

THE WORK OF A CODER



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Upholding a Higher Standard™

PREFACE

Ask five medical coders to describe their work days, and you are likely to get five very different answers. Coder work responsibilities vary considerably, from managing the entire business for a single practitioner in a rural locale, to billing radiology for eight hours in a large metropolitan clinic, to auditing claims for a nationwide payer organization. Medical coders work in IT environments ranging from totally automated systems using electronic medical records equipped with computer assisted coding, to practices that haven't begun filing claims electronically.

AAPC leadership serves more than 68,000 member coders, 50,000 of whom are certified professionals. To better meet member needs, AAPC seeks to more fully understand coder workplace responsibilities. The informal, anecdotal information AAPC receives is reminiscent of the Hindu fable of The Blind Men and the Elephant: each recounted experience is at odds with the previous one. And that's understandable: in an age of franchising, a physician's practice remains one of the few business models today that retains its independence.

Of the 633,000 physicians practicing in the United States in 2005, 15 percent were self-employed, according to Bureau of Labor Statistics (BLS).⁽¹⁾ Many multi-physician clinics remain independent as well. Each independent practice has created its own processes, policies, and cultures, and while the clinical outcomes of providers are expected to meet established standards of medicine, the work performed by coders is indeed as varied as the reports on that fabled Hindu elephant.

The Work of a Coder survey was created to quantify the tasks performed by medical coders. Response to the survey was unprecedented, with more than 12,000 coders participating. The results raise some interesting questions regarding roles, responsibilities and workflows, and these are explored in the Executive Summary.

What follows is a quantifiable snapshot of the workplace and workday of medical coders in clinical environments. With this data in hand, AAPC is able to assess how the expertise of medical coders is being leveraged in the workplace, and make observations regarding improvements that could be implemented to improve practice management, resource allocations, and coding education.

AAPC thanks all the survey participants for taking the time to contribute to this study. As a result of your responses, AAPC has a far better understanding of the challenges encountered by coders, and will continue to issue quarterly surveys for members and non-members to weigh in on important issues in their medical workplace.

Inquiries regarding this survey and report should be directed to the address below.

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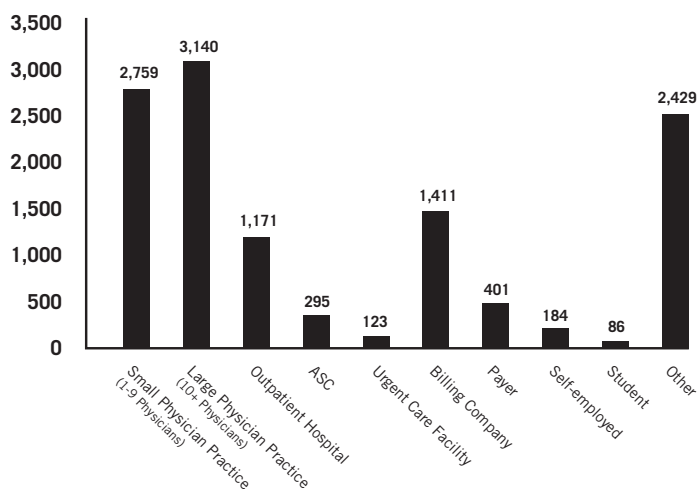
THE WORK OF A CODER

The same information technologies developed to streamline administrative functions and advance clinical crosschecks to safeguard patient health can also be used to evaluate providers for quality, productivity, and reporting accuracy. As a result, today's physicians face unprecedented pressure to reduce costs, improve outcomes, increase productivity, and meet ever-increasing compliance mandates.

What can professional medical coders do to help? Are there improvements that could be made in administrative workflow to mitigate risk or improve productivity in a physician office? To help answer these questions, the American Academy of Professional Coders (AAPC) in January 2008 invited medical coders to partake in a survey of the work they do. Medical coders were informed of The Work of a Coder survey through three email invitations to AAPC members; an invitation posted on the public home page of the AAPC Website; and through press releases distributed to numerous magazines and Websites with coder audiences.

WHICH STATEMENT BEST DESCRIBES YOUR WORK ENVIRONMENT?

[11,999 RESPONDENTS]



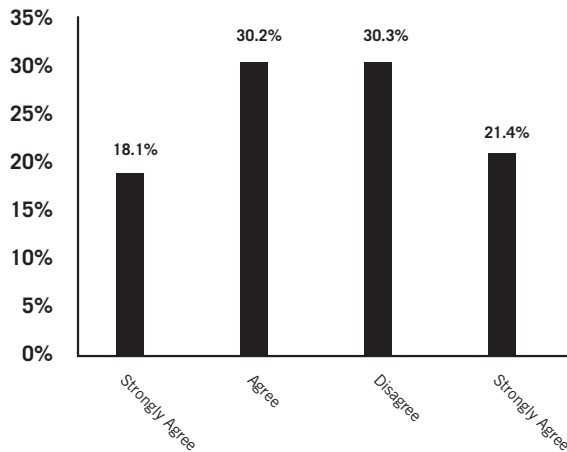
The survey, made available online through a weblink, was open to responses for six weeks. It garnered 12,068 readers, with 8,975 completing the survey. More than 93 percent of respondents are professional coders certified through AAPC. Most worked in physician environments. The final question in the survey was, "Please share here any comments you have regarding the work you do and your work environment." This request received 2,279 responses, some of which are presented in italics in this report.⁽²⁾

"I really enjoy coding. It is like going on a scavenger hunt. You have the doctor's notes and reports as clues and it is up to you to find the right code. It is also a very valuable part of the medical field. Without coders things would run very slowly in a doctor's office. Payments would not get made and the doctors would not get paid as quickly as they do."

POSTPAYMENT REVIEW BY CODERS

Respondents were evenly split on the issue of whether professional coders reviewed payments and handled appeals in their offices, with 51 agreeing that they did, and 49 percent disagreeing.

IN MY OFFICE, PROFESSIONAL CODERS REVIEW EOBs AND HANDLE APPEALS. [7,320 RESPONDENTS]



The intent of the question was to determine if coders were engaged in appeals and claims review occurring in the business office and involving EOBs, COBs, or electronic remittance advice. Because these results were surprising, AAPC was concerned it may have erred in the language used in this question. However, coder comments within the survey show that "EOB" remains a common way to reference correspondence from payers regarding remittance advice, payments, or adjustments to bills.

EOBs and remittance advice report what a payer agrees to pay based on the filed claim. If services are denied or modified, the EOB or remittance advice provides the cause. A claim may be denied for any number of reasons, including many that are tied to coding: medical necessity, lack of modifiers, unbundling, or outdated codes. An experienced biller is unlikely to know why an E/M code is downcoded by a payer, or understand the nuances of correctly coding a procedure performed on the same

day as a preventive medicine visit. If an expert in the codes doesn't audit remittances with the billing staff, how can future coding errors be circumvented? How can current underpayments be identified and appealed?

According to Pam Waymack, MBA, CHFP, CPHIT, author of Denial Management: Key Tools and Strategies for Prevention and Recovery:

“Denials are not part of the fee that providers have contractually agreed to write off with payers. Rather, denials need to be accounted for separately, just like bad debt, charity care, refunds, and other adjustments to charges. However, writing off denials to contractual allowances is a frequent error made by provider organizations. Even larger organizations can slip into it periodically if there is not regular testing of the quality of adjustment posting from EOBs.... Lack of standards and consistency in posting of denials and zero-dollar payments causes the available data to misrepresent the extent of denials, their causes, and the amount of unrecovered revenue.”⁽³⁾

The federal Department of Health and Human Services makes a strong recommendation for keeping coders involved in Medicare correspondence regarding claims. Its voluntary compliance blueprint of recommendations to keep small physician practices out of harm's way. The OIG Compliance Program for Individual and Small Group Physician Practices, cites the value of claims reviews by coders:

A physician practice can also institute a policy that the coder and /or physician review all rejected claims pertaining to diagnosis and procedure codes. This step can facilitate a reduction in similar errors.”⁽⁴⁾

Due to the focus of their business and the volume of claims processed, payers are usually going to outmaneuver providers when it comes to technology and its ability to edit for coding or medical necessity errors. From a provider's point of view, best practices would demand a coding expert be in the remittance loop to search out mistakes that lead to corrections in coding practices or repayments on claims downcoded or denied erroneously by payers. According to The Work of a Coder survey results, half of physician practices are failing to do so.

“We have one person who does all the EOB postings and I do everything else. We are shorthanded but can't get the physicians to realize this.”

“Our central billing office deals with the EOBs and payers but we work closely with them to try to make sure the claims are all clean before billed and we make any corrections that need to be done for reimbursement. I like my job!”

“I don't know the outcome of my coding through billing to EOBs.”

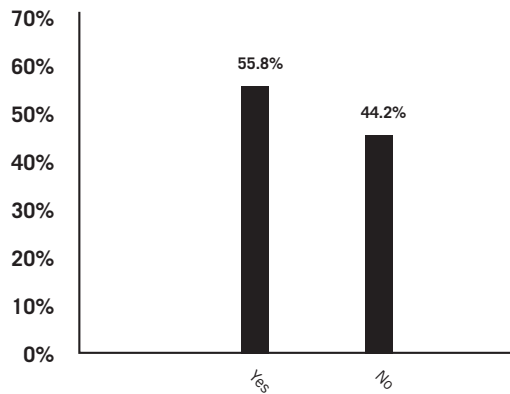
“We have contracts with several payers and therefore have different contract rates. I review all the EOBs/payments to make sure we are paid correctly. I handle appeals process including but not limited to requesting additional payment. The importance of being a CPC comes into play when I review the claims and just by looking at it, I will know why the claim got denied, like if CPT/ASA/DX is not related or the diagnosis does not support medical necessity or even the payment is incorrect because correct modifier is missing.”

AAPC recommends that practice managers, physicians, and coders review their remittance processes to ensure open and frequent communication between coders and billers, and to ensure that the information provided in EOBs, COBs or remittance advice is being used to full advantage to reclaim lost or degraded reimbursement. In some offices, certified coders are employed exclusively as billers, and AAPC endorses this practice. However, even if all parties are certified coders, it is critical that the coding and billing teams communicate to achieve full charge capture.

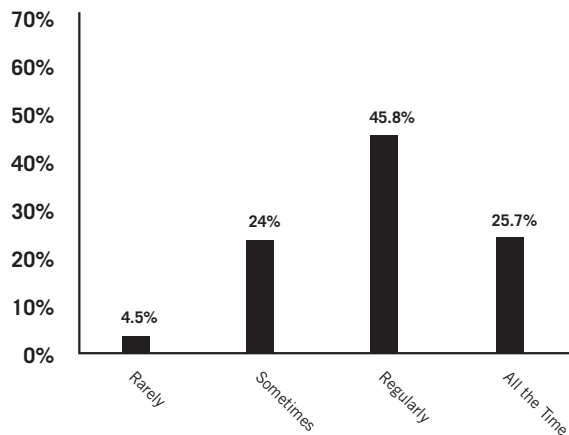
PREVALENCE OF PHYSICIAN CODING

In The Work of a Coder survey, 56 percent of respondents say that their physicians perform coding duties in their practice. Among the physicians who code, 91 percent are selecting E/M codes and 71 percent are selecting ICD-9-CM codes. Fifty-eight percent of respondents disagreed that their providers had formal coding education.

DO PROVIDERS IN YOUR PRACTICE PERFORM ANY CODING DUTIES?
[8,666 RESPONDENTS]



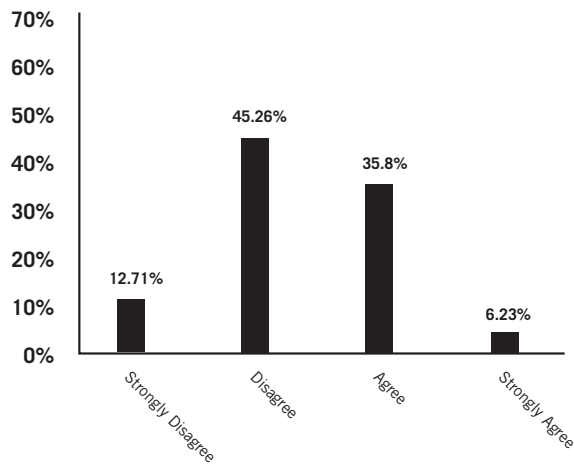
IF YES, HOW OFTEN DO PROVIDERS IN YOUR PRACTICE PERFORM CODING DUTIES? [4,910 RESPONDENTS]



(Of those physicians who code, 71 percent do so regularly or all the time.)

MY PROVIDER HAS HAD FORMAL CODING EDUCATION.

[4,682 RESPONDENTS]



Fifty-eight percent of respondents disagreed that their physicians and other providers had formal coding education.

“We need to be staffed appropriately for the volume of patients and ensure that the documentation supports a good claim. Our issue is not enough documentation and not enough provider education programs.”

“Because of the tremendous volume of visits, each encounter is reviewed quickly, with a trained eye for any physician errors (missing mod 25, appropriate dx for type of visit, medication quantities, etc.). All surgical and procedural coding (ASC) is done by a coder. Although each coder is knowledgeable and shares coding information with the providers, finding time to meet with them is their greatest challenge.”

“It seems that we have very little time to educate the physicians. Sometimes when we do educate the physicians they do not make any changes or they change for awhile and then go back to the way they used to do things. Each coder does not have much interaction with the physicians. Mainly we have a coding educator and a coding manager who meet with the physician but they don’t have a lot of times themselves to meet with all the physicians.”

“I wish we had more time to spend on provider education and a way to make providers receptive to what we have to say.”

“I love the practice I am in. The doctors are all very accepting of constructive criticism and often check with the coding staff regarding correct coding for referrals and authorizations. Very busy work environment, which is fun and challenging.”

“There is little to no training for providers. When do they have time? They learn by us dinging them. This makes them feel we take away their funding. If the providers are going to be expected to code then it should be taught in med school.”

In Accuracy of CPT Evaluation and Management Coding by Family Physicians, presented in the Journal of the American Board of Family Practice,⁽⁵⁾ a study of physician E/M coding skills concludes that “the error rate for physician CPT coding is substantial,” and “the complexity of CPT coding guidelines, along with limited physician training in CPT coding, likely account for results in which physicians and coding experts agreed on code selection 52 percent of the time for established patients, and agreed 17 percent of the time for new patients.” The study compared coding performed by experts and 600 Illinois physicians for six progress notes.

Physicians fare better in The Work of a Coder survey, where 64 percent of respondents say their physicians are correctly coding CPT and ICD-9-CM. Even so, the results beg the question: With today’s stringent productivity pressures and the complexities associated with coding guidelines and compliance issues, why are physicians taking time away from clinical responsibilities to take up the administrative duties of coding?

AAPC recommends physicians consider very carefully the return on investment (ROI) promises of electronic medical records (EMRs). A significant number of respondents with physicians who code are in practices that have adopted EMRs. Nationally, 29.2 percent of office-based physicians reported using full or partial EMR systems in 2006.⁽⁶⁾ Standards governing code lists and coding capabilities of EMR are quite limited. Even those EMRs that have been certified by the federally endorsed Certification Commission for Healthcare Information Technology (CCHIT) do not meet federal coding standards for compliance.

CCHIT credentialing is heralded as an important advancement because those EMRs receiving the credential are guaranteed to have met standards important to provider compliance. The credentialing focuses on information technology issues including interoperability and clinical issues like prescription management. However, EMRs undergoing the expensive credentialing process through CCHIT are not required to apply coding guidelines or abide by coding compliance standards as mandated by CMS and private payers. CCHIT sets “compliance” standards, but these standards relate to interoperability, privacy, and clinical requirements and do not touch upon coding compliance. The coding requirements of CCHIT certification are essentially this: that there be an option for codes to be included in the system.⁽⁷⁾

Criteria in the CCHIT specs for outpatient EMRs:

“The system shall have the ability to provide a list of financial and administrative codes... For example, ICD-9 CM, ICD-10 CM, and CPT-4 codes.”

“The system shall provide the ability to select an appropriate CPT Evaluation and Management code based on data found in a clinical encounter... May be accomplished via a link to another Application... Criterion satisfaction will require that the system can automatically count elements in the history and examination documentation... MDM complexity will still require specification by the provider/coder.”

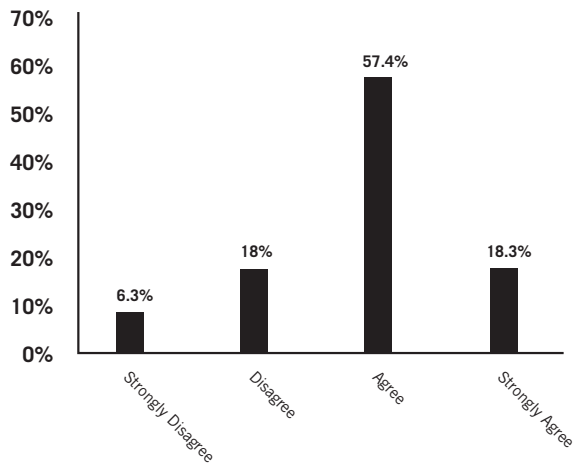
Any practice that is considering the implementation of an EMR should engage its coding staff in the decision-making process to avoid misunderstandings regarding the system's "compliance" and the ability of the physician to accurately code from the system. While many functions changing with an EMR do tell a strong ROI story, an EMR does not perform coding duties and can become a huge liability for a practice that relies upon it for coding compliance.

PREVELENCE OF USE OF PICK-LISTS AND CHEAT SHEETS

Three out of four physicians who code said they pick their CPT and ICD-9-CM codes from "cheat sheets" or EMR pick-lists. This is not surprising, given the popularity of superbill sheets with common code listings and the use of pick-lists within EMR systems.

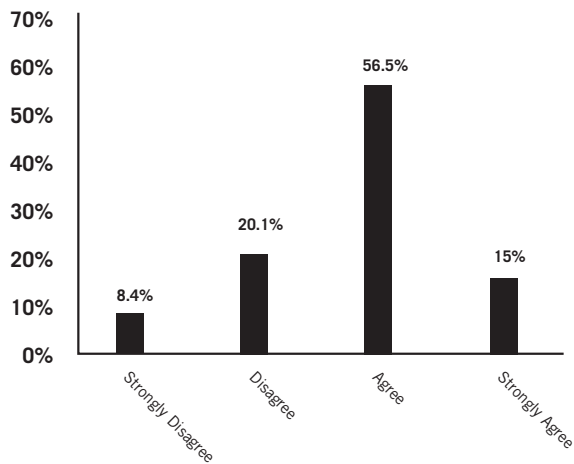
MY PROVIDER SELECTS CPT CODES FROM A PICK-LIST OR CHEAT SHEET.

[4,646 RESPONDENTS]



MY PROVIDER DOES ICD-9-CM CODING FOR HIS/HER SERVICES.

[4,243 RESPONDENTS]



But pick-lists and cheat sheets are not in compliance with coding standards as outlined by the OIG:⁽⁸⁾ According to its recommendations, all coding should follow “the official coding guidelines are promulgated by HCFA, the National Center for Health Statistics, the American Hospital Association, the American Medical Association, and the American Health Information Management Association. See International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) (and its successors); 198 Health Care Financing Administration Common Procedure Coding System (HCPCS) (and its successors); and Physicians’ CPT. In addition, there are specialized coding systems for specific segments of the health care industry.” The complex guidelines within CPT, ICD-9-CM, and HCPCS are not available in pick-lists or cheat sheets, and this practice therefore leads to coding errors.

It’s no surprise, then, that the coding performed by physicians is inaccurate.

The Bush Administration is calling for wholesale adoption of EMRs within six years. At the same time, CMS is targeting EMRs in its compliance audits. Medicare Compliance Alert, on May 29, 2006,⁽⁹⁾ warned that “On a page obtained by Medicare Compliance Alert from an internal National Medicare Fraud Alert, CMS notifies state and federal government law enforcement agencies about the ‘use of medical documentation software programs in a manner that results in the upcoding of office evaluation and management services.’” The 2008 OIG Workplan also targets E/M reporting rules that contain nuances that are difficult for EMRs to communicate and for physicians to apply consistently.

“Most physicians I have worked with do not have the time to devote to coding specificity. Even those who are interested in learning coding usually fall back into old habits and prefer “cheat sheets” especially for E/M coding. Old habits often include using the same codes over and over again, and basing visit levels on ‘time.’ Diagnosis codes are usually repeated as well, such as 250.00 even though the patient may be uncontrolled or have manifestations of the disease.”

AAPC recommends that physicians resist EMR pick-lists and move to the next generation of coding: computer-assisted coding (CAC). CACs are purchased separately as adjunct to EMRs, and use complex systems of natural language processing to abstract from the written record appropriate procedure, diagnosis, and supply codes. These systems require significant structure and contain evolving knowledgebases of medical edits that identify payer specific compliance issues and are programmed to apply the official coding guidelines to claims. CACs are designed to be audited by medical coders who review the coding before the claims are filed. The automated decisions are based upon decisions made and corrections to millions of other claims similarly coded.

CACs are significantly more consistent, efficient, and compliant than PAC -- “physician-assisted coding” -- and free the physician from administrative requirements so that he or she can focus on the clinical needs of patients.

The ROI of CACs over PACs can be a compelling story. Consider how CERT and RAC audits grow in importance for Medicare plans. The Status Report on the Use of Recovery Audit Contractors (RACs) In the Medicare Program published by HHS in February 2008⁽¹⁰⁾ stated that of the errors uncovered in 2007 audits, 42 percent were attributed to coding errors, and 32 percent to lack of medical necessity (a

compliance issue). Only 9 percent of errors involved insufficient documentation, and the balance of errors occurred across a broad spectrum of possibilities. In the very limited RAC pilot program involving only three states, \$357.2 million in overpayments was collected in the pilot program.

The RAC report advised, “Providers can use these findings to help ensure that they are submitting correctly coded claims for services that meet Medicare’s medical necessity criteria.” In other words, providers should be looking at their rate of coding error and medical documentation to protect their business from RACs.

For Contractor Error Rate Testing (CERT) HHS reports⁽¹¹⁾ that \$9.8 billion was overpaid in Medicare services in 2007, and 27 percent of that overpayment went to carriers who reimburse physicians, labs, and ambulances. HHS instructs carriers to seek repayments when overpayments are identified, putting providers at significant risk when errors are found in their billings.

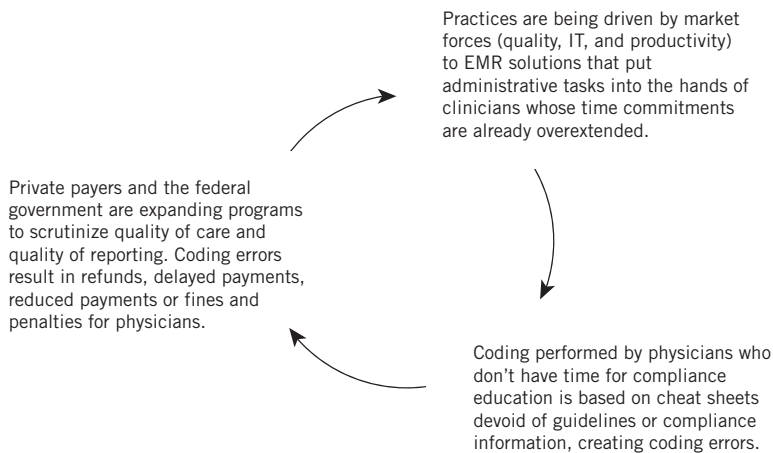
“We use an EMR where the providers have to code their diagnoses, procedures, E/M and then the coders are expected to audit as many as possible. Sometimes the providers cannot locate the diagnosis/procedure so the first diagnosis is entered, not always the most specific, but usually in the category. Also, the exclusion notes are not available in the electronic software. Coders always need to use the coding books!”

“I work with the EHR and I need to review everything the providers enter. The EHR is fairly new to us and it is taking time for everyone involved to be on the same page. Some providers consistently downcode while others upcode. So I have to audit and notify the providers to choose the correct E/M codes, etc. We’re learning and teaching each other too.”

“The docs don’t mind if I correct their coding (by auditing the visit) but they don’t generally want to know about it or why it was changed. Several of my docs seem to spin a wheel to arrive at a code, while others only charge one level at all times. Very frustrating!”

THE WORK OF A CODER SURVEY

When the forces influencing The Work of a Coder are viewed collectively, it appears that physician practices are being attacked by all sides.



AAPC recommends that physicians put the coding in the hands of the coders. With certified professional coders handling coding and billing operations, the business office can be assured that compliance requirements are being addressed by professionals who are continually updating their knowledge on such matters. When the time is right, move your business into a CAC environment that will further standardize coding and compliance results. And finally, recognize the devotion that the coding staff has for their work. The Work of a Coder survey shows us that for medical coders, coding is a passion. AAPC had 5,136 members respond to its annual salary survey performed in from mid May to July 2007. Invitations to this annual Salary Survey were sent in manner identical to The Work of a Coder, which received more than double the responses of the salary survey. What can you infer from this? Coders are passionate about their profession; money is secondary.

“I love being busy, but I believe if I had more time to concentrate on billing and coding issues I could generate more revenue for our office. I believe the current staff is being stretched too thin.”

“Most of us are cross-trained to cover other positions within the business office. I am the only certified coder and the only other person allowed to code is our manager. However, I am also responsible for depleting charts as I code them, help manage the medical record room, cover front desk and scheduling as needed, answer patient billing phone calls, submit claims electronically and on paper. I love my job and my workplace.”

“You have to know so much more than coding when working in the medical field. You have to understand the entire ‘life’ of a charge from the time a patient comes in to the office till the claim is paid. The most challenging part of my job is getting the physicians to understand and change the way they do things. Education for the doctors would be the most challenging thing that I face on a daily basis.”

“The time necessary for researching issues and educating myself is taking up a larger portion of my time each year.”

“I feel that there are a lot of other duties as assigned that sometimes take time away from being able to evaluate and research to apply the right codes to claims. It needs to be a separate position than just put in as a biller to do all other functions along with billing.”

SURVEY AND DATA AGGREGATION METHODOLOGY

The American Academy of Professional Coders (AAPC) in January 2008 invited medical coders to participate in a survey on the work they do. Medical coders were informed of the survey through three email invitations to AAPC members; an invitation posted on the public home page of the AAPC Website; and through press releases distributed to numerous magazines and websites with coder audiences. The survey, made available online through a weblink, was open to responses for six weeks. It garnered 12,068 respondents, of which 93.5 percent were professional coders certified through AAPC. The survey collected demographic information regarding work environment and credentials, and included 40 questions specific to work and working relationships. Completing the exam were 8,975 coders, or 74.4 percent of participants. The data aggregation engine for the survey was provided by SurveyMonkey.com.

Data presented within the body of this report represent total responses, unless otherwise noted. For questions regarding physician activities, “Not Applicable” was an available response for coders who work outside clinical practice, perhaps for payers or students. For these physician-oriented questions, found in Section III of the survey results, “N/A” responses were removed from the calculation of totals and percentiles, so that only those responses from respondents in clinical environments were tallied for clinical environment questions. Unabridged results are found in Appendix A.

The largest body of AAPC members consists of physician coders employed in clinical practices. Even so, AAPC recognizes that a significant number of its members are coders who are not employed within clinical practices, and that their workday responsibilities were not addressed in *The Work of a Coder*. Future AAPC sponsored surveys will address their markets more specifically.

ENDNOTES

- (1) U.S. Department of Labor, Occupational Outlook Handbook, 2008-09 Edition, Physicians and Surgeons, on the Internet at <http://www.bls.gov/oco/ocos074.htm>.
- (2) Extrapolating from AAPC's certified coder database and BLS statistics projecting medical coding and information technician jobs through 2016, less than half of current outpatient coding positions are filled by certified professional coders. Considering both the coding and compliance education requisite to certification and the continuing education requirements of certified coders, it is sensible to conclude that coding compliance and education programs in offices without certified coders would be less comprehensive than what is found in offices employing certified coders. Therefore, these survey results may not reflect the entire medical coding community. Survey results provide insight into areas within physician practice management, and report operational weaknesses that may contribute to problems with productivity and compliance. (Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2008-09 Edition, Medical Records and Health Information Technicians, on the Internet at: <http://www.bls.gov/oco/ocos103.htm>)
- (3) Denial Management: Key Tools and Strategies for Prevention and Recovery, © 2005 HCPro Inc. by Pam Waymack, MBA, CHFP, CPHIT page 23.
- (4) Federal Register, Vol. 65, No. 194, published Oct 4, 2000, page 59439.
- (5) Accuracy of CPT Evaluation and Management Coding by Family Physicians, Journal of the American Board of Family Practice, 14(3): 184-192, 2001, Michelle S. King, MD, Lisa Sharp, PhD, and Martin S. Lipsky, MD.
- (6) HSS, Centers for Disease Control, Advance Data From Vital and Health Statistics, Number 393, Oct 26, 2007. This survey had a 5 percent confidence interval, and excludes radiologists, anesthesiologists, and pathologists.
- (7) 2007 CCHIT Ambulatory EHR Functional Criteria, <http://www.cchit.org/ambulatory/criteria/index.asp>, criteria 67, 234, 235.
- (8) OIG Compliance Program for Individual and Small Group Physician Practices, published in the Federal Register, Volume 65, No. 194, Oct. 5, 2000, page 59439.
- (9) Medicare Compliance Alert, Vol. 18, No.11, Page 1, "CMS, auditors target E/M documentation software," May 29, 2006, Elizabeth Crawford, editor.
- (10) The Status Report on the Use of Recovery Audit Contractors (RACs) In the Medicare Program published by HHS online, February 2008 <http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf>.
- (11) Improper Medicare Fee for Service Payments Report, November 2007 Long Report, www.hhs.gov/apps/er_report_print.asp?.