The goal of the **ParaRev Revenue Integrity Program** (**PRIP**) is to audit and enhance each aspect of the revenue cycle process to ensure that all appropriate revenue is created, captured, coded, priced and paid correctly within compliance guidelines.

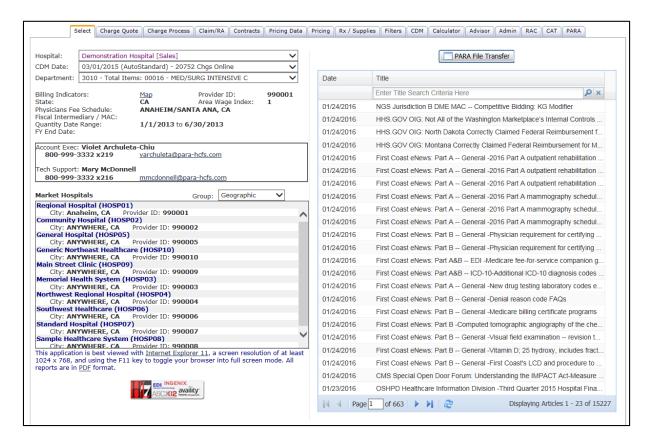
Due to the current reduction in reimbursement and utilization, hospitals need to gain efficiencies; the **PRIP** will allow your hospital to dedicate Staff and resources to areas which will provide a greater return.

The **PRIP** will also integrate your Department Managers into the revenue cycle to make them active participants in charge creation, capture and reimbursement.

There are 5 components to the Program

- 1. Claim audit charge capture, coding and compliance
- 2. Pricing market based pricing with a relationship to fee schedules or cost
- 3. Charge Master code review and maintenance
- 4. Compliance HIM / Business Office assigned codes and modifiers
- 5. Revenue Management Committee oversight, governance and guidance

The **ParaRev Data Editor (PDE)** is utilized in every aspect of the **PRIP**.



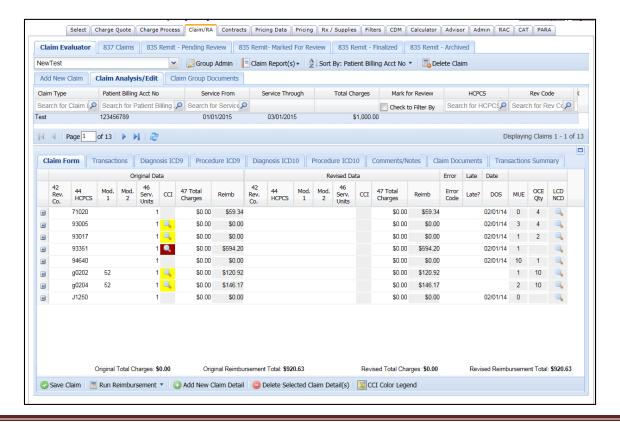
Claim audit – charge capture, coding and compliance

There are disparate data elements which flow together to create a patient claim-the goal of the claim review is to audit and reconcile as many data elements within the claim back to the originating source. The claim review will trace the following items from the claim to the medical record, departmental worksheets or remittance advices.

- 1. HIM coded surgical procedures
- 2. Separately billable nursing procedures
- 3. Supplies charge capture, codes and compliance of charges
- 4. Drugs codes and unit multipliers
- 5. Determination of the evaluation and management levels for emergency and clinic visits
- 6. Business Office / HIM assigned modifiers
- 7. Payments and denials

Claims are processed into the **PDE** using the **Claim/RA Evaluator tab**; the claims are either loaded by processing data tables within the **PDE** (header and transaction tables), EDI 837 records or manual keying. The **ParaRev HIM Staff** will review the claims with the supporting documentation for reporting back to the Revenue Management Committee (**RMC**).

The members of the **RCM** have 24/7 access to all segments of the **PDE** for continuing review.



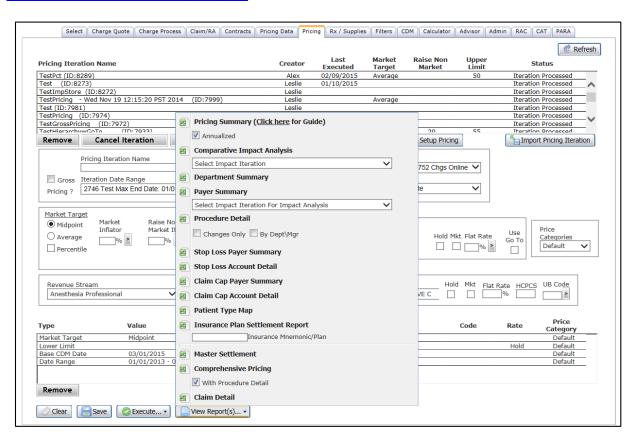
Pricing – market based pricing with a relationship to fee schedules or cost

Pricing is critical to revenue cycle success; the **ParaRev Market Based Pricing Program** is a sub-component of the **PRIP**.

The goal of the **MBPP** is to identify line items in the charge master which have negative patient satisfaction due to high prices, identify gross margin improvement opportunities due to low prices and to establish a rational pricing methodology by setting prices based on fee schedule, APC, cost or competitive market pricing data. There are seven steps in the **ParaRev** pricing process:

- 1. Interview with hospital finance administration to determine goals of the process
- 2. Assessment of competitive market pricing data, creation of "max" iteration
- 3. Loading of the managed care contract matrix into the PDE Contracts tab
- 4. Refinement of iteration parameters, processing of multiple iterations
- 5. Quality review, rounding and smoothing
- **6.** Implementation
- 7. Follow-up

ParaRev Market Based Pricing Program



Pricing – market based pricing with a relationship to fee schedules or cost (continued)

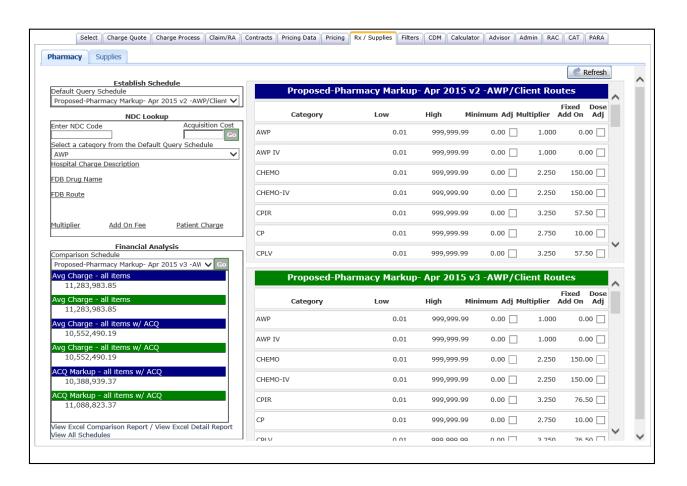
As a part of the annual pricing process, **ParaRev** will reset the pharmacy and materials markup schedules.

The **Rx / Supplies tab** within the **PDE** is utilized for this review.

PARA has the ability to price drugs on any cost basis or Wholesale Acquisition Cost, supplies are commonly priced on the basis of cost.

The tab also contains a process for researching pharmacy NDC codes and supply CMS "C" codes.

The **Rx / Supplies tab** also allows Department Managers a resource to price charge description master additions and changes utilizing the hospital specific mark-up schedule.



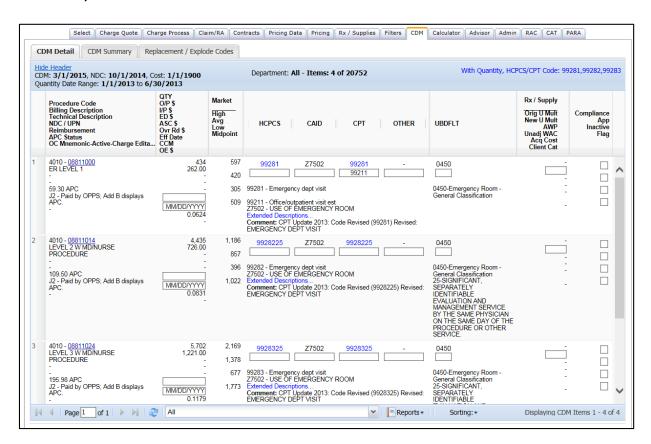
Charge Master – code review and maintenance

With the emergence of codes as the basis for almost all forms of reimbursement, charge master coding and maintenance has become a daily chore.

The **ParaRev HIM Staff** will review Medicare, Medicaid and Workers Comp code changes on a monthly basis and update the charge master where required, any changes which impact the charge creation and capture process will be reviewed in the monthly **RMC**.

The **PDE** will become the focal point for the charge master review, and the updates and changes will be available 24/7 for Manager review and comment. The **PDE** will also provide the Department Manager a one stop view of many different data elements within the revenue cycle.

- 1. Billing and technical descriptions
- 2. Pharmacy unit of service multipliers
- 3. Order entry mnemonics
- 4. Charge, cost and reimbursement
- 5. Summary market pricing data
- 6. CCI, LCD and NCD indicators



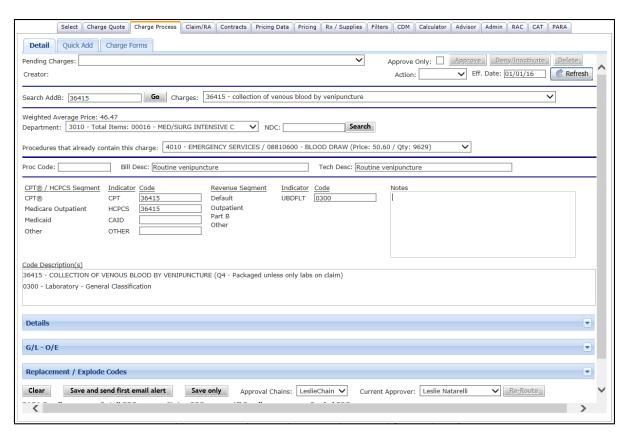
<u>Charge Master – code review and maintenance</u> (continued)

One of the main goals of the **PRIP** is to empower and unleash the entrepreneurial forces contained within each Department Manager. Managers are encouraged to update codes, prices and add services throughout the month, Managers are often frustrated by the slow pace of the current charge maintenance process.

The process within the **PDE** for initiating, approving and implementing changes to the charge master is the **Charge Process tab**.

The charge maintenance process provides a secure email centric creation, approval and implementation process for which the Managers can monitor the progress 24/7, if a charge maintenance item is "lingering" on a desk for approval, the Manager will know the point of delay and be able to take action.

The **ParaRev HIM Staff** will review and implement all changes within 48 hours of receipt, with email confirmation back to the originating Manager; all charge maintenance is accessible to the Manager impacted by the charge items 24/7.



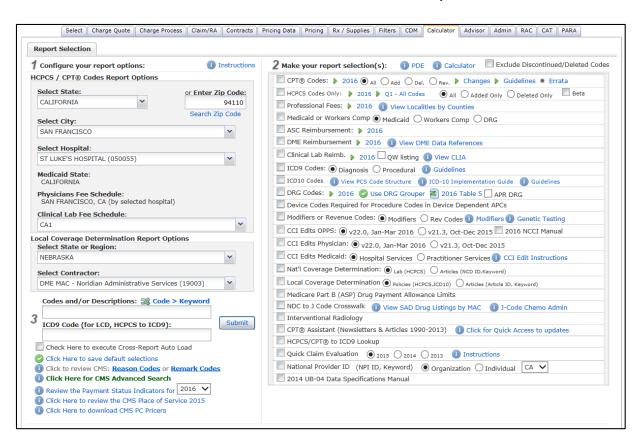
<u>Charge Master – code review and maintenance</u> (continued)

One of the many resources **ParaRev** brings to a hospital to support the revenue department Managers, Business Office and HIM staff is the **PDE Calculator**.

The **Calculator** provides 20 different resources accessible 24/7, with up to 5 years of history for CPT® / HCPCS codes and 25 years of CPT® Assistant.

- 1. CPT® Codes
- 2. HCPCS / CPT® Codes
- 3. Professional Fees
- 4. Medicaid / Workers Comp Fee Schedule
- 5. ASC Reimbursement
- 6. DME Reimbursement
- 7. ICD9 Codes Diagnosis and Procedural
- 8. ICD10 Codes
- 9. DRGs
- 10. Device Dependent Codes
- 11. Modifiers and Revenue codes
- 12. CCI OPPS Edits

- 13. CCI Physician Edits
- 14. CCI Medicaid Edits
- 15. National Coverage Determination
- 16. Local Coverage Determination
- 17. Medicare Part B ASP Drug Payments
- 18. NDC to J Code Crosswalk
- 19. Interventional Radiology Crosswalk
- 20. CPT® Assistant Newsletters & Articles
- 21. HCPCS/CPT® to ICD9 Crosswalk
- 22. Quick Claim Evaluation
- 23. National Provider ID database lookup
- 24. UB-04 Data Specifications Manual



Compliance – HIM / Business office assigned codes and modifiers

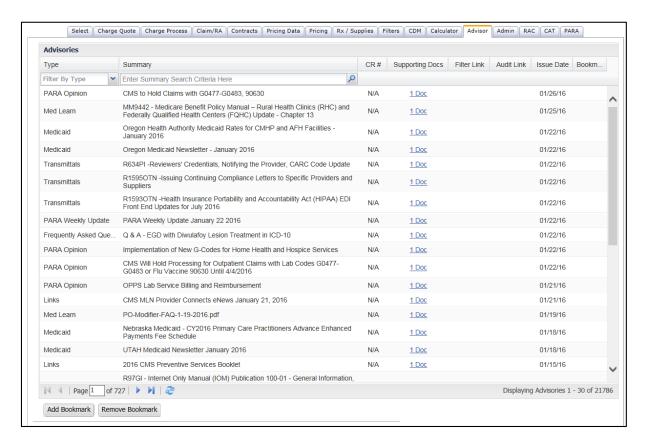
With the growth of RAC type audits, the quality and accuracy of claims is a financial requisite, the time, effort and penalties associated with a claim error are onerous.

The **PRIP** will assist and advise the HIM and Business Office in the correct application and use of codes and modifiers, the coding will be furthered reviewed on an ongoing basis with the claim audits.

The **PDE Advisory Tab** will also provide the Departments Managers a resource to access in regards to regulations and updates.

The most important part of the compliance process is the questioning of modifiers assigned without HIM review, or automatically by the charge master, again the claim review will bring these issues to the forefront.

On an annual basis **ParaRev** will audit the pharmacy NDC codes, J codes assignment and unit of service multiplier, which again have been a focus of audits.



Revenue Management Committee – oversight, governance and guidance

The key component to the **PRIP** is the Revenue Management Committee (**RMC**). The **RMC** is composed of the following:

- 1. Finance Administration
- 2. Business Office
- 3. Health Information Management
- 4. PARA Staff
- 5. Nursing Services
- 6. Surgical Services
- 7. Laboratory
- 8. Radiology
- 9. Pharmacy
- 10. Materials
- 11. Rehab Medicine
- 12. Cardiopulmonary

The goal of the **RMC** is to bring together the key "players" in the revenue cycle to resolve problems and develop processes.

The standing agenda of the **RMC** is as follows:

- 1. Review and acceptance of previous months minutes
- 2. Presentation of claim audit findings insurance and patient requests
- 3. Claim denial presentation
- **4.** Discussion of coding, billing and pricing issues
- **5.** Current regulatory findings
- 6. Updates to the ParaRev Data Editor
- 7. Projects and focus for the month

The **ParaRev** HIM Staff will attend the **RMC** usually by conference call (GoTo Meeting), **ParaRev** will maintain the minutes of the meeting and coordinate activities.