

Today's MEDICAL PRACTICE Coding Productivity Benchmarks

Do you measure up?



Introduction

When it comes to coding productivity, today's medical practices are hard pressed to ensure their coders perform at levels that keep reimbursements flowing to meet financial goals. Your practice's continued profitability hinges upon their ability to stay productive, accurate and efficient. There is a lot of noise that can distract coders from this primary purpose. Medical practice decision makers must stay current on resources available to them to ensure their coders are adequately equipped to meet new and challenging distractions; or go under. This white paper illustrates the top productivity benchmarks to help you compare your own productivity and assess how your coders measure up based on 4 key metrics. It will also expose the recipe for a high achieving coding department (hint: stack your department with coders that match this profile) and lastly the broader trends related to evolving coder responsibilities.

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EXECUTIVE SUMMARY

Establishing coder productivity standards can be difficult because you must take various factors into account, and there are no apple-to-apple comparisons on which you can base your own requirements. However, medical practice managers and administrators can develop coder productivity standards by learning from their peers. DecisionHealth surveyed 178 medical practice administrative professionals — including 90 coders — to determine benchmarks for productivity by measuring common repetitive activities: charts reviewed, claims coded, claims submitted and denials appealed.

Some of the key findings are:

- Productivity of medical practice coders varies by specialty. Orthopedic and pain management coders have the highest per-day average of claims coded at 94 and 93, respectively. Otolaryngology (26), urology (38) and gastroenterology (39) have the lowest average numbers of claims coded per day.
- The most experienced coders are not the most productive. Generally, coders with six to 10 years of experience in medical administration had the highest averages on productivity metrics. Interestingly, coders who had less than a year or more than 20 years of experience had similar productivity numbers, according to the survey.
- Coders use online coding tools more than reference books. Only official manuals, which 100% of coders employed to code, were more widely used than online coding tools (87%). Reference books were used by 72% of coders and payer/carrier websites were used by 70% of that group.

The results of the survey are a snapshot into coder productivity and their current job responsibilities. But increasingly, coders are asked to diversify their roles at their practices, adding management, billing and compliance responsibilities. Those factors could affect productivity benchmarks in the future.

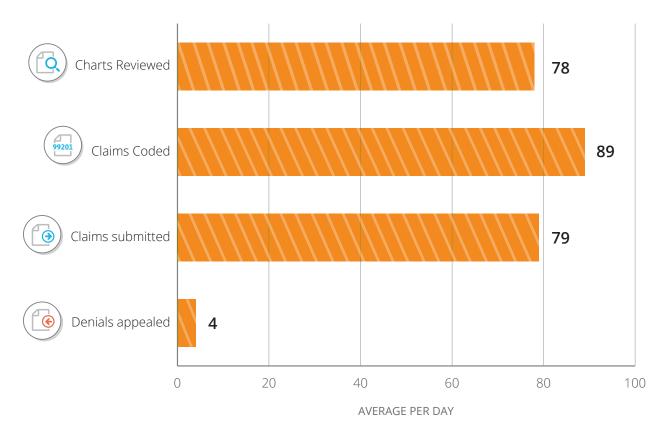


Productivity metrics for coders

Coders in medical practices have a variety of tasks to perform as part of their daily workflow. The survey measured four metrics that demonstrate a coder's productivity: charts reviewed, claims coded, claims submitted and denials appealed. While not every coder performs each task, the ones captured illustrate the expanding role for coders.

Overall, the coders in the study averaged these metrics for productivity on those topics:

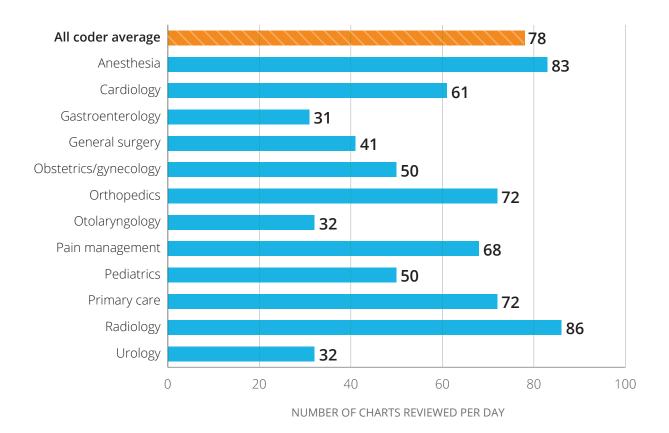
ALL CODERS (AVERAGE PER DAY)



Separating those metrics by specialty shows variation in productivity. (Note that the all coder average contains more specialties than are listed on the following pages.)







Coders in radiology and anesthesiology have the highest chart-per-day review averages at 86 and 83, respectively. Primary care — which includes family practice, general practice and internal medicine — and orthopedic coders review an average of 72 claims per day, also among the highest averages.

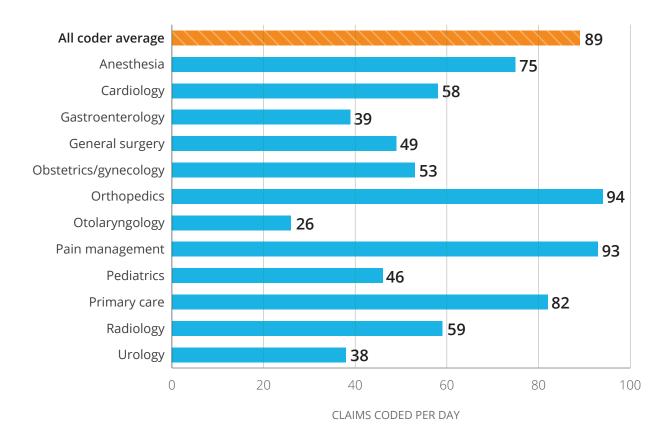
Conversely, gastroenterology (31 charts reviewed per day), otolaryngology (32) and urology (32) coders had the lowest averages of charts reviewed per day.





CLAIMS CODED

While coding isn't the only task many coders perform, it's the main one. Almost 99% of coders do diagnosis coding while 92% do E/M and procedure coding.



Orthopedics has the highest average number of claims coded per day at 94. At one orthopedic practice DecisionHealth interviewed, a program embedded in the electronic health record (EHR) system helped physicians drill down to the most specific ICD-10 codes with drop-down menus. The EHR would prompt them to answer questions about laterality and initial, subsequent and sequela encounters for fractures. That program helped ease code selection.

Pain management coders also had a high number of per-day claims coded at 93, followed by primary care with an average of 82 and anesthesia with an average of 75.

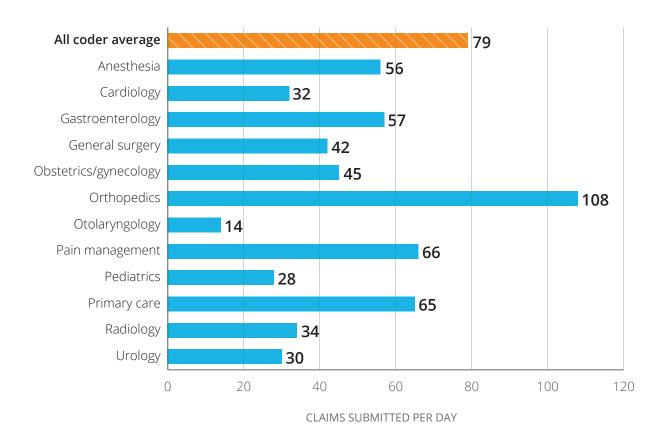
Among the lowest averages for claims coded per day were otolaryngology (26), urology (38) and gastroenterology (39).





CLAIMS SUBMITTED

Coders no longer are tasked with just selecting codes, according to the DecisionHealth survey. Increasingly, they are taking on billing responsibilities. In fact, 53% of coders said they perform billing functions daily and almost 40% file claims.



Submitting claims is most prevalent at orthopedic practices where coders average 108 claims submitted per day, according to the survey. That's far above the all-coder average of 79 claims submitted.

Pain management coders submit an average of 66 claims per day and primary care coders submit an average of 65 claims per day.

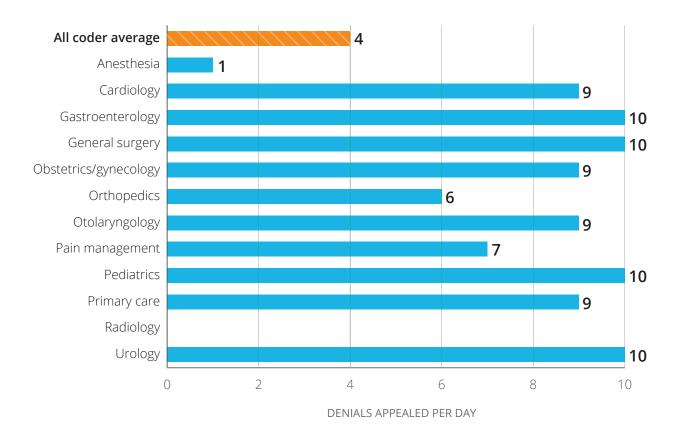
Practices where coders provide billing functions less often not surprisingly have lower average claims submitted per day. For example, just 27% of otolaryngology coders perform billing functions daily, and that may account for the low claims-submitted-per-day average of 14. Similarly, 18% of pediatric coders perform billing functions daily, and coders in that specialty submit an average of 28 claims per day.





DENIALS APPEALED

Appealing claims denials is a task that 16% of coders perform daily, 29% perform weekly and 11% perform monthly.



Coders in gastroenterology, general surgery, pediatrics, radiology and urology appeal an average of 10 claims per day. Cardiology, obstetrics/gynecology, otolaryngology and primary care coders appeal an average of nine claims per day.

Anesthesia coders average just one appeal per day, notably fewer than their counterparts in other specialties. But interestingly, 60% of anesthesiology coders said they never appeal claims denials, which relates to the specialty's low number of denials appealed per day.



Coding metrics by practice size, location

The size of a coding department or the number of providers at the practice can affect coders' productivity metrics.

SIZE OF CODING DEPARTMENT



CODERS/BILLERS IN CODING/BILLING DEPT.	CHARTS REVIEWED	CLAIMS CODED	CLAIMS SUBMITTED	DENIALS APPEALED
10 or fewer	51	55	59	4
11 to 25	34	70	54	4
26 to 50	54	46	44	5
51 to 99	67	69	128	1
100 or more	75	53	53	1

Coding departments with 11 to 25 coders or 51 to 99 coders seemed to have found the most efficiencies coding claims — they have the highest averages of claims coded per day at 70 and 69, respectively. Departments with 26 to 50 coders had the lowest average of claims coded per day at 46.

Coders at practices with coding departments of 100 or more coders reviewed the highest average number of charts per day at 75, while coders at departments with 11 to 25 coders had the lowest average of 34.

Departments with 51 to 99 coders submitted a whopping 128 claims per day on average. All other sizes of coding departments averaged between 44 claims and 59 claims submitted per day.

The smaller the coding department, the more responsibility its members seem to have to appeal denied claims. Coding departments of 10 or fewer coders and 11 to 25 coders appealed an average of four denials per day, according to the survey. Departments with 26 to 50 coders appealed an average of five denials per day.

But at larger coding departments — those with 51 to 99 coders or 100 or more coders — the average number of denials appealed per day dropped to one.



NUMBER OF PROVIDERS IN THE PRACTICE









NUMBER OF PROVIDERS	CHARTS REVIEWED	CLAIMS CODED	CLAIMS SUBMITTED	DENIALS APPEALED
1 to 5	25	27	34	4
6 to 10	43	60	30	2
11 to 25	72	62	137	6
26 to 50	67	103	71	4
51 to 100	55	70	135	3
101 to 250	44	48	52	7
More than 250	60	44	35	2

Practices with one to five providers had the lowest daily average numbers of charts reviewed and claims coded at 25 and 27, respectively. Their average claims submitted per day — 34 — was the second lowest behind practices with six to 10 providers.

But being larger doesn't mean you'll have more productive coders. The biggest practices, those with more than 250 providers, averaged per day 60 charts reviewed, 44 claims coded, 35 claims submitted and two denials appealed.

The practices with the highest average of charts reviewed per day, 72, have 11 to 25 providers. The highest average of claims coded was in the group of practices with 26 to 50 providers. And practices with 11 to 25 or 51 to 100 providers had the highest average number of claims submitted at 137 and 135, respectively.



LOCATION OF CODERS









LOCATION	CHARTS REVIEWED	CLAIMS CODED	CLAIMS SUBMITTED	DENIALS APPEALED
Great Plains (KS, ND, NE, OK, SD)	29	64	131	4
Mid-Atlantic (DC, DE, MD, NJ, NY, PA, VA, WV)	143	88	192	2
Midwest (IA, IL, IN, MI, MN, MO, OH, WI)	101	103	65	3
New England (CT, MA, ME, NH, RI, VT)	91	174	136	14
Pacific (AK, CA, HI, OR, WA)	54	92	141	3
Rocky Mountains (CO, ID, MT, UT, WY)	49	94	45	1
Southeast (AL, AR, FL, GA, KY, LA, MS, NC, SC, TN)	70	73	47	8
Southwest (AZ, NM, NV, TX)	47	42	19	1

The data show an emphasis on different metrics based on location.

Charts reviewed: Mid-Atlantic, Midwest and New England states have the highest average charts reviewed per day at 143, 101 and 91, respectively. Coders in the Great Plains (29), Southwest (47) and Rocky Mountains (49) have the lowest averages.

Claims coded: Coders in New England average the highest number of claims coded per day (174) by far. Midwest coders average 103 claims coded per day followed by the Rocky Mountains (94) and Pacific. Coders in the Southwest average the fewest claims coded per day at 42.

Claims submitted: Coders in the Mid-Atlantic submit the most claims per day on average at 192. The average for coders in the Southwest is just 19.

Denials appealed: The data show that some regions place more emphasis on coders appealing denials. Coders in New England average 14 appealed denials per day, and coders in the Southeast average eight denials appealed per day. Coders in the Rocky Mountains and Southwest average one denied claim per day, indicating that task may not be among their responsibilities.

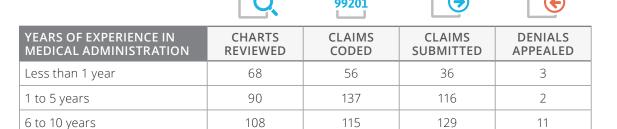


Profile of a productive coder

11 to 20 years

More than 20 years

Experience and tools play roles in how productive coders are. But having more experience doesn't necessarily mean being more productive, the survey shows.



83

64

Coders with six to 10 years in medical administration have the highest daily averages of charts reviewed (108), claims submitted (129) and denials appealed (11).

92

74

65

36

6

3

Their counterparts with one to five years in medical administration have the highest average of claims coded at 137 a day.

Coders with more than 20 years of experience in medical administration on average reviewed 44 fewer charts, coded 63 fewer charts, submitted 93 fewer claims and appealed eight fewer denials than the most productive coders.

New coders — those with less than one year in medical administration — actually had similar numbers to those with more than 20 years of experience, with the exception of average claims coded per day. New coders code almost 20 fewer claims than their highly experienced counterparts.



CODER CERTIFICATIONS

Coders who have taken the time to earn coding certifications have higher productivity averages than those who do not have certifications.

Certified coders review 29 more charts, code almost double the number of claims and submit 14 more claims per day on average than those who do not have certifications. Certifications that coders indicated they have include certified professional coder (CPC), ICD-10 certification, certified outpatient coder (COC), certified coding specialist — physician based (CCS-P), registered health information technician (RHIT), certified compliance professional — physician (CCP-P), certified cardiology coder (CCC), advanced coding specialist — anesthesia (ACS-AN), certified evaluation and management coder (CEMC), certified professional medical auditor (CPMA), advanced coding specialist — cardiology (ACS-CA) and advanced coding specialist — radiology (ACS-RA), among others.







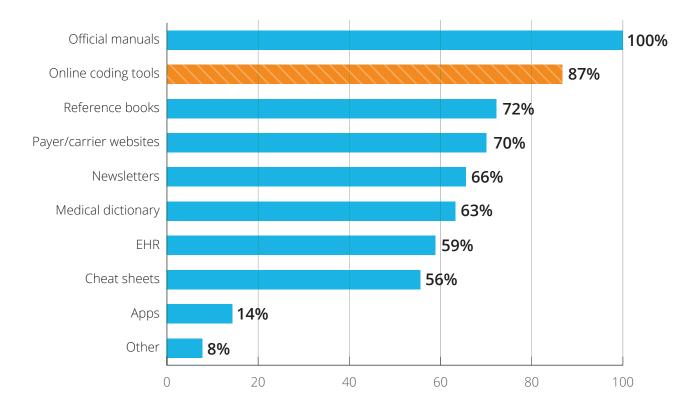


CERTIFICATION	CHARTS REVIEWED	CLAIMS CODED	CLAIMS SUBMITTED	DENIALS APPEALED
Yes	81	94	80	4
No	52	48	66	12

RESOURCES CODERS USE

Coders use a variety of tools to help them increase accuracy and efficiency. Among them, online coding tools are used by 87% of coders, second to only official manuals (CPT®, ICD-10, ASA Crosswalk).

Online coding tools also are used more often than reference books (Answer Books, Coder's Desk Reference, specialty specific books) and payer/carrier websites.



In fact, more than 80% of the most productive coders — the ones with one to five years or six to 10 years of medical-administration experience — use online coding tools, the survey shows.



Trends in coder responsibility

Assigning CPT or diagnosis codes to claims is the traditional role for a medical practice coder, but that's changing. A host of responsibilities are inching into coders' job descriptions, according to surveys conducted by DecisionHealth from 2012 to 2016.

Take note of these trends in new responsibilities:

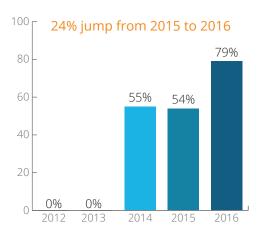
APPEALING DENIED CLAIMS

Coders Responsibilites (2012 to 2016)



▶ **Appealing denied claims:** The percentage of coders performing this task has steadily increased from 2012 when 41% of coders said they appeal denied claims to 2016 when the figure was 60%.

BILLINGCoders Responsibilites (2012 to 2016)

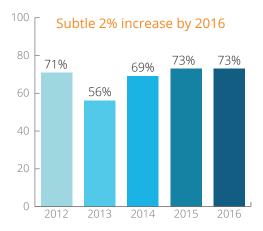


Billing: Performing billing functions jumped 44% since 2014. In that year, 55% of coders said they completed billing tasks; in 2016, that number jumped to 79%. (Note: This option was not offered as a response in 2012 or 2013.)



CONDUCTING AUDITS/INTERNAL REVIEW

Coders Responsibilites (2012 to 2016)



Conducting audits/internal review: This task was common for coders in 2012 when 71% of them reported conducting audits/internal review was part of their jobs. The number dropped to 56% in 2013 but climbed back up to 73% in 2016.

FILING CLAIMS Coders Responsibilites (2012 to 2016)



Filing claims: Traditionally a billing function, this task has become more common for coders to the point in which almost half of coders in 2016 reported filing claims as part of their jobs. Just 30% said so in 2012 — that's a 17% increase over four years.

PERFORMING COMPLIANCE-RELATED ACTIVITIES Coders Responsibilites (2012 to 2016)

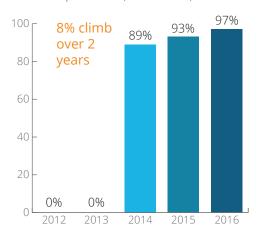


Performing compliance-related activities: Because of the nature of medical practice coding, compliance is essential, but coders have been taking on more compliance-related activities, according to the surveys. In 2014, 74% of respondents noted that they performed compliance-related activities as part of their jobs; that number increased to 79% in 2016. (Note: This option was not offered as a response in 2012 or 2013.)



QUERYING CLINICIANS ABOUT DOCUMENTATION

Coders Responsibilites (2012 to 2016)



• Querying clinicians about documentation: Because of the preparation for the switch to the ICD-10 code set, it's not surprising that coders have increasingly found themselves asking clinicians for more details. The percentage of coders who asked clinicians for details rose from 89% in 2014 to 97% in 2016, the surveys show. (Note: This option was not offered as a response in 2012 or 2013.)

Conclusion

DecisionHealth's surveys show that coding — assigning procedural or diagnosis codes to claims based on provider documentation — continues to be the main task of those with the title of coder or coding specialist.

But they also show that coders and coding specialists need to expand their skills and take advantage of resources to become efficient and productive at all of the tasks now under their purview.

This report has shown these key elements of understanding medical coder productivity:

- **Coder productivity is measured in a variety of ways** but commonly charts reviewed, claims coded, claims submitted and denials appealed. Coders average 89 claims coded per day, but that number fluctuates depending on the specialty.
- The most experienced coders aren't necessarily the most productive. The most productive coders those with the highest average number of claims coded per day were those with one to five years of experience.
- **Successful coders are certified.** Averages of productivity metrics are notably higher for coders who have certifications such as CPC, CCS-P, CCP-P and certified evaluation and management coder (CEMC). And almost all coders (93%) have a coding certification.
- Online coding tools are used more often than reference books and even payer/carrier websites. A full 87% of coders use online coding tools, making those tools the second most used resource behind only official manuals.

DEMOGRAPHICS:

Of the 178 total survey takers, 90 respondents were coders

- All respondents (note that most of the data is coders only, but this is an overview of everyone):
 - 33% have some college education but no degree, and 47% have a two-year or four-year college degree
 - >> 66% have a coding certification
 - >> 97% are female



- >> 74% are between ages 36 and 60
- 3 41% work for a physician-owned medical practice, 9% work for a health system, 9% work for a multi-specialty group
- >> 55% work 40 to 44 hours per week

Just coders:

- 37% have some college education but no degree, and 44% have a two-year or four-year college degree
- >> 93% have a coding certification
- >> 99% are female
- >> 78% are between ages 36 and 60
- >> 37% work for a physician-owned medical practice, 10% work for a hospital-owned practice
- >> 71% work 40 to 44 hours per week

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