OUTLINE OF SERVICES

I. Charge Master Review

A. On-site Meetings and Education with Departments
B. Review for Compliance and Optimal Reimbursement
C. Review Codes (HCPCS/CPT and Revenue Center)
D. Review Line Item Descriptions
E. Evaluate Other Impactive Issues
    1. Modifiers Usage
    2. NCCI Edits
    3. Bundling/Unbundling Issues
    4. OCE Edits
    5. Panels and Charge Explosions
    6. Pharmacy Conversion Factors (i.e., multipliers)
F. Suggest Line Item creations where appropriate, to bill for allowable services/procedures
G. Review volume/usage report to further identify items being underutilized or overutilized
H. Charge Analysis
    1. Comparisons
    2. Medicare Fee Analysis
I. Review a *"sample"* of Encounters and associated bills (UB-04 and Detail Bills)

II. Strategic Pricing Analysis

A. Price/Charge Comparisons at the CPT/HCPCS code level with the selected Peer Group
B. Identify Code Omissions (possible opportunities for Line Item charge creation)
C. Easy to understand Detailed Reports and Comparative Analysis
D. Functional Database with lookup function for reviewing competitive charge data by simply entering the CPT or HCPCS code
E. Assist with Pricing Transparency
F. A line by line charge comparison with your current Charge Master
G. Potential Revenue Impacts of charge adjustments

III. Outpatient Coding Compliance Projects

A. Review Coding (ICD-10-CM Diagnosis, HCPCS/CPT)
B. Review of Charge Master Driven codes as well as HIM Coder assigned codes
C. Evaluate whether all allowable codes/charges are captured
D. Evaluate Clinical Documentation
E. Review for Medical Necessity (LCD/NCD) specific to each facilities' geographic area
F. Other Impactive Issues (Modifiers, NCCI Edits, OCE Edits, etc.)
G. Provide Accuracy Rates (as a group, and at the coder specific level)
H. Provide Financial Impacts of Recommendations
I. Review Billing Documents (UB-04 and Detail Bills)
J. Provide Coder Education (CEUs recognized by AHIMA and the AAPC)

IV. Inpatient Coding Compliance and Clinical Documentation Improvement (CDI) Projects

A. Review Coding to the highest level of specificity (ICD-10-CM Diagnosis and ICD-10-PCS Procedural)
B. Review DRG/MS-DRG Accuracy (understanding of CAH exemptions)
C. Complications and Comorbidities (CCs & MCCs)
D. Evaluate Code Sequencing
E. Provide Accuracy Rates (as a group, and at the coder specific level)
F. Provide Financial Impacts of Recommendations
G. Evaluate Clinical Documentation Improvement (CDI) Opportunities
H. Evaluate Physician Query Utilization
I. Review Present-on-Admission (POA) Indicators
J. Review Discharge Status Codes
K. Evaluate for Code Omissions and Capturing of CCs/MCCs, etc.
L. Review Billing Documents (UB-04)
M. Coder Education (CEUs recognized by AHIMA and the AAPC)
N. Evaluate the Overall Level of Compliance

V. Physician Coding, Documentation, and Compliance Projects (Hospital and Physician Practice based)

A. Review Coding
   1. Evaluation and Management (E&M) Codes (1995 or 1997 E&M Guidelines)
   2. ICD-10-CM Diagnosis Codes
   3. CPT Procedure Codes
   4. Modifiers
B. Other Impactive Issues
   1. Place of Service Codes
   2. Diagnosis Pointers
   3. Global Periods
C. Comprehensive review of the Documentation
D. Billing (#1500 Forms and Superbills)
E. Education as appropriate (Coder, office staff, and/or Physician)
F. Provide Accuracy Rates (as a group, and at the coder and physician specific level)
G. Provide Financial Impacts of Recommendations