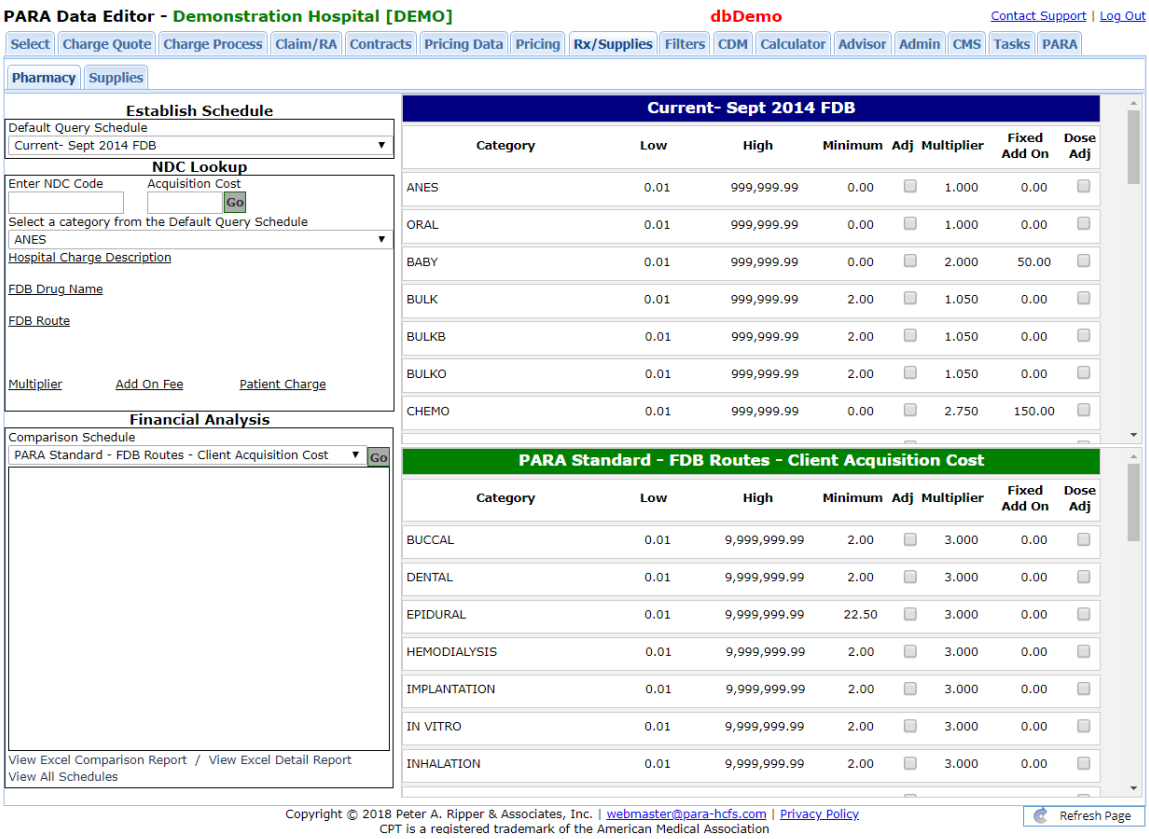
The reports available within the Pricing tab include:

- **Pricing Summary –** this PDF will show the overall impact if the iteration on your Hospital's Gross and Net Revenue, based on the parameters set by the User and the transactions/usage of the date range selected. If working with less than a full year's data, the report can be annualized.
- **Comparative Impact Analysis –** an analysis that can be run by quarter to gauge the impact of the implemented prices.
- **Department Summary –** the results of the pricing iteration at the Department level.
- **Payer Summary –** also the results of the iteration, examined on a payer by payer basis.
- **Procedure Detail –** this report will include the actual line items from the Charge Master, and display the current price, recommended price, and percentage of change to reach the selected market target. The User can elect to see all items in the CDM, including items not moving, or just the items that are changing.
- **Charges Lower than Fee Schedule** – displays any charge master items with prices below the payer fee schedules
- **Procedure Detail –** a report of the entire CDM with current price and recommended price
- **Stop Loss Payer Summary –** the Stop Loss Payer Summary displays totals of all accounts affected by Stop Loss terms.
- **Stop Loss Account Detail –** the details of all accounts affected by Stop Loss terms.
- **Claim Cap Payer Summary –** displays a summary of accounts affected by claim caps.
- **Claim Cap Account Detail –** displays the details of accounts affected by claim caps.
- **Patient Type Map –** this report displays how **PARA** breaks down the individual patient types received from the client into the primary categories: Inpatient, Outpatient, Emergency, Outpatient (Same Day) Surgery, and Non-Patient.
- **Insurance Plan Settlement Report –** this report can be run on any individual insurance payer. Just enter the insurance plan mnemonic, and the User will be able to view a detailed report on the settlement of claims.

Pricing (continued)

- **Master Settlement –** a breakdown of the transaction data, and the type of reimbursement method assigned to the patient type by payer.
- **Comprehensive Pricing –** a package of many of the above reports in a single workbook.
- **Claim Detail –** a report to review individual patient types, or search the transaction data for a specific account, CPT®/HCPCS code, procedure code, revenue code, or DRG

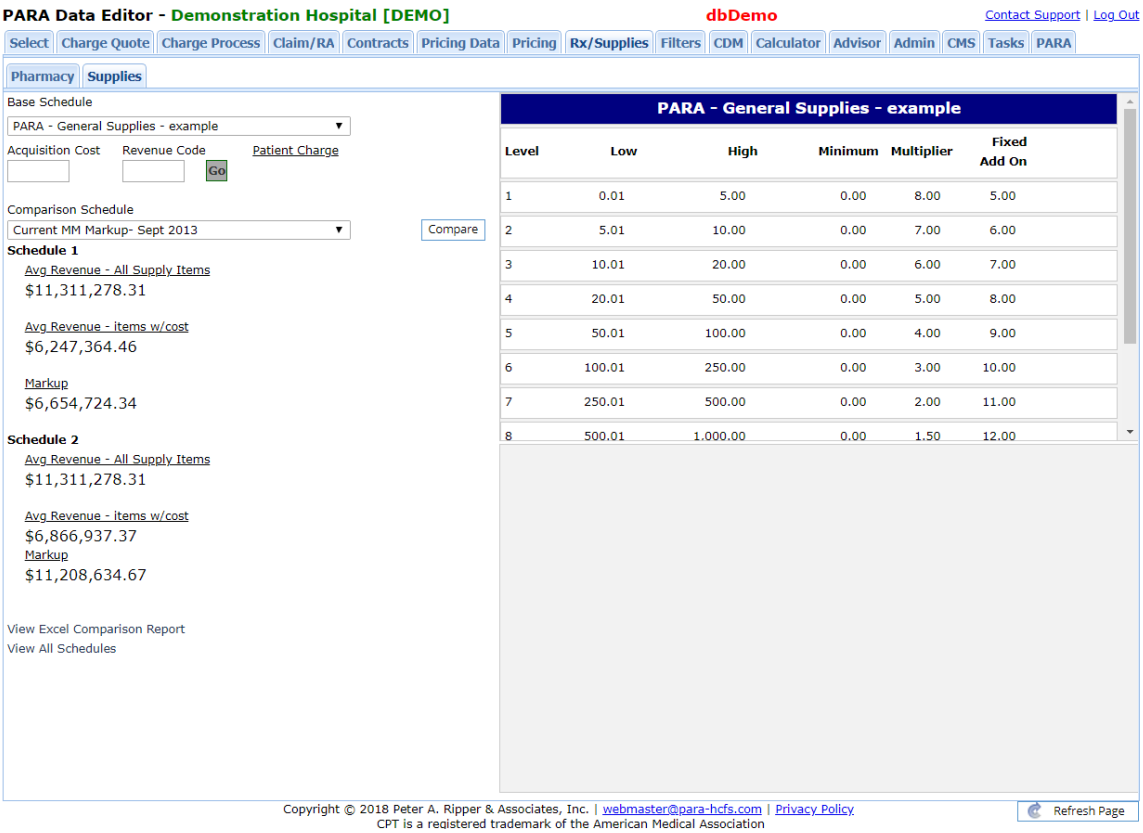
RX/Supplies – Pharmacy



For Pharmacy, patient charges can be calculated based on the hospital's own multipliers and add-on fees. The User selects a default mark-up schedule from the drop-down menu in the Establish Schedule section and a comparison mark-up schedule from the Financial Analysis section. The facility's summary comparison between the two schedules will appear in the Financial Analysis section. An Excel Comparison Report can be downloaded to view the items in detail.

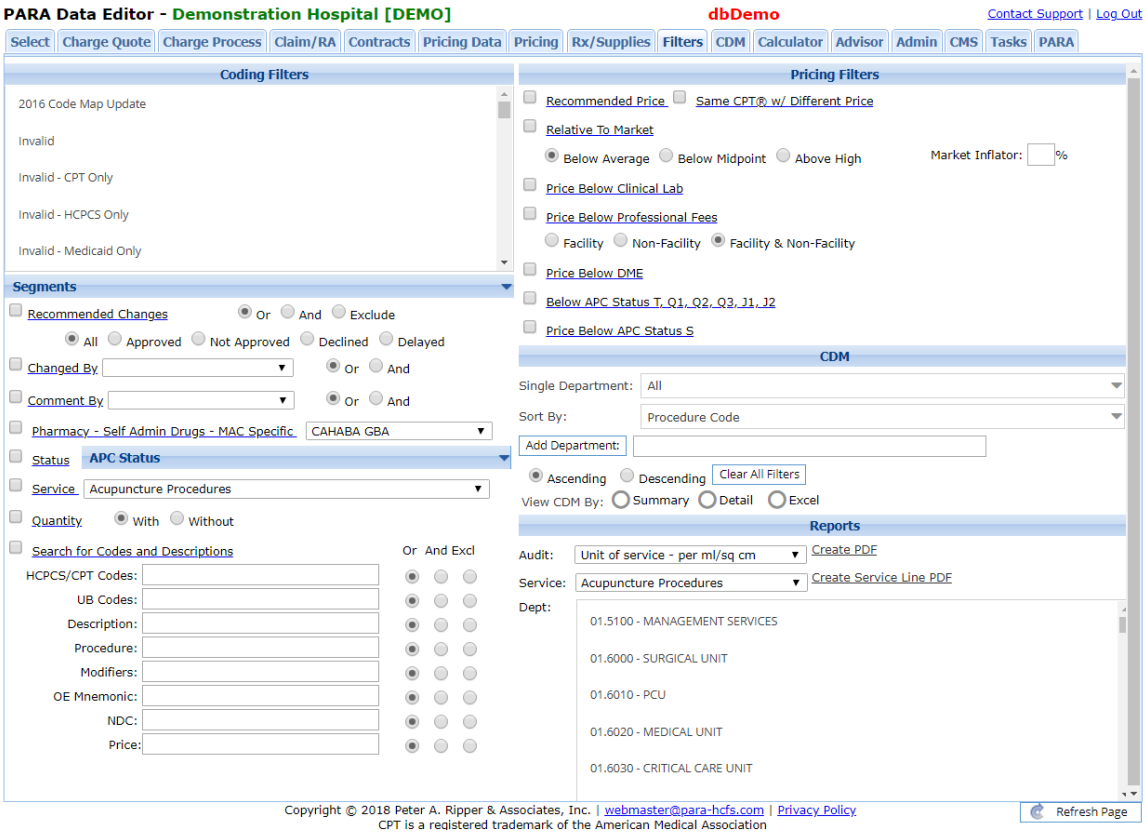
To calculate the patient charge for an individual NDC code, the User either enters or selects a code in the NDC Lookup section. In addition, the User can either let the NDC code fall by route into the appropriate category from the default mark-up schedule, or force the category by selecting it from the drop-down list of categories. After entering the Acquisition Cost and clicking Go, the patient charge will be calculated and other attributes of the NDC code will be displayed in the NDC Lookup section.

Rx/Supplies Tab - Supplies



The **PDE** also provides the ability to calculate correct charge amounts for Pharmacy and Supply items, with the hospital's own cost calculation parameters. The User can select a calculation schedule (General, Implant, or Retail), and then enter the acquisition cost for a supply item. The patient charge will be calculated automatically, based on the loaded cost calculation parameters.

Filters



Our Coding Filters allow the User to look for specific items within the Charge Master that do not comply with current coding regulations. The User can view items with the following filters, utilizing the menu window:

- Invalid codes (codes that have been deleted by the American Medical Association)
- Invalid CPT® Only (isolates the search to the CPT® field only)
- Invalid HCPCS Only (isolates the search to the HCPCS field only)
- Invalid Medicaid Only (isolates the search to the Medicaid field only)
- Unit of Service – per ml/sq cm (codes that include unit of measurement within the CPT®/HCPCS description, that must be billed per ml or per square centimeter)
- Compliance – Marked (codes that are not in compliance with current regulations, i.e. non-billable items with prices, that have been reviewed and marked as compliance issues)
- Compliance – Identified for Review (Items that, based on description, need review-possible compliance issues)
- Compliance – Modifiers (all items hard-coded with modifiers are grouped for review-some modifiers may not be appropriate for item)
- CA Medicaid J3490 Identified for Review (searches for injectable drugs in the Medicaid field)

Filters (continued)

- Pharmacy (all items identified by code or keyword as Pharmacy items)
- Pharmacy – Self Admin Drugs – Currently Billed
- Pharmacy – Self Admin Drugs – Identified for Review
- Pharmacy – NDC Review
- Pharmacy – NDC no FDB Link
- Pharmacy – J Codes
- Pharmacy – J Code Chemo Admin
- Pharmacy – Missing NDC
- Pharmacy – Take Home Drugs
- Pharmacy – Valid NDC
- Pricing – Go To Price
- Pricing – Hold for Iterations (displays all items that are marked in the CDM tab to be held in all Pricing Iterations created in the Pricing tab)
- Codes – C (all items with a C series HCPCS code attached)
- Codes – G (all items with a G series HCPCS code attached)
- Supplies
- Supplies – Revenue Code, Implants Identified for Review
- Flagged for Review (codes that have been flagged for review by one or more Users)
- No Reimbursement (codes that are not payable under any FI or Fee Schedule)
- Part B Only codes (codes that are payable only under Medicare Part B)
- DME OPPS Exempt (codes that are exempt from the DME license requirement)
- DME OPPS Identified for Review (all items triggered by a keyword search as possible DME OPPS Exempt items)
- Zero Price (line items that have a HCPCS/CPT® code assigned but no price listed in the CDM)
- Consistency (allows the User to view inconsistent pricing for the same codes across departments
- Physician 'Incident To' Services (the User can view all items typically performed by Nursing or Technical personnel under the supervision of a Physician)
- Physician Supervision (all items on which Physician Supervision is required)
- Quantity without Cost (all items that have usage quantities but are zero priced)
- Surgical HCPCS (all surgical HCPCS codes assigned to items within the Charge Master)
- Mismatched Revenue Codes (items with revenue codes that do not match the CPT®/HCPCS codes)
- All Explode Codes (isolates items identified as exploding charges)
- Tricare No Pay
- Tricare Questionable
- Radiology Review
- MolDx Z Code Required

Filters (continued)

Below the menu window, these filters are also available:

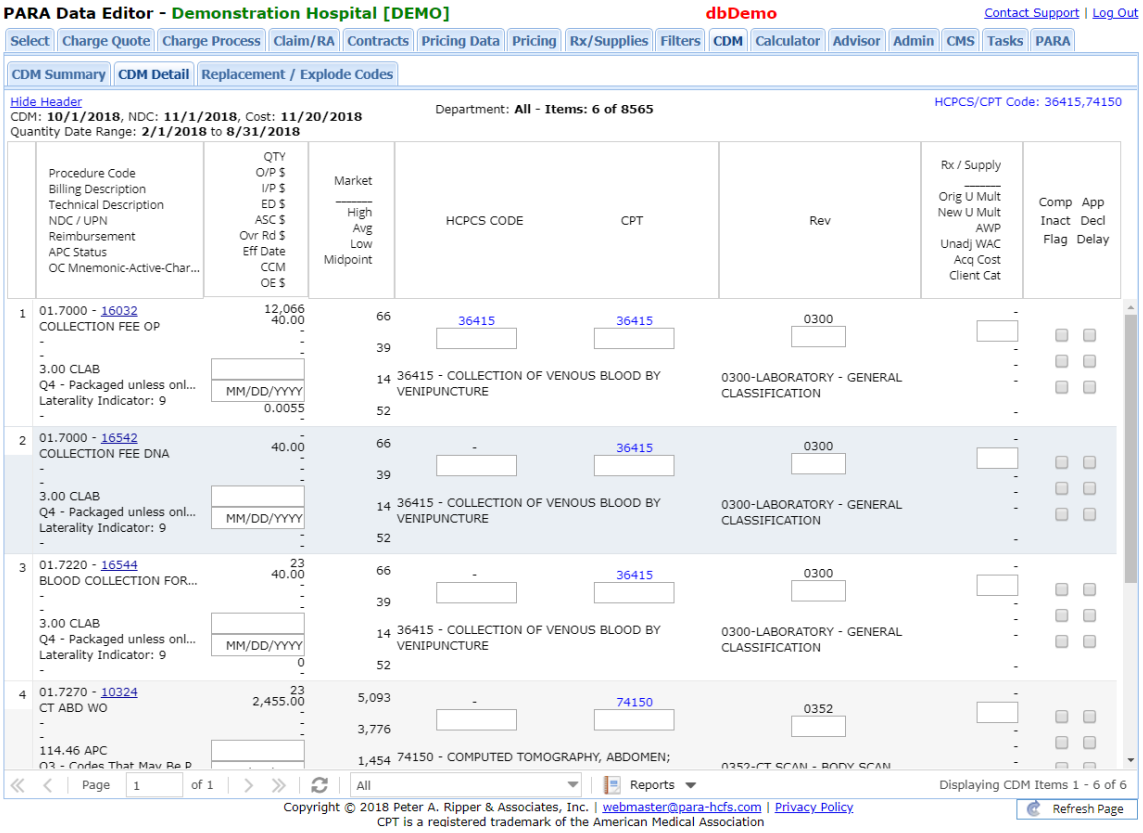
- Recommended Changes (you can sort by All Changes, Approved Changes, or Not Approved)
- Changed By (the User can select from a series of Transmittals to review the coding changes contained within that update)
- Comment By (the User can view items with Comments entered by other Users, or by the Transmittal Updates)
- Pharmacy - Self Administered Drugs – MAC Specific
- Status (allows the User to filter items by a specific APC status)
- Service (allows the User to view all codes associated with a particular service type)
- Quantity (allows the User to look at the items with the highest utilization)
- Codes can also be searched individually, by CPT®/HCPCS code, Revenue code, description, procedure number, modifiers attached, or by NDC number.

These filters allow the User to review select portions of the Charge Master, so that any items can be researched, corrected, or removed from the document in order to maintain a streamlined, compliant Charge Master.

The Pricing Filters compare all items within the CDM to the hospital's current market and the appropriate Fee Schedules to determine which items are below Market Average or Fee Schedule rate, as well as any items that are currently priced higher than other hospitals in the market. This provides the hospital with the opportunity to raise or lower prices as necessary to optimize reimbursement and maintain a competitive edge within their market. For our Pricing clients, there is also an option to examine items across all departments that have the same default CPT®/HCPCS code attached, but have different recommended prices in an iteration that has been created. This occurs when the original price is different, or if the market value is different based on service area and/or modifiers, and allows the User to review these items to determine where consistency in pricing should be maintained.

Audit Reports for all billing and coding regulation changes are produced in PDF format, and will identify items in the Charge Master that are affected by these changes.

CDM Tab

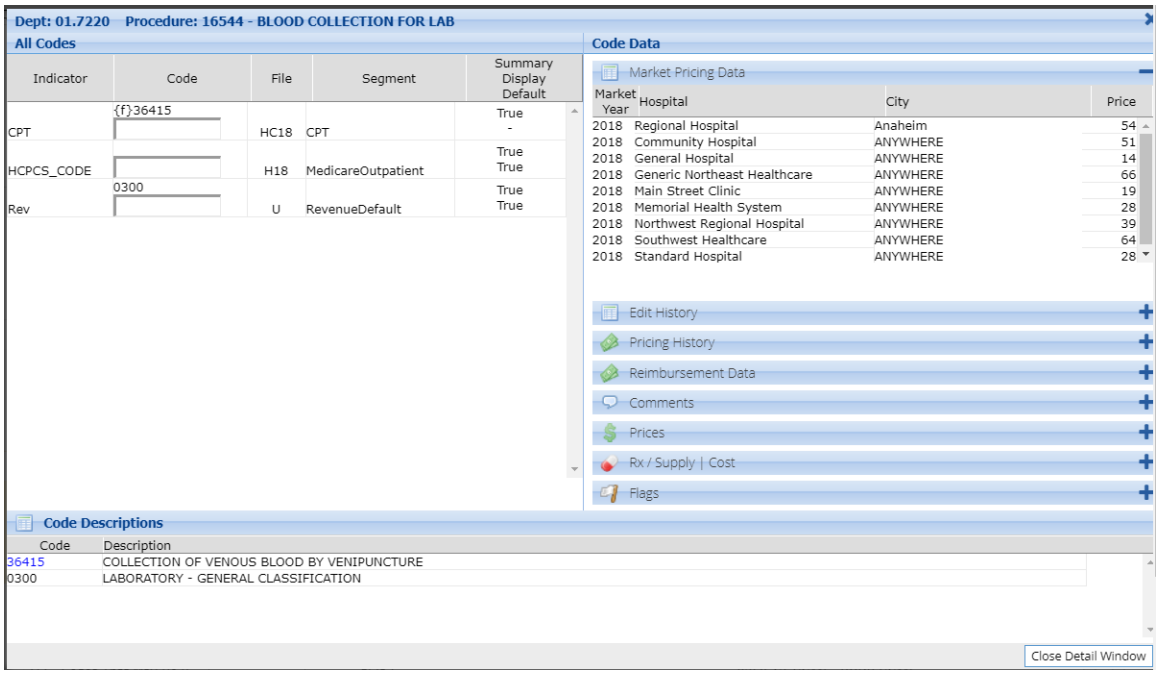


The CDM tab is where any data extracted by the Filters can be viewed. The data can be viewed by individual Department, or by All Departments. In addition to each line item, this tab also displays any market data available, cost data if applicable, all codes associated with the line item, as well as other indicators for Pharmacy/Supply, current activity within the **PDE**, and CCI/LCD information.

Changes can be requested by entering the new information in the text box below that appropriate field. If the change is valid, the data in the box will turn green. If the new data is invalid, a pop-up message will indicate that there is an issue. Any items currently in your Charge Master that are invalid will appear in red in the CPT®/HCPCS or Revenue Code section of this screen. Items can also be flagged for further review, inactivation, exclusion from or inclusion in Charge Quote.

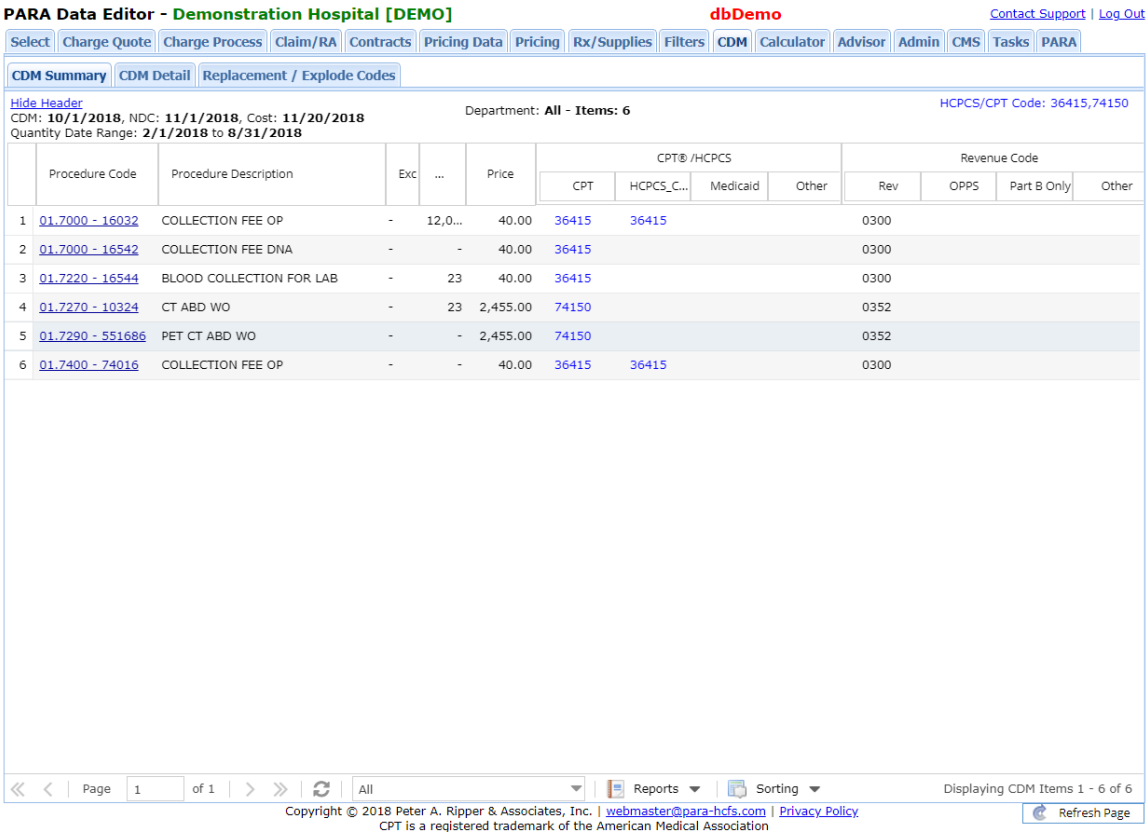
The data can be viewed in two ways: the Detail option, shown above, displays numerous fields of data for each line item. Procedure Code, Billing Description, Technical Description (if applicable), NDC/UPN (if applicable), Reimbursement Rate and Status, and Order Entry information (if received from the client) are shown, as well as Usage Quantity, Current Price, summary level Market Data, and coding fields are visible.

CDM Tab – Procedure Detail



The details for each procedure in the Charge Master can be accessed by clicking on the underlined procedure code in the CDM tab, which will display the pop-up window shown above. The details for each procedure include billing indicators, billing segments, full descriptions for all codes attached to the item, and any comments that have been linked to the item. This window also provides a history of any changes made to the item within the **PDE**, and additional comments can be entered and saved.

CDM Tab – CDM Summary



The second option is to view the items in Summary format. Procedure code, Description, Quantity, Current Price, CPT®/HCPCS and Revenue Code fields are still visible, but are reduced to a single line item so more items can be viewed at once. The detail popup window is still available by clicking on the item Procedure code. The User can select which view they prefer in the Filters tab, or by clicking on the CDM Detail or CDM Summary sub-tabs once the CDM tab has been selected.

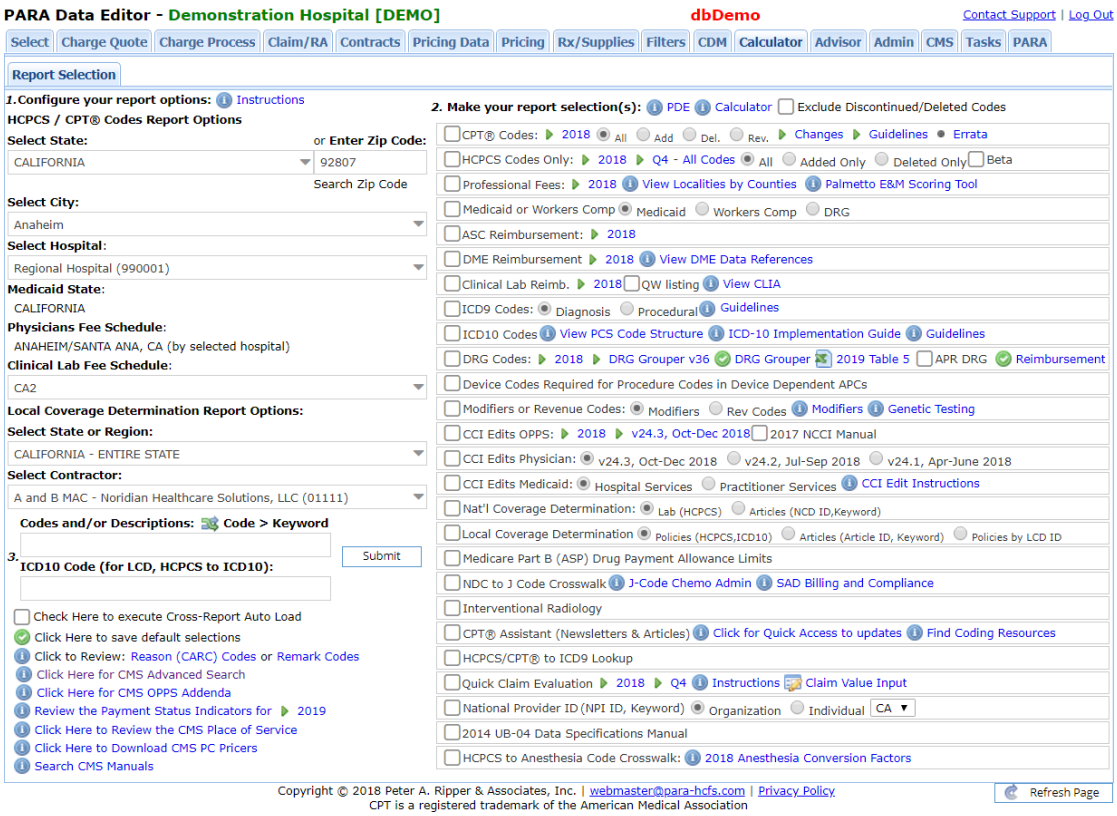
The color code used for items in the page above indicates the following:

Red – indicates an Invalid code

Blue – procedure number, code, NDC, or description which matched the Filter tab query

Green – **PARA**/Hospital User recommended changes

Calculator



The **PARA** Calculator provides our clients with a wealth of data necessary to ensure the efficient maintenance of their Charge Master, as well as data necessary to optimize efforts to produce clean, correct claims. Updates to HCPCS, CPT®, Revenue, ICD-9CM, and Device codes are loaded into the Calculator as soon as they are released, giving our clients access to the most current data available.

The User is able to view a variety of Reference tables, including CCI edits for Physician and Hospital, Modifiers, NDC numbers for "J" series HCPCS drug codes, and Medicare Part B Drug Payment Allowance Limits. The client can also access region and carrier-specific information for Laboratory Fee Schedules, Medicaid Programs, and Local Coverage Determination. All of these functions are contained within a single, easy-to-use page in the **PDE**.

The Main page of the Calculator features several drop-down menus that allow the User to select which state, city, and hospital they are interested in. Local Coverage Determination can be refined by state or region, as well as contracted carrier. These selections can be set as the User's default choices by clicking on that option in the lower left-hand corner of the screen.

Local Coverage Determination can be identified by selecting a Contractor, then selecting a CPT®/HCPCS Code and ICD10 code. Multiple code combinations can also be selected. The report produced will list all examples of the selected code and cross-reference the applicable

Calculator Tab (continued)

companion codes. It will then display if a code combination is billable, not billable, or a modifier is necessary.

Select the report(s) you wish to view, and enter codes you wish to research in the text box on the lower left of the screen, and click on "Submit". The results will be displayed in the tabs that will appear.

A list of Payment Status Indicators can be accessed by clicking the link at the lower left of the page. This will result in a pop-up window that contains information from Addendum D1 from the Center for Medicare Services. This document shows all current Payment Status indicators, the Item, Code, or Service to which they apply, and a description of the Payment Status.

Reports can be generated for the following options:

CPT® Codes
An electronic version of the CPT® code book. The code, it's descriptions, coding guidelines, and a change history are available.

HCPCS Codes
The Results screen will display the code or series of codes selected. The number of codes returned can be further filtered by clicking on the "**All Codes**" indicator in the report title-this will allow the User to select a specific type of code to return. The Results will appear in sub-tabs within the screen. The CPT®/HCPCS report includes the following data points:

- OCE (Outpatient Code Editor) quantity
- the appropriate payment Status for the year selected
- the APC under which the code falls
- the code's weight
- payment rate
- minimum copay
- national copay
- Fee Schedule, including Source
- Modifiers (if applicable)
- Fee
- Appropriate Revenue Codes
- CCI Edit

Professional Fees
If an item is paid by the Professional Fee Schedule, information available includes Global Days, Status code, RVUs for Facility, non-Facility, and MP, and the corresponding payment rates, for items with no modifier, a 26 modifier, and a TC modifier (if applicable).

Medicaid or Workers Compensation Reimbursement
Medicaid reimbursement fields include the HCPCS or Medicaid-specific code, Description, Category, Unit Value, Base Rate, Child Rate, ER Rate, and Rental Rate. If available, Workers Compensation reimbursement rates for codes will be displayed in the sub-tab.

Calculator Tab (continued)

ASC Reimbursement
The code, description, and ASC Reimbursement rates for eligible items will appear in the ASC sub-tab.

DME Reimbursement
The DME results sub-tab will display for each code an OPPS Billable indicator, the Jurisdiction, Category, any Modifiers, and the Fee Schedule rate.

Clinical Lab Reimbursement
The data available in the Clinical Lab Reimbursement report includes the Fee Schedule rate for each item for Modifier 1 (or no modifier), and the rate for the item with Modifier QW.

ICD-9 Codes
ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) Diagnosis and Surgical Procedure Codes can be accessed by checking the Indicator box on the main page, selecting the Diagnosis or Surgical option, and then entering a code, partial code, or partial description. The appropriate code or range of codes will be displayed, as well as the complete description, the current Status of the code, and any comments. This report crosswalks against the ICD-10 report.

ICD-10 Codes
The ICD-10 (International Classification of Diseases, 10th Revision) codes are also available on the **PARA** Calculator. These are the newly structured alpha-numeric Diagnosis codes, designed to streamline the Procedure Coding System. The ICD-10 codes do not include a Procedure Classification. This report crosswalks against the ICD-9 report.

DRG Codes
All DRG Codes can be searched in the Calculator. The Results display the DRG, the applicable MDC (Major Diagnosis Category), the DRG Type, the DRG's Relative Weight, Geometric and Arithmetic Mean LOS (Length of Stay), Transfer Penalty, and the comparable previous DRG (if applicable). There is also a DRG Grouper available on this report option.

Device Codes Required for Device Dependent APCs
Any Device Codes that are required for Procedure Codes in Device Dependent APCs can be determined by selecting that check box on the main page, then entering a code in the Codes and/or Descriptions box. The results tab will list the code, the code's Payment Status, and the Device codes that are necessary. For items where there is more than one device code, there must be a Device code "A".

Revenue Codes
The User can also research current Revenue codes (UB92 codes) and their descriptions, to ensure that the correct Revenue code is being utilized.

Modifiers
The **PARA** Calculator provides Users with the ability to look up Modifiers to ensure that the correct modifier is being used. The User can enter the modifier, a partial modifier, or review all

Calculator Tab (continued)

modifiers within the calculator. The Modifier tab will show the appropriate modifier (or range of modifiers) and the complete description.

CCI Edits OPPS
The **PARA** Calculator is constantly being updated with the latest data available. We currently provide access to the most recent OPPS Correct Coding Initiative Edits, as well as the previous quarter's edits. The User selects a code or description, and the Results tab returns the Primary CPT® code, the second CPT®, the Type of Edit that registered, and the Modifier Indicator.

CCI Edits Physician
The same information sources are displayed for the CCI Physician Edits.

CCI Edits Medicaid
Many Medicaid plans have also implemented CCI edits.

National Coverage Determination – Lab
Items that are covered nationally under the Clinical Lab Fee Schedule, or items that are not covered and are paid by the Fiscal Intermediary.

Local Coverage Determination
Local Coverage Determination can be identified by selecting a State or Regional and a Contractor, then selecting a CPT®/HCPCS Code. The page will list all examples of the selected code and the applicable ICD9 code.

Medicare Part B (ASP) Drug Payment Allowance Limits
Any Payment Allowance Limits included in the Medicare Part B File can be determined by utilizing this feature. Enter a code or partial code within the text box on the main page, make sure the check box for this feature is checked, and click on "Submit". The results page will contain the code or range of codes that include the partial code, the Description, the applicable dosage, and the Payment Limit. Also shown (if applicable) are the ESRD (End Stage Renal Disease) Limit, the Vaccine Average Wholesale Price Percent Markup, Vaccine Price Limit, Infusion AWP Percent Markup, DME Infusion Payment Limit, Blood AWP Percentage, Blood Payment Limit, and any Notes regarding changes, revisions, or corrections.

NDC to J Code Crosswalk
We also provide a crosswalk table that Users can access in order to review the correct information for a "J" series HCPCS drug code. The Calculator will display the HCPCS code, the HCPCS Description, the name of the Labeler, the appropriate NDC (National Drug Code) number, as well as the name of the drug, the dosage, Package information (the size and the quantity), the Billing Units, and the Bill Units package.

Interventional Radiology
This report selection will provide all necessary components to correctly bill an Interventional Radiology procedure. You can enter the Radiology code, the Surgical code, or the device code and the report will show what additional codes are necessary.

Calculator Tab (continued)

CPT® Assistant
PARA now has available an archive of CPT® Assistant Newsletters and Articles available within the Calculator tab. Documents pertaining to a CPT® code can be located by entering the code, selecting the CPT® Assistant option, and then clicking "Submit". Any articles that contain information on that code will appear in the sub-tab. Due to AMA usage guidelines, access to this report option is limited to a specific number of Users at each client, and must be arranged with your Account Executive.

HCPCS/CPT® to ICD9 Lookup
This report will cross-reference CPT® HCPCS procedures with their ICD9 counterparts. As with the other crosswalk reports, either type of code can be entered and the corresponding code(s) will display.

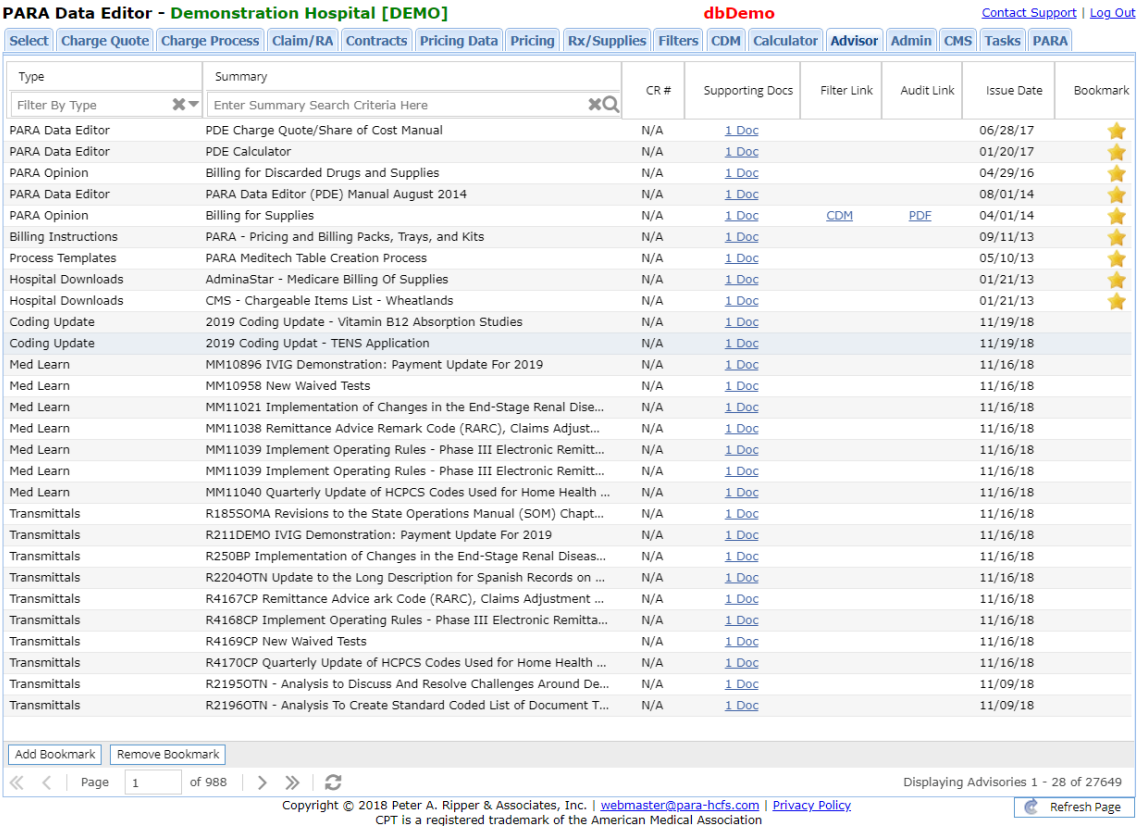
Quick Claim Evaluation
The Quick Claim Evaluation report allows the User to enter a series of CPT®/HCPCS codes and view them in a UB-04 claim format. The report will also display Medicare Reimbursement, and identify any possible CCI edits within the code combinations.

National Provider ID
The Calculator tab also provides access to the NPI database. The User can research and provider (organization or individual) within any state.

UB-04 Data Specifications Manual
The Data Specifications report enables the User to research any of the fields on the UB-04 form, and will display the type of information that needs to be entered in the field, and what format the data should have.

HCPCS to Anesthesia Code Crosswalk
A report that maps the appropriate anesthesia code to the surgical code. Either code component can be searched.

Advisor Tab

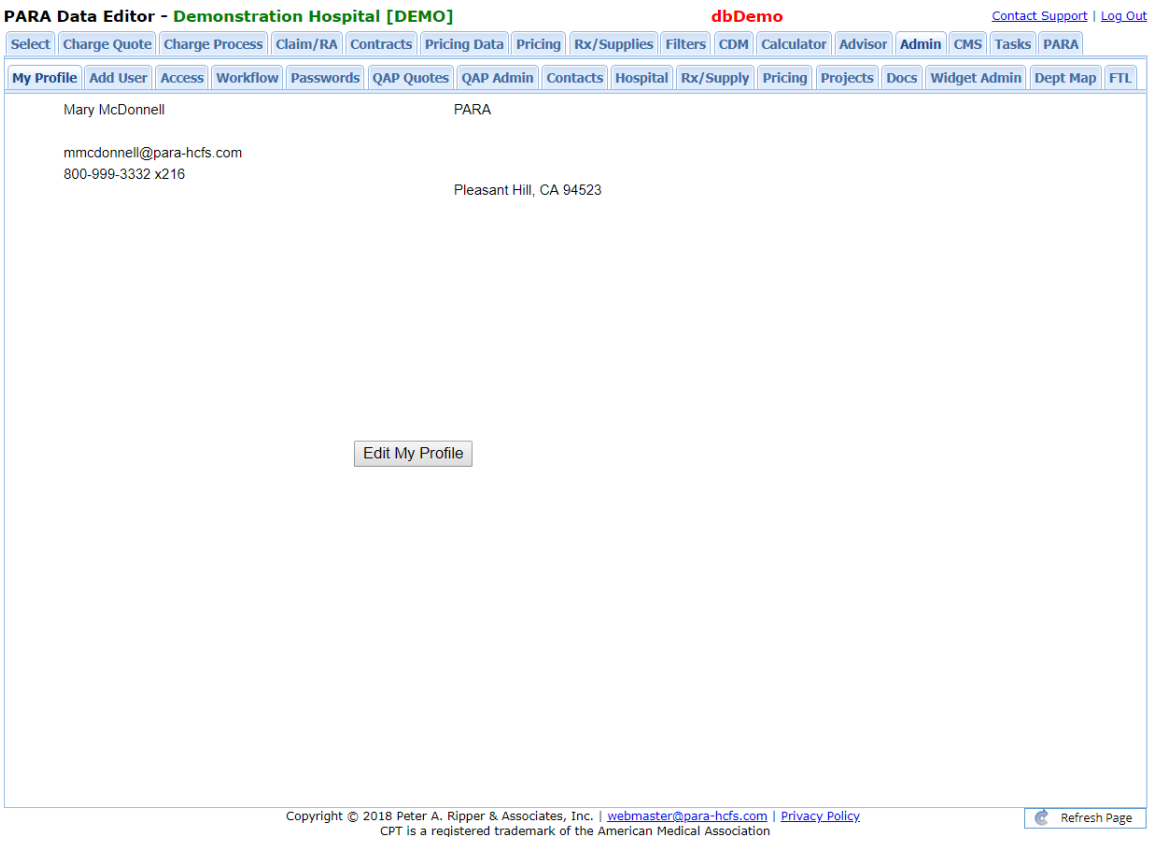


The Advisor Tab is designed to warehouse links to all Bulletins, Transmittals, and Updates **PARA** receives from a variety of sources in a single location. The User can sort by the type of document, search by keyword within the Summary description, and click on the supporting document link to access the original document. Also included in this tab will be Regulation notices and opinion memos created by **PARA** to interpret the guidelines issued by CMS and the Intermediaries/MACs, as well as papers written in response to billing and coding questions posed by **PARA** clients.

Filter Links are available on items that contain coding changes or guidelines. By selecting the **CDM** icon under **Filter Link**, the User will be redirected to the CDM tab of the **PDE**, with all items in the current CDM affected by this transmittal extracted for review.

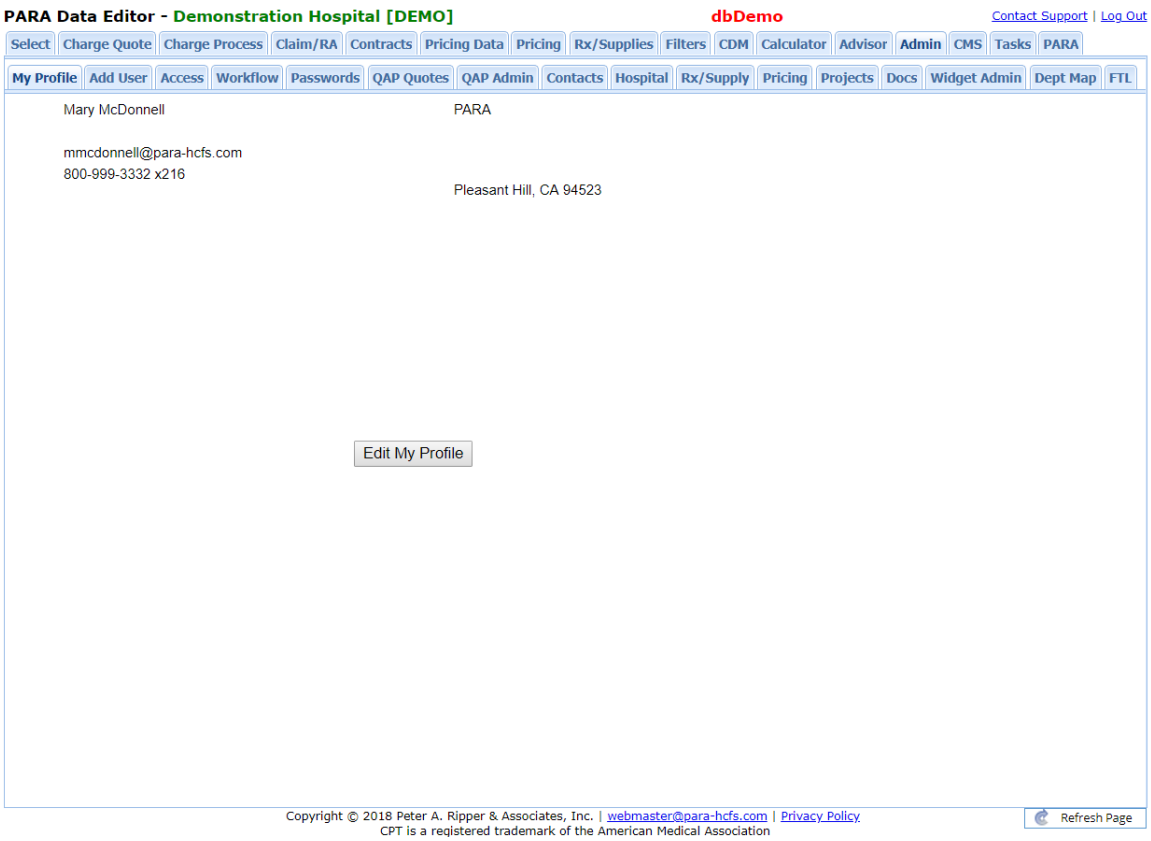
By selecting the **PDF** icon in the **Audit Link** column, the affected CDM items are displayed in an Adobe PDF document, as well as any other items in the Transmittal that are not coded in the Charge Master.

Administration Tab



The Administration tab is where the User can maintain control over who has access to the **PDE**. A hospital-level User can invite new Users within departments and create custom approval chains, so that all activity within the **PDE** is routed to the correct individuals. Users can be assigned different levels of accessibility, so that hospital-level Users can have access to all departments within a hospital, and department-level Users have access to only the appropriate departments.

Administration Tab – My Profile



This tab shows the profile information for the current User. The User's contact information, as well as their password, can be changed by utilizing the "**Edit My Profile**" button.

All fields within this tab can be updated at the User's discretion. If their email address or telephone extension are changed, or if they wish to change their password, those functions can be performed within this tab.

Change Password

If you forgot your password, and have logged in on a system generated password, it is recommended that you change that password to one that you will remember, one of your choice.
Click on the tab labeled **My Profile**.

Click on the **Edit My Profile** button.

On the **Profile** form:

Enter **'the computer generated password'** into the **Current Password** field.

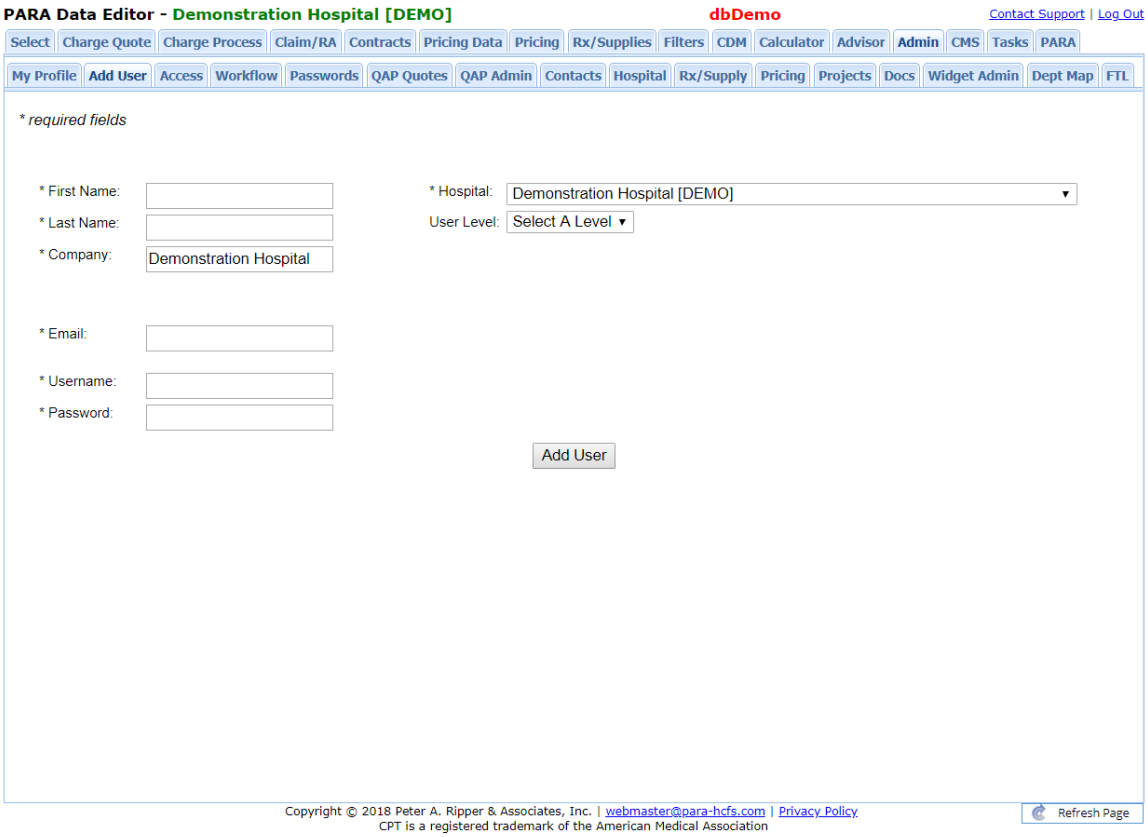
Administration Tab – My Profile (continued)

Enter **'the password you have chosen'** into the **New Password** field.

Enter **'the password you have chosen'** again into the **Repeat New Password** field.

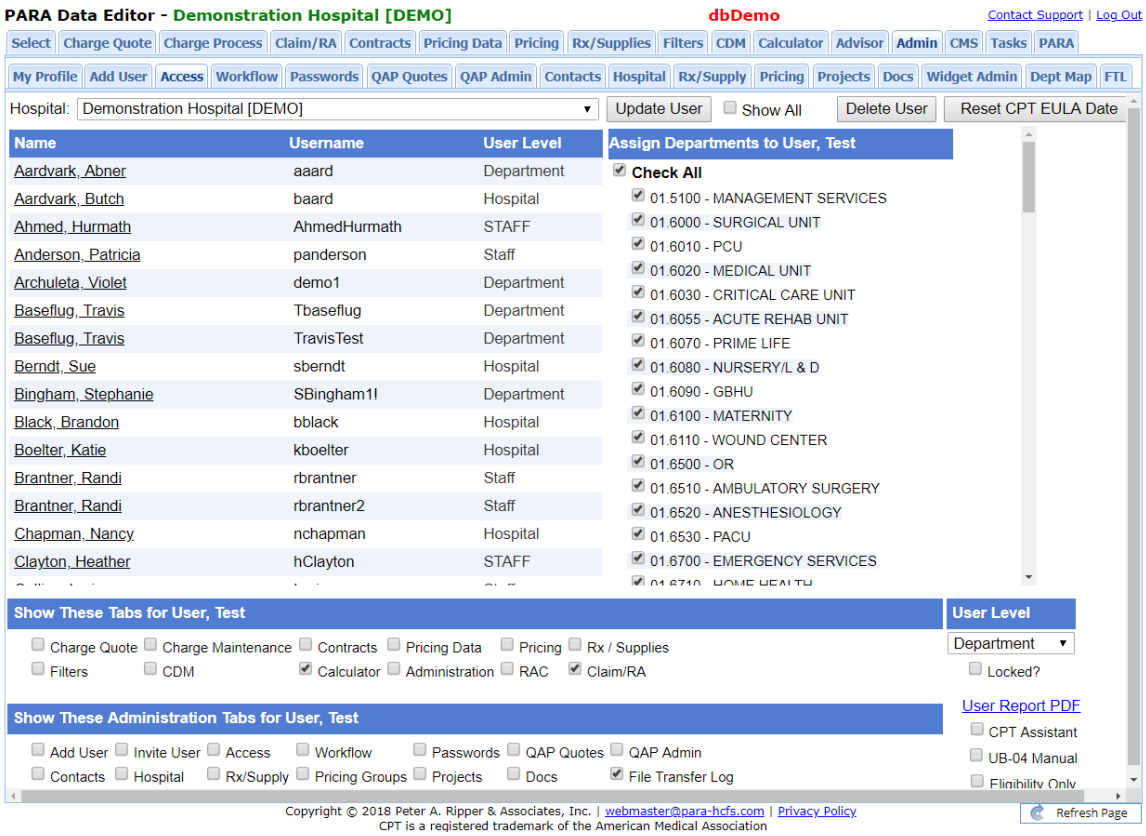
Click the **Update My Profile** button.

Administration Tab – Add New User



If you are a Hospital-level User, with Administrative rights, you can add new Users within your hospital. There is no limit to the number of Users, and you can control what tabs and functions within the **PDE** the new User can access. Fill in the fields with the new User's information, and hit the "**Add User**" button. A message will appear at the top of the screen that the User has been added to the system. Their level of access can be controlled through the "**Access**" tab.

Administration Tab - Access



A complete list of all Users currently set up for the facility can be viewed on this tab. Their access level can be edited by clicking on the underlined name. The User can be granted access to individual departments, multiple departments, or all departments if they are a hospital-level User. Users can also be deleted from this tab if necessary. If you have invited a User within your hospital, they will have to be given access to individual (or all) departments in this tab.

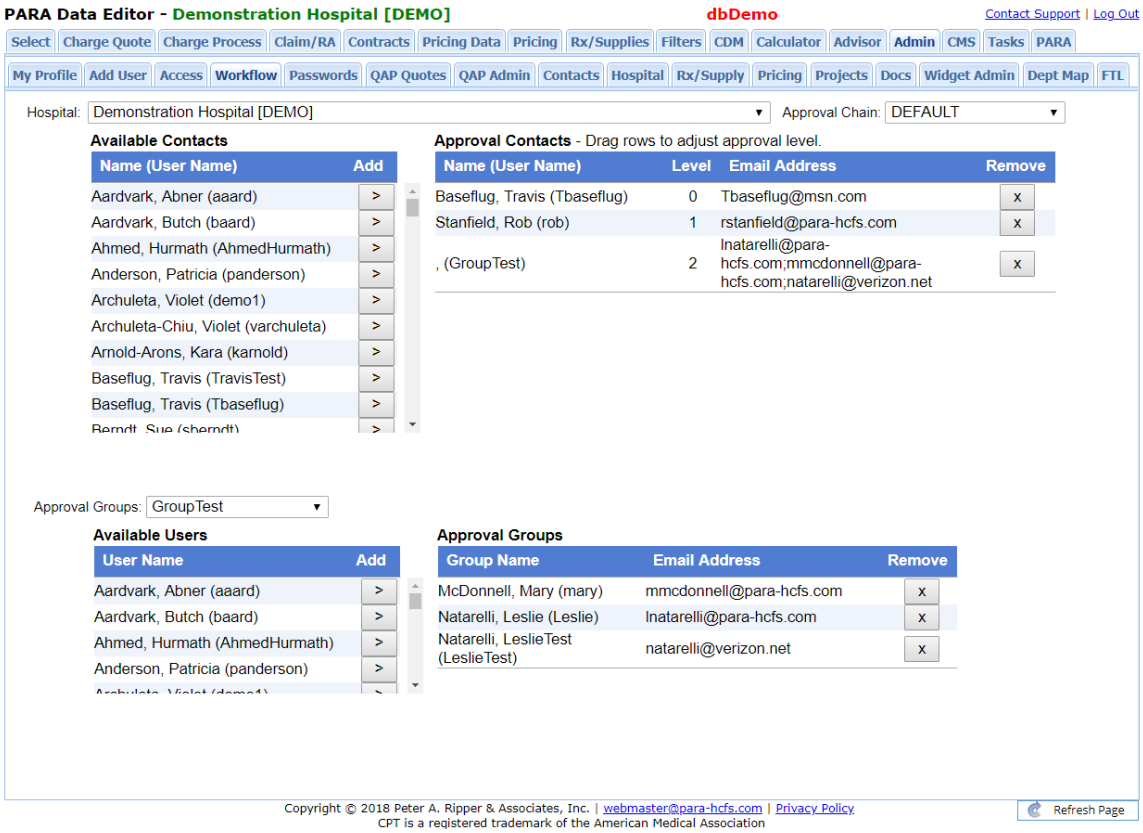
Click on the tab labeled **Access**. A listing of system Users will appear.

Click on the appropriate **User's Name**. A **Department Listing** will appear on the right side of the screen.

Check the **specific departments** for the User to have access, or check the **All** button at the top of the list.

Click the **Update User** button at the top of the screen.

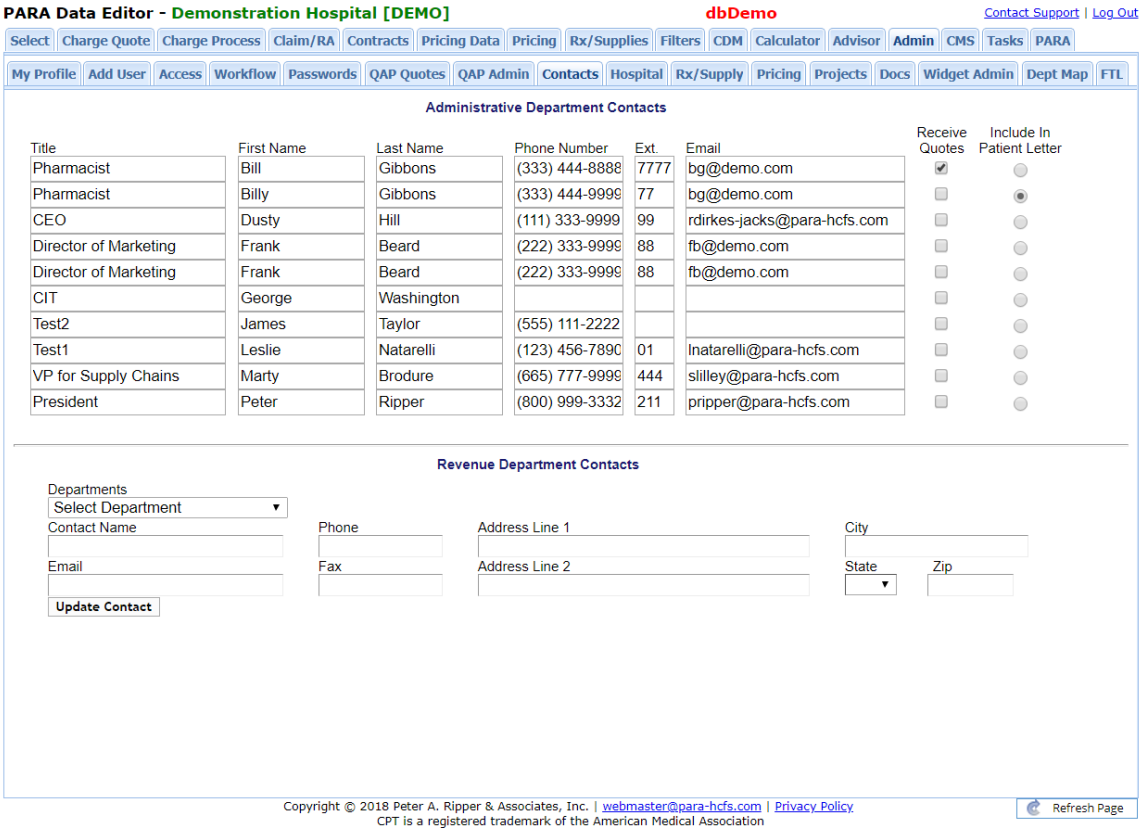
Administration Tab - Workflow



Approval chains can be created and maintained within the "**Workflow**" tab. From a list of available contacts for the facility, the User can be added to an approval chain by clicking the "Add" button. The User's level within the approval chain can be adjusted by dragging their name to the appropriate level. All changes made within the Charge Process and CDM tabs do not directly affect the hospital's current Charge Master. Approval for these edits can be managed from within this tab.

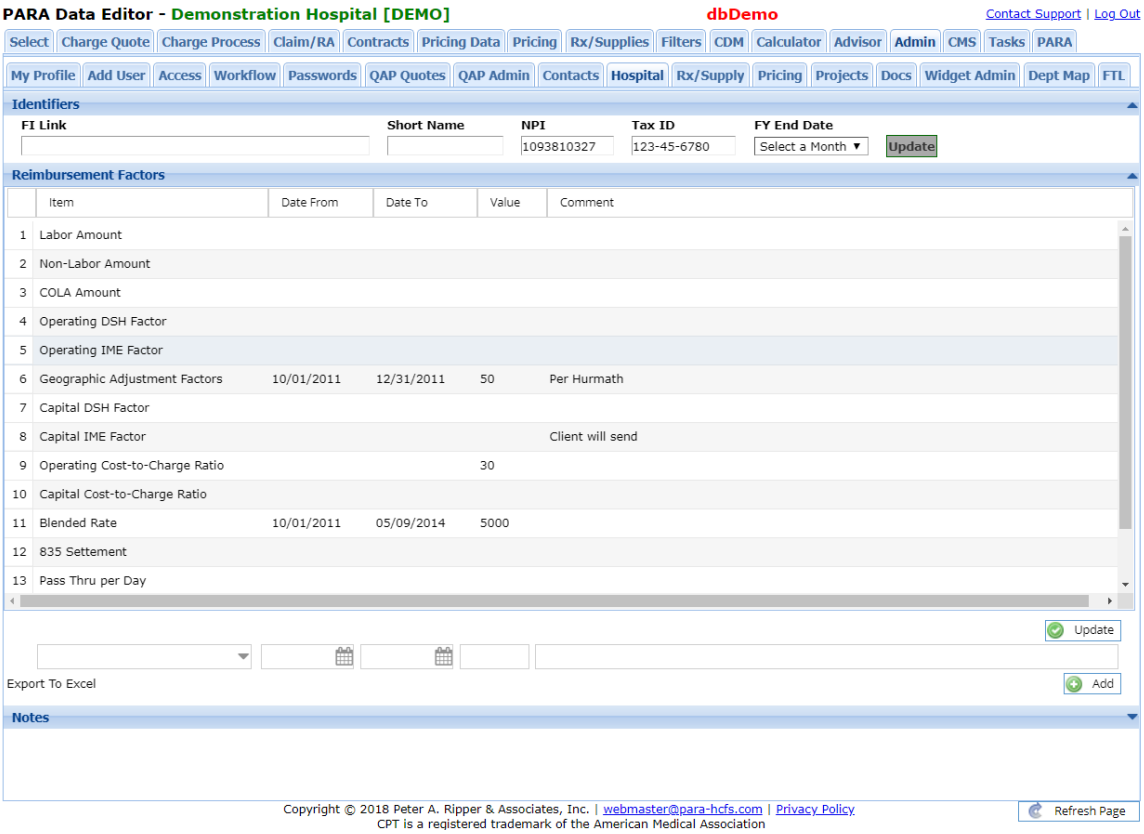
There is also an option to create and add an Approval Group to an Approval Chain-this allows multiple approvers at a single level in the chain, in case of absence or vacation-only a single User within the group needs to approve to forward the request to the next level within the chain.

Administration Tab - Contacts



All contacts within the hospital can be maintained from this tab. Their contact information, whether or not they receive copies of the quotes and patient letters generated by Charge Quote, can be added and updated within this tab. Revenue Department contacts can also be entered, for approval of changes to CDM items in the Charge Process/CDM tabs.

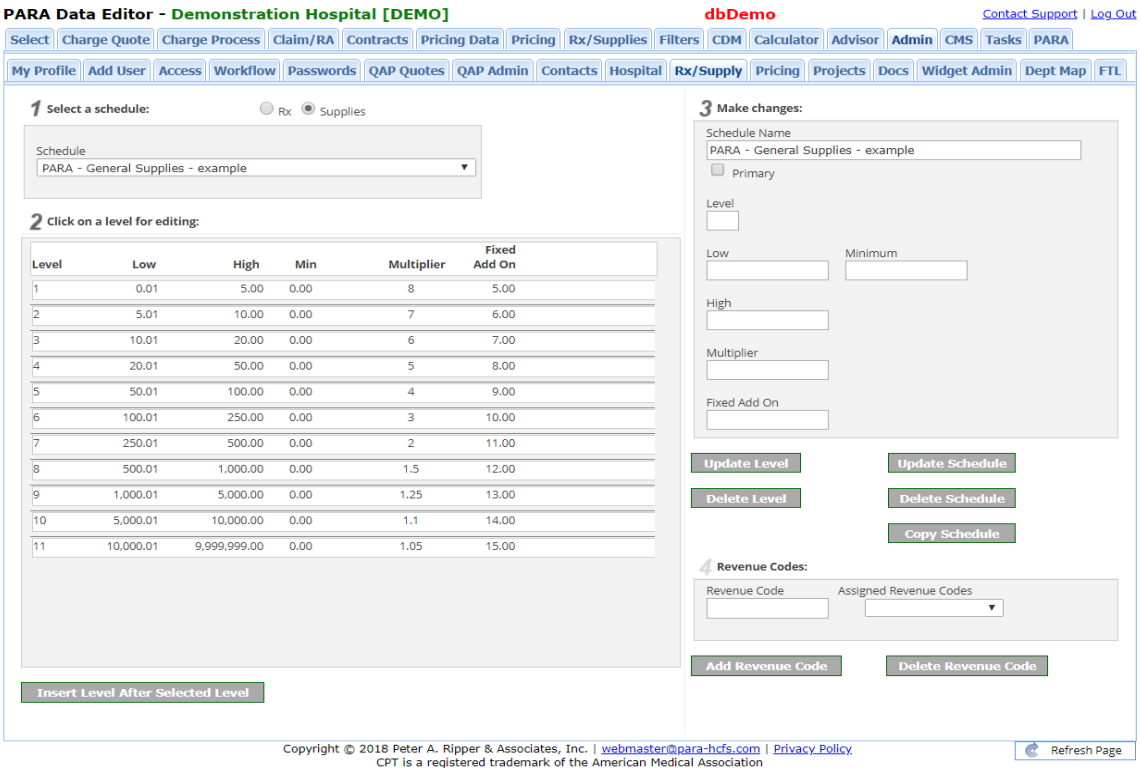
Administration Tab - Hospital



Hospital-specific information, such as the current Average Wage Index (AWI) and the current Fiscal Intermediary (FI) can be updated in this tab. Blended rates can also be viewed and updated if necessary.

There is also an area where notes, entered by the User, as well as copies of pertinent emails can be saved so that the User can view the history of a project or a particular area of the **PDE**.

Administration Tab – Rx/Supplies



This tab can be utilized to establish the Hospital's individually created mark-up schedules for Pharmacy and Supply items.

The parameters for the Pharmacy and Supply calculations are entered on this page, which is found within the Administration tab. Levels can be updated, added, copied, or deleted as necessary.

A common scenario in supply schedules is for lower pricing to have higher multipliers. This can result in an acquisition cost at the bottom of one tier having a lower patient charge than an acquisition cost at the top of a lower tier. Consider this schedule:

Acquisition Cost From	To	Multiplier
$0.01	$100.00	2.5
$100.01	$200.00	2.0

An item with an acquisition cost of $100.00 results in a patient charge of $250.00, while an item with an acquisition cost of $100.01 has a patient charge of only $200.00

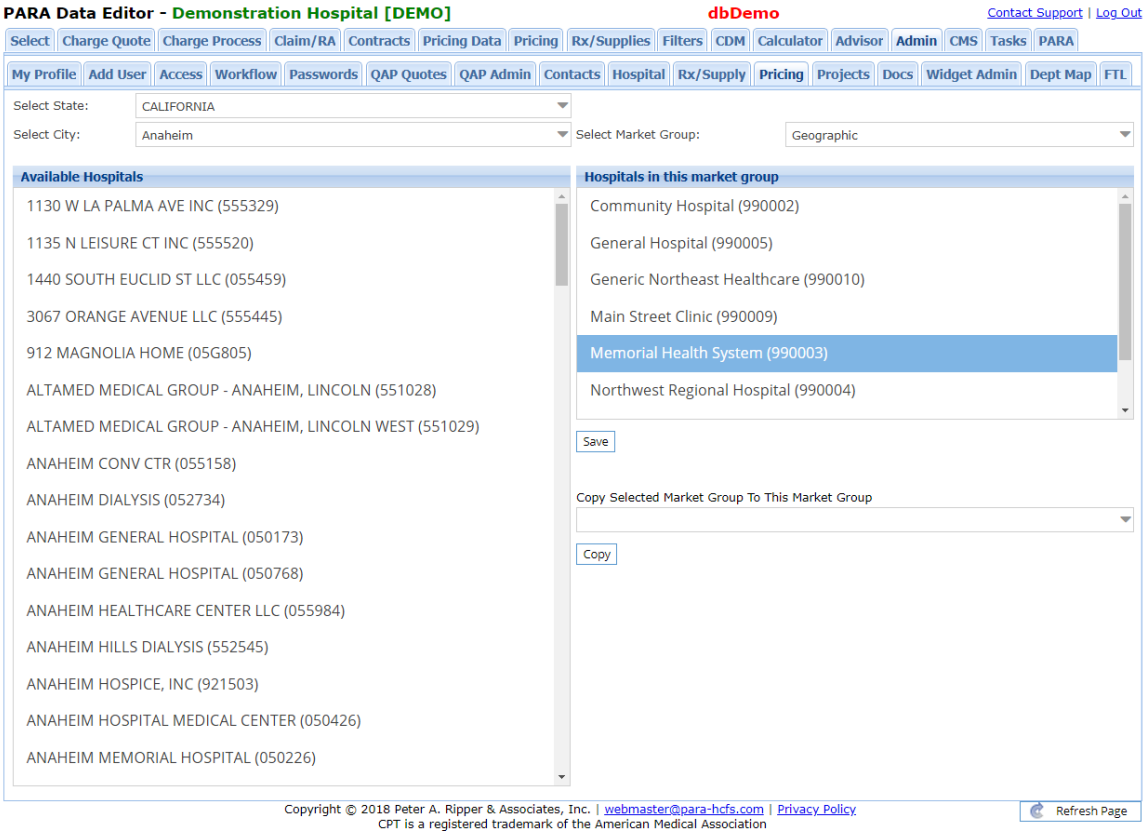
In order to smooth out these patient charge peaks as the multiplier is lowered for higher acquisition costs, the patient charge will not be less than the highest possible patient charge in the next lowest tier.

Administration Tab-Rx/Supplies Calculation (continued)

In the example above, acquisition costs would be converted to patient charges as follows:

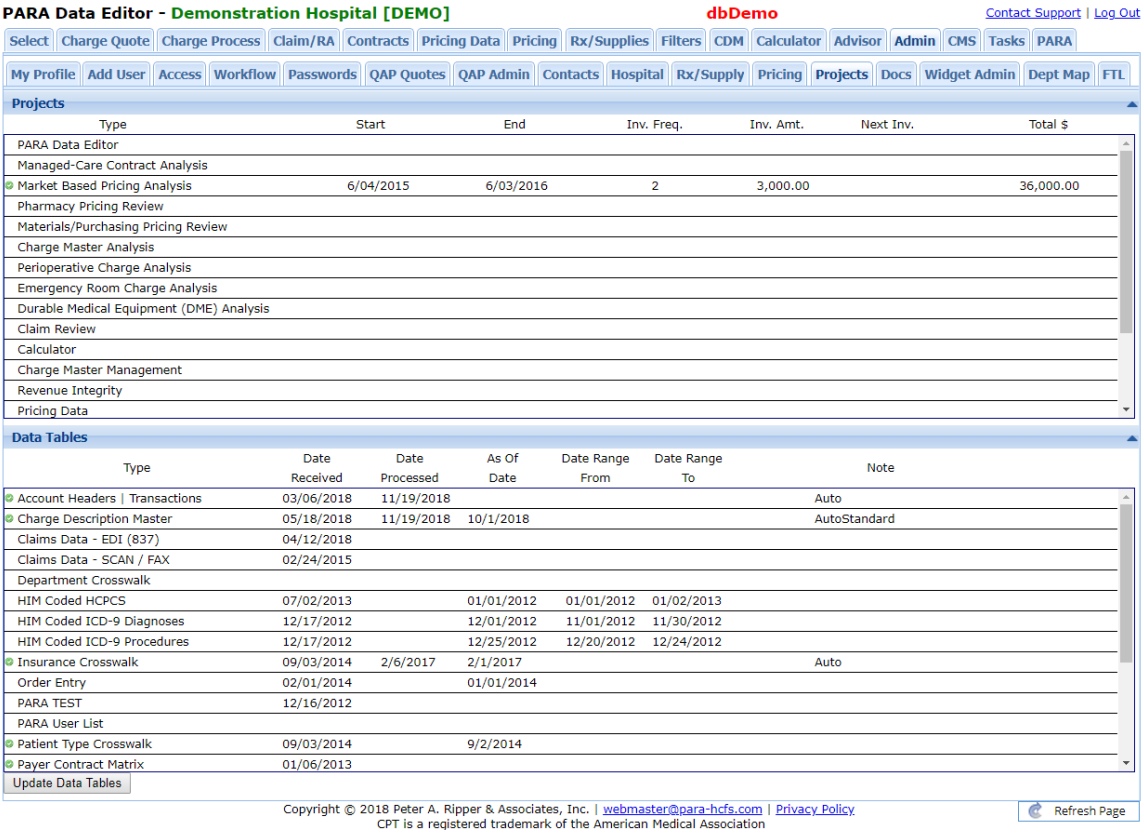
Acquisition Cost	Patient Charge (without smoothing)	Patient Charge (with smoothing)
$70.00	$175.00	$175.00
$80.00	$200.00	$200.00
$90.00	$225.00	$225.00
$100.00	$250.00	$250.00
$110.00	$220.00	$250.00
$120.00	$240.00	$250.00
$130.00	$260.00	$260.00

Administration Tab – Pricing



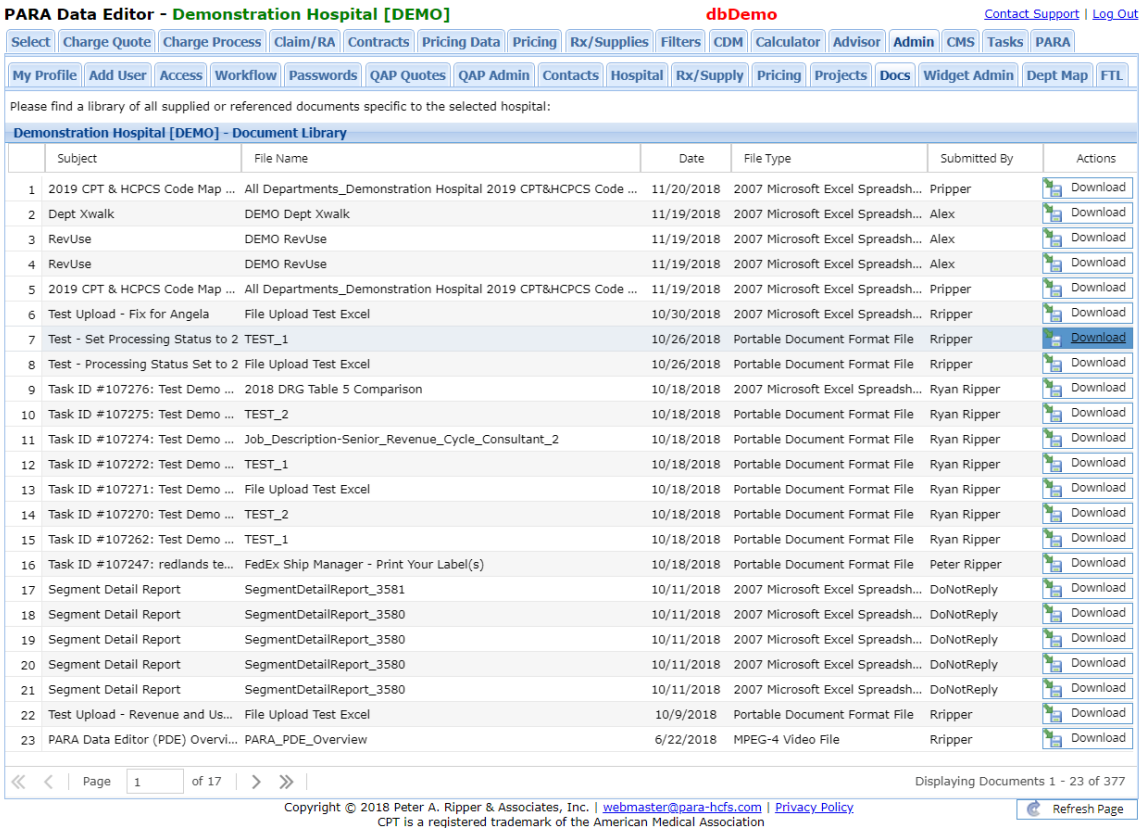
The User now has the capability to set their own market group, or multiple groups, within the **PDE**. The available market groups can reflect the hospital's geographic area, an Organizational group, or a Service-Related group. To create a new group or change an existing group, select the type of group from the drop-down menu on the upper right of the screen. Select the state (the User can select hospitals from different states if they choose), and then the city. A list of available hospitals within that city will appear in the box on the lower left. To select a hospital from the list, double click on the hospital name or click and drag it to the box on the right. A maximum of nine peer hospitals can be included in a group. When the User has selected the market, click "**Save**". That market is now available in the Pricing Data tab, and can be selected for comparison for any of the reports.

Administration Tab – Projects



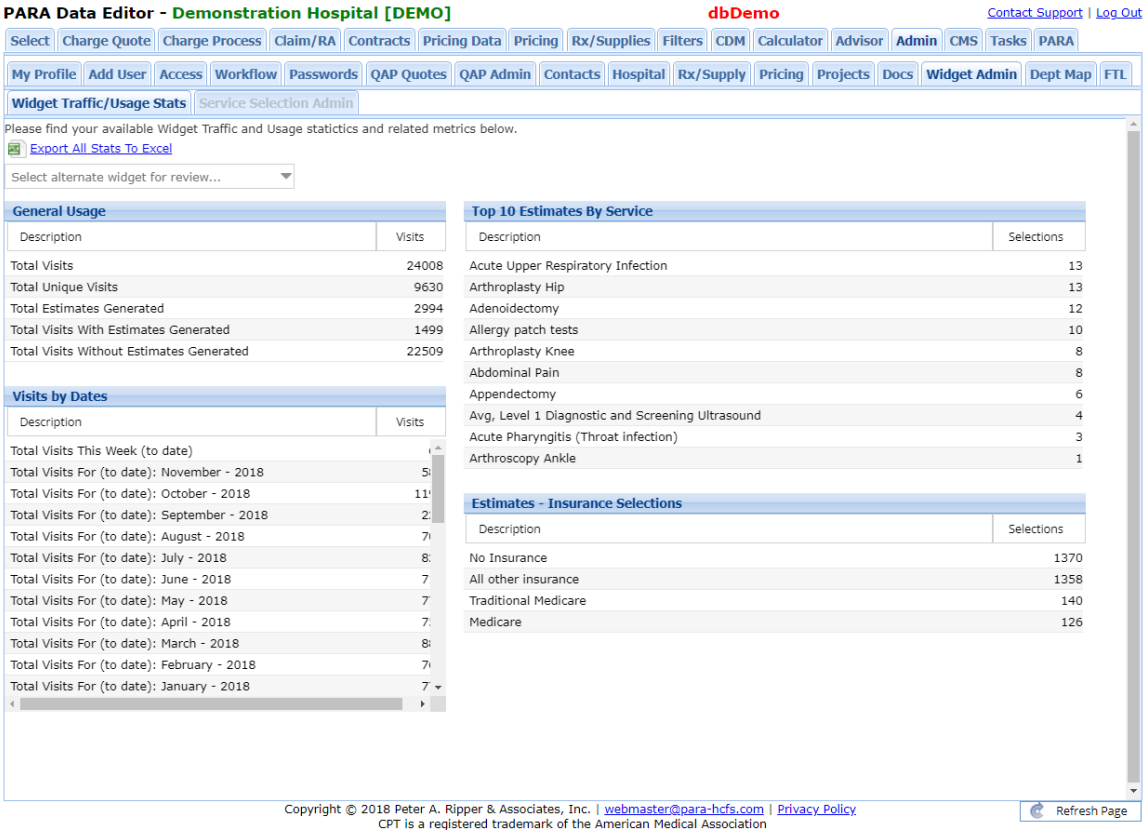
The Projects tab provides a listing of all of **PARA**'s Project options, with indicators for the project type for which the Hospital is currently contracted, as well as the applicable Data Tables in use for that project. Also noted are the Data Tables' history, with date ranges.

Administration Tab – Docs



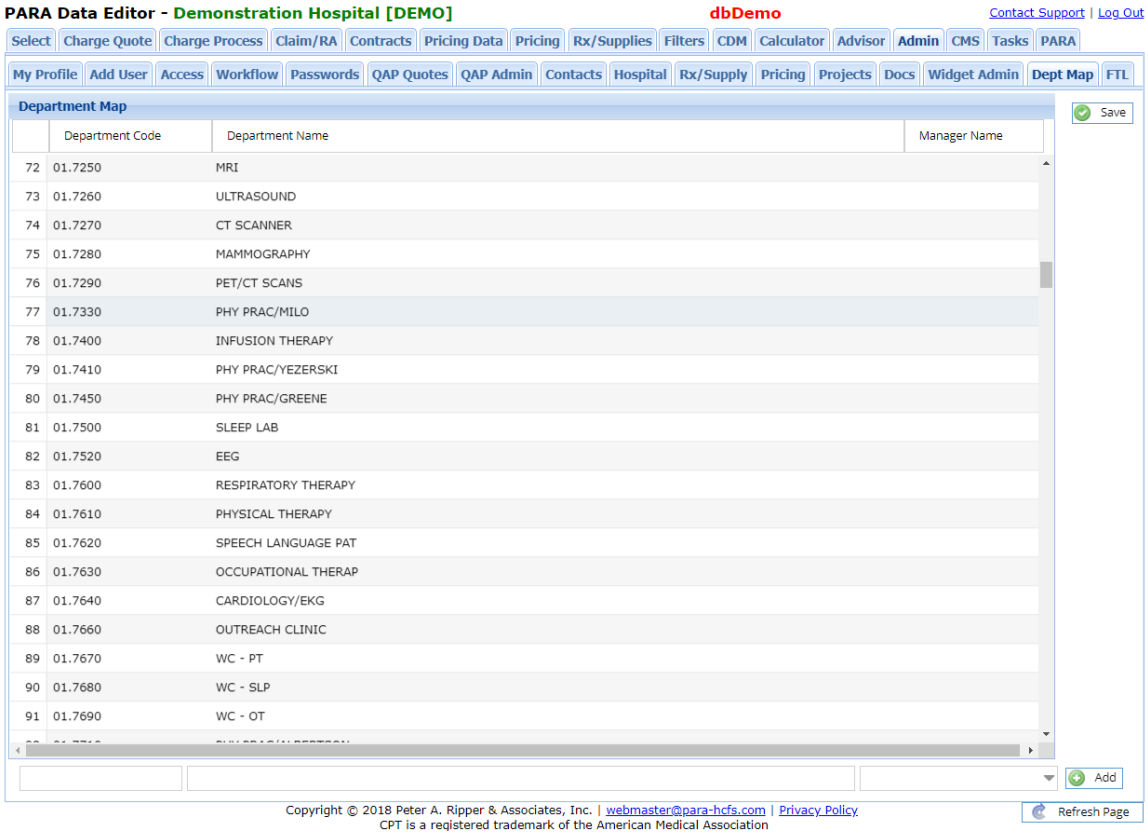
All email correspondence between client representatives and **PARA** is copied to the **PARA Data Editor**. All document attachments are logged in the "**Docs**" sub-tab within Administration.

Administration Tab – Widget Administration



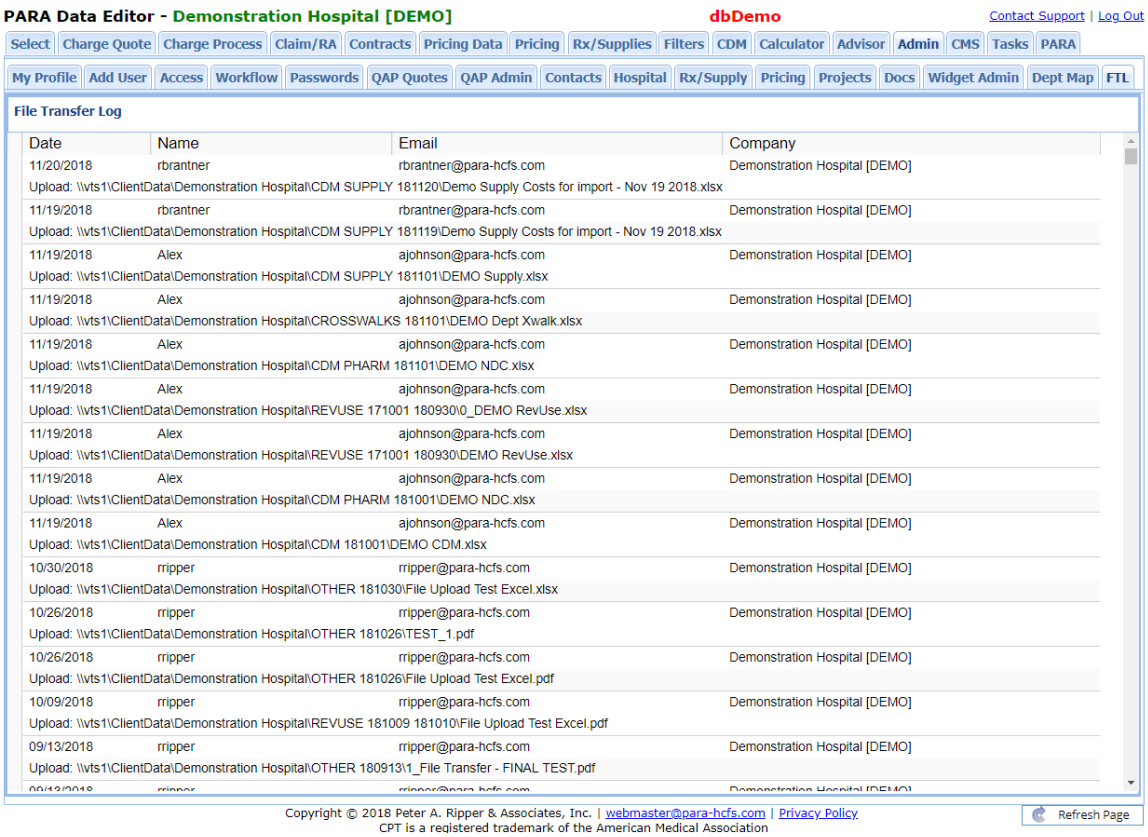
If a client elects to incorporate the **PARA** Widget into their own website, services can be updated and usage traffic can be tracked.

Administration Tab – Department Map



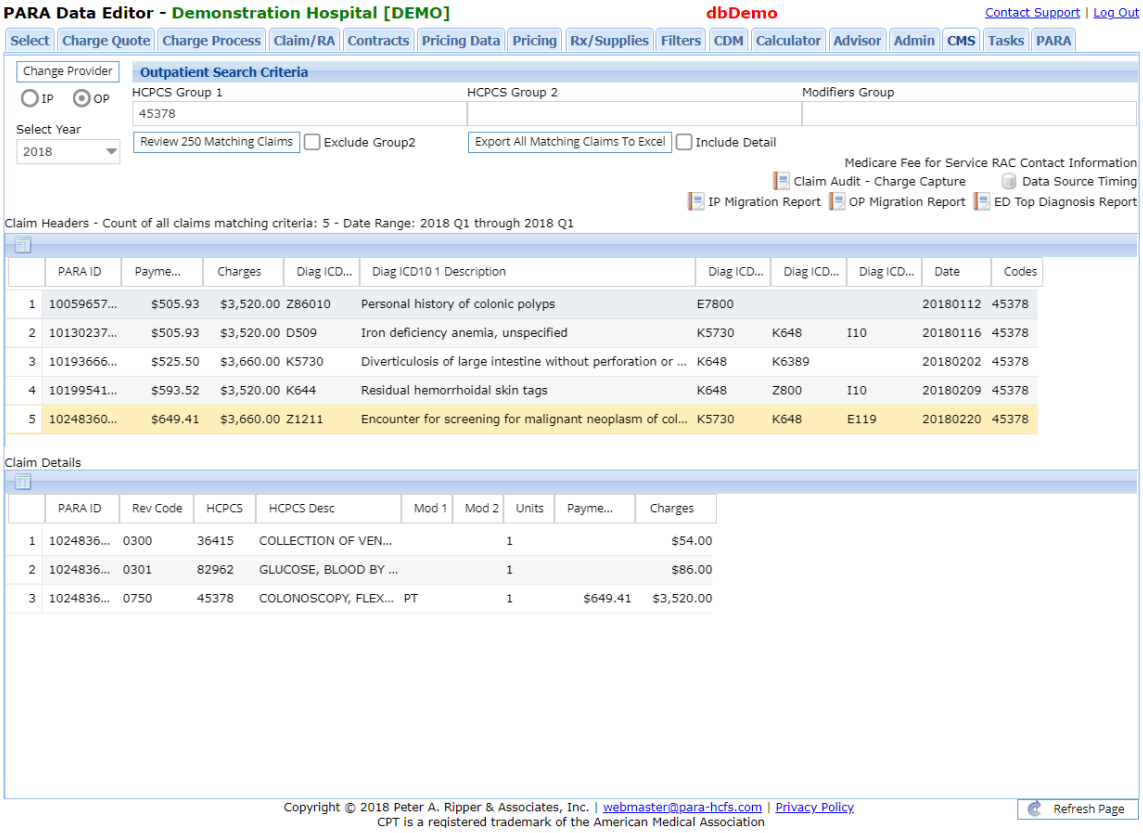
This tab displays the department code, department name, and the manager's name for each department in the hospital's charge master.

Administration Tab – File Transfer Log



This tab displays all files uploaded to the **PDE** via File Transfer. The date of the transfer, the User's name, email address and the name of the file are all stored for reference.

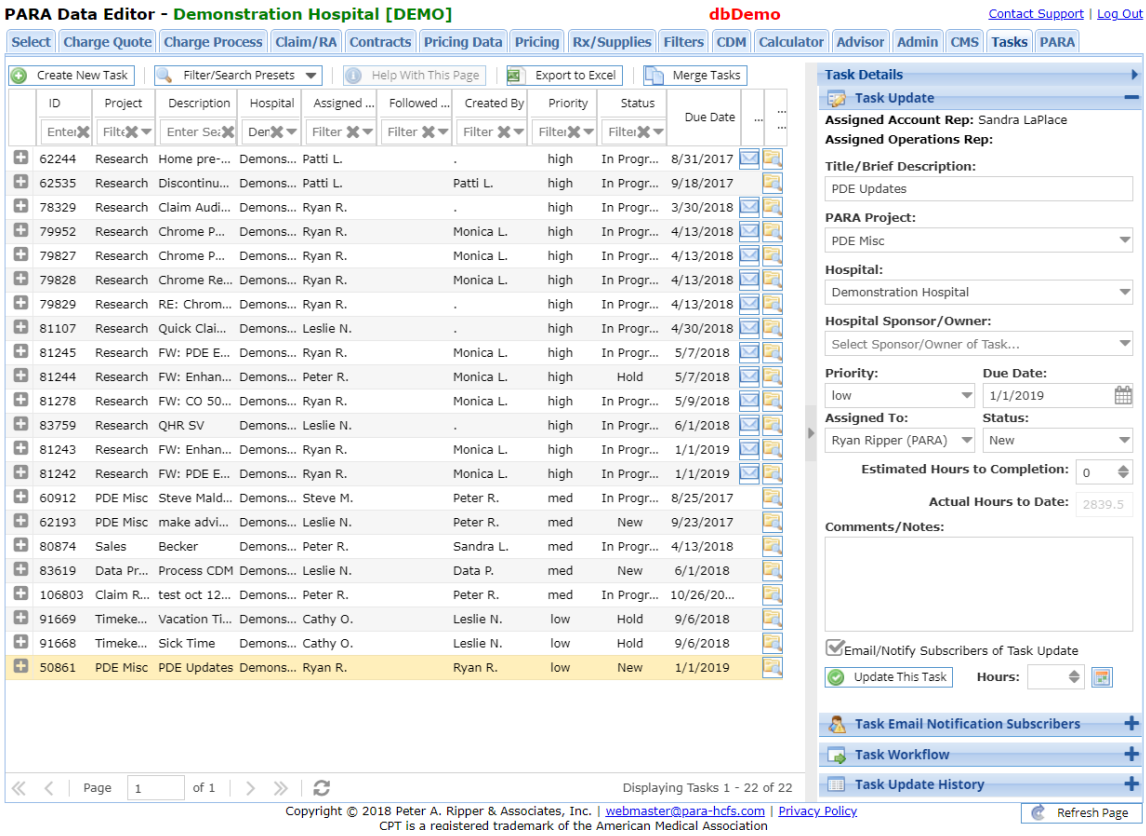
CMS Tab



The CMS tab allows a hospital to perform the following:

- Perform queries on both inpatient and outpatient claims
- String queries with multiple “or” or “and” logical expressions
- Export the queries into a Excel worksheet
- View line item payments on outpatient claims

Tasks Tab



All **PARA** staff track hours within the Tasks tab-other staff and Hospital contacts can be subscribed to follow any task, so they receive email updates every time a task is noted.