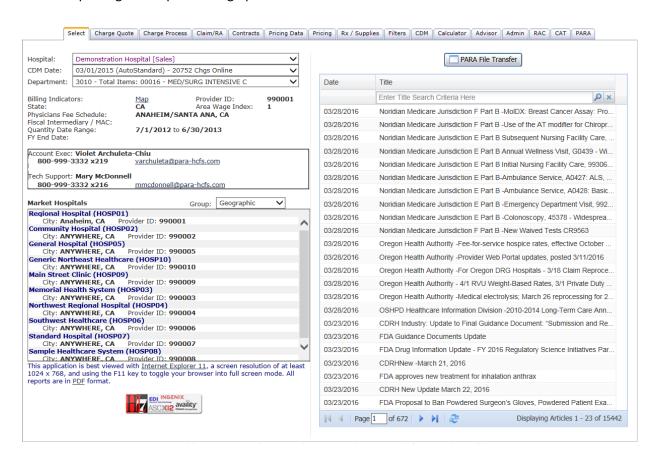
The **ParaRev** charge master audit process utilizes the **ParaRev Data Editor (PDE)** to create a series of focused screens and reports utilized by the **ParaRev HIM Coding Staff** to identify and correct charge master errors, compliance issues, and missing charges.

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

The desk review can be expanded with an "on-site review" to meet with each of the Revenue Department Managers and complemented with a "Claim Review" and on-site visit.

There are 5 phases to the ParaRev Charge Master Desk Review process:

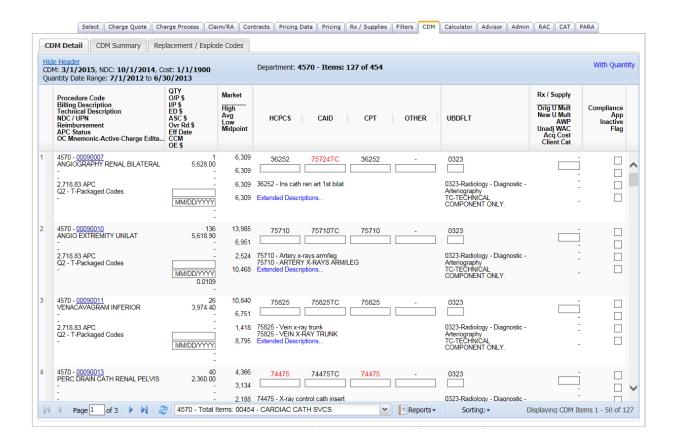
- 1. Checking Invalid HCPCS and Revenue Codes
- 2. Checking Line Items for Charge Compliance and Modifiers
- 3. Checking Valid Code Assignment
- 4. Checking pricing against fee schedule and APC
- 5. Reporting and implementing updates



All queries in the PDE CDM tab are color coded:

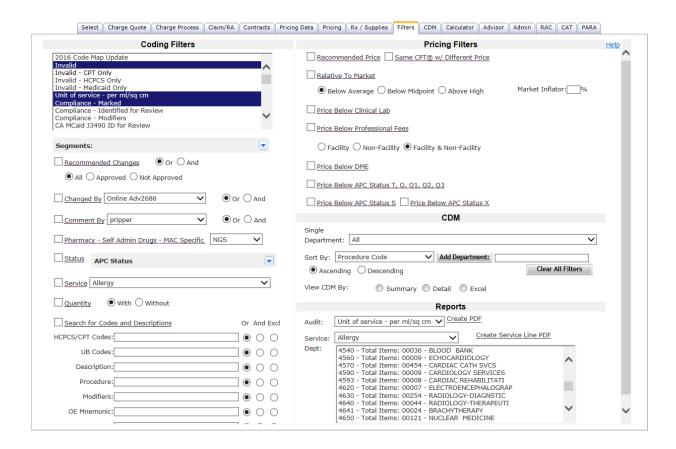
- 1. Red Invalid code
- 2. <u>Blue</u> Code, procedure number, NDC, OE mnemonic or description which matches the filter query
- 3. **Green ParaRev /** Hospital recommended changes
- 4. <u>Purple</u> ParaRev advisory recommended changes, to be reviewed by Hospital prior to implementation

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



Phase I - Checking Coding

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



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

Phase I - Checking Coding (continued)

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

Phase II - Checking Line Items for Charge Compliance and Modifiers

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

Medicare Chargeable Items List

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

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

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

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

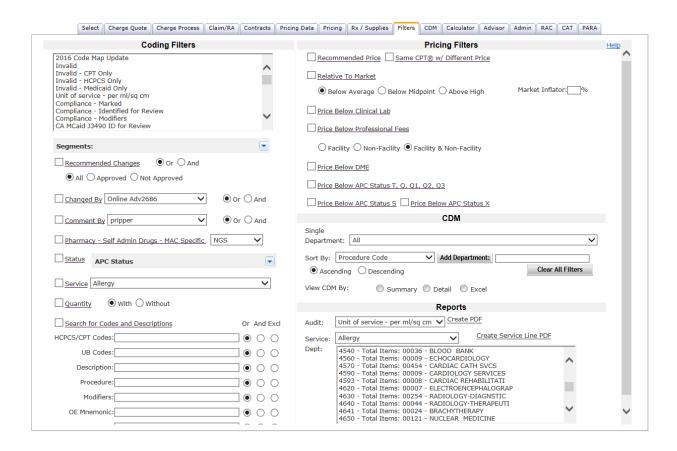
This list is not all-inclusive.

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

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

Phase III - Checking coding and usage

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



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

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

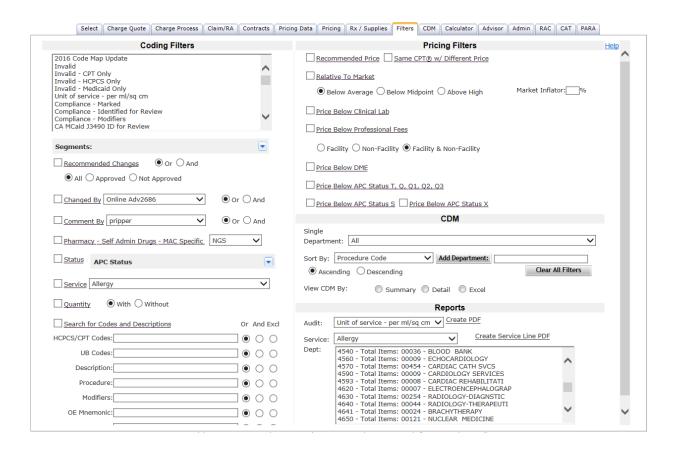
Phase IV - Checking pricing against fee schedule and APC

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

The available pricing filters are as follows:

- 1. Price below Clinical Lab fee schedule
- 2. Price below Professional Fee schedule
- 3. Price below DME fee schedule
- 4. Price below APC Status T, Q1, Q2, Q3
- 5. Price below APC Status S
- 6. Price below APC Status X

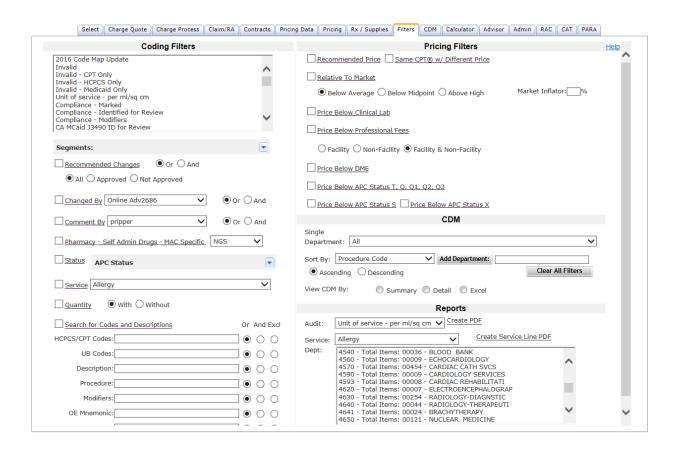
The market pricing filters contain the most current peer market pricing data available, the market prices are always up to date for every User within the **PDE**.



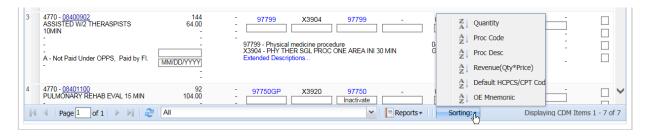
Phase V - Reporting and implementing updates

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

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



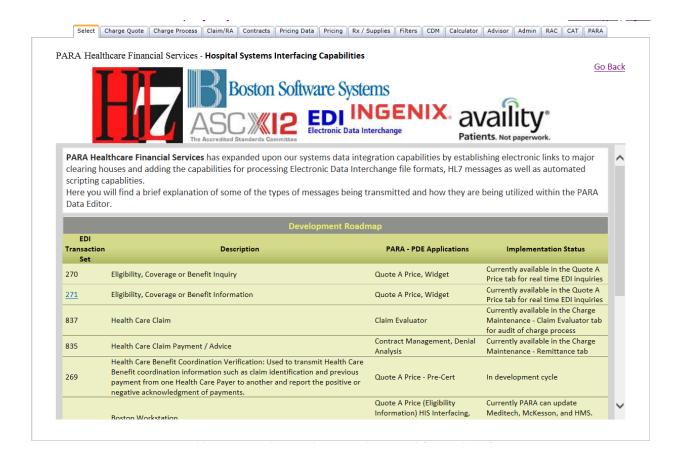
The User then has options on how the report is to be sorted (procedure code, HCPCS / CPT® code, gross revenue, charge description) and reported (PDF or Excel) summary or detail.



Phase V - Reporting and implementing updates

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

ParaRev provides a service to update the codes and prices using Boston Workstation, utilizing a remote access connection.



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