Value Cycle Excellence: Chargemaster Management for Multi-Hospital Health Systems

Tuesday, October 4, 2016
Noon – 1:00 Pacific / 1:00 – 2:00 Mountain / 2:00 – 3:00 Central / 3:00-4:00 PM Eastern

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Presenters

**Ed Hazard**  
**Dir. Revenue Capture and Benchmarking, Catholic Health System**  
Ed Hazard created and manages the Charge Description Master team at Catholic Health System and serves as a liaison between IT, Finance and Revenue Cycle. With health system leadership, he helped develop the system’s revenue cycle benchmarks. Benchmark milestones include achieving a 75% reduction in DNFB and reducing days in AR from 55 to 40 days. Prior to his current role, Ed was a senior member of the team responsible for implementing Catholic Health System’s Soarian suite of revenue cycle applications. Previously, Ed was Revenue Cycle Systems Director at Rochester General Hospital. He has over 16 years of healthcare experience and holds an MBA from University of Rochester and a BS in Mathematics from Roberts Wesleyan College.

**Emily Casto**  
**Client Success Manager, Craneware**  
Emily Casto manages the Client Success Team at Craneware, working with revenue cycle and revenue integrity staff to improve the financial health of their hospitals and health systems. In her 17 years of healthcare experience, Emily has specialized in hospital revenue integrity, CDM management, pharmacy reimbursement, charge capture, process design, change management, and project risk assessment. Emily earned a Bachelor of Science from The Ohio State University.
Agenda

- Different approaches to corporate CDM maintenance and standardization found in modern health systems
  - Advantages and disadvantages of standardization
  - Strengths and weaknesses of each model
- How to approach a standardization project
  - Considerations and common pitfalls to avoid when adding new hospitals into an existing standard (same and different HIS)
- Understand how to operationalize and efficiently maintain a corporate CDM standard across multiple hospitals
Change is Driving Innovation

An evolving healthcare marketplace is rapidly driving shifts to new financial performance metrics focused on value.
Revenue Cycle

• Fee-for-service
• Connect charges to units of service provided

“All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue”

Value Cycle

• Value-based and other alternative payment models
• Connect costs to units of service and charges
• Evolves from acute/ambulatory to comprehensive care strategy
• “The process and culture by which healthcare providers pursue quality patient outcomes and optimal financial performance through the management of clinical, operational and financial assets.”

Patient Access | Service | Charge Capture | Coding | Claim | Denial Mgmt. | Clinical Data | Operational Data | Financial Data
Health Systems are Juggling Mergers and Acquisitions, EHR Conversions

• In 2015, healthcare deals broke records set in 2014, with nearly $400 billion in agreements announced.

• For the past several years, a growing number of hospitals are choosing to upgrade their existing EHRs or convert to new ones.

Sources:
hfmc magazine, Feb 2015: maximizing patient care revenue throughout a major HIS conversion
Pros and Cons of Standardization

**Pros**
- Adds consistency and efficiency
- Introduces corporate oversight
- Streamlines validating rules and regulations
- Simplifies mapping a new facility
- Makes managing disparate billing systems easier
- Eases in system conversion

**Cons**
- Huge Endeavor
  - Limited Staff
  - Limited Support Systems
- Culture Shift
  - Needs support and priority from Senior Leadership
- Consolidation and reallocation of roles and responsibilities
- Lack of automated CDM maintenance solution
A “Standard” Chargemaster

• What does a “standard” chargemaster standardization mean to you?
  • A to Z – CDM number to pricing
  • Mapping ONLY

• How standard can you get?
  • Same platform v. multiple disparate system
Corporate Standard

A master corporate chargemaster, created and maintained utilizing defined health system standards or guiding principles that define how a corporate line is created and how it maps to facility-based line items.

Benefits:
- Maintenance
  - Ease
  - Consistency
- Visibility
- Focus on other Initiatives

Uses:
- Reporting & Analysis
- Bringing on New Facilities
- HIS Conversion
- Future Alignment Goals
- Measure Variance
Corporate Standardization Models

Less Standardization

Corporate Oversight
Hospitals manage their CDMs independently but with corporate oversight.

Moderate Standardization
Corporate manages the CDMs with help from system hospitals.

More Standardization

Full Standardization
Corporate manages one CDM and hospitals’ data is automatically updated.

One CDM for all facilities
One corporate CDM is used throughout the corporate HIS. System hospitals don’t have separate data.
Corporate Oversight

Hospitals manage their CDMs independently but with corporate oversight.

Pros

• Provides a minimum level of visibility into how CDMs are being managed locally and how charges are being used

• Little disruption to current processes

• More personal interaction between CDM team and clinical teams

Cons

• CDM visibility is only at a minimal level and may not be enough

• Need to staff each facility with CDM resources – $$ and skills

• Difficult to identify problems/opportunities and slow to implement changes
Corporate Oversight

Hospitals manage their CDMs independently but with corporate oversight.

• This model should be considered when:
  • There are many disparate HIS platforms
  • Limited corporate CDM team resources
  • Vision for corporate standard not fully formed yet
  • Strong resources exist at the local level
  • The health system is still young in its formation
  • As an interim step before HIS platform conversion
Corporate Manages a set of key fields in the CDM and passes changes to those fields to facilities. Facilities independently implement changes received from corporate and maintain the rest of the CDM on their own.

**Pros**

- Gives limited visibility into how CDM are being managed locally and how charges are being utilized
- More consistent change control process on key fields
- Minimal process change for facilities

**Cons**

- CDM visibility is still low and may not be enough
- Need to staff each facility with CDM resources – $$$ and skills
- Changes may not get implemented in a timely manner
- Can take a long time to identify problems/opportunities
Moderate Standardization

Corporate Manages a set of key fields in the CDM and passes changes to those fields to facilities. Facilities independently implement changes received from corporate and maintain the rest of the CDM on their own.

- **This model should be considered when:**
  - There are disparate HIS platforms
  - Limited corporate CDM team resources
  - Corporate wants facilities to maintain ownership
  - Limited, but solid resources exist at the local level
Full Standardization

Corporate manages one CDM and hospitals’ data is automatically updated.

Pros

• Consistent process on how CDMs are managed and how charges are used
• Consistent change control process
• CDM expertise can be concentrated at Corporate
• Quick identification of problems/opportunities

Cons

• Significant process change for both facility and corporate
• Need to staff and maintain a corporate team and scale accordingly
• Facilities may try to circumvent process
• Significant investment of time and $$$
Full Standardization

Corporate manages one CDM and hospitals’ data is automatically updated.

- This model should be considered when:
  - Most facilities are on the same HIS platform, or there aren’t significant variances on how the platforms are set up
  - Strong corporate CDM team resources
  - Corporate wants high degree of control of CDM changes across enterprise
  - Limited, weak or no resources exist at the local level
One CDM for all facilities

One corporate CDM is used throughout the corporate HIS. System hospitals don’t have separate data.

Pros

• Mandates how CDMs are managed and how charges used.
• One change control process
• CDM expertise can be concentrated at Corporate, possibly with a limited number of staff
• Quick identification of problems/opportunities

Cons

• Significant investment of time and $$$
• Significant process change for both facility and corporate
• Need to staff and maintain a corporate team and scale accordingly
• May be hard to allow for necessary variances
One CDM for all facilities

One corporate CDM is used throughout the corporate HIS. System hospitals don’t have separate data.

• This model should be considered when:
  • There is only one HIS platform and it supports a single CDM for multiple facilities
  • Strong corporate CDM team resources
  • Corporate wants to eliminate the possibility of variance across facilities unless approved
Catholic Health System

• Formed in 1998 with the merger of several hospitals, nursing homes and clinics.
• With its network of facilities, Catholic Health continues a healing ministry that dates back more than 165 years.
• Catholic Health is a mission driven organization centered in Buffalo, NY.
• Catholic Health has grown to one of the largest health care systems serving Western NY with over 1,000 beds across four hospitals on five campuses.
Five Chargemasters

- At its formation, Catholic Health maintained five distinct chargemasters.

- Initially, no attempt at standardization was attempted due to;
  - Limited staff and technical resources to manage a project.
  - Lack of strategic plan for billing systems.

- Each CDM continued to be maintained separately by each facility until a new billing system was selected.
Standardization Plan

• Once our single HIS platform and billing system was selected, a plan for standardization was formed.

• The model chosen was standardization by service line across all facilities:
  • CPT, Revenue and modifier codes
  • Pricing
  • Hard and soft coding

• System design made description standardization difficult in some cases.
Corporate Standardization

- Additions
- Modification
- Deactivations
- Variance Alignment

Define Corporate Standard
Define Departments
Define Guiding Principles
Standardization Process
Ongoing Maintenance
Reporting & Analysis
Corporate CDM Team Before

• Built from scratch, one person trying to manage all

• On-the-job and self-taught

• No prior Corporate CDM Standardization experience

• Dependent on IT team
Staggered Implementation

• Implementation of the HIS system spanned several years with each facility implementing at a different time.

• This required maintenance of legacy CDM files as well as building and maintenance of the new CDM be done concurrently.

• The build of the first facility’s CDM was copied across each facility on the new platform to start the standardization.

• Annual and quarterly updates were performed on active legacy systems as well as the new platform for all facilities.

• As each facility was prepared for conversion, a complete review of the CDM on the new platform was compared to the legacy CDM and updated as needed.
Challenges

• Multiple duplicate steps to maintain redundant CDM files.

• Limited staff due to larger HIS project.

• Due to length of HIS project, unnecessary build and maintenance was performed.

• No automated system to assist with build and maintenance. Excel and Access were employed but still required extensive manual work.

• Differences between legacy systems and new systems often resulted in missteps and rework as the HIS project progressed.
Benefits

• Incremental nature of HIS project spread standardization efforts over several years.

• Subsequent HIS implementations required less effort due to ongoing concurrent maintenance and standardization efforts.

• Maintenance on new platform was far easier due to standardization efforts.

• Communication and training of departments was simplified by standardization.
CDM Maintenance Tool

Shortly after last site converted to new HIS system Catholic Health purchased a CDM Maintenance Tool.

• Despite recognizing the value, we could not get over the hurdle of budget restraints prior to that time.

• After working with the CDM tool, we realized the tool would have made the HIS conversion as well as CDM standardization easier and more efficient.

• Our tool could have been built to manage both the legacy system and the new HIS system to a single corporate model. This would have eliminated much of the duplicate manual work.
In 2016, Catholic Health added another hospital to its organization. Merger of a new facility into a group of existing, presents its own challenges:

- Differences in policies and procedures.
- Differences in payer contracts.
- Differences in pricing models.
- Differences in marketing strategies.
- Differences in billing systems.
- Differences in service lines.
2016 Merger – New Hospital Added

Questions Catholic Health is facing as a result of this merger:

• If and when will the new facility convert to the Catholic Health billing system?
• What will the standardization policy be in the interim period?
• Which policies and procedures are best practice?
• The new hospital is in a different county and economic region. Will pricing be standardized?
• Without a system to assist with automating standardization across multiple platforms, is it feasible and worth the effort?
• Are the hospitals structured similarly to make standardization possible?
Ongoing Maintenance

Catholic Health shifts to a mixed standardization model as these questions are addressed.

• The four existing sites continue to be highly standardized as we bring the new hospital’s CDM under corporate oversight.

• Both new and existing facilities use the same CDM tool. CDM analysts are learning from each other as they merge.

• Communication is key as the CDM tools are not configured to manage both CDM files to a corporate standard.

• Analysis and review of two CDM files is occurring now well in advance of any changes in HIS systems.
Lessons Learned

• Have a CDM maintenance / automation tool
  • Flexibility and time savings
• Internal CDM staff / resources
• Executive sponsorship is crucial
• Have a clearly defined plan, guidelines and mapping
How to Approach A Corporate CDM Standardization Project
Project Outline

• Planning
  – Desired Outcome - Approach
  – Resource allocation
  – Timeline and implementation plan

• Defining corporate standard
  – Creation of standardization guiding principles
  – Creation of Department Crosswalk
  – Creating of mapping guidelines

• Standardization
  – Process of mapping the facility CDM items to the corporate standard CDM

• Implementation of the standard

• Corporate CDM maintenance
Planning

• What is the desired outcome of Standardization?
  – Selecting the Standardization Model that is best
  – Does current infrastructure support the selected model?

• Resource Availability
  – Does the corporate CDM team already exist?
  – What resources are needed from the facilities?
  – What are the competing priorities?

• Timeline
  – Driven by your answers to the first 2 points above
  – Is standardizing the CDM a step in the HIS conversation process?
  – Manual standardization, CDM standardization tool, consulting engagement or a mix of all three?
Creating a Corporate Chargemaster Team

Defined by the model you choose

– Corporate Oversight
– Moderate
– Full
– One CDM
– Align the team
  ▪ Align by hospital
  ▪ Align by service line
  ▪ Hybrid models
– Facility revenue cycle liaison
Defining the Standard
What Inputs Are Needed?

Dept. Crosswalk
Corporate Standard
Guiding Principles

Corporate Mappings
(Reports & Built-in Software)
Defining the Corporate Standard

• What will be used as the Corporate Standard?
  – Does it need to be created from scratch?
  – Will the “largest” facility or CDM be used?
  – Compiled from the “best practice departments” of the facility CDMs?

• Creation of Guiding Principles
  – What will be standardized and what will not?
  – What key data elements will drive standardization?
  – How will you handle particular coding situations?
    - SADs
    - Status M,B and E, etc…
Defining the Corporate Standard

- Creation of Department Crosswalk
  - Understanding how each of the facility departments corresponds to the Corporate Standard
    - What departments might need to be added?
    - What departments might be consolidated?
- Creation of Mapping Guidelines
  - What will be mapped? Will anything be left as “local”?
  - What level of specificity will mapping happen at?
Guiding Principles and Mapping

• Mapping to corporate file
  – In order to align like charges across organizations for visibility and/or standardization, one must first map all charges from local facilities into like groupings using a set of guiding principles approved by the corporate leadership
    ▪ Numerous decisions must be made prior to mapping in order to achieve goals

• Guiding principle influence how mapping is performed.

• These decisions influence the ease or complexity as well as the hours of labor required to complete mapping
Guiding principles will need to be defined regarding the following:

- Input Codes
- Description
- CPT / HCPCS Codes
- Use of Modifiers
- Soft coding practices
- Medicare Excluded HCPCS
- Self Administered Drugs (SAD)
- Statistical charges
- Exploding charges
- Deactivation of charges without volume
Examples of visibility of variations across five hospitals in system: Procedures are mapped by CPT code, regardless of location performed

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Dept.</th>
<th>CDM</th>
<th>Description</th>
<th>CPT</th>
<th>Revenue Code</th>
<th>Charge</th>
<th>Volume</th>
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<tbody>
<tr>
<td>Example Health Care System</td>
<td>32099</td>
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<td>FNA W/IMAGING GUIDANCE</td>
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Bolded values represent variations at local level when compared to corporate mapping for description, CPT and revenue code. This shows variability in price and volume. How variations will be centrally managed is at the heart of the standardization decision making process.
Examples of Factors that Drive Corporate Mapping

• Departmental/clinic procedures
  – Revenue code assignment for revenue tracking
  – Revenue code assignment for soft vs hard code logic
  – Revenue code assignments that impact patient copayments
  – Revenue codes that may impact global reimbursement

• Supplies
  – HCPCS code detail to support payer contracts
  – Level of specificity: detailed \(\rightarrow\) supply price banding; tie back to item master
  – Revenue code assignment to support contractual carve-outs
  – Non-billable/routine/patient convenience items

• Statistical charges
• Lab panels
• Exploding charges
Examples of Factors that Drive Corporate Mapping

Pharmacy

– Level of detail for mapping
– Where is multiplier assigned?
– Rules for HCPCS and revenue code assignment
  ▪ Self administered drugs for Medicare and other payers
  ▪ Statutorily excluded drugs for Medicare and other payers
  ▪ DME only drugs
  ▪ Use of non-specific codes J3490 (does hospital report NDC on 837?)
Guiding Principle: Map to greatest level of detail

Result: 5 Corporate line items for drug mapped by drug, dose, route and size

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<tr>
<th>Facility Name</th>
<th>Department</th>
<th>CDM</th>
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</tr>
</tbody>
</table>
Guiding principle: Map to level of drug, dose and route to support billing units

Result: 2 Corporate line items mapped by drug, dose and route

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Department</th>
<th>CDM</th>
<th>Description</th>
<th>Revenue Code</th>
<th>Alt Rev Code</th>
<th>CPT</th>
<th>Alt CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example Health Care System</td>
<td>33099</td>
<td>36603639</td>
<td>DEXTROSE 5%-NAACL 0.45%</td>
<td>258</td>
<td>636</td>
<td>J7042</td>
<td>S5010</td>
</tr>
<tr>
<td>Example Hospital Northern</td>
<td>33010</td>
<td>36603867</td>
<td>DEXTROSE 5%-NAACL 0.45% 1000ML</td>
<td>258</td>
<td>636</td>
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</tr>
<tr>
<td>Example Hospital Southern</td>
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</tr>
<tr>
<td>Example Hospital Western</td>
<td>43988</td>
<td>9876545</td>
<td>DEXTROSE 5%-NAACL 0.45% 1000ML</td>
<td>258</td>
<td>636</td>
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<td>S5010</td>
</tr>
<tr>
<td>Example Hospital Central</td>
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<td>5437654</td>
<td>DEXTROSE 5%-NAACL 0.45% 1000ML</td>
<td>258</td>
<td>636</td>
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<td>S5010</td>
</tr>
<tr>
<td>Example Hospital Northern</td>
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<td>7687677</td>
<td>DEXTROSE 5%-NAACL 0.45% 500ML</td>
<td>258</td>
<td>636</td>
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<td>S5010</td>
</tr>
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<td>DEXTROSE 5%-NAACL 0.45% 500ML</td>
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</tr>
<tr>
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<td>7764553</td>
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<td>636</td>
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<td>S5010</td>
</tr>
<tr>
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<td>7798767</td>
<td>DEXTROSE 5%-NAACL 0.45% 500ML</td>
<td>258</td>
<td>636</td>
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<td>S5010</td>
</tr>
<tr>
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<td>DEXTROSE 5%-NAACL 0.9%</td>
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<td>S5010</td>
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<tr>
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</tr>
<tr>
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<td>9987878</td>
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<tr>
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<tr>
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<td>Example Hospital Northern</td>
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<tr>
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<td>3126587</td>
<td>DEXTROSE 5%-NAACL 0.9% 250ML</td>
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</tr>
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<td>9085641</td>
<td>DEXTROSE 5%-NAACL 0.9% 250ML</td>
<td>258</td>
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</tr>
<tr>
<td>Example Hospital Central</td>
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<td>DEXTROSE 5%-NAACL 0.9% 250ML</td>
<td>258</td>
<td>636</td>
<td>J7042</td>
<td>S5010</td>
</tr>
</tbody>
</table>
Guiding Principles: Pharmacy Sample Excerpt

Self Administered drugs (SAD):
- SADs will be coded according to the prevailing MAC, LCA52800 from WPS, which lists rules for SAD and state (in part): “Absent evidence to the contrary, oral drugs, suppositories, topical medications and inhaled medications are considered to be usually self-administered by the patient.”
- HCPCS code is assigned as Medicare/default with rev code 637 as the Medicare/default with the ALT revenue code assigned to 636.
  - If there is no HCPCS code, Medicare/default revenue code is 637 and ALT revenue code is 250.

Status indicators M or B:
- HCPCS codes are not accepted by Medicare OPPS therefore the this HCPCS was not used for the Medicare/default field

Status indicator E:
- HCPCS codes with status E will be assigned the HCPCS code with modifier GY for Medicare/default. Medicare/default revenue code is 636.
  - Alt CPT code will be assigned without the GY modifier

S Codes:
- S codes will never be assigned as Medicare/default. They may only be assigned in the Alt CPT field, never in the Medicare/default field

J3490:
- Validate recommended code is J3490
  - Use J3490 for Medicare with rev code 636 for Medicare
    - If file has an S code, assign J3490 and rev code 636 in Medicare columns and S code in Alt CPT column and 636 in Alt Rev code
    - If like drugs (same route, dose, description) and some with J3490 and some without, apply J3490 to all
Standardization

Process of mapping and aligning facility CDM items to the corporate standard CDM

- Must follow the defined guiding principles
- Will CDM Reviews that “clean up” and align the facility CDMs with the guiding principles happen before standardization begins? If not, how will this be addressed during the standardization process?
- Will you be using a tool to assist with the mapping and aligning process or will it be a completely manual?
- How will you conduct meetings with clinical leaders across facilities to assess service offerings?
Implementation of the Standard

• How will you communicate the process change?
  – Developing new policies and procedures for CDM
  – How will facilities access the Corporate Standard CDM?
  – Education on new process to local CDM Staff
  – Education on new process for clinical leaders

• How will you get the information from the Corporate Standard into the live HIS at the facility?
  – Can the data elements be uploaded directly?
  – Will someone need to key the changes into the system?
  – Will it happen as part of HIS conversion?
  – How will the implementation be audited?
Corporate CDM Maintenance

How will you approach CDM Maintenance moving forward?

– Needs to follow new policies and procedures
  ▪ How will variances from standard be addressed?
  ▪ How will the process be audited for adherence/compliance?

– Will a Corporate CDM maintenance tool be used?
  ▪ Education and training to local CDM Staff on tool
  ▪ Education and training for clinical leaders on tool

– Will it be a manual process?
Risks to Standardization

- Project Management
- Staffing
  - Takes time away from other projects
  - Skill Required
- Consistency
  - Not Following Guidelines
- Time
- Visibility
- Confirmation
- Ongoing Maintenance
Reward of a Corporate Standard CDM

- Standard GL department mappings
- Statistical codes standardized
- Productivity, cost & margin comparisons
- Supply standardization
- Non-billing data standardized

Strategic Reporting and Analysis

- HCPCS, descriptions, rev codes & modifiers standardized
- Large homogenous departments standardized

Revenue Enhancement Transparency

- Patient friendly descriptions
- Completeness assessments
- Pricing comparisons
- Best practice / Facility Comparison

Efficiency and Accuracy

- Most departments and most codes standardized
- Standardized workflows
- Hard/soft codes
- Central compliance alerts

Cycle Time, Compliance, Accountability
QUESTIONS?
To Complete the Program Evaluation

The URL below will take you to HFMA on-line evaluation form. You will need to enter your member I.D. # (can be found in your confirmation email when you registered)

Enter this Meeting Code: 16AT50

URL: http://www hfma.org/awc/evaluation.htm

Your comments are very important and enables us to bring you the highest quality programs!