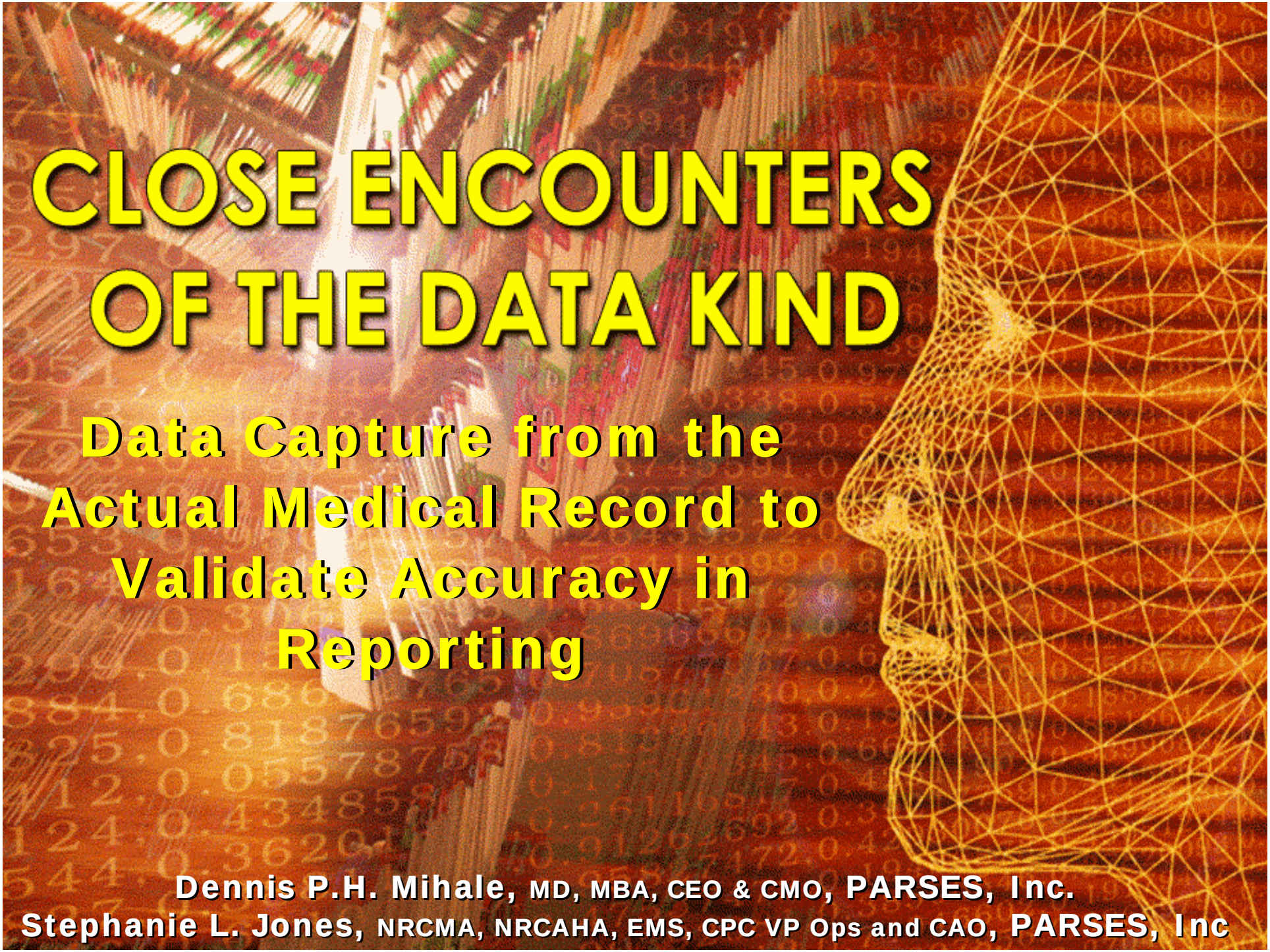
CLOSE ENCOUNTERS
OF THE DATA KIND
Data Capture from the Actual Medical Record to Validate Accuracy in Reporting
Dennis P.H. Mihale, MD, MBA, CEO & CMO, PARSES, Inc.
Stephanie L. Jones, NRCMA, NRCAHA, EMS, CPC VP Ops and CAO, PARSES, Inc

Why PARSES Knows Data

- Has used Auditors, Statistical Validation, and Analytic Tools to validate coding from the actual medical record since 1999
- Data Mining of multiple terabytes of physician claims data with > 500,000 comparative MR reviews

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Introduction

- "Close Enough" E/M encounter coding hurts practices, payers, patients, & employers.
  - Reasons to ensure accuracy in Evaluation & Management documentation & coding:
    - **P4P**
    - **HSAs and Employer driven plans**
    - **HIPAA reporting capabilities:** Rate Setting, Utilization, and Quality measurement

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The Advantage of Standard Code Sets:

- Valuable data for analysis
- Uniform capture of Diagnoses, Procedures, and Utilization

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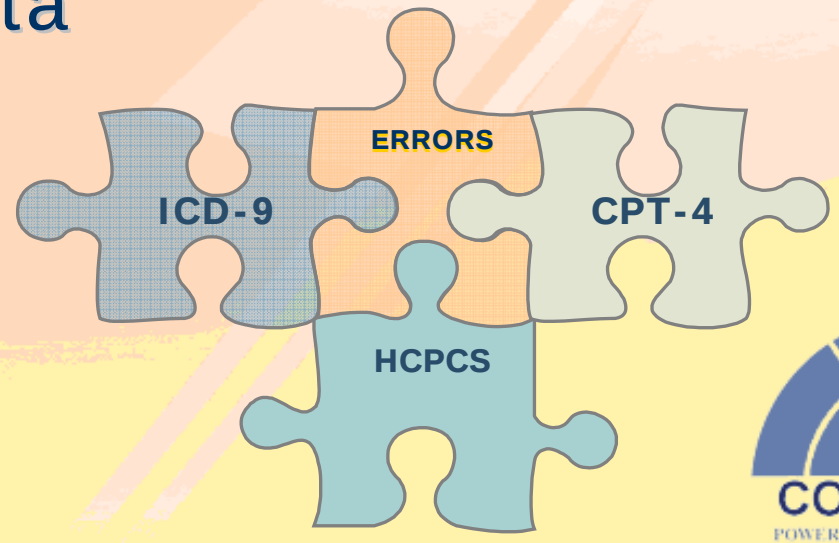
Hidden within the Code Sets Data…

- E/M Coding Mistakes Cost >$22B
- Overpayments -- up to 10%
- The appearance of ↓ Access to Care
- Incomplete P4P data



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Data Capture from the Actual Medical Record:

- Identifies Under-documentation and Over-coding
- Adds significant (granular) data and information:
  - History, physical exam and treatment
  - Specialty issues and individual patient needs
  - Trending capabilities /Exceptions and alerts

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Why do Providers Miscode?

- Innocent mistakes
- No correctness incentive
- Ignorance
- Easier to not report it
- Fraud and Abuse

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Most Common CPT-4® E/M Errors

- ↑ coding Level 5 pt visits
- ↑ coding New Patient visits as Consults
- ↑ coding Level 3 visits to Level 4
  - template abuse: pt severity low
- ↓ coding Level 4 visits to Level 3
  - audit avoidance: pt severity moderate to high

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Most Common ICD-9 Errors

- Loss of persistency
- Incorrect diagnoses coding
- Improper sequencing
- Missing the Highest Level of specificity

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Methods to Improve Accuracy

- Auditing
- Education
  - On-line Video Series
  - Auditing with claim specific audit trail
  - One on one web conferences
  - Monitor/Re-audit activities

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Other Common Findings

- Unreported services
- Under-documentation
- Unbundling
- Abuse
- Fraud

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Auditing = New Trend-able Data

- Actual history of illness: reason for visit (CC)
- Documentation of physical exam
- Assessment and related problems
- Plan of treatment
- Key labs and tests

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Why not review the MR?

The Problem	Outsourcing as a Solution
"It's expensive!"	Medical Record Review Firms - audit Data Analytic Firms – claims selection
"Providers complain!"	
"It's a storage problem!"	
"I'd have to analyze data!"	

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Resources to Get More Information

- http:// www.codexact.com
- http://www.ama-assn.org
- http://www.cms.hhs.gov/

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Summary

- Validating Data by Medical Record audit ensures best outcomes
- Additional data can only be obtained by a medical records audit
- Outsourcing solutions are becoming more available

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