Latest Look at Coding Trends

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The April Journal of AHIMA (vol. 72, no. 4) "Coding Notes," article "Developing Facility-specific Productivity Measures," serves as the backdrop to this report on the results of our national survey of current coding practices. In the April article, we argued that coding productivity was affected by additional compliance and billing duties and record complexity. To obtain more detailed and current information for our members, we randomly distributed a survey to AHIMA members.
Our survey was sent via e-mail to 815 AHIMA members with a 9 percent valid response rate.1 Thanks to these respondents, we are able to update data that had appeared previously in the Journal of AHIMA, Advance for Health Information Professionals, and For the Record.

About the Respondents

Our respondents represented many segments of the healthcare industry, including acute care hospitals (67 percent), physician practices (19 percent), and a variety of alternative and specialty settings (14 percent) such as psychiatric facilities, rehabilitation/therapy, transitional, and eating disorder units, as well as long-term and skilled care facilities.2 In addition, valid responses were received from all nine geographic areas of the United States and one overseas location.

Our hospital respondents worked in organizations that had bed sizes ranging from 11 to 1,240. Because much of our coding efforts today are based on outpatient services, the survey captured outpatient test volume. The average volume of annual outpatient tests was 138,000; minor and major outpatient procedures averaged 13,500; and ER visits averaged 34,200. Several facilities had ambulatory care clinics, which experienced 1,800 visits annually. Many of these organizations owned physician practices as well. However, these ambulatory care clinics had the widest range of activity with annual visits of 260 (less than one per working day) to 95,300 visits (340 per working day). Of the physician practices responding, a total of 118 physicians were included in the facilities that responded, indicating they had 186,400 encounters or an average of nearly 1,600 encounters per physician.

Productivity Requirements

Although only five respondents said they had an incentive plan for coding productivity, more than half (57 percent) of the respondents had production standards. See "Average Records Per Day, Coding Only" on page 95. These standards have decreased since 1996.3
Coding production standards were present in environments where the coders performed a variety of duties, as well as those environments where the coding functions were limited to coding, abstracting, and data collection. The expectation for these coding professionals was lessened to accommodate their other assignments, including registries, analysis, assembly, release of information, cancer registry follow-up, handling subpoenas, managing transcription, staffing the medical necessity work station, assisting the business office, birth certificates, sterilizations, chart audits, and educating other patient care professionals. See "Average Records Per Day, Multiple Responsibilities" below.

Coders work a variety of shifts, with 68 percent working 7.5 to 8 hours. However, 5 percent work 9.5 or more hours a day, with many of these coders working abbreviated weeks. Some respondents encourage abbreviated weeks to retain coders and to deal with space limitations. Several coders work Monday through Thursday or Tuesday through Friday and a few work Wednesday through Saturday or Sunday through Wednesday. Regardless of the schedule selected, each coder has a three-day break from work each week and the facility has coverage seven days a week.

One respondent offered a solution for those coding professionals who have multiple duties, code a variety of records, or work varied hours. This hospital assigns minutes per record, as follows:

- 30 minutes per record for inpatient records
- 8.5 minutes per record for observation, ambulatory surgery, and minor procedure records
- 3.3 minutes per record for outpatient tests
- 4.2 minutes per record for ER visits

Using the data from "Average Records Per Day, Coding Only" and assuming an average work day of 465 minutes, the average minutes per record type is noted in "Average Minutes Per Record Type" below.

Coding Credentials

A recent issue of Medical Records Briefing (MRB) discussed coder recruitment dilemmas. By region, the article identified current salary ranges as well as the degree of difficulty healthcare organizations were having recruiting and retaining experienced coders. Our survey results appear to support MRB findings. "Coder Credentials," this page, indicates that 69 percent of the coders employed by our survey respondents were credentialed (CCS, CPC, RHIT, RHIA) and 13 percent had more than one credential. However, many of the coders had no credentials, perhaps indicating that the healthcare organizations we surveyed are attempting to "grow their own" coders. At physician practices, 34 percent of coders did not have credentials, while 30 percent of coders at the hospitals and other facility types were non-credentialed.

A Coder's Daily Duties

According to 42 percent of respondents, coders continue to specialize in inpatient or outpatient records. Outpatient coding continues to be the training ground for new coders who may or may not expand their coding skills to inpatient coding. Coding teams appear to have mixed skills, with 40 percent of the respondents having some coders in their teams who code both inpatient and outpatient records as well as single record-type coders. Only 18 percent of the respondents indicated that all coders coded both types of records.

Only 8 percent of the coders solely apply codes and do not perform any other function. More than 80 percent of the coders are required to code and abstract. Of these, 28 percent are required to code, abstract, and perform some data collection such as entering occurrence screens or performance improvement information. Twenty-four percent of the coders also analyze records.
As expected, in smaller facilities, coders performed a variety of duties including release of information, registry activities, transcription, assembly, and more. Respondents indicated that coders perform registry abstracting in 11 percent of the cases, with 63 percent supporting cancer registry, 38 percent supporting trauma registry, and 25 percent supporting spinal cord registry requirements.

Record Condition For Coding

More than half of the time (55 percent), coders work with assembled and orderly records, and 58 percent of the respondents said their records are entirely on paper. However, 35 percent indicated that coders must work with both paper and online records to accurately code their records. Only 7 percent work with fully computerized records.

Unfortunately, 61 percent of our respondents code incomplete records. Physicians may be queried for additional clarification on what is in the chart. The query and response (or lack thereof) is kept in the record by 56 percent of coders, while only 30 percent require the physician to document his or her response in the patient record. According to some HIM practitioners, their PROs are stating that while the query provides guidance, the documentation must be in the patient's progress notes or discharge summary.

Other findings on record conditions included:

- 48 percent of the respondents do not code until the pathology report is on the record
- 48 percent of the respondents do not code outpatient tests until they have a physician's order
- 11 percent require the discharge summary to be in the record before coding

Trends in Coding

Our coders' roles are expanding beyond traditional ICD-9-CM and CPT-4 coding. More than 13 percent of the coders are providing the E/M code for physician services. However, several respondents indicated that they code from the encounter form only or only assist with coding when edits reject claims or when surgical cases need additional coding. Only by having qualified personnel evaluate the documentation and assign a code will we be able to reduce error rates and potential for Office of Inspector General investigations.

In addition to the traditional coding systems of ICD-9-CM and CPT-4, we have professionals who have become skilled in ICD-10, DSM-IV, and CDT coding. Often these coding systems are touched on only superficially in our educational programs. However, as providers recognize the skills our professionals have, the need to teach our students about these classification systems will be imperative.

Key Figures

From the data captured, we were able to establish some ratios regarding inpatient/outpatient coding and physician/ hospital coding. For hospitals, we found there were 2.29 coders per 100 hospital beds.4 And when considering all patient care activity units (inpatient discharges, ER visits, tests, procedures, and clinic visits), our respondents experienced an average of 16,237 units per coder.5 For the freestanding physician practices, there was an average of 13,580 visits/encounters per coder.

Average Records Per Day, Coding Only

Expectation/Day	Record Type
23	Inpatient Records
32	Observation Records
30	Ambulatory Surgery Records
44	Minor Procedures (-scopies, lesion removal, etc.)
230	Outpatient Tests (lab, radiology, etc.)
106	ER Visits
108	Clinic and Physician Office Visits

Average Records Per Day for Coders, Multiple Responsibilities

Expectation/Day	Record Type
19	Inpatient Records
24	Observation Records
29	Ambulatory Surgery Records
37	Minor Procedures (-scopies, lesion removal, etc.)
161	Outpatient Tests (lab, radiology, etc.)
83	ER Visits
70	Clinic and Physician Office Visits

Average Minutes Per Record Type

Expectation/Day	Minutes/Record	Record Type
23	20	Inpatient Records
32	15	Observation Records
30	16	Ambulatory Surgery Records
44	11	Minor Procedures (-scopies, lesion removal, etc.)
230	2	Outpatient Tests (lab, radiology, etc.)
106	4.4	ER Visits

108	4.3	Clinic and Physician Office Visits

Additional graphics available in PDF format by clicking here.

Notes

1. 94 responses were received. Of these, 13 were invalid because the respondent sent back a blank response or no response was attached and 9 individuals responded refusing to participate or asking to be removed from the survey list.
2. Throughout this summary, you may find that the numbers may not add up to 100 percent. This is because some respondents did not provide information for each question asked and because some questions permitted multiple responses.
3. Dunn, Rose. "Productivity Standards: A Survey of HIM Professionals, Part II." Journal of AHIMA 67, no. 6 (1996).
4. This is an increase since the prior two surveys. In 1997 the average was 1.2 coders per 100 beds and 1996's average was 1.13 per 100 beds. See "1997 Survey Results: Staffing Issues" by Rose Dunn in Journal of AHIMA 68, no. 8 (1997).
5. The facilities responding had an average 328 outpatient activity units and 56 inpatient discharges per hospital bed.

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