Dear reader,

Establishing coder productivity standards can be challenging if you don’t know where to begin. There are many factors affecting productivity levels, from record type to the tools coders have available to them. However, establishing fair standards for your coders is important, as is knowing whether your department is running efficiently.

This special report allows you, as an HIM director or manager, to examine your own coder productivity levels and standards by comparing them with others in the field.

The report includes selected results from HCPro’s January 2011 coder productivity survey, which polled 276 readers located mainly in the following settings:

- Acute care hospital: 68%
- Clinic/physician office: 9%
- Critical access hospital: 4%
- Long-term acute care hospital: 4%
- Inpatient rehab: 1%
- Home health: 1%
- Clinic/physician office: 9%
- Inpatient rehab: 1%
- Home health: 1%

The report provides information on coder productivity according to bed size and record type, and outlines changes in productivity that have occurred since our last survey in April 2009.

We also take a look at other factors that affect productivity, including working remotely, hybrid and electronic records, non-coding-related tasks, and the anticipated effects of ICD-10-CM/PCS.

We hope this report is useful to your organization.

Sincerely,

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Overview of surveyed facilities

Hospitals accounted for 77% of survey responses, with another 9% of respondents located within clinics or physician offices.

Survey respondents work in facilities of varying sizes, reporting, if applicable, the following bed counts:

➤ Fewer than 25 beds: 6%
➤ 25–99 beds: 18%
➤ 100–199 beds: 24%
➤ 200–299 beds: 21%
➤ 300–399 beds: 10%
➤ 400–499 beds: 8%
➤ 500 or more beds: 13%

Survey respondents were located throughout the country, with all but six states represented. (The largest percentage—10%—was located in Texas. There were no responses from facilities in Delaware, Idaho, Nevada, Rhode Island, South Dakota, or Utah.)

Organizations reported an average case mix of 1.56, with numbers generally ranging between 0.9 and 3.7; nearly half reported case mixes between 1.3 and 1.6.

Respondents also reported the following:

➤ **Inpatient encounters:** The median response was 6,800 inpatient encounters annually. However, 16% reported fewer than 1,000 encounters and 6% reported more than 50,000.

➤ **Observation encounters:** Respondents reported a median of 1,740 observation encounters annually, though 38% reported fewer than 1,000 encounters.

➤ **ED encounters:** Respondents averaged a median of 33,500 ED visits annually.

➤ **Ambulatory surgery and outpatient encounters:** The survey’s median response was 5,200 encounters annually. However, some respondents from the largest facilities reported hundreds of thousands of encounters.

➤ **Outpatient testing encounters:** The median response was 40,700. However, several respondents reported well over 1 million test encounters.

➤ **Clinic visits:** Responses yielded a median of 16,300 clinic visits each year.

Changes in coder productivity

Productivity standards have changed through the years, as have the role of coders, the resources they have at their disposal, and coding quality standards and enforcement, as evidenced by coding survey results collected by HCPro in 2005, 2009, and 2011. Consider the following changes:

➤ In 2005, 72% of survey respondents indicated their facility had established productivity standards. In 2009, that percentage rose slightly to 73%. In 2011, it was 76%. But productivity expectations have not necessarily increased during that time. Consider the bottom graph on p. 5, which illustrates that the standard for inpatient records coded per hour has dropped slightly since 2009.

➤ Far fewer respondents indicated they have established quality standards in 2011 than in the past. In 2009, 77% reported that their facility had quality standards. However, in 2011 that number fell to only 52%.

➤ Coders are experiencing changes in the other duties they perform. For example, the percentage of coders that perform abstracting is falling, while the percentage that perform charge-posting for other departments continues to rise. (See the top-left graph on p. 5 for details.)

➤ The percentage of respondents that reported using encoders is approximately the same, though the number has fallen overall since 2005, when 92% indicated they used encoders. In 2009 and 2011, those numbers fell to 83% and 84% respectively.

➤ The percent of respondents who reported using concurrent coding (as opposed to retrospective) continues to decline. In 2005, 17% reported using concurrent coding at their facility. In 2011, that fell to 4%.

➤ The number of coders with individual printers at their disposal continues to hover around 30%, according
to survey findings. The lowest percentage (28%) was recorded in 2005; the highest (35%) was in 2009. Similarly, the percentage of coders who work in a quiet, private area has changed little during the past few years, remaining nearly constant at approximately 70%.

➤ External coding audits have declined slightly since 2005, when 86% of respondents reported conducting external audits at least every two years. In 2011, that fell to 79%. Consider the following:

- In 2005, 37% conducted external audits annually; 25% did so quarterly
- In 2009, 27% conducted external audits annually, and another 27% conducted them quarterly
- In 2011, 21% reported conducting external audits annually, and another 20% did so quarterly

➤ There has been a dramatic shift away from permitting coders to select the records they code each day. In 2005, 80% of coders selected their assignments. In 2011, that number has dropped to slightly below one quarter. Meanwhile, the percentage of coders who receive assignments based on floor or patient care areas rose from 11% to 33% over the same time. (See the graph immediately below for additional information.)

### Changes in inpatient coding productivity standards in records per hour

<table>
<thead>
<tr>
<th>2009</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>3–3.5:</td>
<td>29%</td>
</tr>
<tr>
<td>3.5–4:</td>
<td>14%</td>
</tr>
<tr>
<td>Fewer than 3:</td>
<td>12%</td>
</tr>
<tr>
<td>We don’t code this record type:</td>
<td>14%</td>
</tr>
<tr>
<td>4 or more:</td>
<td>16%</td>
</tr>
<tr>
<td>We don’t have a standard:</td>
<td>15%</td>
</tr>
</tbody>
</table>

### Changes in coding assignments

- Coders are assigned certain number ranges to code
  - 2005: 19%
  - 2011: 13%
- Coders are assigned certain letters of the alphabet to code
  - 2005: 7%
  - 2011: 9%
- Coders are assigned to certain floors or care areas
  - 2005: 11%
  - 2011: 33%
- Coders self-select the records they code each day
  - 2005: 80%
  - 2011: 24%
Outpatient coder productivity

Facility size may play a role in outpatient coding productivity, according to survey results (see the bottom graph on this page, which compares bed size with productivity standards for a sampling of outpatient coding types). Other findings include the following:

➤ 46% of respondents reported that coders code the professional E/M services for ED or clinic physicians at their facility.

➤ Some coders also check charges for omissions or errors on different types of records. Respondents reported the following:
  – 52% said coders check ED records
  – 44% said coders check ambulatory surgery and outpatient procedures
  – 37% said coders check observation cases
  – 33% said coders check inpatient records
  – 31% said coders check outpatient testing
  – 24% said coders check clinic visits

➤ In terms of ED services, 68% of respondents said their coders report facility diagnoses, compared with 66% who said their coders report facility procedures and 38% who said their coders report the facility E/M level.

See the graph immediately below for additional results on other ED services coders often code.

### Which ED services do coders code?

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Fewer than 25 beds</th>
<th>25–99 beds</th>
<th>100–199 beds</th>
<th>200–299 beds</th>
<th>300–399 beds</th>
<th>400–499 beds</th>
<th>500 or more beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility diagnoses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician E/M level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnoses for the physician’s bill</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedures for the physician’s bill</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coders do not code these services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion (in %)</td>
<td>68%</td>
<td>66%</td>
<td>38%</td>
<td>30%</td>
<td>20%</td>
<td>21%</td>
<td>24%</td>
</tr>
</tbody>
</table>

### How does facility size affect coding productivity expected standards in records per hour?

#### Ambulatory surgery records

<table>
<thead>
<tr>
<th>Facility Size</th>
<th>Fewer than 4</th>
<th>4–5</th>
<th>6–7</th>
<th>8–9</th>
<th>10–11</th>
<th>12 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 25 beds</td>
<td>0%</td>
<td>50%</td>
<td>0%</td>
<td>50%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>25–99 beds</td>
<td>4%</td>
<td>36%</td>
<td>36%</td>
<td>16%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>100–199 beds</td>
<td>0%</td>
<td>28%</td>
<td>39%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>200–299 beds</td>
<td>4%</td>
<td>26%</td>
<td>40%</td>
<td>19%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>300–399 beds</td>
<td>5%</td>
<td>29%</td>
<td>48%</td>
<td>10%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>400–499 beds</td>
<td>0%</td>
<td>35%</td>
<td>35%</td>
<td>12%</td>
<td>6%</td>
<td>12%</td>
</tr>
<tr>
<td>500 or more beds</td>
<td>4%</td>
<td>40%</td>
<td>40%</td>
<td>8%</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

#### ED records

<table>
<thead>
<tr>
<th>Facility Size</th>
<th>7 or fewer</th>
<th>8–9</th>
<th>10–11</th>
<th>12–13</th>
<th>14–15</th>
<th>16–17</th>
<th>18–19</th>
<th>20 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 25 beds</td>
<td>27%</td>
<td>14%</td>
<td>14%</td>
<td>0%</td>
<td>27%</td>
<td>0%</td>
<td>0%</td>
<td>14%</td>
</tr>
<tr>
<td>25–99 beds</td>
<td>9%</td>
<td>13%</td>
<td>26%</td>
<td>13%</td>
<td>13%</td>
<td>0%</td>
<td>4%</td>
<td>22%</td>
</tr>
<tr>
<td>100–199 beds</td>
<td>6%</td>
<td>9%</td>
<td>21%</td>
<td>15%</td>
<td>21%</td>
<td>0%</td>
<td>3%</td>
<td>24%</td>
</tr>
<tr>
<td>200–299 beds</td>
<td>6%</td>
<td>6%</td>
<td>21%</td>
<td>26%</td>
<td>11%</td>
<td>4%</td>
<td>6%</td>
<td>19%</td>
</tr>
<tr>
<td>300–399 beds</td>
<td>10%</td>
<td>0%</td>
<td>30%</td>
<td>25%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>400–499 beds</td>
<td>13%</td>
<td>7%</td>
<td>20%</td>
<td>0%</td>
<td>7%</td>
<td>13%</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td>500 or more beds</td>
<td>16%</td>
<td>8%</td>
<td>28%</td>
<td>8%</td>
<td>4%</td>
<td>16%</td>
<td>8%</td>
<td>12%</td>
</tr>
</tbody>
</table>
Outpatient coder productivity standards: Records expected to be coded per hour

**Ambulatory surgery records**
- Fewer than 4: 2%
- 4-5: 21%
- 6-7: 26%
- 8-9: 10%
- 11 or more: 9%
- We don’t code this record type: 18%
- We don’t have a standard: 15%

**Observation cases**
- Less than 5: 18%
- 5-6: 24%
- 7-8: 8%
- 9-10: 4%
- 11 or more: 5%
- 9-10: 4%
- We don’t code this record type: 24%
- We don’t have a standard: 16%

**ED records**
- Fewer than 5: 18%
- 5-6: 24%
- 7-8: 8%
- 9-10: 4%
- 11-15: 18%
- More than 19: 13%
- We don’t code this record type: 21%
- We don’t have a standard: 13%

**Clinic visits**
- Fewer than 4: 9%
- 4-5: 14%
- 6-7: 18%
- 8-11: 20%
- 12-15: 18%
- More than 23: 13%
- We don’t code this record type: 7%
- We don’t have a standard: 16%

**Interventional testing reports per hour**
- Fewer than 20: 6%
- 20-23: 14%
- 24-31: 14%
- 26-37: 14%
- 32-37: 6%
- 38-45: 5%
- 45+: 7%
- We don’t code this record type: 32%
- We don’t have a standard: 16%

**Non-interventional testing reports per hour**
- Fewer than 20: 10%
- 20-25: 14%
- 26-31: 14%
- 32-37: 6%
- 38-45: 5%
- 45+: 7%
- We don’t code this record type: 25%
- We don’t have a standard: 15%
- More than 37: 16%
Inpatient coder productivity

Are your coders as productive as they should be when it comes to inpatient coding? This is something most survey respondents could weigh in on: 87% code inpatient records, and of those, 81% have productivity standards in place. The standards generally fall between three to four records per hour, though a small percentage has a higher standard. (For more detail, see the graphs immediately below.)

But while the majority have standards in place, there are those who believe their presence is unwise. As one commenter stated, “Placing productivity numbers on codes only increases errors and stress levels for the coder.” Another respondent noted that it can be frustrating for coders to be held to productivity standards when auditors and revenue integrity employees are not, even though the coders often receive less in terms of education and compensation.

Survey results point to several factors that affect inpatient productivity. For example, making a dedicated printer available to each coder is correlated with higher productivity standards (see the top graph on p. 12). This may indicate that investing in certain resources is worth the up-front cost as it may increase long-term productivity.

Note, however, that other tools appear less likely to cause an increase in productivity expectations. For example, coders with dual monitors at their disposal actually show slightly lower productivity standards than their peers who lack the enhancement. Twenty-nine percent of coders without the extra screen have a standard of four or more records per hour, versus only 16% of those with dual screens.

Other factors seem to have less effect on productivity. For example, survey results show that an increase in a facility’s coding quality baseline does not necessarily affect productivity expectations, which is a good thing. As one respondent said, “It’s good to have somewhat of a baseline of an average productivity level, but what is more important is the quality of the coding!”

Those with baselines of 94%–95% or lower are generally expected to complete no more records per hour than those with baselines of 96%–97% or higher. In other words, setting higher baselines for quality for coders doesn’t necessarily slow down their work.

The effect of facility size on inpatient coding productivity is illustrated in detail in the bottom-left graph.

Encoders

Only 16% of respondents indicated their coders do not use an encoder. Of those who use an encoder, 79% use 3M and 12% use Quadramed. The remaining 9% use Ingenix/HHS and IRP/Accuro/MedAssets, among others. But do encoders improve productivity? Consider the chart below, which compares standards across several common encoders.
Department structure and practices

How do you structure your coding department and the work done there? Survey results provide a glimpse into this information.

According to survey results, coding is most often performed in the following departments:
➤ HIM department that includes coding (72%)
➤ Coding, as a department separate from HIM (22%)
➤ Clinical documentation improvement (5%)
➤ Patient financial services/business office (4%)
➤ Case management/utilization review (3%)

Within the coding departments themselves, the majority (68%) of respondents use some specialized coders (e.g., certain coders handle only inpatient records) and some coders who code all types of records.

Managers delegate assignments to coders using a variety of methods. One-third of respondents said coders are assigned to patient care areas. Almost one-quarter of respondents said coders select the records they code daily. (See the bottom-right graph for more detail.)

While 58% of respondents indicated coders don’t work weekends at their facility, the remaining have coders present on Saturdays, Sundays, or both. Consider the following:
➤ 7% reported that some coders work Saturdays only
➤ 3% reported that some coders work Sundays only
➤ 29% reported that some coders work on both days
➤ 3% reported that all coders rotate weekend coverage

Survey results also showed the following:
➤ Nearly half (47%) of the departments code incomplete records when coders believe there is sufficient information present to do so. Another 16% permit coders to code incomplete records but require coders or managers to review the coding again after the record is complete. However, 24% require the discharge summary and operative and pathology reports to be present, if applicable, before any coding can be done.
➤ The majority (59%) of respondents reported that their coding staff only codes records retrospectively. (See the bottom-left graph for more information.)
➤ Regarding discharge not final billed (DNFB) expectations, 17% reported that all or most records must be coded within their designated hold period. (Smaller percentages require this within a few days after the hold period.) However, 25% said that all or most must be coded within four days of discharge. Another 18% reported they must be coded within five days of discharge, and an additional 10% require coding within seven days. Nineteen percent reported that there is no set expectation and records are simply coded as soon as possible.
➤ 17% said physicians must sign coding summaries (i.e., the list of codes a coder assigns) at their facility.

How are coding assignments delegated?

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>By medical record number ranges</td>
<td>13%</td>
</tr>
<tr>
<td>By alphabetic ranges</td>
<td>9%</td>
</tr>
<tr>
<td>By patient care areas</td>
<td>33%</td>
</tr>
<tr>
<td>By time frame (e.g., certain days of the week)</td>
<td>11%</td>
</tr>
<tr>
<td>By dollar amount (e.g., high-dollar records)</td>
<td>14%</td>
</tr>
<tr>
<td>Through self-selection</td>
<td>24%</td>
</tr>
<tr>
<td>Other</td>
<td>24%</td>
</tr>
</tbody>
</table>

Do coders code concurrently or retrospectively?

- Retrospectively: 59%
- Concurrently: 4%
- Both: 37%
Coder credentials

Almost half (49%) of all respondents reported that their facility employs coders only if they are credentialed. Five percent, however, have no credentialed coders on staff. The rest (46%) employ a combination of the two.

What credentials do coders have? A wide variety, to be sure; however, the majority reported having coders with CCS/CCS-P and RHIA/RHIT credentials on staff (71% and 70% respectively). For additional information on coder credentials, see the graph immediately below.

<table>
<thead>
<tr>
<th>Coder credentials do staff members have?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCA</td>
</tr>
<tr>
<td>CCS/CCS-P</td>
</tr>
<tr>
<td>CPC/CPC-H</td>
</tr>
<tr>
<td>CPMA</td>
</tr>
<tr>
<td>HCS-D</td>
</tr>
<tr>
<td>RCC/CIRCC</td>
</tr>
<tr>
<td>RHIA/RHIT</td>
</tr>
<tr>
<td>RN/LPN</td>
</tr>
</tbody>
</table>

Coder compensation

Survey respondents indicated most coders are paid hourly, though some are salaried or compensated through a combination of hourly and pay-for-performance methods (i.e., they receive additional compensation for exceeding a certain number of records per pay period).

But while one respondent noted that he or she thinks paying coders an hourly rate plus an incentive for additional charts coded per pay period should be implemented on a national level, another disagrees completely; this respondent is not in favor of a payment incentive scheme as it often makes coders feel rushed. “An hourly rate with reasonable production standards is most beneficial, as I’d rather have quality than quantity,” the respondent states.

None of the respondents indicated their coders are paid based purely on a pay-for-performance model. See the graph immediately below for more information.

Staff vacancies

Two-thirds of survey respondents reported they have no current coding staff vacancies. For those still hiring, some have been searching for several months already. See the graph immediately below for more information.
**Non-coding duties**

Survey respondents indicated there are many non-coding duties in which coders are responsible for in their facility. For example, the vast majority (88%) query physicians. More than half reported that their coders are also responsible for tasks such as assigning present-on-admission indicators, answering utilization review or case management questions, and fielding business office or patient financial services calls. Other tasks include:

- 79% of coders perform the abstracting required to release or drop claims
- 20% of coders perform the charge-posting function for surgery, ancillary departments, the ED, and other charge-generating departments, according to respondents
- 29% complete part of the Inpatient Rehab Facility Patient Assessment Instrument (IRF-PAI) for rehab patients (though 26% complete only the coding section)
- 10% complete at least part of the Minimum Data Set for SNF residents when applicable, though only 1% of respondents said coders complete it in its entirety

In terms of the time spent performing these duties:

- 31% of respondents indicated their coders spend fewer than three hours per week
- 27% spend 3–5 hours per week
- 17% spend 6–8 hours per week
- 16% spend 9–17 hours per week
- 10% spend 18 or more hours per week

### What non-coding related tasks do coders work on?

<table>
<thead>
<tr>
<th>Task</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answering business office/financial services questions</td>
<td>56%</td>
</tr>
<tr>
<td>Answering questions from physician offices</td>
<td>47%</td>
</tr>
<tr>
<td>Answering utilization review/case management coding questions</td>
<td>52%</td>
</tr>
<tr>
<td>Abstracting—cancer registry</td>
<td>8%</td>
</tr>
<tr>
<td>Abstracting/collecting occurrence data</td>
<td>22%</td>
</tr>
<tr>
<td>Abstracting—core measures data</td>
<td>11%</td>
</tr>
<tr>
<td>Abstracting for the operating room (blood loss, anesthesia type, etc.)</td>
<td>22%</td>
</tr>
<tr>
<td>Abstracting—performance improvement data (open/closed record review)</td>
<td>16%</td>
</tr>
<tr>
<td>Providing analysis (deficiencies)</td>
<td>18%</td>
</tr>
<tr>
<td>Appealing denials</td>
<td>24%</td>
</tr>
<tr>
<td>Assigning present-on-admission indicators</td>
<td>63%</td>
</tr>
<tr>
<td>Assigning working DRGs</td>
<td>37%</td>
</tr>
<tr>
<td>Assisting with or performing release of information</td>
<td>7%</td>
</tr>
<tr>
<td>Assisting with or performing transcription</td>
<td>3%</td>
</tr>
<tr>
<td>Performing clinical documentation improvement activities</td>
<td>36%</td>
</tr>
<tr>
<td>Filing coded records</td>
<td>11%</td>
</tr>
<tr>
<td>Handling incomplete records management</td>
<td>11%</td>
</tr>
<tr>
<td>Obtaining information to support medical necessity</td>
<td>39%</td>
</tr>
<tr>
<td>Assisting with record assembly</td>
<td>7%</td>
</tr>
<tr>
<td>Recording retrieval/filing (including inserting loose materials)</td>
<td>7%</td>
</tr>
<tr>
<td>Responding to RAC requests</td>
<td>18%</td>
</tr>
<tr>
<td>Serving as director/manager of the department</td>
<td>7%</td>
</tr>
<tr>
<td>Querying physicians</td>
<td>88%</td>
</tr>
</tbody>
</table>
Coder tools and resources

Twenty-nine percent of survey respondents say their coders each have dedicated printers. More than half (58%) have dual computer screens so they can view reports and other data simultaneously. Nearly three-quarters work in a quiet, private area. See the charts below for examples of how tools such as printers or a quiet, private workspace can affect coder productivity expectations.

<table>
<thead>
<tr>
<th>How does having a dedicated printer for coders affect the coding productivity expectation for inpatient records per hour?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coders do not have individual printers</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Each coder has a printer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How does having a quiet, private space for coders affect the coding expectation for ED records per hour?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coders don’t have quiet, private space</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Coders have quiet, private space</td>
</tr>
</tbody>
</table>

Do remote coders affect productivity?

More than half (52%) of respondents indicated their facility offers remote coding as an option. Another 17% have plans to begin doing so in 2011. As might be expected, the number of remote coders has risen since the last coder productivity survey conducted in early 2009. The number of facilities offering the option has risen from one-third to just over one-half of facilities during the two-year time period.

As more coders work remotely, what does this mean for coding productivity? Many survey respondents indicated that offering a remote option affects productivity, often positively. See the graph at left for details.

If you offer a remote coding option, has it affected productivity?

Productivity has increased: 41%
Productivity has decreased: 17%
Productivity has remained the same: 42%

What causes decreased activity for your remote coders?

Slow Internet connections: 83%
Disconnects and other connectivity issues: 66%
Lack of self-discipline or motivation: 24%
Home interferences (e.g., children, spouse): 24%
Lack of interaction with coworkers (e.g., to ask questions): 38%
Quality standards and auditing

Just over half (52%) of survey respondents that have a quality standard at their organization use 95% accuracy as a baseline. Another 10% use a baseline of 94% or less. However, 22% of respondents have a baseline of 97% or more.

In terms of ensuring coding quality, the majority of respondents (68%) conduct both internal and external audits. The graphs at the bottom of the page detail the frequency of these audits.

Physician query tracking and response rates

Nearly three-quarters of survey respondents indicated they have a process in place for tracking physician queries, including response rates.

The responses varied, however, regarding the percentage of queries to which physicians respond within seven days.

One-third indicated that physicians answer less than one-quarter of their queries within one week. And another quarter of survey respondents said that between 25% and 50% of their queries are answered within that time frame.

The good news?

Twenty-eight percent of respondents said their physicians respond to more than three-quarters of their queries within seven days.

How often does your facility conduct audits?

Internal audits

- Monthly: 48%
- Annually: 12%
- Quarterly: 32%
- Every two years: 2%
- Twice per year: 7%

External audits

- Quarterly: 27%
- Monthly: 16%
- Every two years: 16%
- Annually: 28%
- Twice per year: 13%

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ICD-10-CM/PCS and coder productivity

Most believe the changeover to ICD-10 in 2013 is going to affect coding productivity, but how much and for how long?

Survey respondents had mixed opinions on this, as seen in the graph at right.

Minimizing the productivity drop will be a challenge; many organizations seem to think that early preparation is crucial. Sixty-three percent of survey respondents have already begun to prepare coders for ICD-10-CM/PCS.

In addition, consider the following comments from respondents on the topic of ICD-10-CM/PCS and productivity:

➤ “If our training is thorough enough, I would hope that we have a minimum of drop in productivity. We are [already] sharing some ICD-10 information monthly and will aggressively train our staff in 2012.”

➤ “Coding productivity has been one of the most difficult areas to streamline. Each facility that I have worked with has various duties for their coders. I certainly look forward [to using] ICD-10. This is a great opportunity to regroup.”

➤ “Surgical inpatient procedure coding productivity will drop the most, followed by outpatient surgery coding. (We assign both ICD-9 & CPT codes). Least impacted will be ED coding.”

How will the changeover to ICD-10-CM/PCS affect coder productivity?

![Graph showing productivity drop options]

- Productivity will drop by 50%, and while it will gradually improve, it will never return to today’s level: 23%
- Productivity will drop for a short period (6 months or less) and then return to normal: 50%
- Productivity will not drop: 5%
- Productivity will drop by 25% and probably not return to today’s level: 22%

Paper vs. hybrid vs. electronic records

What type of record do you have, and does it affect coder productivity? One respondent noted EHRs have decreased productivity at his or her facility.

Consider the graph at right, which provides a glimpse at the status of EHR implementation nationwide. Meanwhile, the graph below shows an example of how a record is maintained may be a factor in coder productivity standards for facilities that code ambulatory surgery records.

What is your productivity standard for ambulatory surgery records per hour?

<table>
<thead>
<tr>
<th></th>
<th>Fewer than 4</th>
<th>4–5</th>
<th>6–7</th>
<th>8–9</th>
<th>10–11</th>
<th>12 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper</td>
<td>14%</td>
<td>14%</td>
<td>43%</td>
<td>14%</td>
<td>0%</td>
<td>14%</td>
</tr>
<tr>
<td>Hybrid (paper and electronic)</td>
<td>1%</td>
<td>39%</td>
<td>30%</td>
<td>14%</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>Hybrid (scanned paper and electronic)</td>
<td>1%</td>
<td>29%</td>
<td>44%</td>
<td>16%</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Electronic</td>
<td>5%</td>
<td>27%</td>
<td>41%</td>
<td>5%</td>
<td>18%</td>
<td>5%</td>
</tr>
</tbody>
</table>
An expert response

What it all means: Productivity in today's environment

by Rose T. Dunn, RHIA, CPA, FACHE, MBA

An impressive number of individuals responded to this year’s survey. We thank all who took the time to complete the survey so that this information could be shared with MRB readers. MRB’s Senior Managing Editor Andrea Kraynak did an excellent job summarizing the reams of data obtained from the survey.

Let me remind readers that this data is a guide and should not be assumed to be the Holy Grail. Every facility has its own idiosyncrasies and, as we saw on p. 11, coding professionals may have a variety of other duties that take time away from coding. These other duties and the unique conditions present at your organization must be factored into any productivity expectations that you establish.

Changes and trends

I noted several interesting trends from this year’s survey. The first is the charge-posting trend that Andrea displayed in the graph on p. 5. The fact that charge-posting by coding professionals and/or by HIM in general has doubled in five years clearly indicates that HIM is being recognized for attention to detail in data capture and charge-posting integrity, which departments may have lacked in the past. However, charge-posting is no easy task; it can be excessively time-consuming and can affect the discharge not final billed balances if not designed efficiently. Before taking on charge-posting, study the prior department’s process and understand any hurdles that department encountered (rejected entries, unrecorded services, dual-entry efforts, etc.) so that these can be corrected before HIM takes on the function.

The decline in concurrent coding, as detailed on p. 9, is not a surprise given the increase we have been seeing in the implementation of clinical documentation improvement (CDI) programs. Concurrent coding efforts were initiated in the past to provide an opportunity to interact with the physician, educate the physician about coding documentation requirements, and—hopefully—obtain more precise documentation for the coders. CDI programs have a similar focus.

Quality, auditing, and ICD-10

The decline in external coding audits (see p. 13) is concerning. However, the data indicates that 48% of the respondents are conducting monthly internal audits. Clearly, if organizations can catch coding errors in a more timely fashion by auditing monthly, that is more effective than finding an error during an annual external audit.

The decrease in inpatient coding productivity expectations (see p. 8) is unsurprising given the higher level of scrutiny on inpatient records by an increasing number of external review entities. The challenge posed by EHRs, where clinicians often cut and paste the same documentation, is another new obstacle for coders trying to decipher the new information. That time cuts into productivity.

From a cash flow perspective, kudos to those 42% of the respondents who have extended coding into the weekend and the 43% who responded indicating that they are coding within five days of discharge. (See p. 9 for more detail.) Your CFOs should be very proud of you!

The forecast for ICD-10 appears on target, as seen on p. 14. ICD-10-PCS may be a greater challenge than ICD-10-CM due to the sheer magnitude of the additional codes and the specificity required from the surgeon’s documentation. This upcoming change, coupled with the 13% of respondents who have had coding staff vacancies for longer than 75 days (see p. 10), means that timely coding in the future will definitely be a challenge.

Editor’s note: Dunn is chief operating officer at First Class Solutions, Inc., in Maryland Heights, MO.