US Healthcare Market Training

This course is developed as a mandatory Business training to all Nepal employees of Verscend Technologies.

The participants will understand:

- what is the market we are working on?

Why this Training?

Vs.

- To understand
  - What are we building?
  - How does your day-to-day work contribute to bigger picture?
  - How do the work from different teams and departments come together?

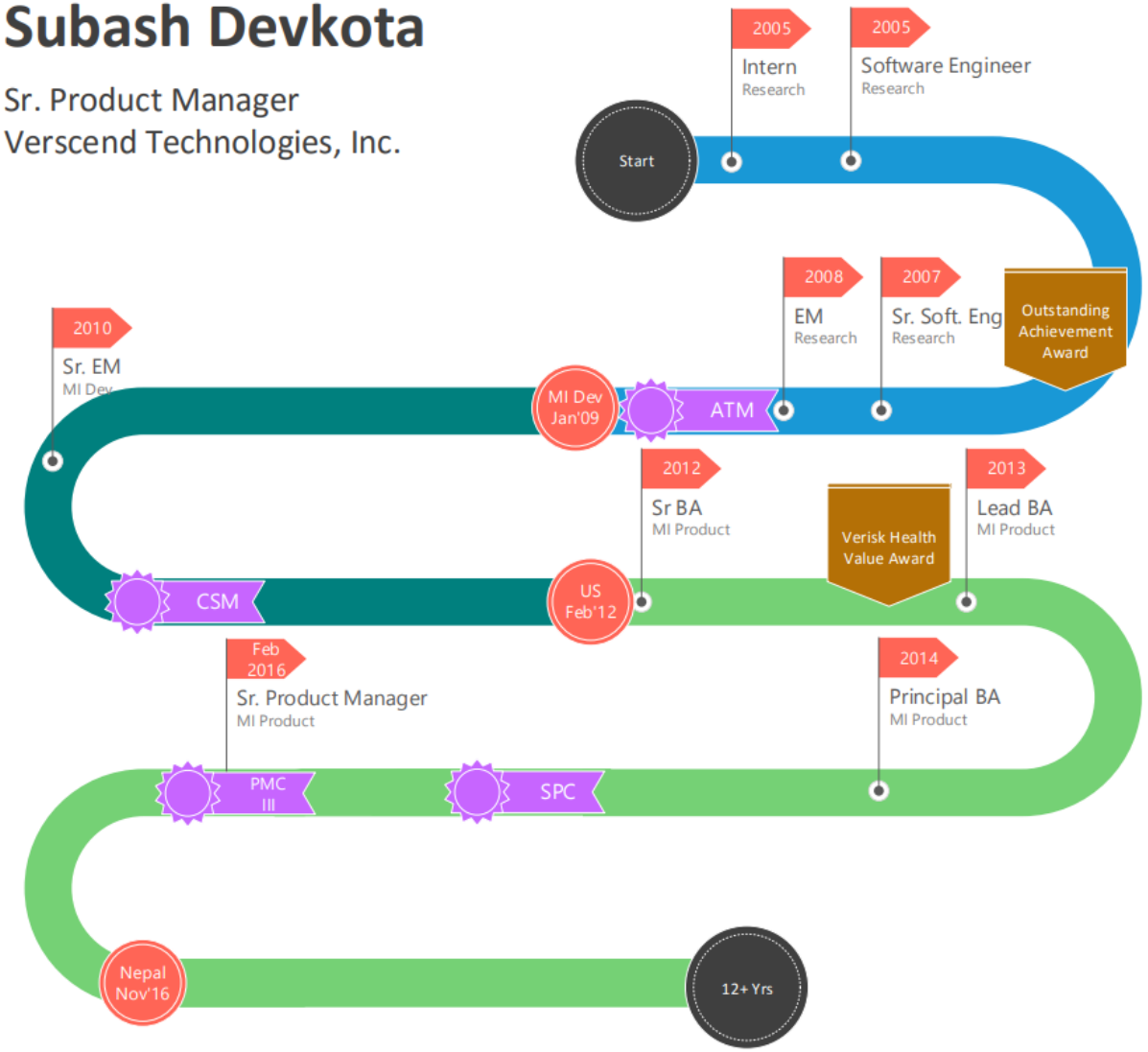
Course Outline

- US Healthcare Business (3 hrs)
  - US Healthcare Global View
  - US Healthcare System
    - Players in US Healthcare System
    - Private (Commercial) Insurance
    - Medicare and Medicaid Programs
  - US Healthcare Billing and Coding
    - Medical Billing
    - Rx Billing
    - Claim Forms and Coding

Know your Trainer

Subash Devkota

Sr. Product Manager
Verscend Technologies, Inc.



Additional Experiences

CMMI ML3

- Process Definition
- Process Audit
- Apraisal Team Member
- Project Management
- Process Management

Agile

- Scrum Master
- SAFe Implementation
- SAFe Program Consultant

Product Management

- Roadmap Preparation
- Release Planning & Execution
- Pragmatic Product Management

US Healthcare Business

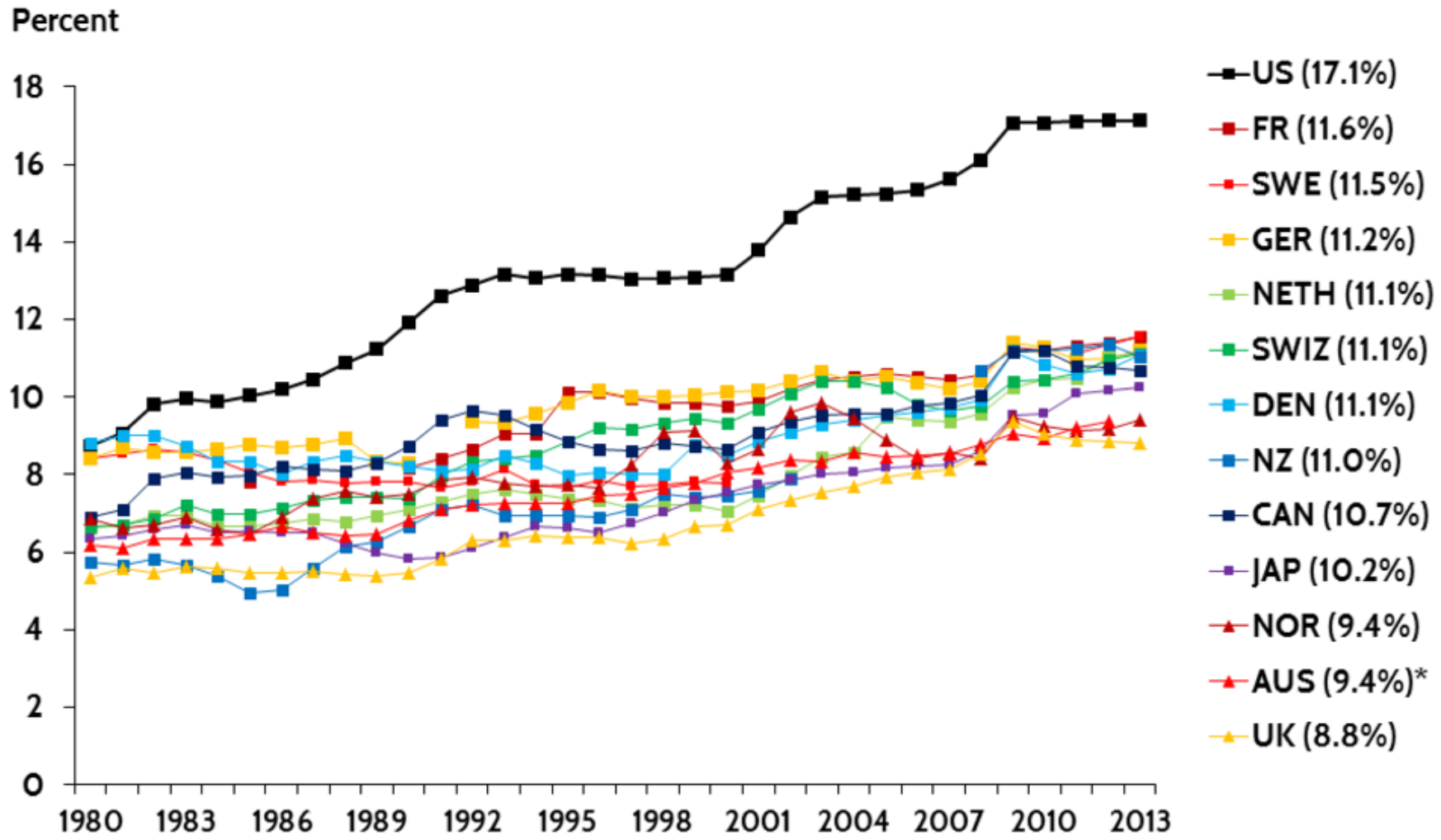
What is the market we are working on?

US Healthcare from a Global Perspective

Reference:

http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



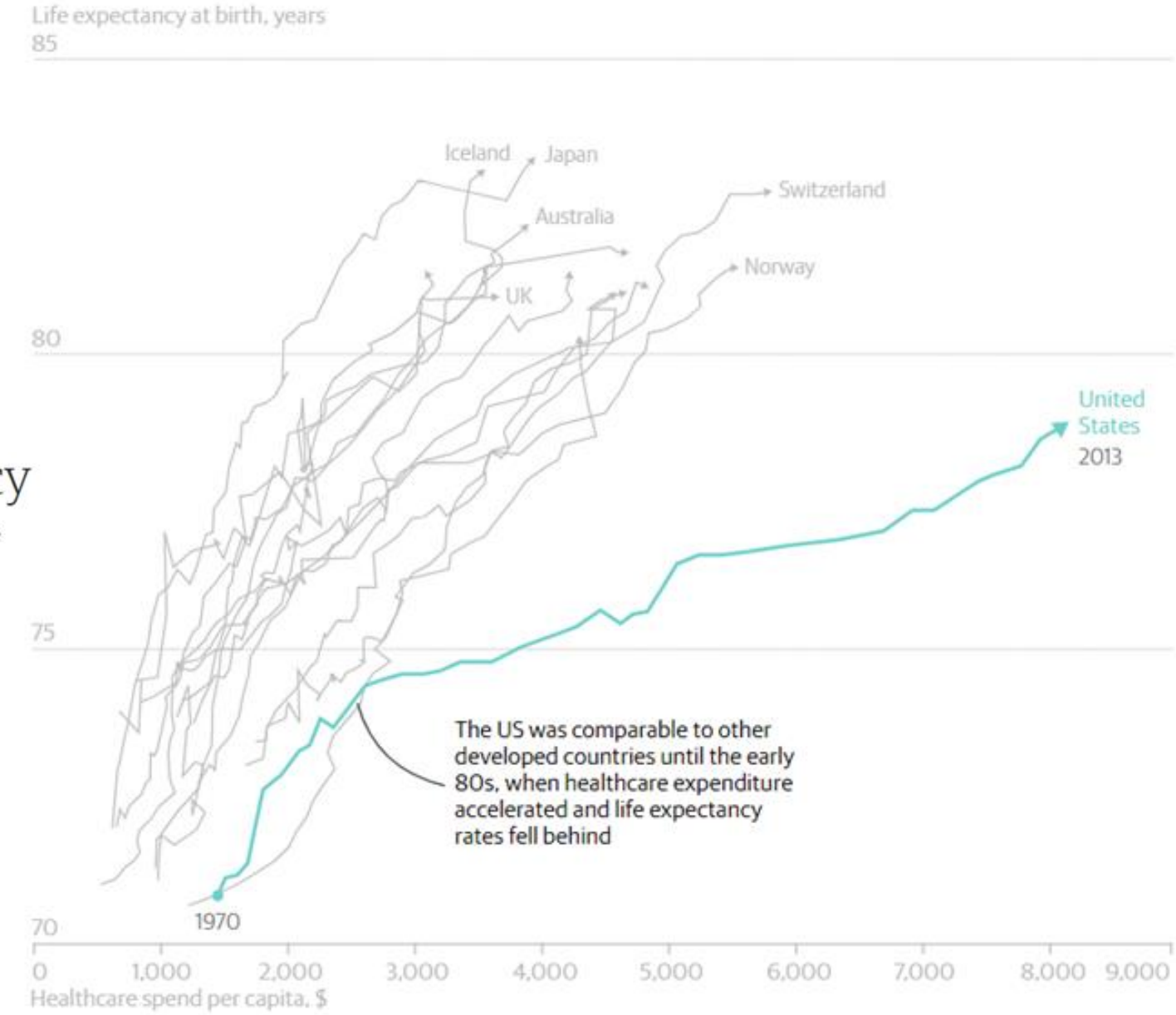
* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

Spending compared with life expectancy

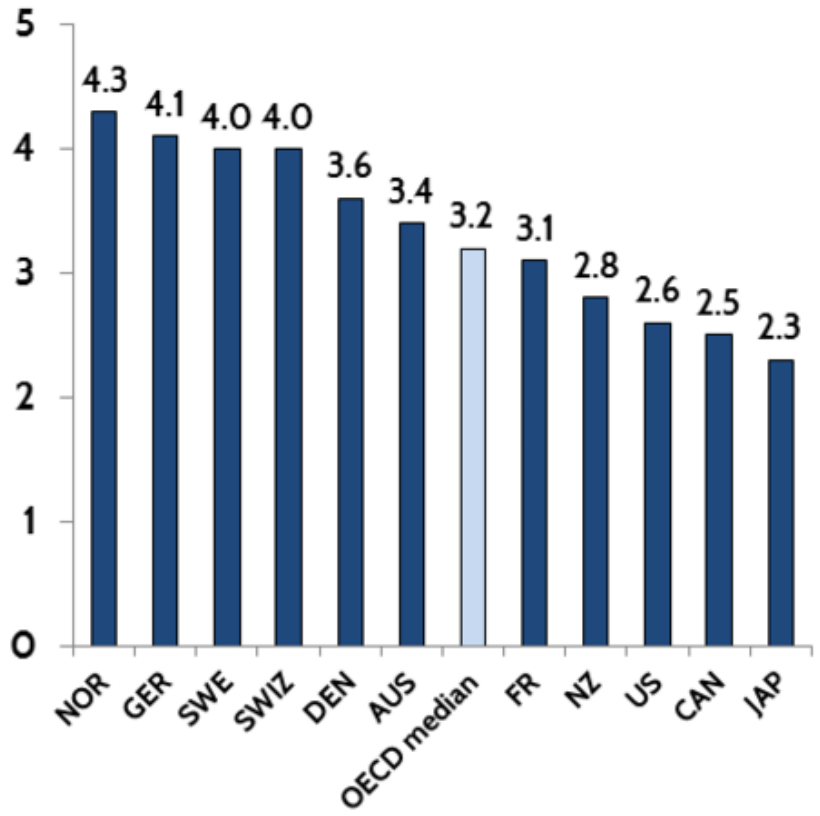
Life expectancy in the US is still lower than other developed countries, despite health funding increasing at a much faster pace.



Guardian graphic | Source: OECD, World Bank

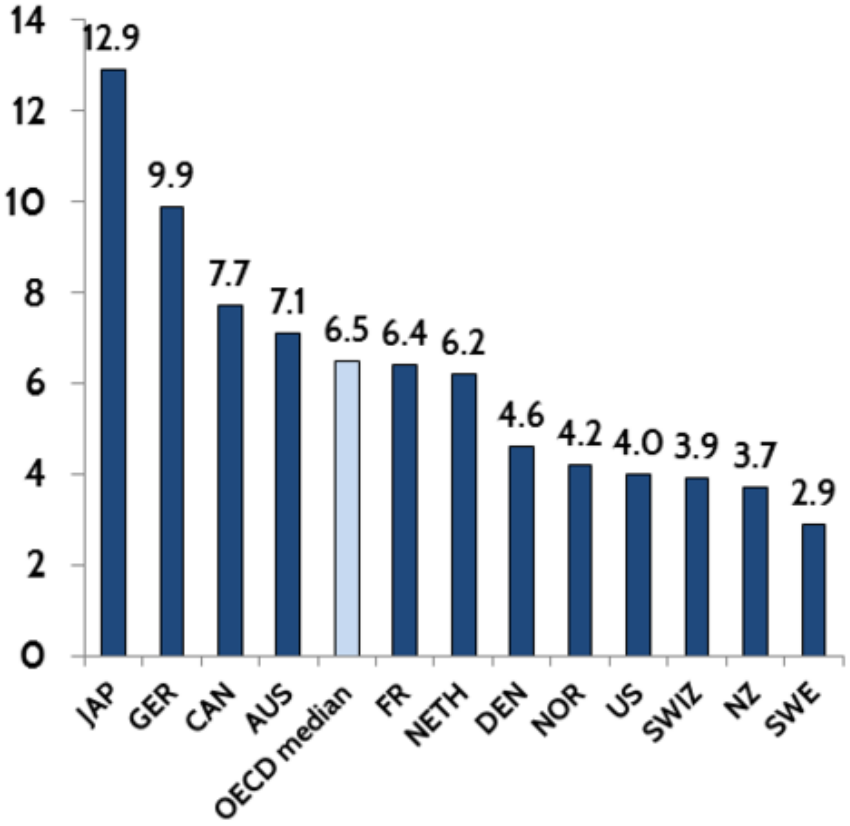
Exhibit 3. Physician Supply and Use, 2013 or Nearest Year

Practicing physicians per 1,000 population



Note: Data from 2012 in Canada, Denmark, Japan, and Sweden.

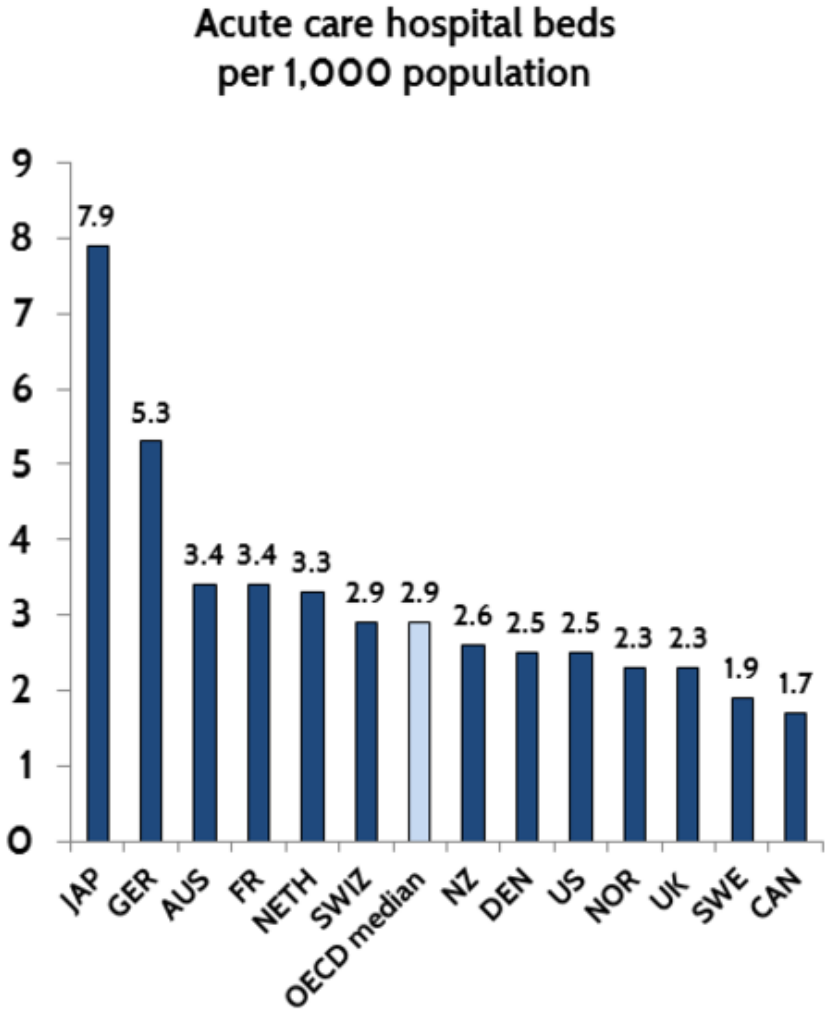
Annual physician visits per capita



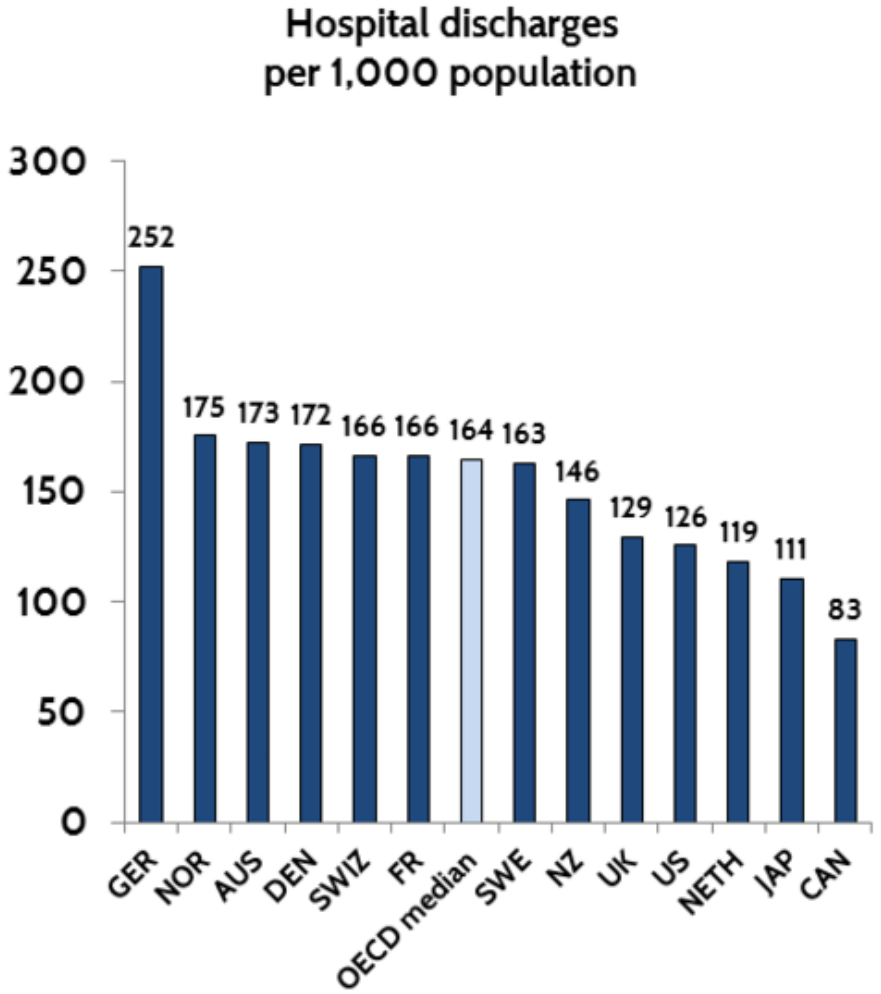
Note: Data from 2012 in Canada, Japan, Sweden, and Switzerland; and 2010 in the U.S.

Source: OECD Health Data 2015.

Exhibit 4. Hospital Supply and Use, 2013 or Nearest Year



Note: Data from 2012 in Australia, Canada, the Netherlands, and the U.S.



Note: Data from 2012 in Australia, Canada, the Netherlands, and Switzerland; 2011 in Japan; and 2010 in Denmark, Norway, Sweden, and the U.S.

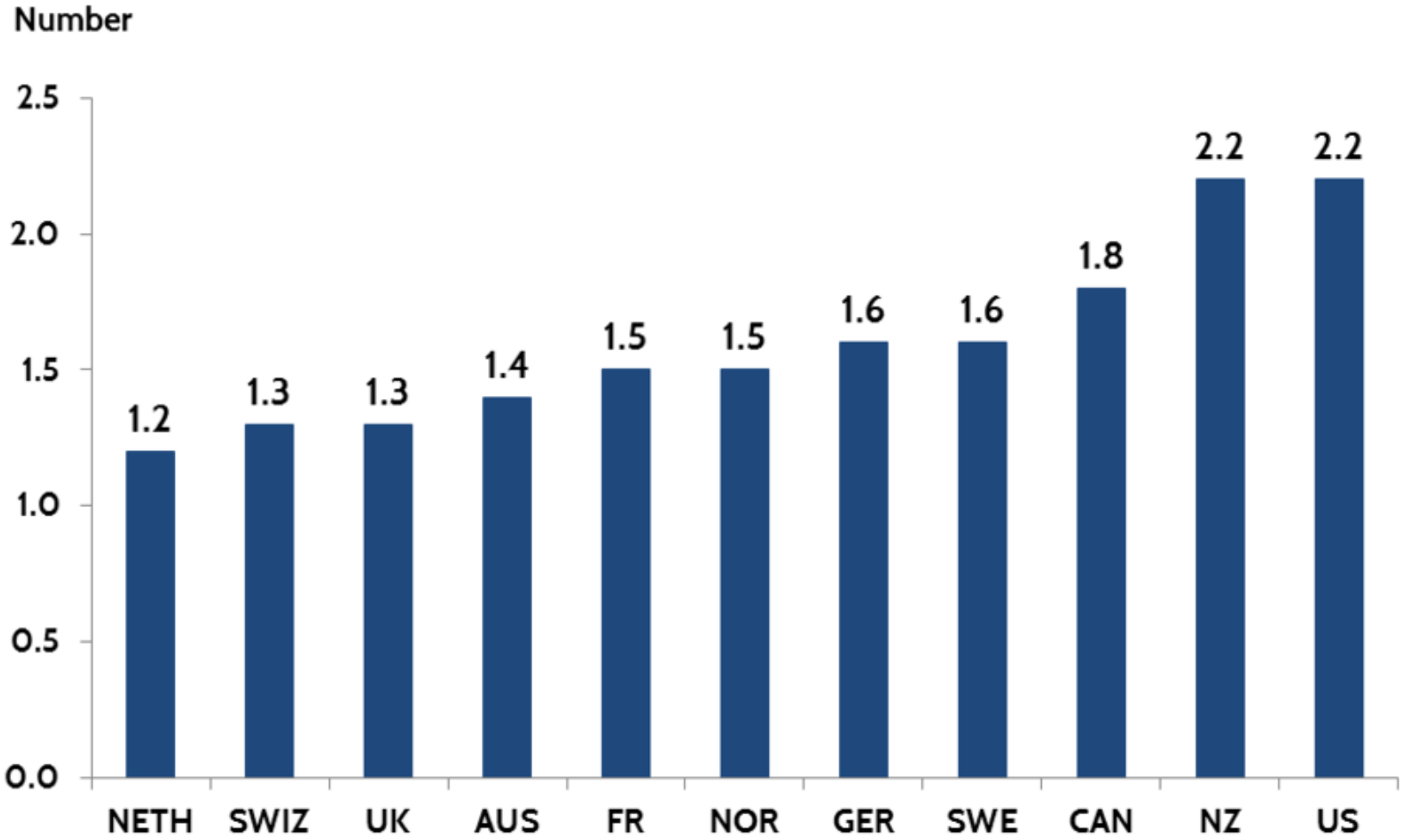
Source: OECD Health Data 2015.

Exhibit 5. Diagnostic Imaging Supply and Use, 2013

	Magnetic resonance imaging		Computed tomography		Positron emission tomography	
	MRI machines per million pop.	MRI exams per 1,000 pop.	CT scanners per million pop.	CT exams per 1,000 pop.	PET scanners per million pop.	PET exams per 1,000 pop.
Australia	13.4	27.6	53.7	110	2.0	2.0
Canada	8.8	52.8	14.7	132	1.2[a]	2.0
Denmark	–	60.3	37.8	142	6.1	6.3
France	9.4	90.9	14.5	193	1.4	–
Japan	46.9[b]	–	101.3[b]	–	3.7[b]	–
Netherlands	11.5	50.0[b]	11.5	71[b]	3.2	2.5[a]
New Zealand	11.2	–	16.6	–	1.1	–
Switzerland	–	–	36.6	–	3.5	–
United Kingdom	6.1	–	7.9	–	–	–
United States	35.5	106.9	43.5	240	5.0[a]	5.0
OECD median	11.4	50.6	17.6	136	1.5	–

[a] 2012. [b] 2011. [c] 2010.
Source: OECD Health Data 2015.

Exhibit 6. Average Number of Prescription Drugs Taken Regularly, Age 18 or Older, 2013



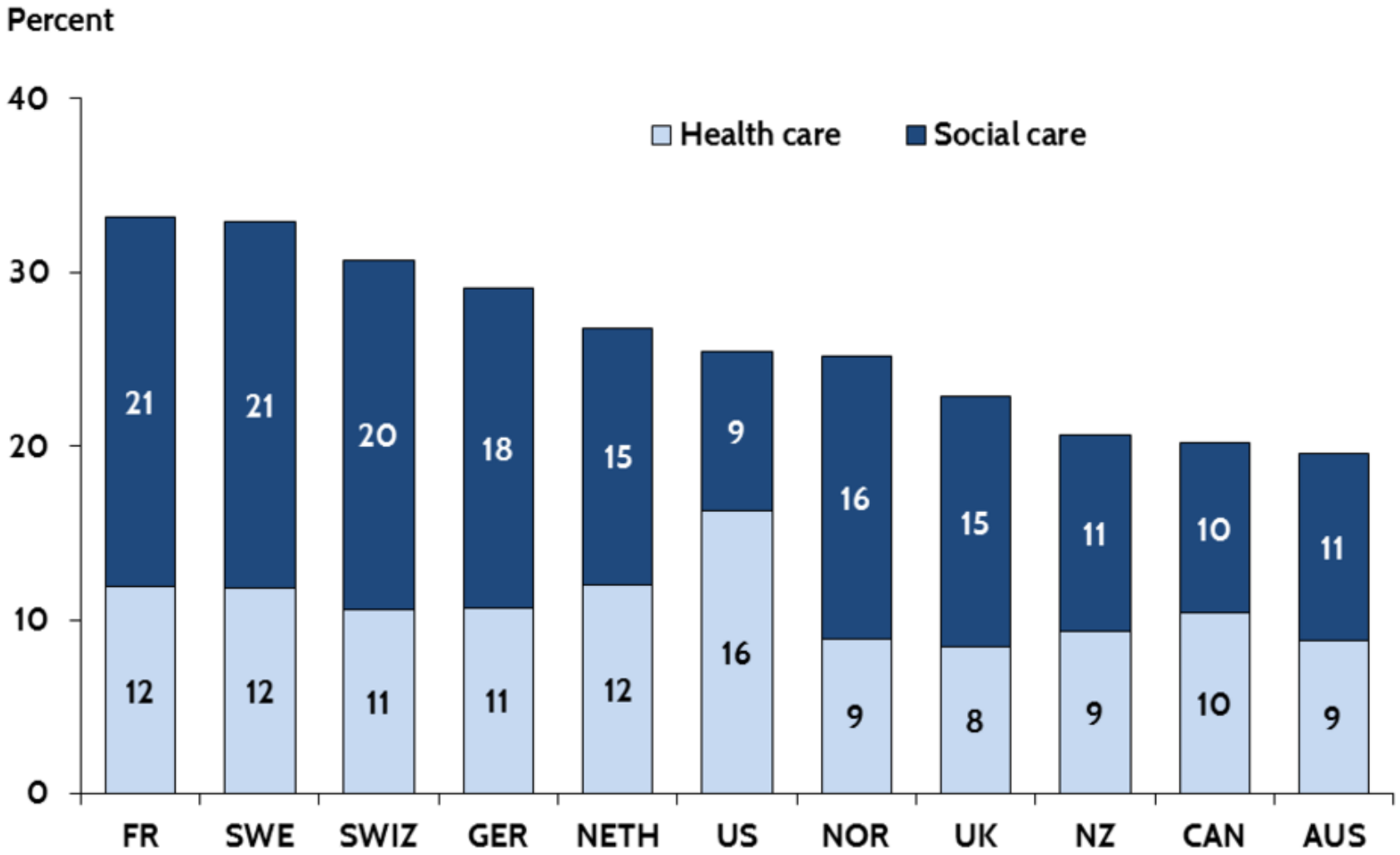
Source: 2013 Commonwealth Fund International Health Policy Survey.

Exhibit 7. Prices for Hospital and Physician Services, Pharmaceuticals, and Diagnostic Imaging

	Total hospital and physician costs, 2013[a]		Diagnostic imaging prices, 2013[a]		Price comparison for in-patent pharmaceuticals, 2010 (U.S. set to 100)[b]
	Bypass surgery	Appendectomy	MRI	CT scan (abdomen)	
Australia	$42,130	$5,177	$350	$500	49
Canada	–	–	–	$97	50
France	–	–	–	–	61
Germany	–	–	–	–	95
Netherlands	$15,742	$4,995	$461	$279	–
New Zealand	$40,368	$6,645	$1,005	$731	–
Switzerland	$36,509	$9,845	$138	$432	88
United Kingdom	–	–	–	–	46
United States	$75,345	$13,910	$1,145	$896	100

[a] Source: International Federation of Health Plans, 2013 Comparative Price Report.
[b] Numbers show price indices for a basket of in-patent pharmaceuticals in each country; lower numbers indicate lower prices.
Source: P. Kanavos, A. Ferrario, S. Vandoros et al., "Higher U.S. Branded Drug Prices and Spending Compared to Other Countries May Stem Partly from Quick Uptake of New Drugs," *Health Affairs*, April 2013 32(4):753–61.

Exhibit 8. Health and Social Care Spending as a Percentage of GDP

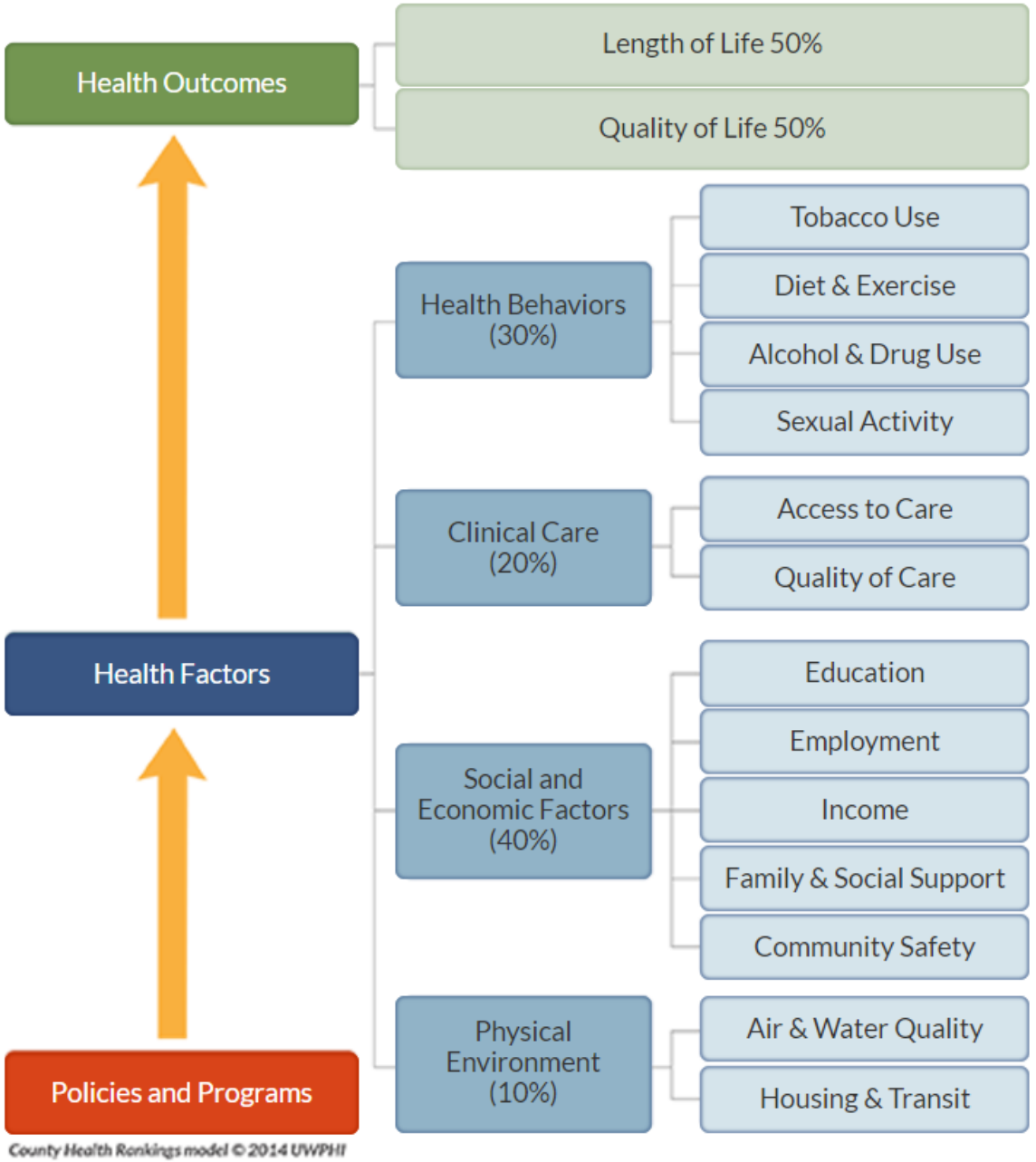


Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Factors contributing to Health Outcome

- Reference
  - http://www.countyhealthrankings.org/our-approach

- US spends 16% of GDP on Clinical Care and 9% of GDP on Social Care
- Other countries have spending on reverse order

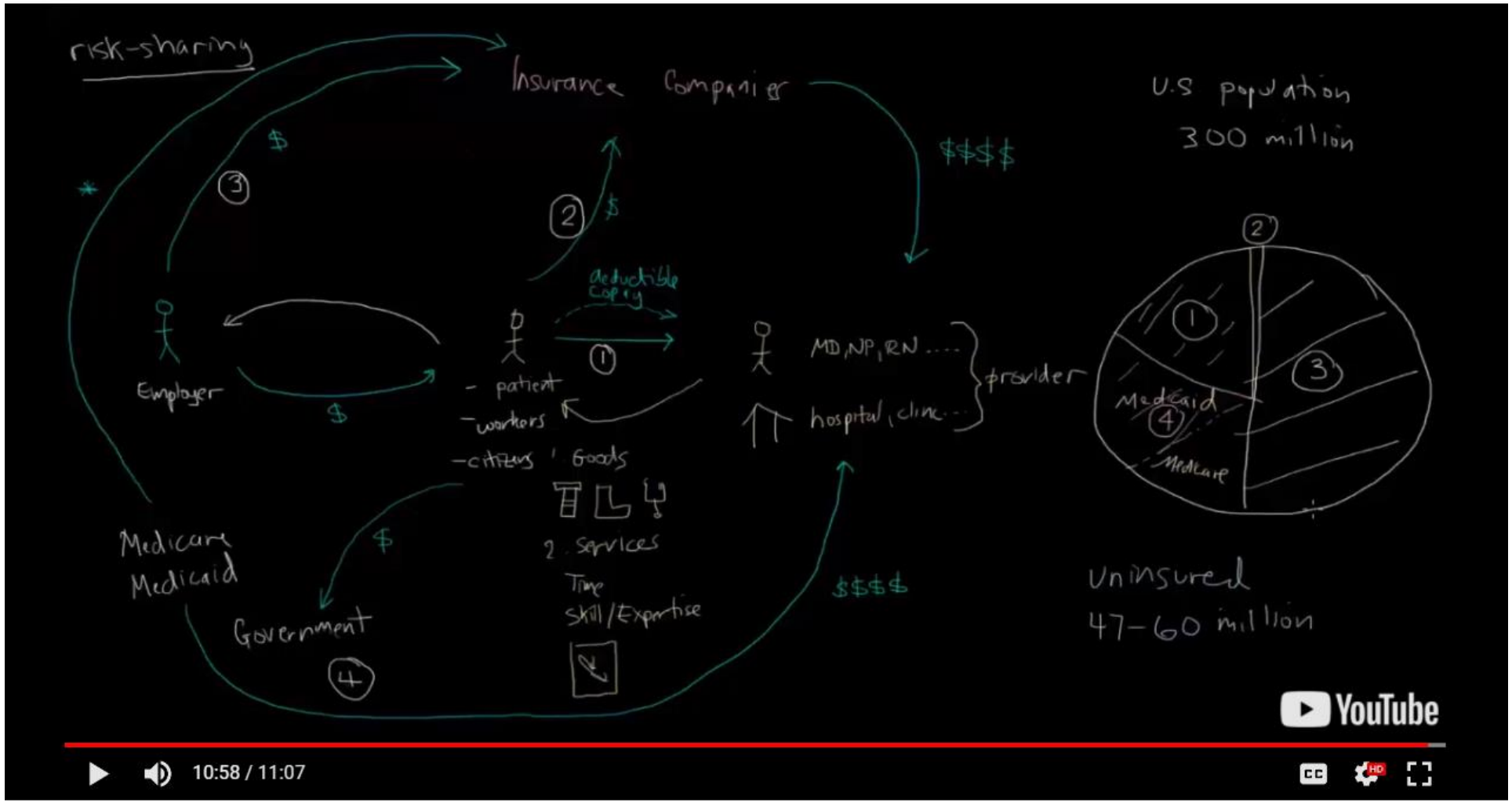


US Healthcare System

Reference:
https://www.khanacademy.org/partner-content/brookings-institution/introduction-to-healthcare

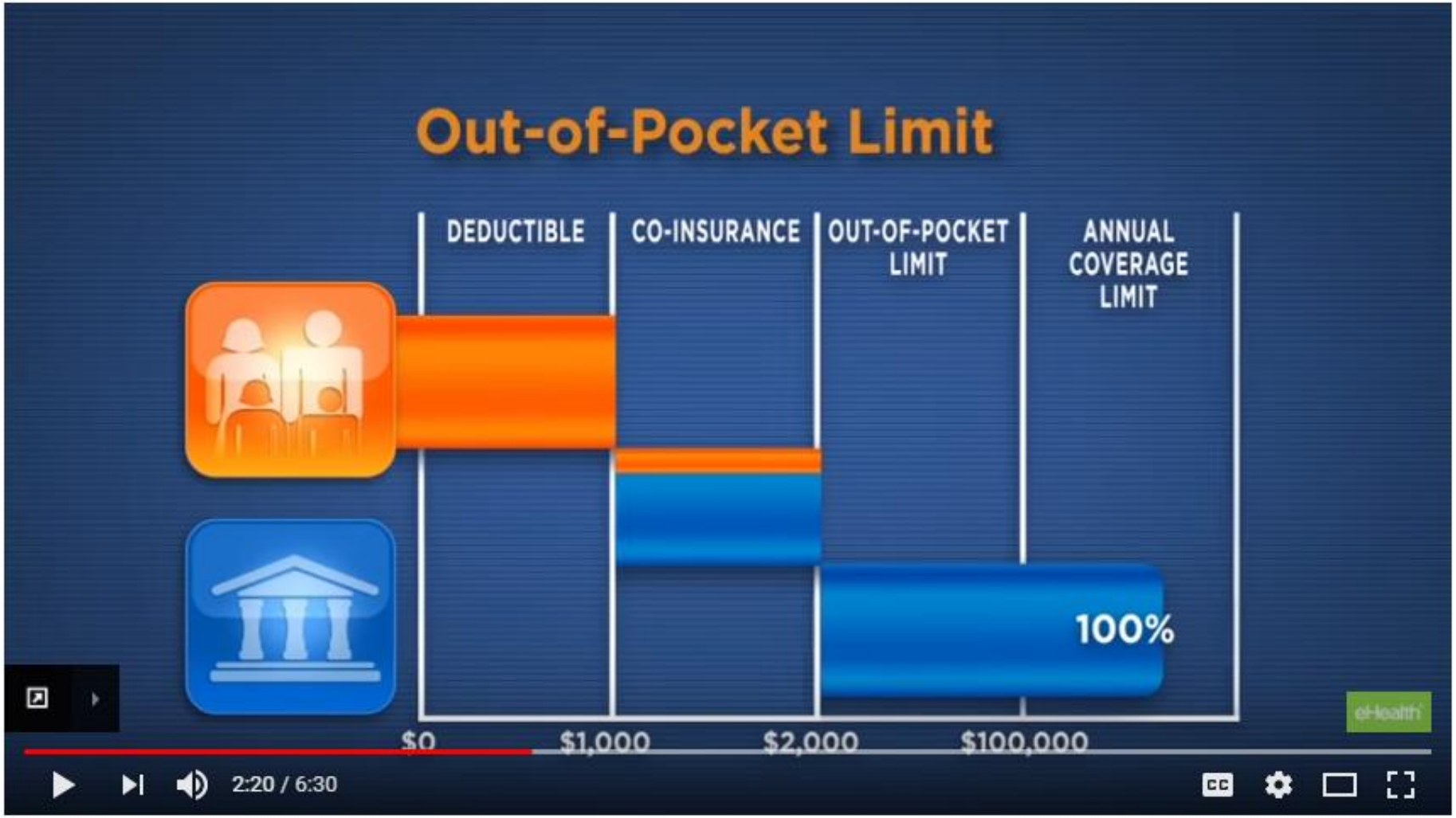
Introduction to the U.S. Healthcare system

- 11 minutes video



How Health Insurance Works

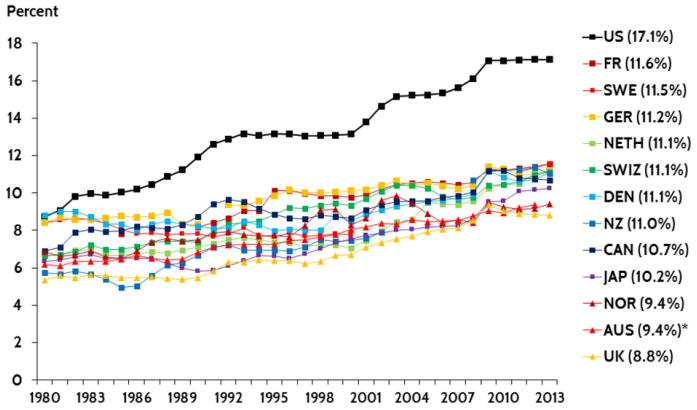
- 6 minutes video



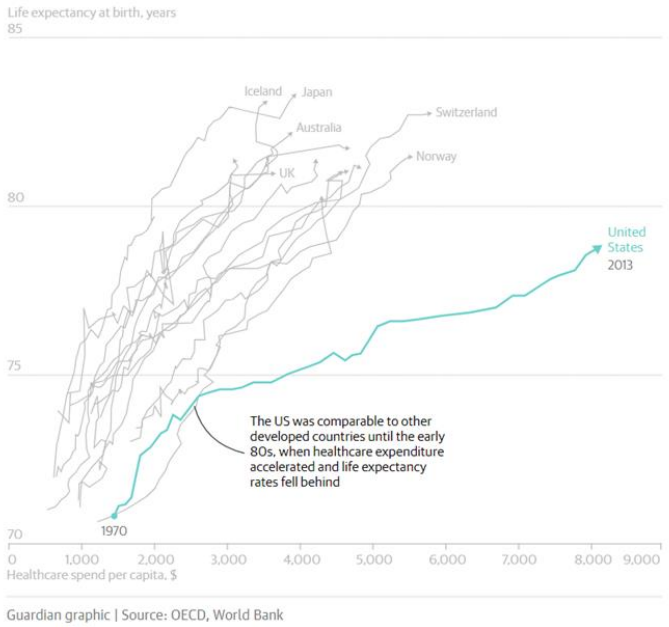
End of Day 1

Recap from Day 1

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.
Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.



Guardian graphic | Source: OECD, World Bank

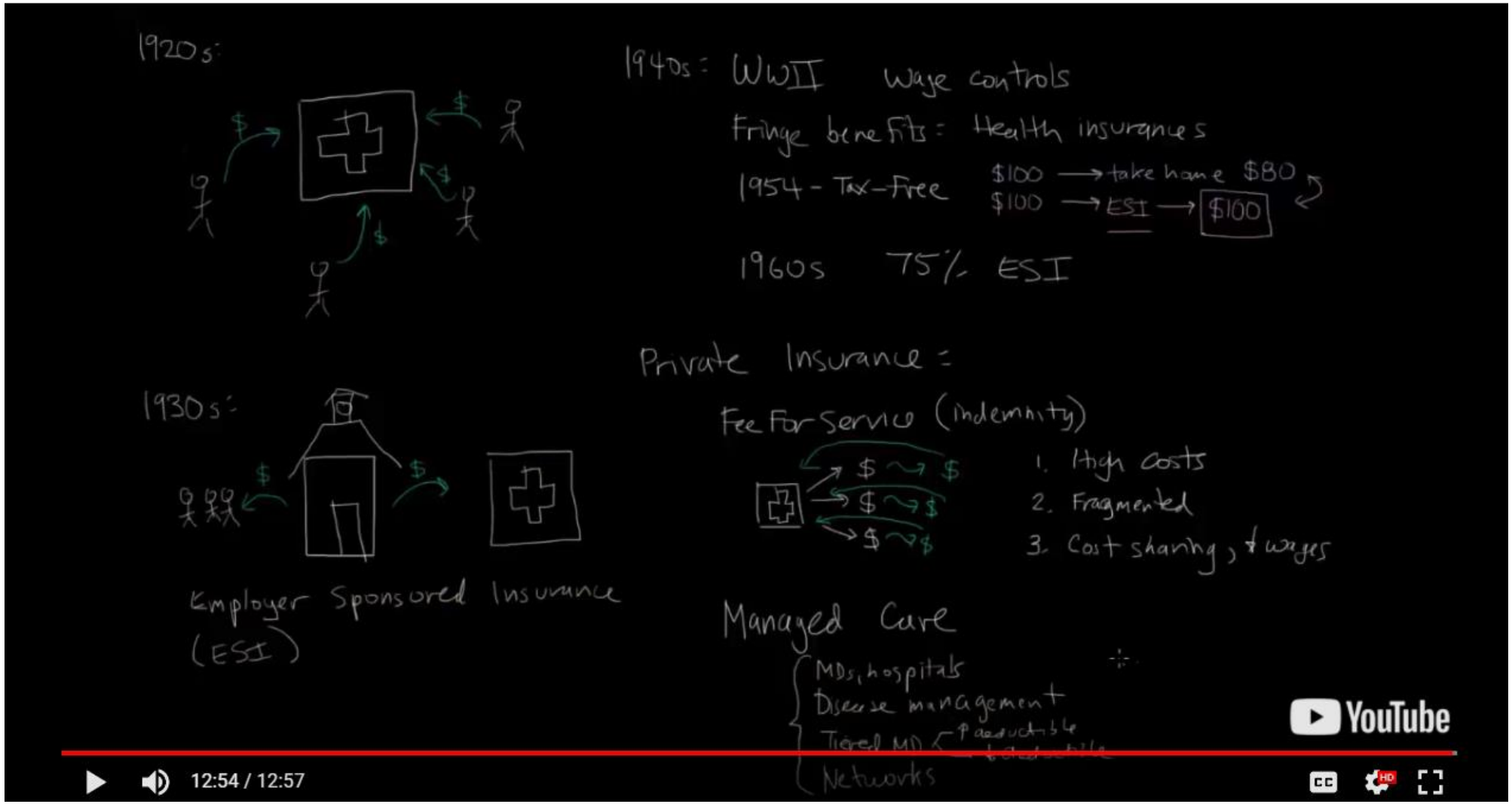
- What is causing US healthcare to be expensive compared to other developed countries:
  - Higher providers per member?
  - Higher physician visits per member?
  - Higher admissions per member?
  - Higher MRI/CT-Scan/PET-Scan utilization per member?
  - Higher drug utilization per member?
  - Higher cost per procedures?
  - Higher investment on social care?

- What % does Clinical Care contribute to total health outcome?
- What % does Social & Economic factors contribute to total health outcome?

- Concepts and terms
  - Payer, Provider, Employer
  - Deductible, Copay, Coinsurance
  - Out of Pocket Limit

Private Health Insurance

- 13 minutes video

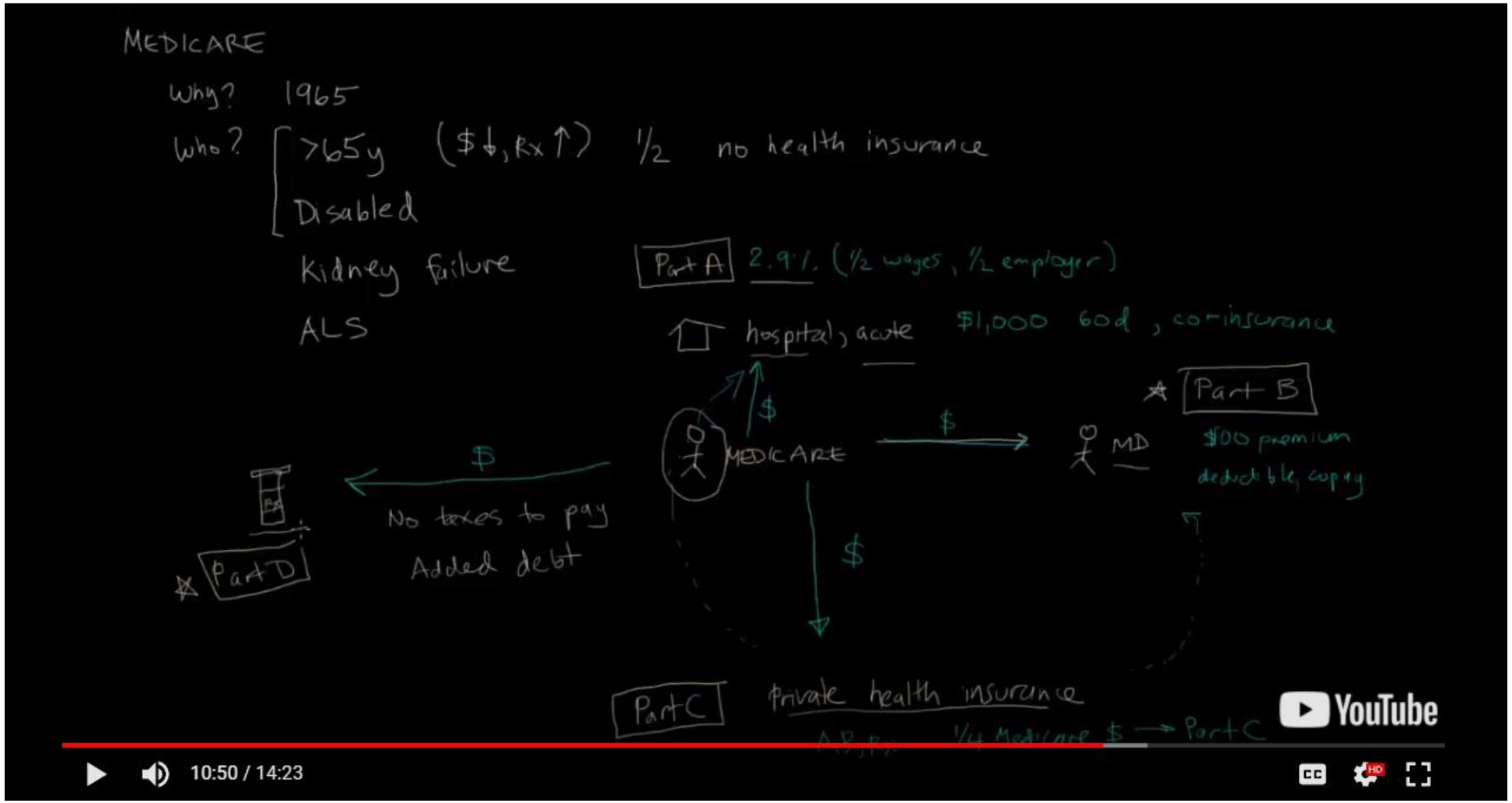


Medicare Program

- 15 minutes video

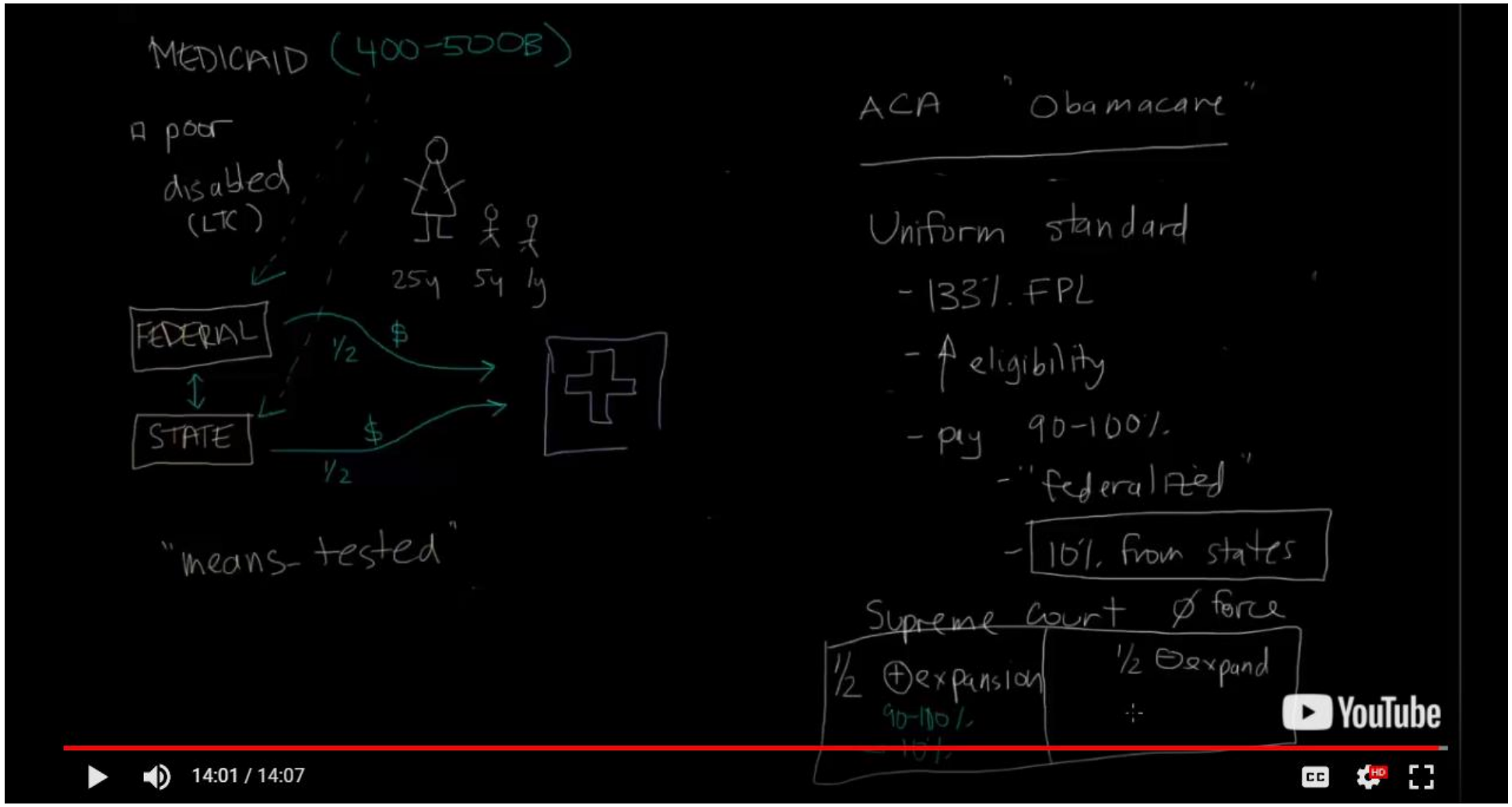
Medicare

Go to lesson page



Medicaid Program

- 14 minutes video



End of Day 2

Recap from Day 2

- What are three important health insurance plans?

- What is Commercial plan?
- Who pays for Commercial plan?

- What is Medicare Program?
- Who pays for Medicare?

- What is Medicaid Program?
- Who pays for Medicaid?

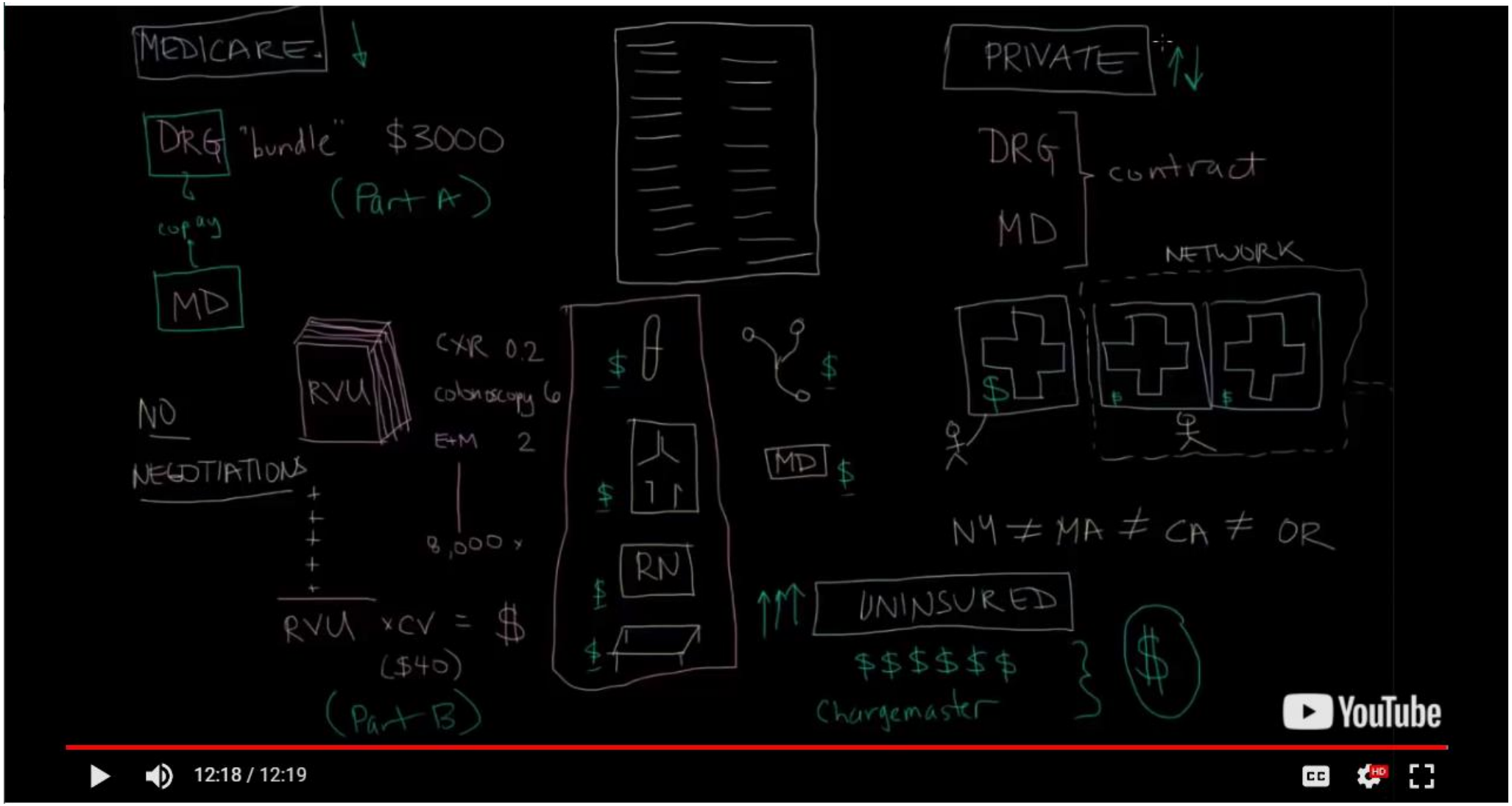
US Healthcare Billing and Coding

Reference:

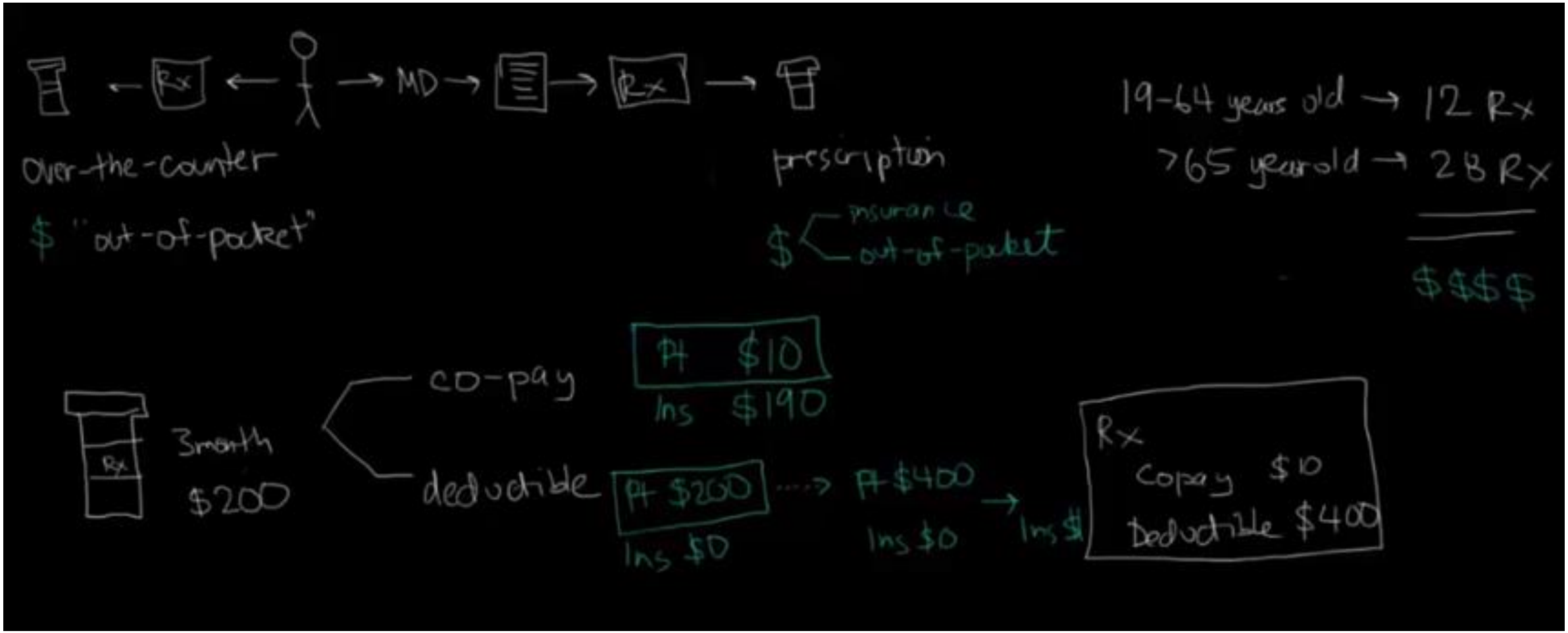
1. https://www.khanacademy.org/partner-content/brookings-institution/introduction-to-healthcare
2. Verscend internal training slides from Phoebe Ling

Understanding Medical Bill

- 13 minutes video



Paying for Medicines: copays and deductibles



Claims Processing Work Flow

- 3 minutes video

Claim Forms and Coding

Slides originally from Phoebe Ling

Two Claim Forms: UB-04 and CMS-1500

- **CMS-1450, aka UB-04 – Facility Claim Form**
  - Original **Uniform Bill** known as UB-82 was developed in 1982 by National Uniform Claim Committee (NUCC)
    - Single hosptal billing form used nationally
  - Upgraded to UB-92 in 1992
  - HIPPA version of UB, known as 837I (I = institution) was introduced in 2003
  - To better align UB with its HIPPA equivalence, UB-04 was introduced in 2004

- **CMS-1500, aka HCFA 1500 – Professional Claim Form**
  - Originally call **HCFA** – Health Care Financing Administration.
  - HCFA was finalized to CMS 1500 between 2007-2008 to accommodate the implementation of HIPPA and NPI (National Provider ID).
  - The electronic version is 837P (P = professional)
  - NUCC is responsible for maintaining the integrity of the data sets and physical layout of the hard copy 1500 Claim Form

Common Bill Form designator:

- **CMS 1450: F (Facility), U (UB)**
- **CMS 1500: P (Professional), H (HCFA)**

How do Facility and Professional Claims Differ

- **Facility Claims (UB-04/ CMS-1450):**
  - Facility claims represent resource utilization
  - Types of Facilities who bill on a UB-04:
    - Acute care facilities – hospitals
    - SNFs – Skilled Nursing Facilities
    - Psychiatric facilities
    - Drug and alcohol treatment facilities
    - Standalone clinics
    - Ambulatory surgery centers
    - Subacute facilities
    - Home care agencies
    - Hospice organizations
  - Originally designed for submitting claims for Medicare Part A reimbursement of both inpatient and outpatient services to Medicare FIs and Medicare Administrative Contractors (MACs).

- **Professional Claims (CMS-1500):**
  - Professional claims represent the skills and knowledge of highly-trained healthcare professionals
  - Used by:
    - Individual doctors & practices
    - Nurses and professionals, including therapists, chiropractors.
    - It is not typically hospital or facility-oriented
    - Sometimes suppliers such as Durable Medical Equipment (DME) *(may differ by practice)*

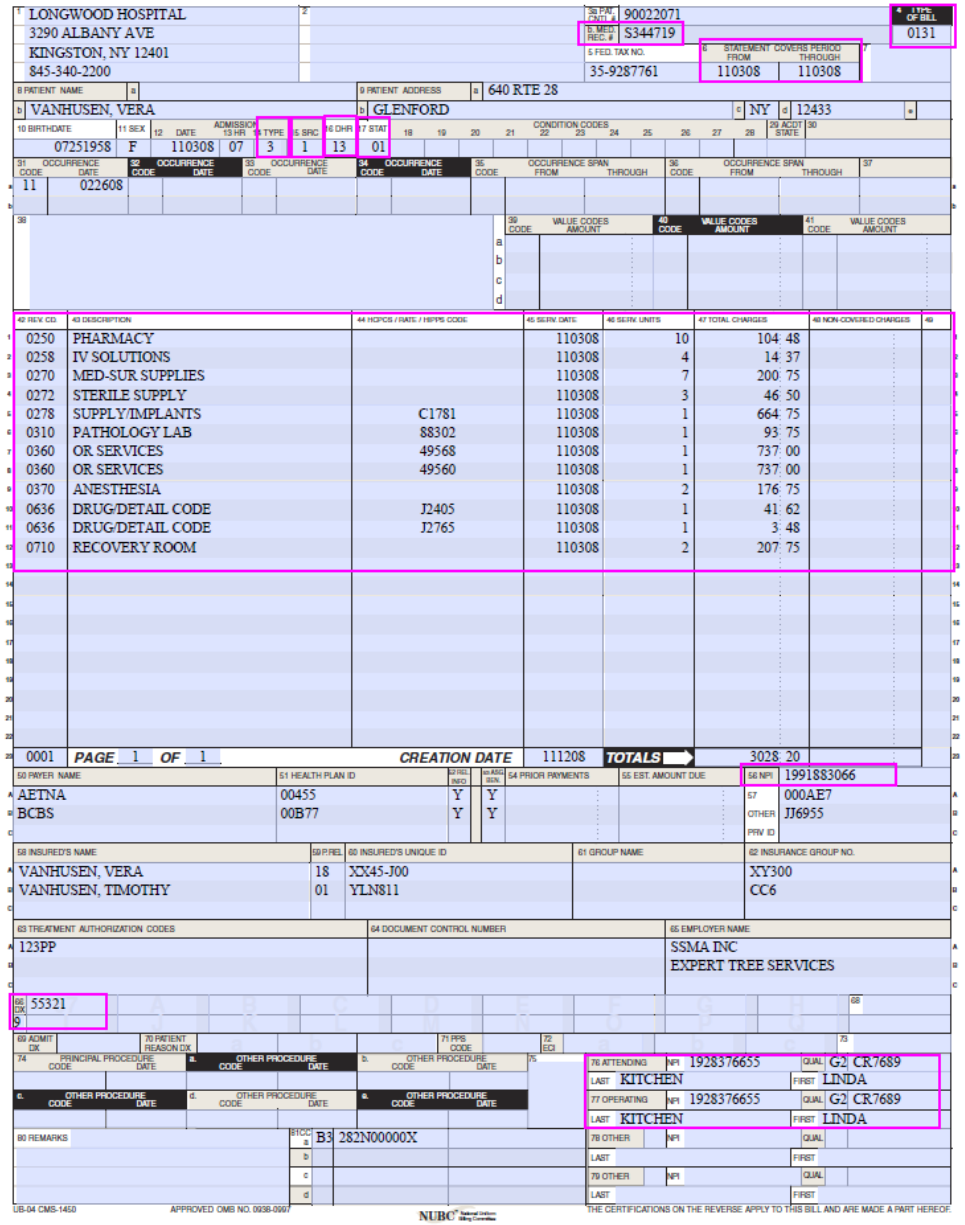
Claim Header vs. Claim Lines

- **Claim Header:** contains information applicable to the entire claim.
- Example:
  - Patient information
  - Payer / Insurance information
  - Provider Information
  - Diagnosis code(s)
  - **Facility claim**
  - Type of Bill
  - Principal / secondary Procedure
  - Admit Diagnoses
  - Admit Source and Discharge Status

Claim Line: information applicable to only a claim line of service.

- Example:
  - **Professional claim line**
    - Date of service, Place of Service
    - Unit, charge amount
    - HCPCS, CPT code
    - Procedure code with a diagnosis pointer
  - **Facility claim line**
    - Date of service,
    - Unit, charge amount
    - Revenue code
    - HCPCS

UB-04 – Example (Outpatient)



LONGWOOD HOSPITAL
3290 ALBANY AVE
KINGSTON, NY 12401
845-340-2200

| | | |

UB-04 – Outpatient Example Continue

Revenue Codes are descriptions and dollar amounts charged for hospital services provided to a patient.

The revenue code tells an insurance company whether the procedure was performed in the emergency room, operating room or another department.

- **ICD** for Diagnoses
- **CPT** for procedures
- **HCPCS** for medical goods and services

Admission Date

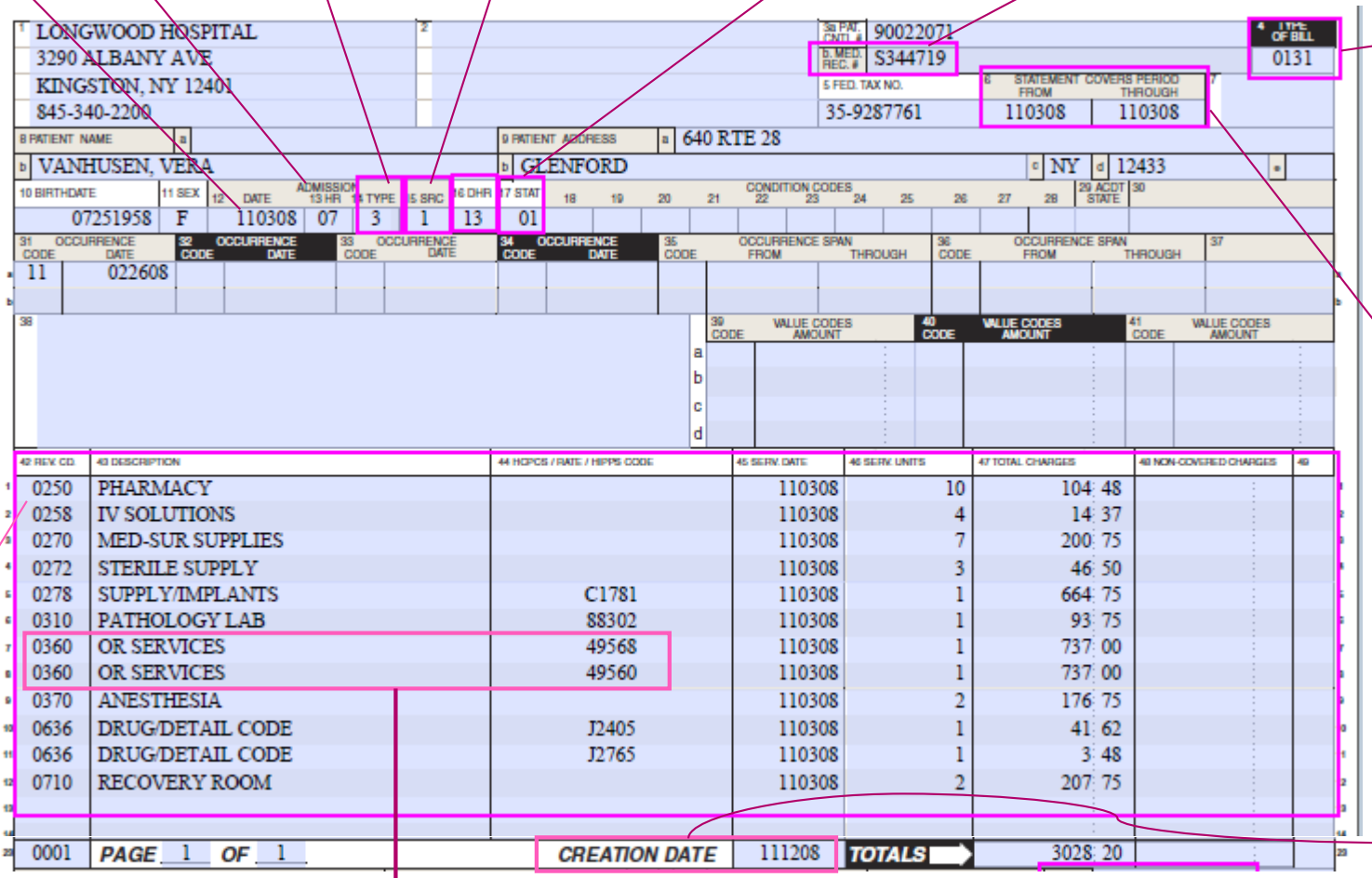
Admission Hour: 7 AM

Admit Type Code 3 = elective (prescheduled)

Admission Source 1 = physician referral

Discharge Status 1 = Home

Medical Record # from Provider, **not** the claim #



1	LONGWOOD HOSPITAL 3290 ALBANY AVE KINGSTON, NY 12401 845-340-2200	2	3a PAT. CNTL # 90022071 b. MED. REC. # S344719 5 FED. TAX NO. 35-9287761 6 STATEMENT COVERS PERIOD FROM 110308 THROUGH 110308	4 TYPE OF BILL 0131

8 PATIENT NAME		9 PATIENT ADDRESS				
b VANHUSEN, VERA		b GLENFORD		c NY	d 12433	e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
07251958	F	110308	07	3	1	13	01			

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
11	022608													

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a					
	b					
	c					
	d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	PHARMACY		110308	10	104 48		
0258	IV SOLUTIONS		110308	4	14 37		
0270	MED-SUR SUPPLIES		110308	7	200 75		
0272	STERILE SUPPLY		110308	3	46 50		
0278	SUPPLY/IMPLANTS	C1781	110308	1	664 75		
0310	PATHOLOGY LAB	88302	110308	1	93 75		
0360	OR SERVICES	49568	110308	1	737 00		
0360	OR SERVICES	49560	110308	1	737 00		
0370	ANESTHESIA		110308	2	176 75		
0636	DRUG/DETAIL CODE	J2405	110308	1	41 62		
0636	DRUG/DETAIL CODE	J2765	110308	1	3 48		
0710	RECOVERY ROOM		110308	2	207 75		
0001	PAGE 1 OF 1		CREATION DATE 111208		TOTALS 3028 20		

- **Revenue Code:** not required for outpatient claim but required for inpatient admission
- One for each line
- HCPCS /CPT code may be required for the line depending on the revenue code
- E.g. Rev 250 does not require detail proc code but 636 requires "J" drug code
- **Up to 2 Modifier codes** can be added at the end of each HCPCS/CPT code

Type of Bill (3-digit code with leading zero):

- 1st: Type of Facility; 1 = Hospital
- 2nd: Bill classification; 3 = Outpatient
- 3rd: Frequency;1 = Admit through Discharge claims

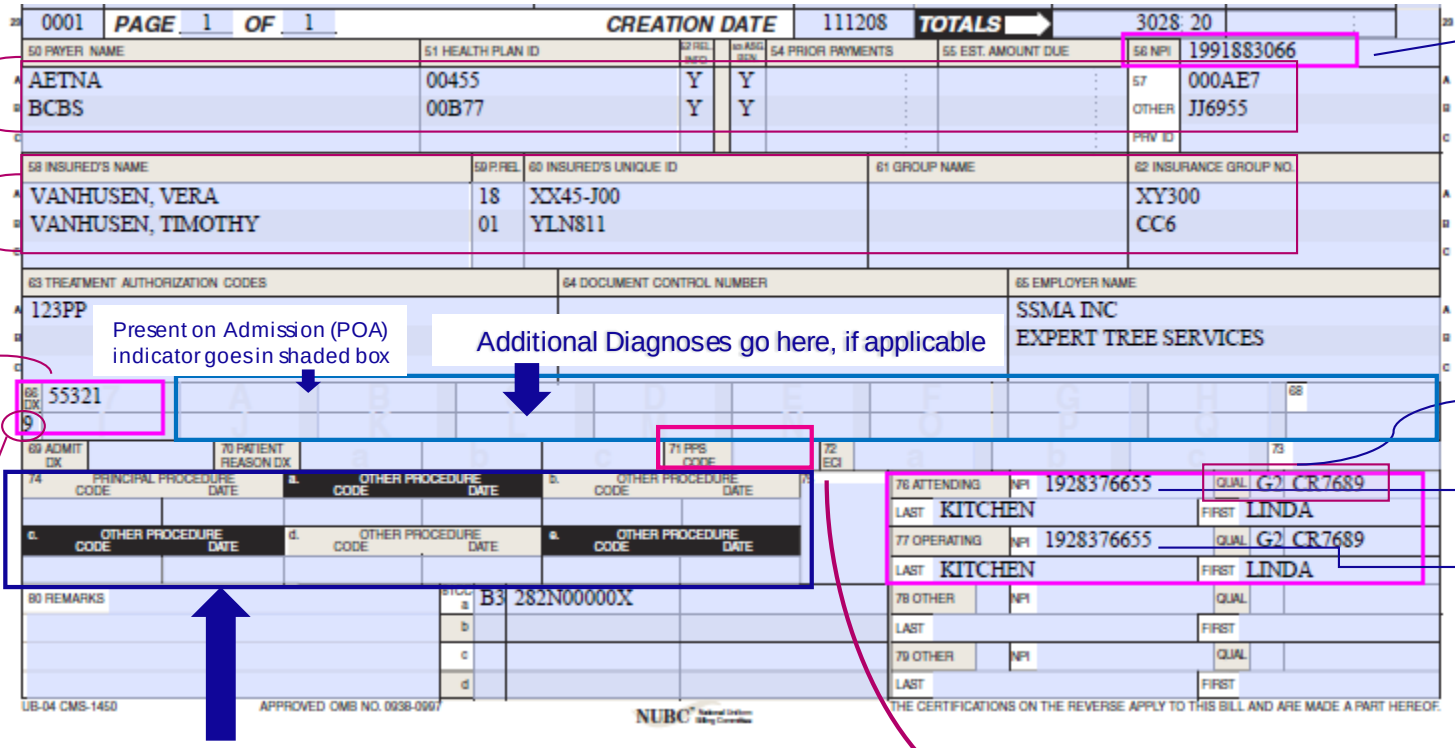
Type of Bill will definitively tell you where the facility service is performed

Header billing from and through date – same date for Outpatient

Create Date may be different than the date of service

- **What was done in the Operation Room (OR)? CPT code or HCPCS will describe:**
  - **CPT 49568 =** Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection
  - **CPT 49560 =** Repair initial incisional or ventral hernia; reducible

UB-04 – Outpatient Example Continue



Insurance information: this person has 2 insurance

Insurer's name(s)

Diagnosis Code: 55321: Incisional hernia (Incisional hernia without mention of obstruction or gangrene)

ICD Indicator

Present on Admission (POA) indicator goes in shaded box

Additional Diagnoses go here, if applicable

NPI of the Hospital

Qualifier may be used for Medicare or Medicaid billing

NPI of the Attending Physician

NPI of the Operating Physician

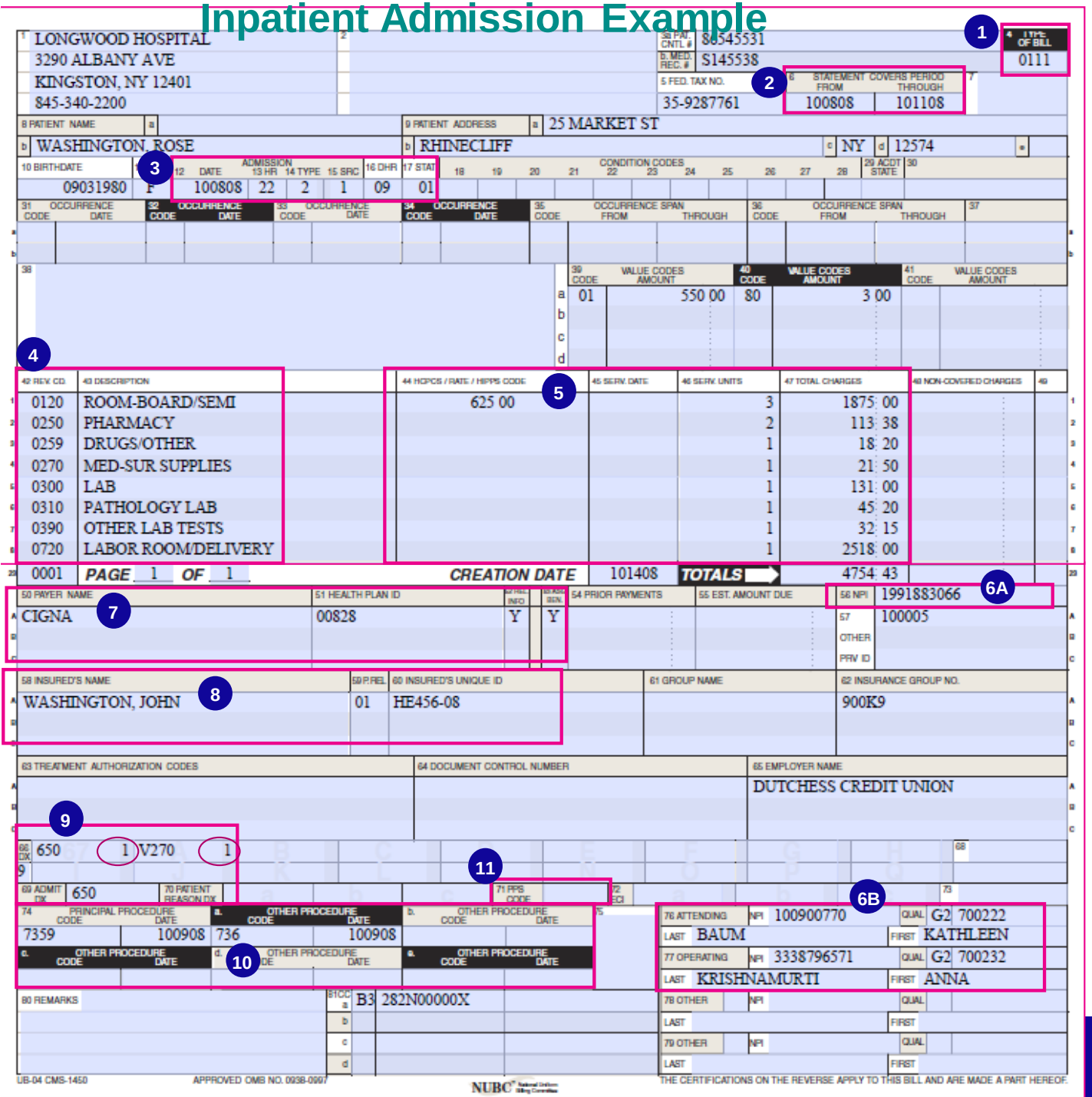
Diagnosis Code is header information and applies to the whole claim

Prospective Payment System (PPS) Code, if **DRG** is used.

Report procedures performed only in U.S. hospital inpatient health care settings.

When inpatient providers report ICD-9-CM diagnosis and procedure codes or ICD-10-PCS (Procedures) on claims, the MAC uses the codes to assign discharges to the appropriate Medicare Severity-Diagnosis Related Group (MS-DRG).

Inpatient Admission Example



1 **Type of Bill:**
1st: 1 = Hospital
2nd: 1 = Inpatient
3rd: 1 = Admit thru discharge

2 **Claim From and Through Date**
Oct 8th to 11th

3 **Admit and Discharge Info:**
- Admit Date: Oct 10, 2008
- Admit Hour: 10 PM
- Admit Type: 2 = Urgent
- Admit Source: 1 = Dr Referral
- Discharge Hour: 9 AM
- Discharge Status = 1 = Home

4 **CLAIM LINES: Revenue Code**
- For each claim line

5 **CLAIM LINES: HCPCS/ CPT related to Revenue Codes**
- 62500 not a valid code
- HCPCS and CPT codes not always required with rev code
- Service units and charge amount provided
- **Up to 2 Modifier Codes** can be added each HCPCS code

6 **NPI included:**
- Hospital NPI
- Attending NPI
- Operating NPI

7 **Payer /Insurance info**
- Provided: CIGNA

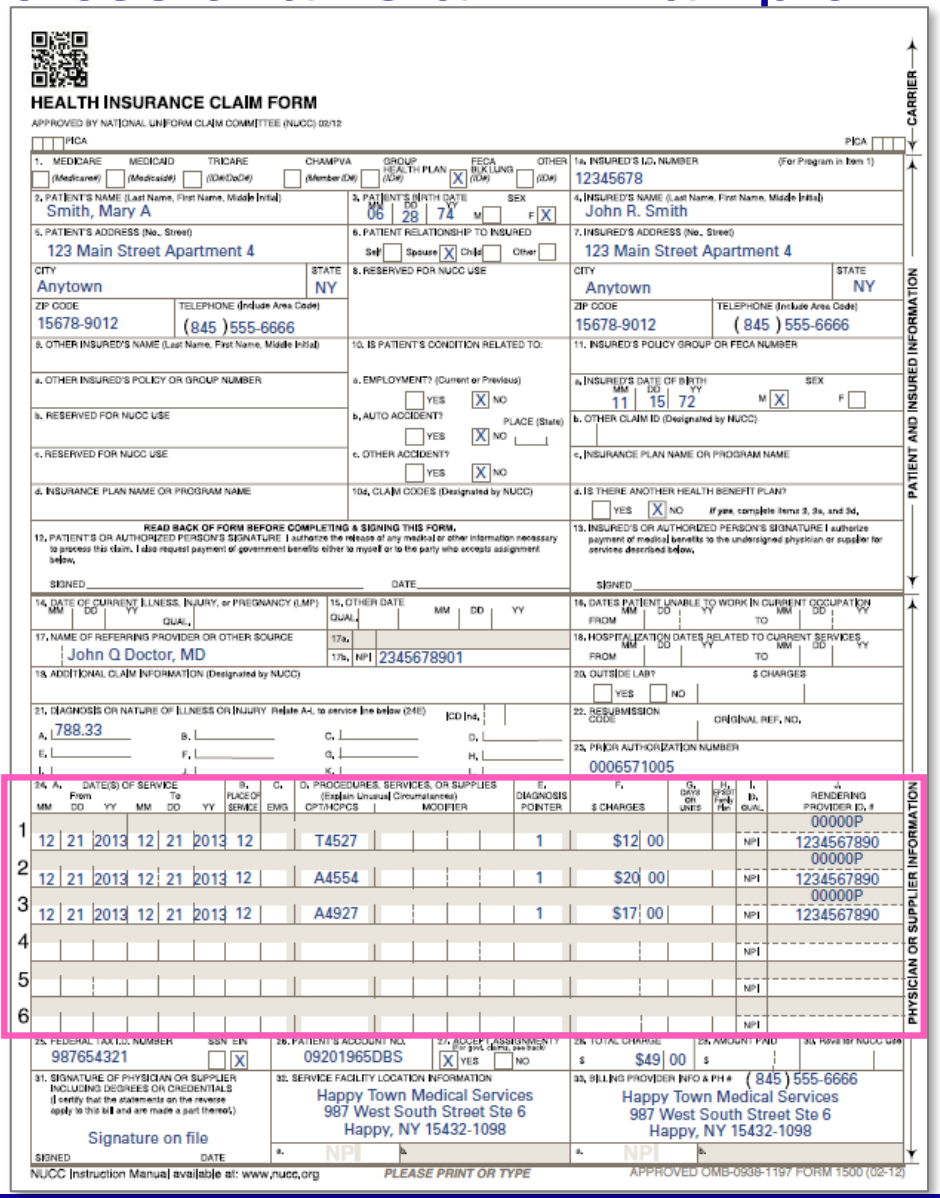
8 **Insured Info**
- Provided: under spouse's plan

9 **Diagnosis Codes**
- **ICD Indicator:** 9
- **Diag 1: 650:** Encounter for full-term uncomplicated delivery
- **Diag 2: V270:** Deliver-Single Liveborn (Outcome Of Delivery, Single Liveborn)
- **Admit Diag: 650**
- **Present on Admission (POA): 1 =** if the diagnosis is exempt from POA reporting

10 **Procedure Codes**
- **Principal Procedure:**
  - **7359 – ICD-9:** Manual Assist Deliv NEC (Other Manually Assisted Delivery)
- **Procedure 2: 736:** Episiotomy

11 Prospective Payment System (**PPS**) Code, if **DRG** is used

CMS-1500 – Professional Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [X] (Medicare#) | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

1a. INSURED'S I.D. NUMBER: 12345678 (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Mary A

3. PATIENT'S BIRTH DATE: 06 28 74 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): John R. Smith

5. PATIENT'S ADDRESS (No., Street): 123 Main Street Apartment 4

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Main Street Apartment 4

CITY: Anytown STATE: NY

8. RESERVED FOR NUCC USE

CITY: Anytown STATE: NY

ZIP CODE: 15678-9012 TELEPHONE (Include Area Code): (845) 555-6666

ZIP CODE: 15678-9012 TELEPHONE (Include Area Code): (845) 555-6666

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 11 15 72 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: John Q Doctor, MD

17a.

17b. NPI 2345678901

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 788.33 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 0006571005

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 21 2013	12 21 2013	12		T4527		1	$12 00			NPI	00000P 1234567890
2	12 21 2013	12 21 2013	12		A4554		1	$20 00			NPI	00000P 1234567890
3	12 21 2013	12 21 2013	12		A4927		1	$17 00			NPI	00000P 1234567890
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 987654321 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 0920196SDBS

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ $49 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on file

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Happy Town Medical Services
987 West South Street Ste 6
Happy, NY 15432-1098

a. NPI b.

33. BILLING PROVIDER INFO & PH # (845) 555-6666

Happy Town Medical Services
987 West South Street Ste 6
Happy, NY 15432-1098

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

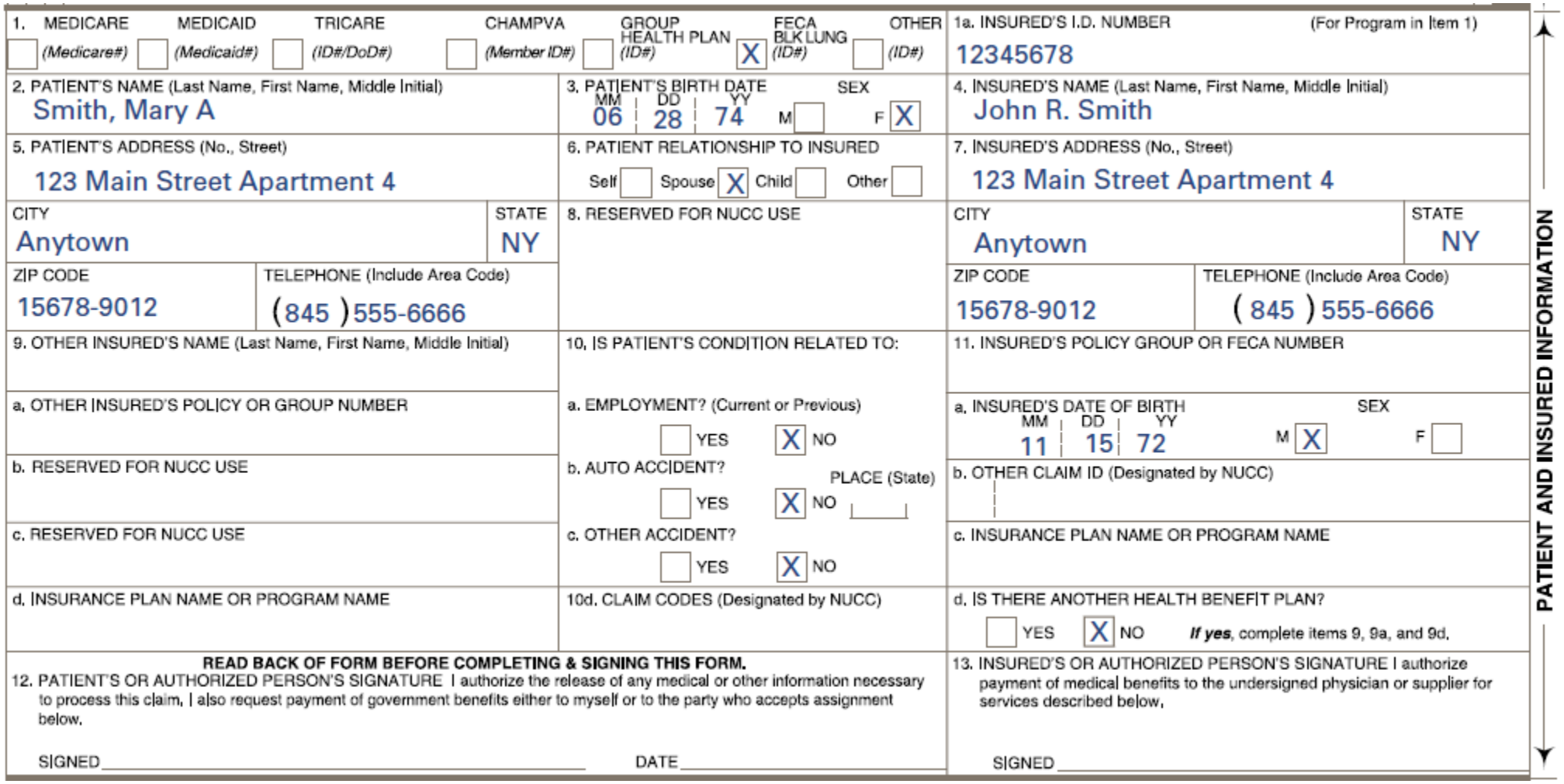
PHYSICIAN OR SUPPLIER INFORMATION

Claim Header

Claim Line info

Claim Header

CMS-1500 – Claim Header: Patient and Insured Info



1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [X] (ID#) OTHER [ ] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 12345678	
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CITY Anytown STATE NY	8. RESERVED FOR NUCC USE	CITY Anytown STATE NY
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a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM 11 DD 15 YY 72 SEX M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X]	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

PATIENT AND INSURED INFORMATION

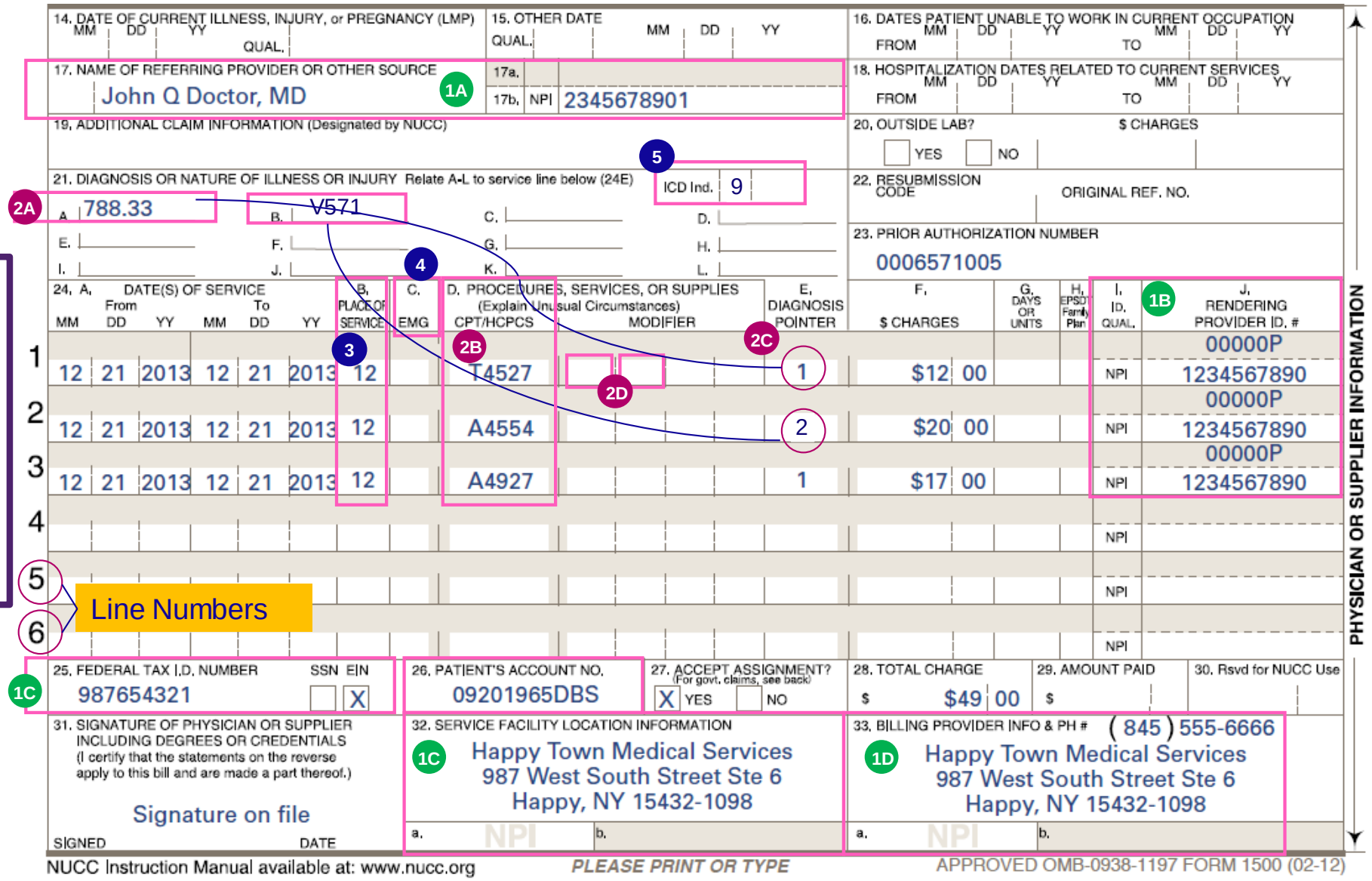
CMS-1500 – Physician and Claim Lines/Service Info

1A to 1D: Provider Info

- 1A Referring Provider and NPI
- 1B Rendering (Service) Provider and NPI for each service line
- 1C Service Provider Location (& NPI)
- • (Service) Provider Tax ID
- 1D Billing Provider & NPI

Diagnosis, Diagnosis Pointer, and Procedure Codes Relationship

- 2A Up to 12 diagnosis code per claim
- 2B Each claim line requires a procedure code (mostly CPT, sometimes HCPCS)
- 2C A procedure code is associated with the diagnosis via Diagnostic Pointer
- • Diagnoses have no cost but procedures do
- 2D Up to 2 Modifier Codes per procedure code (modifier is for upcoding usually to justify a higher charge amount



3 **Place of Service**
- Required

4 **Emergency flag for the illness/injury**
- Optional

5 **ICD Indicator**

Verscend – Market Fit

Verscend drives better healthcare outcomes through data analytics, supporting payers' financial performance and quality improvement initiatives.

Payment Accuracy

an end-to-end approach for maximum cost containment

Verscend Payment Accuracy is the industry's only real-time, pre-pay, integrated claim accuracy and fraud detection solution scalable for any size of payer. A convergence of technology, data, and analytics, our solutions incorporate a unique element: expert clinical review, a process that drives increased accuracy of claims payment.

Risk Adjustment

Our Risk Adjustment solutions offer end-to-end support for all payment and reconciliation facets of a risk-adjusted payment model. Our solutions are built around the CMS calendar and leverage the experience of our professional staff.

BlueCross BlueShield

NCQA Measuring quality. Improving health care.

Quality Improvement

The ability to collect and analyze accurate, timely information about the care that individuals receive has never been more important. Plans—and increasingly providers—are looking for a true strategic partner to help measure and report evolving quality metrics confidently, efficiently, proactively, and repeatedly. Verscend leads the way with our top-rated solutions.

Performance Analytics

For 20 years, Verscend Performance Analytics solutions—including the ground-breaking DxCG Intelligence risk adjustment and predictive models—have been helping payers understand and do what's best for their members, minimizing clinical and financial risk in the process.

Q
A

End of US Healthcare Market Training