



## Survey on Coding Quality Measurement: Hospital Inpatient Acute Care

In November 2007, the AHIMA e-HIM Quality Work Group on Coding Performance Measures and the Foundation of Research and Education (FORE) sponsored a survey to begin establishing standards used in evaluating, benchmarking, and improving the quality of coding.


The purpose of this survey was to:

- Collect coder error reasons, documentation inadequacies that lead to coding errors, and other contributing causes that lead to coding errors in an effort to understand the underlying causes of coding errors and coder variation
- Report data on coding quality review outcomes to understand how coding review data is used to improve the quality of coding, reduce coder variation, and develop best practices for national coding consistency

The survey was distributed to HIM directors and managers in acute care hospitals as documented in the AHIMA member database. Invitations to participate were delivered to 632 members. Two reminder e-mails were sent at one week intervals. Sixty-eight responses were received for a response rate of 10.76 percent. Given the exploratory and foundational nature of this survey, the results will be used, with follow-up in 2008 and beyond building on these findings.

### Results

Almost half (47 percent) of respondents were in an HIM supervisory position, with facility coding supervisor and other next highest at just over 17.5 percent each. Examples of other job titles included corporate coding manager, data quality specialist, and compliance professional.

1. Please select the title that most closely represents your current position (select only one).			
Responses	Total	%	Percentage of total respondents
Facility coding supervisor (internal)	12	17.65%	

Facility coding auditor (internal)	5	7.35%	
Coding auditor for multiple facilities (internal)	3	4.41%	
HIM director/assistant director/manager	32	47.06%	
Coding consultant/auditor (external)	4	5.88%	
Other (please specify)	12	17.65%	
<b>Total Responses</b>	<b>68</b>		

### Frequency of Coding Quality Measurements












Respondents were asked how frequently they performed coding quality and DRG validation audits. Two-thirds of respondents (67.67 percent) perform complete coding audits and DRG validation audits quarterly or more often.

#### 2. Please select how often complete quality coding audits are performed (every diagnosis and every procedure code validated) (select only one).

Responses	Total	%	Percentage of total respondents
Every other year	5	7.35%	
Annual	6	8.82%	
Semi-annual	2	2.94%	
Quarterly	17	25.00%	
Monthly	16	23.53%	
Daily (concurrently or pre-bill)	13	19.12%	
Not performed	5	7.35%	
Do not know	2	2.94%	
Not applicable	1	1.47%	
Other (please specify)	1	1.47%	
<b>Total Responses</b>	<b>68</b>		

#### 3. Please select how often DRG validation audits are performed (only diagnoses or procedures that impact DRG assignment such as PDX, SDX, or procedures are validated). (Select only one).

Responses	Total	%	Percentage of total
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			respondents
Every other year	3	4.41%	
Annual	7	10.29%	
Semi-annual	2	2.94%	
Quarterly	14	20.59%	
Monthly	17	25.00%	
Daily (concurrently or pre-bill)	15	22.06%	
Not performed	4	5.88%	
Do not know	2	2.94%	
Not applicable	1	1.47%	
Other (please specify)	3	4.41%	
<b>Total Responses</b>	<b>68</b>		

### Causes of Coding Errors

The next section of questions attempts to determine the causes of coding errors as perceived by survey respondents. Respondents were asked to rank the answers. In order to assess them, responses were weighted. For question 4 where respondents ranked the category that has the most coding errors, the answer of complication or comorbidity assignment was given an overall ranking score higher than principal diagnosis because so many more people ranked it second. The results are shown below.

4. RANK 1 through 5 with #1 representing the category attributing to most coding errors and #5 representing the category attributing to least coding errors:						
Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)
Complication or comorbidity assignment	18	27	12	6	5	1 (251)
Principal diagnosis assignment	26	10	14	7	11	2 (237)
Secondary diagnosis assignment	13	14	17	20	4	3 (216)
Principal procedure assignment	0	12	14	26	14	4 (156)
Secondary procedure assignment	8	3	11	9	32	5 (135)
Do not know	3	0	0	0	1	6 (16)
Not applicable	0	2	0	0	1	7 (9)

(Did not answer)		0
<b>Total Responses</b>		<b>68</b>

### Reasons for Coder Error

Questions 5–9 asked respondents to rank many different potential causes of coder error specific to coders. Under knowledge of medicine the respondents felt that coder inability to synthesize sometimes conflicting documentation could cause errors. Within coding guidelines and conventions, inconsistent or misinterpretation of guidelines ranked only slightly higher than overreliance on encoder logic. Within coding query, respondents ranked coder lack of understanding of the clinical indications for a query highest. Within the final miscellaneous category including work habits and education respondents ranked an inability to reconcile productivity requirements with coding quality standards the highest. Question 9 asked for any causes that had not been listed. Hurrying through the work was most often cited.

5. Coder: Knowledge of Medicine (Clinical Knowledge)						
Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)
Inability to synthesize the complex and oftentimes conflicting medical record documentation about the patient's medical care and ability to match the clinical condition or procedure to the most accurate code assignment	33	13	11	6	3	1 (265)
Inability to discern when a query is or is not necessary	10	11	24	12	2	2 (192)
Lacks appropriate understanding of the pathophysiology of disease process, anatomy, medical terminology, or pharmacology	6	23	12	11	8	3 (188)
Lacks effective communication skills in working with the Medical Staff on query or clinical documentation improvement efforts	5	12	11	23	7	4 (159)
Do not know	1	2	0	1	3	5 (18)
Not applicable	2	0	0	0	2	6 (12)
(Did not answer)						0
<b>Total Responses</b>						<b>68</b>

### 6. Coder: Knowledge of Coding Convention, Official Guidelines for Coding and Reporting, and Policy/Procedures

Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)
Does not consistently apply, misinterprets, or does not use the most up-to-date official guidelines (Official Guidelines for Coding and Reporting)	14	11	13	10	8	1 (181)
Relies primarily on encoder logic resulting in some inaccurate code assignment	21	8	7	6	9	2 (179)
Does not consistently apply, misinterprets, or does not use the most up-to-date AHA <i>Coding Clinic</i> advice	9	18	8	11	6	3 (169)
Does not consistently apply, misinterprets, or does not use the most up-to-date facility specific coding guideline	5	7	18	15	5	4 (142)
Does not consistently apply, misinterprets, or does not use the most up-to-date payer specific coding guideline	3	10	8	11	16	5 (117)
Not applicable	6	0	0	0	0	6 (30)
Fails to consistently follow Standards of Ethical Coding	0	1	0	3	10	7 (20)
Do not know	2	0	0	0	1	8 (11)
(Did not answer)						1
<b>Total Responses</b>						<b>68</b>

### 7. Coder: Correct Application of Query Policy

Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)
Lacks clear understanding of clinical indicators for the condition being queried	10	12	13	6	4	1 (153)
Writes an unnecessary query	10	4	14	8	5	2 (129)
Does not follow-up on leading or unnecessary queries written by a Clinical Documentation Improvement (CDI) Clinician such as a nurse or case manager	10	11	3	7	6	3 (123)

Writes a leading query	6	9	6	8	10	4 (110)
Does not consistently apply, misinterprets, or does not use the most up-to-date facility Query Policy	9	3	5	10	12	5 (104)
Not applicable	13	0	1	0	2	6 (70)
Do not know	1	2	0	0	0	7 (13)
(Did not answer)						6
<b>Total Responses</b>						<b>68</b>

### 8. Coder: Work Habits, Education, Use of Resources, and Communication

Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)
Inability to prioritize and/or multitask the demands of productivity standards along with coding quality expectations	11	13	5	8	6	1 (144)
Makes "honest" mistakes	14	6	4	3	8	2 (120)
Does not engage in lifelong learning to elevate knowledge of coding and medicine	3	10	5	12	8	3 (102)
Relies heavily on other coders' opinions for code selections	8	8	6	2	7	4 (101)
Lacks initiative to network or utilize resources to research coding questions	5	7	8	6	3	5 (92)
Does not make significant improvements as a result of individual coder performance improvement plans (as a result of coding audits/action plan follow-up)	3	3	11	10	6	6 (86)
Does not apply the knowledge acquired through continuing education (CE) into daily work habits	6	2	5	8	10	7 (79)
Lacks appropriate communication skills to verbalize questions, apply critical thinking skills, and make a decision on code selection	4	3	10	3	4	8 (72)
Uses unofficial coding resources for coding advice	0	1	3	4	2	9 (23)

Do not know	3	2	0	0	0	9 (23)
Not applicable	2	0	1	0	0	10 (13)
(Did not answer)						1
<b>Total Responses</b>						<b>68</b>

### The Contribution of Documentation to Coding Error

Documentation that does not indicate the severity of illness or support a cause-and-effect relationship were ranked as most often leading to nonspecific codes, while the physician failure to indicate a definitive diagnosis was ranked highest as the documentation cause for incorrect code assignment. Other reasons along with the respondent rankings are found below.

10. Documentation Leading to Nonspecific Codes or the Need to Query						
Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)
Lacks the severity of illness in the documentation contributing to non-specific code assignment (e.g., acute, chronic; with or without exacerbation; with or without hemorrhage; malignant, benign; uncontrolled, controlled)	25	10	5	12	11	1 (215)
Lacks documentation that supports the cause and effect relationship between two conditions (e.g., renal failure to diabetes, gastric ulcer to hemorrhage, positive organism on lab result to pneumonia)	12	16	19	13	3	2 (210)
Lacks anatomical specificity in the documentation contributing to non-specific code assignment (e.g., congestive heart failure versus, diastolic or systolic heart failure; dysrhythmia versus atrial fibrillation, atrial flutter; leg, lower leg, ankle; intestine, large intestine, colon, sigmoid colon)	7	17	19	6	12	3 (184)
Lacks documentation to support the reason for admission (underlying etiology) for the manifestations presented at admission (e.g., the patient may present with manifestations of angina, shortness of breath, gastrointestinal pain, numbness, but no underlying etiology is documented for the symptomatology)	12	8	13	15	10	4 (171)
Lacks specificity as to whether the conditions was present at the time of admission in determining principal diagnosis assignment (e.g., sepsis, acute respiratory failure)	5	12	5	14	22	5 (138)
Illegible documentation	4	1	3	5	6	6 (49)
Do not know	1	0	0	0	0	7 (5)
Not applicable	0	0	0	0	0	0 (0)
(Did not answer)						0
<b>Total Responses</b>						<b>68</b>

### 11. Documentation Leading to Incorrect Code Assignment or Need to Query

Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)
Attending physician does not conclude with a definitive diagnosis (after study) as the reason for admission to the hospital (UHDDS definition) (e.g., congestive heart failure, respiratory failure, and acute renal failure)	23	8	5	4	9	1 (179)
Documentation by the attending physician or hospitalist is conflicting or inconsistent with the use of closely related synonymous terms (e.g., acute renal failure and acute renal insufficiency)	10	12	7	7	8	2 (141)
Documentation is not clear on whether differential diagnoses were ruled out (admitted with differential diagnosis of pulmonary embolus, congestive heart failure, myocardial infarction without further documentation to confirm whether conditions were ruled out)	7	11	7	10	4	3 (124)
Documentation of a condition in the discharge summary but no documentation of this condition in body of the medical record (e.g., urinary tract infection is documented in the discharge summary without supporting documentation in the body of the medical record)	6	3	13	4	10	4 (99)
Documentation does not support whether a condition is clinically significant to the patient's stay (e.g., moderate mitral valve stenosis noted on echocardiogram)	4	8	7	4	8	5 (89)
Documentation by the attending physician or hospitalist conflicts with documentation by other physicians (consultants, surgeons) involved in the case (e.g., consultant documents aspiration pneumonia and attending consistently documents community acquired pneumonia)	2	6	9	11	1	6 (84)
Documentation of treatment, but no correlating condition or diagnosis (e.g. Tegretol but no documentation of seizure disorder)	5	6	2	4	8	7 (71)
Documentation is not clear on whether a previous condition is a "history of" diagnosis or a current condition (e.g. breast cancer – not clear if this is a history of or current breast cancer)	1	4	5	7	6	8 (56)
Illegible handwritten documentation	4	0	4	3	3	9 (41)



Documentation of condition or diagnosis but no documentation of treatment (congestive heart failure but no documentation of Lasix)	0	2	4	9	1	10 (39)
Name of the procedure and the body of the operative report (technique) do not match (open reduction internal fixation of the hip fracture versus closed reduction and internal fixation of hip fracture)	0	3	1	0	1	11 (16)
Do not know	2	0	0	0	0	12 (10)
Incorrectly transcribed report	0	0	0	1	2	13 (4)
Not applicable (Did not answer)	0	0	0	0	0	0 (0)
<b>Total Responses</b>						<b>68</b>

### Other Causes of Coding Errors

Among the remaining categories of coding errors, those most highly ranked included physician delayed response to queries and the pressure of day-to-day management. Evidently HIM leadership is not seen as an obstacle since “Not applicable” was ranked highest. Lack of administration holding medical staff accountable to medical staff bylaws was ranked highly. Question 16 asked for any additional reasons, with lack of resources given by two respondents.

12. PHYSICIAN RESPONSE TO QUERIES OR DELAYS IN Documentation						
Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)
Delayed response to queries (multiple attempts to query)	23	14	8	7	4	1 (213)
No response to query	14	18	8	9	5	2 (189)
Delayed documentation of history and physical, consultations, operative or procedure dictation	8	10	6	16	3	3 (133)
Invalid physician response to query	5	6	15	8	9	4 (119)
Delay in documenting the discharge diagnoses at the time of discharge	8	6	8	8	12	5 (116)
Delay in documenting the discharge summary (within timeline accepted by the hospital R&R for medical record completion)	3	5	13	6	14	6 (100)
Do not know	2	0	0	0	0	7 (10)
Not applicable (Did not answer)	0	0	0	0	2	8 (2)
						3

13. Coding Leadership						
Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)
Consumed with day-to-day operations devoting limited time to analyzing, trending and reporting	25	15	1	1	2	1 (192)
Priority on productivity over quality coding in evaluating work performance expectations	6	5	4	3	7	2 (75)
Technically sound in coding skills but lacks effective management skills	6	5	3	2	3	3 (66)
Limited internal or external coding audit program in place	4	5	4	4	3	4 (63)
Does not eliminate non-coding jobs from coder daily duties	2	8	3	1	4	5 (57)
No feedback loop from business office to HIM on insurance denials due to coding	4	2	5	4	2	6 (53)
Inability to follow-through with improvements identified as a result of audits	2	1	10	1	6	7 (52)
Inadequate ongoing coder education and training program	2	2	2	7	2	8 (40)
Ineffective regular (annual) coding compliance and coding policy/procedure training	0	2	3	7	1	9 (32)
Not applicable	5	0	0	1	2	10 (29)
Not technically sound in coding skills and cannot serve as a coding resource to coding staff	1	1	1	3	1	11 (19)
Does not use coding audit data as part of the annual coder performance review	0	2	1	3	2	11 (19)
Inadequate new hire orientation and training	0	1	3	1	1	12 (16)
Minimal reference material available to support quality coding (Merck manual, medical dictionary, drug book, Coder's Desk Reference, DRG Expert, etc)	0	1	2	2	0	13 (14)
Does not attend regular educational services outside of hospital	1	0	3	0	0	13 (14)
Do not know (Did not answer)	2	0	0	0	4	13 (14)
<b>Total Responses</b>						<b>68</b>















14. HIM Leadership							
Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)	
Not applicable	19	1	0	2	6	1 (109)	
Ineffective workflow process to support quality coding	8	9	3	4	0	2 (93)	
Lack of electronic or computerized tools to support the coder (encoders, E&M calculators, computer-assisted-coding)	10	6	4	2	2	3 (92)	
No coding manager directly involved in day-to-day operations (oOversight is by HIM director or other HIM manager/supervisor)	8	4	5	3	1	4 (78)	
No external audit program in place	7	4	4	1	4	5 (69)	
Do not know	2	0	2	1	2	6 (20)	
(Did not answer)							7
<b>Total Responses</b>							<b>68</b>

15. Administration (CEO, CFO, COO, ECO)							
Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)	
Does not hold medical staff accountable to the bylaws and R&R for timely and complete medical record documentation	16	13	9	3	0	1 (165)	
Focuses on financial aspects of coded data only	14	8	4	3	4	2 (124)	
Lack facility-wide clinical documentation improvement initiative	10	4	8	4	5	3 (103)	
Does not allocate funds for coder education and/or coder reference materials	5	4	3	4	5	4 (63)	
Does not advocate for the role of a physician advisor in the facility or corporation	2	7	5	1	5	5 (60)	
Delays in implementing the electronic health record	4	3	3	7	5	5 (60)	
Commercial contracts with payers that have payer specific coding requirements are not shared. with the coding staff (upfront)	0	3	7	8	4	6 (53)	
Holds only the coding staff accountable for Case Mix Index (CMI)	2	6	1	4	3	7 (48)	
Does not allocate funds for routine coding audits	4	1	3	2	2	8 (39)	
Lacks an effective compliance committee	0	2	3	5	1	9 (28)	

Not applicable	4	0	0	0	2	10 (22)
Limited attention to coding audit results	0	3	1	2	2	11 (21)
Do not know (Did not answer)	1	0	0	1	2	12 (9)
<b>Total Responses</b>						<b>68</b>

## Reporting Coding Quality Outcomes

Respondents were next asked to indicate how they reported their coding quality review outcomes. Respondents were able to select more than one choice. When asked how the results were categorized, coder, DRG/APC, and percent accurate were selected most often.









17. After coding audit data is collected, how do you classify coding errors for reporting and trending analysis? (Select all that apply)			
Responses	Count	%	Percentage of total respondents
By reimbursement (undercoded or overcoded)	34	50.00%	
By query	15	22.06%	
By code accuracy reported as a percent	46	67.65%	
By DRG or APC accuracy reported as a percent	47	69.12%	
By add, delete, revise, re-sequence	21	30.88%	
By coding guideline, coding convention, or coding clinic	32	47.06%	
By documentation issue	31	45.59%	
By coder	50	73.53%	
By root cause of the coding error	21	30.88%	
Do not trend and report audit results	2	2.94%	
Do not know	2	2.94%	
Not applicable	2	2.94%	
Other (please specify)	2	2.94%	
(Did not answer)	0	0%	

<b>Total Responses</b>	<b>305</b>	<b>20%</b>	<b>40%</b>	<b>60%</b>	<b>80%</b>	<b>100%</b>
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Multiple answers per participant possible. Percentages added may exceed 100 since a participant may select more than one answer for this question.



More than half of respondents indicated that a coder could dispute a recommendation from a coding auditor and another auditor would review the record.

**19. What method does your facility have in place for a coder to dispute recommendations made by a coding auditor (not a billing insurance denial)? (select only one)**

Responses	Count	%	Percentage of total respondents
Appeal the record and another coder reviews (peer review)	10	14.71%	
Appeal the record and another internal auditor/coding manager reviews	39	57.35%	
Appeal the record and an impartial external auditor or external coding expert provides advice	4	5.88%	
Do not have an appeals process and the coder accepts the auditor's recommendation	3	4.41%	
Do not know	5	7.35%	
Not applicable	3	4.41%	
Other (please specify)	4	5.88%	
(Did not answer)	0	0%	
<b>Total Responses</b>	<b>68</b>		<b>20%</b> <b>40%</b> <b>60%</b> <b>80%</b> <b>100%</b>

When asked about performing a quality review of the auditor, respondents were split between having an external reviewer perform the check and not performing a check at all. Having an internal auditor review the work followed closely.

**20. Select the type of annual audit oversight process is in place to audit the auditor for coding quality (select only one)**

Responses	Count	%	Percentage of total respondents
External audit company reviews a small percent of the auditor's work	20	29.41%	
Internal auditor (includes corporate	17	25.00%	

internal auditor) reviews a small percent of the auditor's work								
Do not perform this type of review	20	29.41%						
Do not know	9	13.24%						
Not applicable	1	1.47%						
Other (please specify)	1	1.47%						
(Did not answer)	0	0%						
<b>Total Responses</b>	<b>68</b>		<b>20%</b>	<b>40%</b>	<b>60%</b>	<b>80%</b>	<b>100%</b>	

Respondents were asked to indicate when cases with corrected codes were rebilled. Close to half rebilled any code change, while more than 63 percent rebill any codes that impact reimbursement. Respondents were able to select any answers that applied.









<b>21. Which cases are rebilled to the payer with corrected codes (as a result of a retrospective coding audit)? (select all that apply)</b>			
<b>Responses</b>	<b>Count</b>	<b>%</b>	<b>Percentage of total respondents</b>
All codes that impact reimbursement only (principal dx, CC, procedure code impacting DRG)	43	63.24%	
Any code whether it impacts reimbursement or not (reimbursement and data quality errors are rebilled to payer)	33	48.53%	
Any code that impacts quality reporting only (CMS Core Measures or codes impacting hospital report cards)	26	38.24%	
Overpayments	37	54.41%	
Underpayments, if within the allowed payer rebill timeframe	37	54.41%	
None	1	1.47%	
Do not know	6	8.82%	
Not applicable	2	2.94%	
Other (please specify)	3	4.41%	
(Did not answer)	0	0%	

<b>Total Responses</b>	<b>188</b>		<b>20%</b>	<b>40%</b>	<b>60%</b>	<b>80%</b>	<b>100%</b>
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Multiple answers per participant possible. Percentages added may exceed 100 since a participant may select more than one answer for this question.

Question 22 about steps and measures taken if a coder did not meet facility-specific coding quality goals revealed that almost 67 percent choose one-to-one education with a performance improvement plan. The performance plan was given anywhere from 30 to 90 days before disciplinary action was initiated according to question 23.

**22. Please select the measures that are taken if the coder does not meet your facility specific coding quality goal (select all that apply)**








Responses	Count	%	Percentage of total respondents
1:1 education	31	45.59%	
1:1 education with follow-up review for coding errors identified as a trend	36	52.94%	
1:1 education with initiation of individual coder performance improvement plan (action plan) and follow-up review	45	66.18%	
None	2	2.94%	
Do not know	3	4.41%	
Not applicable	3	4.41%	
Other (please specify)	2	2.94%	
(Did not answer)	0	0%	
<b>Total Responses</b>	<b>122</b>		<b>20%</b> <b>40%</b> <b>60%</b> <b>80%</b> <b>100%</b>

Multiple answers per participant possible. Percentages added may exceed 100 since a participant may select more than one answer for this question.

**Insurance Billing Denials**










Question 24 asked respondents to list three reasons for insurance billing denials. Two answers, the wrong or inappropriate code was used and lack of payer using the correct guidelines, appeared frequently. Question 25 shows that almost half of respondents believe that appeals are usually overturned in their favor, while more than 30 percent may not track the outcome of appeals since they report not knowing the result of outcomes.

**25. For those cases in which an appeal letter is submitted for insurance billing denials due to coding, how often are the appeals overturned (in your favor)? (Select only one)**

Responses	Count	%	Percentage of total respondents
Always	2	2.94%	
Usually	32	47.06%	
Never	2	2.94%	
Do not know	22	32.35%	
Not applicable	4	5.88%	
Other (please specify)	6	8.82%	
(Did not answer)	0	0%	
<b>Total Responses</b>	<b>68</b>		<b>20% 40% 60% 80% 100%</b>

Respondents were asked about their methods and frequency for reviewing the effectiveness of their coding compliance program. Some performed the review as often as twice a year, while just over 40 percent were reviewed annually either by an external company or a corporate office. Surprisingly, just over 20 percent did not have an identified process to review their coding compliance program.

**26. What method does your facility have in place to review the effectiveness of your coding compliance program (perform a coding department evaluation including policies and procedures, etc)? (Select only one)**








Responses	Count	%	Percentage of total respondents
Annual (or every other year) review by an external company	16	23.53%	
Annual (or every other year) review by corporate office	13	19.12%	
Bi-annual (twice a year) review by external company	11	16.18%	
Bi-annual (twice a year) review by corporate office	2	2.94%	
Do not have a process in place to review coding compliance program	14	20.59%	
Do not know	6	8.82%	
Not applicable	5	7.35%	
Other (please specify)	1	1.47%	
(Did not answer)	0	0%	



<b>Total Responses</b>	<b>68</b>		<b>20%</b>	<b>40%</b>	<b>60%</b>	<b>80%</b>	<b>100%</b>
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Question 27 attempted to assess the impact of a clinical documentation improvement (CDI) program on coding quality. Close to 40 percent of respondents felt that a CDI program was essential for increasing the quality of coding.

**27. If your facility has a concurrent clinical documentation improvement (CDI) program in place to improve physician documentation, describe it's impact to coding quality (Select all that apply)**

Responses	Count	%	Percentage of total respondents
Essential to increase the quality of coding (code assignment is more specific and more accurately reflects clinical condition of the patient)	27	39.71%	
Moderate impact to increased the quality of coding	10	14.71%	
Limited positive impact to the quality of coding	10	14.71%	
Do not know	3	4.41%	
Not applicable	23	33.82%	
Other (please specify)	3	4.41%	
(Did not answer)	0	0%	
<b>Total Responses</b>	<b>76</b>		<b>20%</b> <b>40%</b> <b>60%</b> <b>80%</b> <b>100%</b>

Multiple answers per participant possible. Percentages added may exceed 100 since a participant may select more than one answer for this question.

**Impacts on Coding**

The coding team was understandably assessed as having the largest impact on coding. The medical staff came in a very close second though, actually garnering more #1 rankings, but less #2 rankings, than the coding department.

**28. Rank the top 5 departments (1 having the largest impact and 5 being the least impact) to influencing the quality of coded data?**

Responses	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Weighted Rank (Score)
Coding Team	20	23	5	2	2	1 (213)
Medical Staff	27	10	4	4	6	2 (201)



Health Information Management	12	12	14	6	1	3 (163)
Quality Department	2	6	13	10	8	4 (101)
Business Office	1	7	8	6	6	5 (75)
Administration	2	1	6	11	7	6 (61)
Compliance Committee	1	2	7	7	9	7 (57)
Risk Management	0	2	2	4	4	8 (26)
Decision Support	0	1	1	2	3	9 (14)
Do not know	2	0	1	0	1	9 (14)
Do not report coding audit review data	1	0	0	0	0	10 (5)
Not applicable	0	0	0	1	0	11 (2)
Marketing	0	0	0	0	1	12 (1)
(Did not answer)						0
<b>Total Responses</b>						<b>68</b>








Respondents were asked how both administration and medical staff support and influence quality coding. Respondents indicated that administration supports quality coding by providing them with coding resources and education funds, as well as their clinical documentation improvement programs. Medical staff support most often was seen with support of a documentation improvement program. A few respondents did indicate that they received very little medical staff support.

Question 31 asked respondents about the tools, references, and resources they found most useful for the quality of coded data. Selections were not offered so as to minimize bias. *Coding Clinic* was listed by more respondents within the top 3 than any other answer. The next most listed response was the assistance of an electronic encoder. After these two responses the answers became more diverse and included choices such as pharmacological manuals, special coding books and others.

### Changes in Coding Quality

When asked about a change in the quality of their coded data within the past year, a clear majority (73 percent) of respondents believe that it has either improved or remained the same.

<b>32. Thinking back to your overall coding accuracy scores one year ago compared to today, has your facility or corporation experienced an (increase, decrease, or no change) in overall quality coding scores as a result of your coding compliance/quality audit program? (Select only one)</b>			
<b>Responses</b>	<b>Count</b>	<b>%</b>	<b>Percentage of total respondents</b>
Increased	37	54.41%	
Decreased	3	4.41%	

No change	13	19.12%	
Do not track	3	4.41%	
Do not know	9	13.24%	
Not applicable	3	4.41%	
Other (please specify)	0	0%	
(Did not answer)	0	0%	
<b>Total Responses</b>	<b>68</b>		

### National Coding Consistency

Question 33 asked respondents for their opinion regarding differences in national coding consistency if they had coded for a variety of hospitals and corporations. A number of respondents indicated that payer variation in the interpretation of coding guidelines and rules appear to result in the assignment of different codes. Documentation variation, practice differences, encoder variation, and coder education differences were also listed.

Respondents were asked to list the top three diagnosis or procedure codes that attribute to the most coding variation, particularly for secondary diagnosis and secondary procedure coding. V and E codes were listed frequently for history of illness and causes of injury, with concerns expressed regarding the coding of transfusions and debridement procedures.

### Impact of EHRs on Coding Quality

The final question asked respondents to identify how they felt EHRs would help with coding quality. The majority of respondents felt that EHRs would not have an impact, though some did indicate they thought that EHRs would improve documentation legibility, completeness, and timeliness.

### Conclusion

This survey has established a current baseline for evaluating the quality of coding. AHIMA, FORE, and the professional practice staff will continue to address the important issue of coding quality.

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