Addressing the Demand for Medical Coders

Recommendation Report
of the
Medical Coding Task Force
1199SEIU League Training and Upgrading Funds

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Introduction

Medical coders play a key role in providing essential support for hospital and outpatient services. They are the health information management professionals responsible for reviewing all tests, diagnoses, procedures, results and medications and assigning them a code for billing and record keeping purposes. Their work requires substantial clinical understanding as well as knowledge of medical records and computer technology.

The medical coders' role in assuring that all information is accurate and complete is crucial to the economic well-being of the hospital since their entries determine the amount of reimbursement for patients covered by Medicaid, Medicare and other insurance programs. Coder efficiency in timely processing of coded bills maintains the flow of income into the institution. Additionally, inaccurate or inappropriate coding can lead to problems of fraud and abuse; therefore, the healthcare institution's compliance with government rules and regulations depends in part on effective coder performance.

An alarming problem facing healthcare institutions at present and expected to persist in the coming years is the shortage of medical coding staff. The United States Department of Labor's Occupational Outlook Handbook (OOH) projects an 18 percent increase in the number of health information technology/management jobs to be filled through 2016. This projection is greater than for most healthcare occupations as a result of the increased utilization of hospital services by an aging population and the rapid growth in the number of tests, treatments, and procedures. The national coder shortage was confirmed by New York facilities when 54.5% of League institutions that responded to the 2011 TUF survey on occupational demand reported they anticipate a shortage of coders over the next three to five years.

This need for more and better-trained coders is exacerbated by the implementation of ICD-10, on the horizon for completion by October 2014. This new version of the ICD (International Statistical Classification of Diseases and Related Health Problems), the international standard for medical classification, is used to classify a wide variety of signs, symptoms, injuries and diseases. According to the American Medical Association, it has 155,000 different codes compared to 18,000 for its predecessor, ICD-9. The greatly increased number of codes reflects their higher levels of specificity. ICD-9's codes were solely based on the name of the procedure, but the ICD-10 codes reflect the intent of the procedure as well. Since many of these codes have no straightforward correspondence to each other, the transition is not a simple matter of substitution. As a result, the task of applying the new ICD classifications to medical codes for inpatient and/or outpatient diagnoses and procedures will be much more complex and labor-intensive.

Recognizing the urgency of a proactive response to the issues related to medical coders, the trustees approved the creation of the 1199 SEIU/League Training and Upgrading Fund Medical Coding Task Force in 2011. This Task Force, composed of management, the union, medical coders and the Training Fund, worked to identify the challenges facing medical coding staff and to recommend solutions for filling current and anticipated medical coding openings as well as upgrading the knowledge and workplace skills of incumbent coders. The Task Force created three committees, namely Education and Schools, Experience, and Workplace Skills. These committees were charged with addressing the following challenges:

1. Identifying the best quality coding education with an emphasis on education that prepares students for Certified Coding Specialist (CCS) certification examination;
2. Creating a pathway for new graduates to obtain the necessary experience to obtain employment as coders; and
3. Assisting coders and institutions in preparing for the transition to ICD-10.

Background and Purpose

Despite the ever-increasing demand for coding staff, obstacles to entering the coding profession have led to a nationwide shortage. Many hospital employees working in other capacities have expressed interest in becoming medical coders, and recent graduates of coding programs have sought to obtain employment in the field. Nevertheless, coding vacancies remain unfilled. A major cause of this disconnect between supply and demand is the widespread employer pre-requisite of hands-on coding experience for newly hired coders. The effect of this on-the-job practice requirement, based on the universally acknowledged steep initial learning curve for a novice coder, is to hinder entry into the profession, while exacerbating current shortages.

Incumbent coders also have significant concerns about their future in the profession. A survey conducted in October, 2010 by the Professional and Technical Department of 1199 SEIU among one hundred twenty-six (126) incumbent coders in New York State and Massachusetts revealed widespread recognition of the need to address gaps in knowledge. Coders expressed interest in receiving training to prepare for the transition from ICD-9 medical classifications to the highly specific coding necessitated by ICD-10, which requires entry into new frontiers of knowledge, including a more profound scientific understanding of the processes involved in anatomy, physiology, pathophysiology and pharmacology. Virtually all of those who did not possess certification among the coders surveyed expressed a desire to obtain the Certified Coding Specialist (CCS) credential from AHIMA (American Health Information Management Association) that confirms their knowledge and, consequently, leads to higher wages, greater job security and increased marketability. The CCS is the “gold standard” credential for hospital-based coders, and it should be noted that AHIMA recommends two years of experience prior to taking the certification exam. The quest for greater knowledge and certification has led both potential coders and incumbent coders to seek coding education from schools promoting programs targeted to them. The quality of these programs varies greatly from school to school, however, and there is currently no reliable mechanism for identifying which schools offer the best quality coding education.

Education and School Quality

1199SEIU members need and enroll in two types of coding educational programs: programs designed to assist incumbent coders in passing the AHIMA Certified Coding Specialist exam (CCS) and education programs for people from other occupations who are interested in becoming coders. The Education and School Quality Committee looked at the quality of both types of programs.

Medical coders with the experience and skills to successfully perform the duties of the job are at a premium; even those coders with extensive experience must constantly update and upgrade their knowledge, especially in light of the coming transition to ICD-10. A significant number of these experienced coders lack the CCS credential from AHIMA employers seek or, in some instances, require for retention of employment.

Nationally, less than half of the people who take the AHIMA exam pass it. Given the hands-on knowledge 1199's experienced coders have accumulated on the job, they are ideal candidates for the CCS credential but usually need additional didactic education to pass the examination. A variety of preparation courses exist but are of varying quality.

Recommendation 1

The Task Force recommends that vendors providing medical coding classes intended to assist incumbent coders in passing the CCS exam develop a curriculum based on the following **80-hour Optimal Curriculum**:

1) "Science Refresher" – Review of Anatomy and Physiology, Medical Terminology, Pathophysiology, Pharmacology and Laboratory Procedure – *20 hours*
2) ICD 9/CPT (Current Procedural Terminology) *(total of 40 hours)*
    a. ICD-9 - *20 hours,* especially-coding clinic (rules/guidelines disseminated quarterly by AHIMA; examples of how to assign codes: primary, secondary, etc.)
    b. CPT - *20 hours* - Sample scenarios, test examples
3) Documentation, Reimbursement, Privacy - *20 hours*
    a. Documentation includes: how to navigate records and where to find information; content of medical records, querying, DRG (Diagnosis Related Group) studies
    b. Privacy (2-3 hours)

c. Reimbursement, including DRG

Test-taking strategies and real exam scenarios and examples should be integrated throughout the curriculum. Books and computer assessment/instruction would supplement direct instruction; coding by the book versus actual practice would be incorporated into instruction.

***Progress To Date and Next Steps**: TUF was awarded a Healthcare Worker Retraining Initiative grant for coding education. Most of the grant must be used for assisting incumbent coders with passing the AHIMA CCS certification exam.TUF is contracting for preparation courses only with vendors that meet the committee's standards. In some cases, TUF has successfully worked with colleges to change their curriculum to meet the committee's proposed standards.*

The Task Force also recognizes the responsibility of the Training and Upgrading Fund (TUF) to play an active role in providing guidance with respect to choice of schools to members interested in starting a career in coding. The Task Force recognizes that TUF can serve members' interests by encouraging schools to offer courses based on its recommended curricula. Drawing on their experience as managers and coders, the members of the Education Committee designed the ideal content for a course intended for people with no previous coding experience who want to enter into the profession.

Recommendation 2

The Task Force proposes a framework for a **180-hour Long-term Certificate Program** to be recommended to vendors providing coding education to members without previous coding experience who seek entry into the medical coding field. The proposed curriculum would be developed in the following areas:

- Medical Terminology 16 hours
- Anatomy and Physiology; Pathophysiology 38 hours
- Basic and Intermediate ICD-9 Coding 36 hours
- CPT (Current Procedural Terminology) Coding 32 hours
- DRG (Diagnosis Related Group) Studies 16 hours
- PRG (Professional Review Guide) Studies including labs and Pharmacology 12 hours
- Direct hands-on coding of actual redacted Inpatient and Outpatient Charts supplied by a hospital 30 hours

Practicum opportunities should be offered in conjunction with medical records coding studies.

***Progress To Date and Next Steps**: At TUF's urging, the New York City College of Technology has adopted the above curriculum content. TUF will continue to work with additional schools and colleges throughout the metropolitan area to adopt the standards set forth by the Education Committee and will provide a list of recommended schools to members.*

An additional educational problem exists in that CUNY currently only offers non-credit certificate coding programs. The content of these programs can be modified to meet industry demand as proposed above; however, students seeking to continue in their education to associates degrees will not transfer in any credits toward the degree.

Creating credit-bearing certificate programs pose additional challenges, including the fact that colleges take at least a year to approve credit-bearing programs and participants are required to pass the increasingly difficult entrance exams.

Recommendation 3

The committee proposes that TUF staff **work with CUNY to develop a credit-bearing certificate program** and that TUF staff combine this program with a **bridge to college program** to enable coders earning a certificate to pass CUNY entrance exams. Although this is a long-term strategy, members will benefit by the potential to earn higher-level credentials and the industry will have a pipeline of Health Information Management Professionals.

Experience: A Pre-requisite for Employment

Despite the urgent need to bring new coders into the workforce, many potential coders aspiring to enter the medical coding profession are often unable to enter the field because hands-on experience is often a prerequisite for employment. This requirement deters hospital workers interested in transitioning to coding positions and negates the educational investment of new graduates of coding programs.

This paradoxical prerequisite of hands-on practice, limiting opportunities for 1199 members aspiring to become medical coders and graduates of medical coding programs, will have multiple negative impacts, including: 1) expanding shortages in the medical coding field; 2) growing workloads for incumbent coders; 3) increasing error rates; and 4) worsening fiscal and administrative issues. Clearly, these outcomes will severely affect the continuity and quality of healthcare service delivery.

A solution is needed to assist graduates of high quality coding education programs to bridge the theory-practice gap. This solution should benefit new graduates of coding certificate programs, while also assisting institutions with finding the experienced coders they need.

Recommendation

The Task Force proposes creation of an apprenticeship program to address the challenge posed by the lack of a bridge to employment in medical coding. The committee recommends that any apprenticeship program include the following: A **Pre-assessment** of readiness should be utilized to determine the qualifications, experience, and literacy of all candidates applying to the apprenticeship. Assessments would identify the strengths and weaknesses of each individual and would pinpoint gaps in the apprentice's knowledge. It is recommended that new graduates from coding programs score 70 percent or better on the AHIMA readiness assessment tools to be accepted into the coding apprenticeship program.

The apprenticeship program should include between six months and one year of **combined classroom training and on-the-job training** using 'real world' examples to develop competency levels. The apprenticeship will provide additional education and supplemental practice to help individuals strong practice skills. The educational component would include the 'coding clinic' which describes coding guidelines. Experienced coders should serve as **preceptors**, providing day-to-day guidance to apprentice coders on the job. Preceptors would oversee and assess apprentices' hands-on coding performance. These mentors would foster professional growth and

encourage further learning according to the needs of the apprentices. Once the apprenticeship program has been completed, **the AHIMA competency assessment tool will be** administered to determine if the apprentice has demonstrated competency. A score of 80 (eighty) percent or better is the desired outcome.

Next Steps: *This recommendation should be reviewed by the League, the union and TUF Trustees for concurrence. If a decision is made to proceed with an apprenticeship, terms will need to be negotiated. Areas for consideration include but are not limited to use of trainee job designations, length of apprenticeship and employer recognition of apprenticeship as experience.*

ICD-10 and Transition Support

The greater coding accuracy demanded by ICD-10 is expected to lead to higher quality information for measuring healthcare service quality, safety, and efficiency. Additionally, the transition to ICD-10 will align the USA to the rest of the world, and thus improve our ability to track and respond to international public health threats in our increasingly globalized community.

These benefits will demand substantial investments, however, since the ICD-10 coding system is far more complicated than that which is currently utilized in ICD-9. ICD-10 will place high demands on a wide spectrum of healthcare workers, with medical coders shouldering a significant portion of the burden. Preparation for the onset of ICD-10 requires coders to strengthen their understanding of anatomy and physiology as well as their knowledge of pharmacology and the pathophysiology of diseases and traumas.

The experience of institutions in other countries demonstrates that the transition is certain to have an adverse effect on coder productivity. According to a 2006 report on the experience one Canadian hospital had with this transition, the quantity of records coded dropped precipitously, achieving approximately 50% of prior levels after the first three months of implementing ICD-10. Even a year later, the number of records processed per hour remained at only 80% of the rate previous to ICD-10 implementation. It is also important to bear in mind that this institution had committed substantial resources to the project well before its implementation.

Although the majority of the Task Force's recommendations center on the medical coders, as with most complex and challenging endeavors, teamwork is crucial to success. Successful implementation depends on the full commitment from the administration, the clinical staff, and the IT Department as well as the business units of the institution.

The Task Force's recommendations for supporting the transition to ICD-10 are divided into two main areas. The first is the development of a series of 'Supplemental Modules' targeted at the current coders to help them meet the demands of ICD-10 by refreshing and upgrading their skills. The supplemental modules are designed for incumbent coders, including coders who have the CCS certification but need to build skills to transition to ICD-10. The second category of recommendations is a set of Endorsements of Principles related to Documentation Accuracy.

Recommendation 1

The ICD-10 Transition and Support Committee recommends **Supplemental Educational Modules** to build skills in areas where ICD-10 implementation requires expanded knowledge. Live instruction for these modules would be supplemented by resources available online; lab instruction would enhance instruction in several of the modules. Instructors for these courses must have a successful record of delivering similar training.

This training would be divided into the following modules:

- **Medical Terminology for Medical Coders**
  Review ICD-9 terminology and learn specific ICD-10 terminology
- **Anatomy and Physiology for Medical Coders**
- **Pathophysiology for Medical Coders**
  - The most common types of disease processes
  - Pharmacology of these most common processes

The modules will provide extra support and practice, but must be complemented by in-service training provided by the institution that is specific to the different internal policies and practices of each institution, such as decisions related to IT, software, and business rules.

Recommendation 2

The committee recommends establishing a **Practice ICD-10 Coding Module for incumbent coders to practice using ICD-10 on-the-job.** This innovative module would build awareness of ICD-10CM/PCS and familiarity with the application of ICD-10 coding. Coders would be provided with the opportunity to develop their own coding skills in the context of ICD-10 independently, using real life medical records with personal information deleted.

Recommendation 3

Communication problems between coders and clinical staff can hinder the timely and complete exchange of information required to fully and accurately code records. Management and frontline coders on the Task Force set forth several **Endorsements of Principles related to Documentation Accuracy** for institutions to consider**.** Once each institution has adopted these principles, it is recommended a lead physician who

would play a critical part in their implementation be appointed. This "physician champion" would understand the needs of coders, doctors and nurses alike and could transmit an understanding of the needs of the coding area to their fellow clinicians. The physician champion would play a central role in raising awareness of the need for clinical and support staff to collaborate in the preparations for the transition to ICD-10.

The committee recommends that institutions form labor-management committees to explore and implement adoption of the following principles:

- A "physician champion" would play an important role serving as a go-between to facilitate collaboration between clinical and coding staffs;
- Existing issues between coders and clinicians that could potentially hinder collaboration should be identified and surfaced;
- "Root Cause Analysis" methods should be adopted to examine the circumstances under which communication between coding and clinical staff breaks down;
- A 'Just Culture' to foster collaboration should be established in the workplace. Just Culture is an important part of Root Cause Analysis in which the shared goal is to reduce the number of errors. This way of doing business creates a safe atmosphere for admitting mistakes since discovery of mistakes is key to accomplishing the mutual goal; and
- Factors that could enhance the environment in which coding takes place should be assessed and a plan of action developed to minimize obstacles to effective transition to ICD-10.

Appendix I: Summary of Recommendations

Education and School Quality:

1. Vendors should provide medical **coding classes to assist incumbent coders** in passing the CCS exam by developing a curriculum based on the **80-hour Optimal Curriculum** developed by Task Force Members.

2. Vendors should build curricula a **180-hour Long-term Certificate Program** for medical coding classes **for members without previous coding experience** on the framework proposed by the Task Force.

3. TUF staff should **work with CUNY to develop a credit-bearing certificate program;** that program should be combined with a **bridge to college program**.

Experience: A pre-Requisite for Employment:

1. **An apprenticeship program** should be created to address the challenge posed by the lack of a **bridge to employment** in medical coding. The apprenticeship program would **combine classroom training and on-the-job training**.

ICD-10 Transition Support:

1. **Supplemental Educational Modules** should be offered to **build skills** in areas where ICD-10 implementation requires expanded knowledge.

2. To build awareness of ICD-10CM/PCS and the application of ICD-10 coding, a **Practice ICD-10 Coding Module** should be developed for incumbent coders to **practice independently on-the-job.**

3. Timely and accurate coding is in the interest of all institutions; therefore, institutions are recommended to consider a set of **Endorsements of Principles related to Documentation Accuracy** that **promote communication between coding and clinical staffs**.

Appendix II: Medical Coding Task Force Members

NAME	ORGANIZATION
Aida Morales	1199 SEIU United Healthcare Workers East
Andrew Taylor	Brookdale University Hospital and Medical Center
Angela Doyle	1199 SEIU United Healthcare Workers East
Antonia Fletcher-Boyce	The Mount Sinai Hospital
Ayana Culley	Long Island Jewish Medical Center
Beverly Dacres-Gray	Bronx Lebanon Hospital Center
Bridgette Kreuder	North Shore LIJ
Bruce Richard	1199 SEIU United Healthcare Workers East
Carlos Trinidad	1199 SEIU United Healthcare Workers East
Cheryl Thombumpus	Interfaith Hospital
Christine Negro	The Brooklyn Hospital Center
Christine Scaminaci	Wyckoff Heights Medical Center
Christine Wilson	St. Joseph's Hospital
Claribel Santos	Peninsula Hospital
Claudia Fields	The Brooklyn Hospital Center
Claudette Spencer	1199 SEIU United Healthcare Workers East
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David Kranz	1199 SEIU United Healthcare Workers East
Deborah Mallon	North Shore LIJ
Diane Johnson	Bronx Lebanon Hospital Center
Dolores Chase	1199 SEIU United Healthcare Workers East
Ernestine Fitzgerald	The Brooklyn Hospital Center

Estela Vazquez	1199 SEIU United Healthcare Workers East
Ethel James	New York Presbyterian Hospital
Fernando Wilson	1199 SEIU United Healthcare Workers East
Gail Temple	Montefiore Medical Center
Gauge Hansen	St. Barnabas Hospital
Gillian Peters	The Brooklyn Hospital Center
Gladys Wrenick	1199 SEIU United Healthcare Workers East
Glenna Friedman	New York Presbyterian
Janine Lacerra	Brookdale University Hospital and Medical Center
Karen Hardy	Beth Abraham Hospital
Kathy Seifried	The Brooklyn Hospital Center
Keion Marshall	Beth Israel Medical Center
Keith Johnson	Montefiore Medical Center
Luis Izaguirre	New York Methodist Hospital
Margaret West-Allen	1199 SEIU United Healthcare Workers East
Maria Carpio	Brookdale University Hospital and Medical Center
Mark Quartson	New York Presbyterian Hospital
Marlene Boney	The Mount Sinai Hospital
Marva Mitchell	Interfaith Hospital
Mary Ann DiMaggio	St. Luke's Roosevelt
Mazette Edwards	Montefiore Medical Center
Mercedes Machado	Brookdale University Hospital and Medical Center
Nerine Webb	Maimonides Medical Center
Pandora Meyers	Flushing Hospital Medical Center
Patricia Fiedler	Visiting Nurse Service
Patricia Maxwell	Community Hospital

Paul Strafer	Maimonides Medical Center
Phyllis Smith	Visiting Nurse Service
Ray Cosner	Beth Israel Medical Center
Reeba Mathew	The Mount Sinai Hospital
Roxanne Acosta	Kingsbrook Jewish Medical Center
Saily Cabral	1199 SEIU United Healthcare Workers East
Stewart Presser	Greater New York Hospital Association
Susan Cohen	The Mount Sinai Hospital
Susan Tabickman	Community Hospital
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