

Beth Friedman  
Susan Gatehouse



healthcare financial management association [www.hfma.org](http://www.hfma.org)

## diagnose your coding problems

Learn how to spot coding's most common ailments—and how to cure them.

At their best, clinical coding departments produce high-quality, consistent, timely data for reimbursement and reporting. However, when people, processes, or systems are faulty, organizations begin to experience chronic aches and pains—primarily financial. The three most common coding ailments are staffing issues, problems with quality and consistency, and low coder productivity, which usually manifest themselves through a low or fluctuating case mix. By accurately diagnosing and treating the core issue, providers can take a more active role in improving coding outcomes—and enhancing fiscal health.

### Accurately Diagnosing the Problem

Case mix index is used in many ways by healthcare organizations. CMI reflects the mean weight of the various diagnosis-related groups assigned to hospital patients. It is considered a marker for the severity of illness treated within a facility, and it is tracked by Medicare. Equally important, CMI is often used by healthcare executives as the barometer of coding success.

If the CMI falls below the annual budgeted indicator, the first place executives turn is to health information management, specif-

ically coding. If the case mix is higher than budgeted, it may be an indicator of overcoding. If the case mix is lower than budgeted, it may be the reverse, undercoding. As a benchmark, CMI should be monitored monthly at a minimum, and if significant fluctuations are occurring, a closer look is warranted. Any change in services provided, patient population served, or staffing within the coding department could impact CMI (see the exhibit on page 101). Although CMI might be the first indication of coding problems, the root cause can often be related to several factors outside the coding area.

Within the coding realm, there are three key issues that impact CMI: staffing, quality, and productivity.

### Staffing Issues: The Common Cold of Coding

The most common staffing issue provider organizations face is the recruitment and retention of highly qualified coders. If your organization is experiencing problems in this area, you are not alone. In fact, a recent American Health Information Management Association survey found that 82 percent of hospitals nationwide have difficulty finding

the qualified coders they need (Friedman, B., "Coding Technology Today: AHIMA Survey Sheds Light on Coding's Progress Toward Automation," *Journal of AHIMA*, April 2006, pp. 66-68). And 20 percent of HIM directors surveyed state that staffing is their top management issue (Meadowcraft, T., "HIM Salary Survey," *For the Record*, June 26, 2006, pp. 16-20). Staffing issues are most simply identified through ongoing coder vacancies.

If one or more coder positions have been left unfilled for a period of three or more months, there is a staffing problem. Other indications of staffing issues include long-term backlogs in the coding process, consistent use of overtime hours, use of outsourced coding resources, and unacceptable staff turnover rates. For each of these symptoms, there are generally accepted thresholds for action, and new solutions including remote coding, complete business process outsourcing of the coding function, and aggressive coder retention programs.

**Coders go home.** Introduced early in this century, remote coding has become a cost-effective solution to attract and retain

coders. Similar to the transcriptionist-at-home trend established in the 1990s, coding from home has flourished, with 21 percent of coders now working from home. Remote coding programs give coders the flexibility of lifestyle they seek, while providing a competitive recruitment and retention advantage for their employers. The technology delivers faster turnaround times at less cost. In addition, if a completely electronic medical record is already in place, coders can access these systems remotely.

Many vendors offer remote coding technology using an application service provider or hosted model. For example, Ridgeview Medical Center, a 109-bed acute care hospital in Waconia, Minn., uses a web-based remote coding application to scan and send medical records to a home-based coding team. Ridgeview had one coder position open for seven months before turning to remote coding in 2002. For the past four years, coding has been fully staffed, job satisfaction has improved, and the program has delivered a strong ROI to the organization.

Remote coding is also available through most outsourced coding agencies. This provides facilities with the coding expertise they need, without the travel costs they don't want to incur. For example, Denise Hunt, RHIA, manager of medical informa-

tion management, Sierra Nevada Memorial Hospital in Grass Valley, Calif., uses a team of remote outsourced coders in conjunction with her own staff. Now, all outpatient surgery and emergency department records are processed through the remote coding system and coded by the outsourced team, and the data are electronically uploaded into the hospital's abstracting and billing system.

**Pursue complete business process outsourcing for coding.** Another possible remedy for staffing issues is outsourcing. Although outsourced coding can be expensive when used as a short-term, interim "fix" for staffing issues, long-term partnerships are very cost-effective. A recent industry white paper provides steps organizations can take to establish more successful, long-term outsourcing partnerships for coding services.<sup>4</sup>

Renee Williams, director of health information management at St. Joseph's Mercy Health Center in Hot Springs, Ark., experienced the advantages of a long-term coding partnership firsthand (SDS, Inc., *Clinical Coding: From Backlogs to Benefits*, St. Joseph's Mercy Health Center case study, [www.sdshealth.com/sol\\_hconcases-studies.htm](http://www.sdshealth.com/sol_hconcases-studies.htm)). After several years of persist-

a. MedQuist Inc., "Establishing Excellence in Health Information Management Outsourcing Partnerships," [www.medquist.com/whitepapers\\_articles](http://www.medquist.com/whitepapers_articles).

ent accounts receivable and revenue management problems due to clinical coding, the organization outsourced all inpatient coding to a firm that provided a team of remote coding experts and accompanying technology.

Williams reports that long-term partnerships provide three benefits: flexibility, quality, and cost. From a flexibility perspective, long-term outsourcing provides more coding options. For example, from time to time, an organization may prefer to have the outsourced coders on-site, and this option is usually provided. An outsourced coding team is typically more skilled at identifying complications and comorbidities, which results in a more accurate CMI. Finally, from the financial perspective, guaranteed access to additional coding staff ensures that discharged not final billed goals are more easily met.

**Innovative incentives reduce turnover.** Another treatment for staffing woes is to focus on retaining the high-quality coders that you currently have. In a recent coding focus group, some innovative ideas were discussed, including:

- > Flexible work hours, work days, and "leave when you're done" policies
- > Career ladders and step incentives for coders
- > Productivity and quality financial incentives

#### THE EFFECTS OF CASE MIX INDEX ON CODING

Case Scenario	Impact on CMI	Steps to Take in Coding
Hospital adds new services: coronary stenting and insertion of defibrillators	Cardiac procedures have a high relative weight and significant impact on CMI. If coded correctly, they can increase the CMI. If coded incorrectly, they can have a devastating impact on the CMI.	Coders must be educated on the procedure (how and why it is performed) in order to assign correct codes. Incorporate coder education into planning and executing the launch of new services.
Coding quality control program has been in place for five years with good results. Quality control manager resigns and the position remains vacant for six months.	CMI declines. Without internal quality control measures in place, there will be CMI fluctuations.	A formal quality control program for coding is essential. If an internal resource is not available to provide this service, seek outside resources.

- > Education and membership reimbursement programs
- > Team-building activities and events
- > Advanced technology tools
- > Quarterly retention bonuses

consistency across the entire team will mandate a different type of quality program. And with the onset of the all patient refined DRG system as well as ICD-10, facilities are forced not only to improve and maintain

Jacksonville, Fla., follows this practice with its new coders, to accomplish two objectives: to ensure the claims are accurate while educating the coder, and to identify any query opportunities prior to submitting the bill.

## When coders resign, a detailed exit interview should be conducted and the results analyzed at the executive level.

Today's coders are offered numerous incentives to switch positions or become coding consultants. When coders resign, a detailed exit interview should be conducted and the results analyzed at the executive level. Early detection of negative turnover trends within the coding department is essential. Organizations should continually revisit their coder retention strategies to reduce turnover, minimize recruitment headaches, and keep a consistent, high-quality coding team.

### Quality and Consistency: The Right Codes Every Time

Coding quality is a moving target. Coding guidelines, conventions, and policies are constantly changing. To remain financially viable in today's dynamic healthcare environment, healthcare entities must be vigilant in maintaining coding quality and consistency. Tools such as coding quality plans, review of national benchmarks, prebill reviews, and postbill audits can help.

There are numerous coding quality plans available. It is up to the facility to determine the one that best meets its needs. If a hospital has a group of seasoned, proficient coders, the coding quality program may not be as aggressive as one designed for mid-level coders. If the organization has a centralized coding function, maintaining

today's coding quality, but also to educate staff on the future changes in coding.

**Analyze your quality.** To begin analyzing quality, there are several indicators available to assist facilities in benchmarking against peer groups and discovering potential areas of improvement. MEDPAR data as well as the Program for Evaluating Payment Patterns Electronic Report are two such indicators. MEDPAR data are most commonly used to compare the complication and comorbidities capture rates of a facility against those of its peer group and the national benchmark. A hospital with percentages higher or lower than its peer group would benefit from a review of these DRGs.

The PEPPER report indicates outliers in relation to one-day stays and seven-day readmissions, as well as such DRG ratios for complications and comorbidities. Fiscal intermediaries review such measures to determine whether hospitals have potential compliance issues. If a facility has outliers in any of these areas, it is important to perform a focused coding review on them.

**Perform prebill and postbill reviews.** If coding quality is poor, it may be beneficial for a facility to place the coders on a prebill review, with coding accuracy being reviewed prior to the bill being submitted for reimbursement. Shands Hospital in

If the coding accuracy in a facility is adequate, a postbill review will suffice. Some facilities, such as Gwinnett Medical Center in Atlanta, have an internal review specialist in the inpatient and outpatient areas, as well as a coding educator. This is considered "best practice" and allows the facility to proactively manage quality, productivity, and education. A review from an outside agency on an annual basis is also recommended.

Quality and productivity go hand in hand and should be the cornerstones of any coding department. It has become commonplace for facilities to have a coder incentive program in which coders are compensated based on their production and their quality.

### Coder Productivity: What Really Happens in That Cube?

Even with a full complement of coding staff and the utmost in quality, organizations can experience low coder productivity. Coder productivity problems manifest themselves in high DNFB due to coding backlogs and subsequent A/R issues. According to AHIMA in a 2002 Practice Brief (Hughes, G., "Using Benchmarking for Performance Improvement," AHIMA Practice Brief, *Journal of AHIMA*, February 2003, pp. 64A-D), a good industry benchmark for coder productivity is 32 inpatient charts, 72 outpatient surgery charts, or 33 ED charts coded per day. These volumes can be affected by a variety of things, including the type of cases coded, other noncoding tasks, and general office distractions.

The first step is to minimize outside distractions and reduce noncoding tasks. In gen-

eral, coders should have approximately 36 square feet of space per coder in a closed, quiet environment that minimizes or eliminates outside distractions. If such space is not available, allowing coders to work from remote or home-based offices may be a better solution. Finally, many coders have been saddled with a wide variety of noncoding tasks. A complete evaluation of coding workflow and identification of all adjunct tasks is vital.

## Organizations should carefully evaluate their staffing mix, enforce daily coding goals or quotas, and take advantage of new technology tools.

Beyond space and focus, coders are being asked to complete more coding in less time each and every year. To maintain a high level of quality, yet consistently keep up with demand, organizations should carefully evaluate their staffing mix, enforce daily coding goals or quotas, and take advantage of new technology tools. According to recent surveys, 61 percent of coding departments are short-staffed.<sup>b</sup> Although adding FTEs is never easy, if DNFB and A/R are consistently affected by coding, this may be the most cost-effective solution. Outsourcing also may be an option to provide additional staff at a low cost, especially if these outsourced coders can work remotely.

b. MedQuist Inc., "The Impact of Computer-Assisted Coding," [www.medquist.com/whitepapers\\_articles](http://www.medquist.com/whitepapers_articles).

### *Technology's impact on productivity.*

Technology has been used as part of the coding process since the early 1980s, when first-generation encoders were introduced. Today's encoders are web-based, which provides two advantages. They can integrate with a remote coding environment, and from a budgetary perspective, allow for an operational (versus capital) technology purchase. Third-generation encoders use advanced decision logic, incorporate online coding references and automatic editing

software, and are APR-DRG and ICD-10 ready. With several new systems entering the market in 2006, the time is right for organizations to replace or upgrade their existing encoders as a way to improve productivity and increase coder morale.

Another new technology that has demonstrated a dramatic effect on coder productivity is computer-assisted coding. With CAC, natural language processing technology is used to electronically read clinical documentation. The system then presents the coder with a list of "suggested" codes for review, validation, and use. Primarily used in emergency and outpatient coding, CAC was shown in the previously cited surveys to nearly double coder productivity levels. Coders begin with a list of suggested codes

instead of starting from scratch, which saves coder time and improves code consistency across coding teams.

### **Can Coding Be Cured?**

Just as the revenue cycle can't be improved by focusing on only one area, coding can't be cured with any one step. It takes the ability to accurately diagnose the problem and then apply a combination of effective solutions.

A fluctuating CMI may be the first indicator, but further investigation is necessary. New services and changes in coder staffing might be the culprit. Additional problems may lie in the areas of coder vacancies, quality, and consistency across the coding team and productivity. By accurately diagnosing the issues that affect coding outcomes, providers can work toward curing the common aches and pains of the coding process. ●

---

### **About the authors**



**Beth Friedman**

is president, The Friedman Marketing Group, Gainesville, Ga. (beth@tfmgcom.com).



**Susan Gatehouse**

is president, Gatehouse Consulting, Cumming, Ga. (susan@gatehouse-consulting.com).