Call for Additional Coding Metrics

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The call for HIM professionals to develop measures and metrics that guide HIM efforts is not entirely new. Linda Kloss, MA, RHIA, FAHIMA, president of Kloss Strategic Advisors and former chief executive officer at AHIMA, discussed the importance of these measures in a *Journal of AHIMA* article in September 2013. "HIM can't manage what it can't measure, and information management has operated with too few tested metrics for too long," Kloss wrote. "HIM professionals need to know where their efforts are and where they need to be."[1] This observation remains just as true today, particularly in coding operations where data abounds, but metrics are primarily limited to basic coding accuracy and productivity rates. This article discusses suggestions for additional coding metrics that should be used to assess HIM coding operations.

The following are common metrics that have been used to measure coding operations, with little change over the last decade:

- Coder accuracy
- Coder productivity
- Discharged not final coded (DNFC)
- Case mix index (CMI) trends

Additional Metrics Would Ensure Quality and Integrity

While these metrics are important, expanded uses of coded data have required the measurement of additional metrics to ensure that coded data quality and data integrity support information governance practices. Today, HIM professionals must be able to measure and track the quality of coded data with more depth. Monitoring and process improvement should be informed by better data, and coding performance expectations are more realistic and impactful if data-driven.

Some suggested additional metrics to measure coding operations include:

- Accuracy rates by DRG
- Unspecified diagnosis code rates
- Denied claim rate due to coding errors (clean claim rate)
- DRG shift trends
- Mismatch between hospital and physician data

More Data Needed for Accuracy Rates by DRG

Most coding professionals would agree that certain DRGs are more error-prone than others. However, these traditional beliefs and common assumptions about error-prone DRGs may or may not be accurate. The intuitive concept of a correlation between outlier status and billing errors is one that has existed for some time and is used as the basis of fraud programs and recovery audit efforts. However, an article published in 2008 reported study results that showed irregular billing patterns are not always indicative of payment errors.[2] Furthermore, DRG accuracy rates reported by payers are focused on the payer's payment recovery objectives and thus likely limited to specific DRGs.

More comprehensive data is needed to determine if any of the DRG pairs/triplets are inherently error-prone, and if so which ones. HIM professionals should be pushing for this information. Data-driven evidence that determines if the de facto standard of 95 percent accuracy is appropriate across all DRGs would be extremely valuable. National norms specifying acceptable standard deviations for specific DRGs might be established if there was indeed evidence that certain DRGs are more error-prone. And comparative data on accuracy rates by DRG would be helpful to establish data-driven performance standards and focus corrective actions. As a starting point, HIM professionals should endeavor to track accuracy by DRGs over time. In addition, they should expect—and perhaps demand—that auditors share unbiased data.

Unspecified Diagnosis Code Rate a Useful Comparative Measure

Another useful metric is the unspecified diagnosis code rate which reflects a qualitative perspective of coder performance and coding results. It's calculated by dividing the number of unspecified diagnosis codes by the total number of diagnosis codes assigned on a sample of cases. To do this, simply identify (count) how many diagnosis codes there are on each case (denominator) and how many of them use the term "unspecified" in the description (numerator). For example, in a 50-record sample there will likely be approximately 500 diagnosis codes assigned. If 100 of those are unspecified, 100 divided by 500 is 0.2, for an unspecified code rate of 20 percent.

The unspecified diagnosis code rate correlates with the quality of clinical documentation, of course, but it may also correlate with a coder's quality, making it a useful comparative measure. For example, if Coder A regularly has an unspecified code rate of 20 percent and Coder B's rate is 40 percent, then the coding manager may need to work with Coder B to ensure that individual is taking the necessary steps to identify relevant specificity within the clinical documentation before finalizing code assignments.

The unspecified diagnosis code rate is also particularly significant in the transition to a new code set. ICD-10-CM codes, for example, have more specificity available than the ICD-9-CM codes currently in use. However, the specificity of ICD-10-CM codes is only useful if the more specific codes are indeed assigned. It is important to establish a baseline ICD-9-CM unspecified diagnosis code rate and then track and trend the ICD-10-CM unspecified diagnosis code rate. This will empower coding managers to ensure the rate is not impacted by the code set change since an increase in unspecified code use is expected to correlate to an increase in claims denials.[3]

Other Metrics to Consider

HIM coding managers should also consider the applicability of existing metrics. For example, an organization's patient financial services department likely tracks the number and type of rejected or denied claims by payer (the denied claim rate or clean claim rate).[4] This information could be cross-referenced by coder to track the percent of a coder's claims that require re-work. This would be another useful qualitative measure of coder performance and could help identify trends that require focused training. Most hospitals address claims issues with very little emphasis on the factors that lead to those denials. As a result, they repeatedly experience the same type of re-work.

Data trends are also important, and far too often neglected. HIM departments should be able to pull DRG data so they can monitor the volume of DRGs from month to month. Monitoring DRG shifts in this manner could provide an early warning sign of unexpected shifts that requires investigation. Monitoring DRG shift trends will be even more critical in the transition from ICD-9-CM to ICD-10-CM/PCS as there are some conditions and procedures that do not map into the same DRG in both versions of the code sets.[5]

It will be important to benchmark any high risk DRGs by volume and cost and continue to monitor this on a regular basis. The HIM manager responsible for coding operations should be involved in this data trending to uncover DRG shifts inadvertently caused by anomalous ICD-10 coding practices.

As the code sets become more refined and the healthcare industry's use and re-use of coded data becomes more sophisticated, so too must HIM operational metrics become more advanced. A new concern has been raised that the increased specificity available in ICD-10-CM may cause a mismatch in diagnoses between the hospital claim and the claims submitted by physicians for professional services.[6]

As a result, the ability to measure coding accuracy longitudinally to ensure consistency in reporting services on all the claims related to a particular healthcare event will become even more important. HIM professionals must develop creative measures to coordinate coding and denials management across healthcare settings.[7]

These are just a few suggested approaches to improve HIM coding metrics. After all, "if you can't measure it, you can't manage it." The clear trend in the healthcare industry is toward evidence-based methods for monitoring and evaluating key indices of performance. It's time for HIM to get on board.

Notes

[1] Kloss, Linda L. “Leading Innovation in Enterprise Information Governance.” *Journal of AHIMA* 84, no. 9 (Sept 2013): 34-38.

[2] Davis, George et al. “Irregular Billing Patterns: Are They Indicative of Payment Errors?” *Compliance Today* 10, no. 3 (March 2008): 50-55.

[3] Eramo, Lisa. “Don’t Deny the Denials.” *Journal of AHIMA* 85, no. 6 (June 2014): 30-33.

[4] Workgroup for Electronic Data Interchange. “ICD-10 Critical Metrics.” October 5, 2012. www.wedi.org/docs/resources/wedi_impact_assessment_swg_white_paper_icd10_metrics_revised_111412-pdf.pdf?Status=Master.

[5] Ibid.

[6] Ibid.

[7] Eramo, Lisa. “Don’t Deny the Denials.”

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