

The Coding Challenge

Retaining Coders
and Revenue in 2013



ManpowerGroup™

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The Coding Challenge: Retaining Coders and Revenue in 2013

As of October 1, 2013, all HIPAA transactions and claims, both outpatient and inpatient, must carry the new set of ICD-10 codes. ICD-10 replaces the existing 17,000 codes with over 150,000 diagnosis and procedure codes. While the enhanced granularity will ultimately result in enhanced metrics and patient care, the ICD-10 mandate will disrupt existing healthcare operations. In fact, nearly 30 percent of respondents to the 2011 HealthLeaders Leadership Survey¹ report that over the next three years, ICD-10 will have a negative or strongly negative impact on their organizations; 41 percent of healthcare technology leaders anticipate adverse impacts from changes required by ICD-10².

In the Leadership Survey, CEOs cite cost reduction as their number one priority, followed by patient safety and reimbursement. In the 2010 survey³, reimbursement was the fifth most concerning issue. The criticality of a healthy bottom line, coupled with the changes propelled by ICD-10, place the importance of medical coders and accurate coding at the center of the financial equation. Organizations focused on a successful ICD-10 implementation in 2013 are advised to ramp up their coder development and retention strategies now.

Coder Profile

Experienced medical coders are already in demand.

In 2009 when unemployment was near 10 percent nationally, unemployment for coders was significantly lower – between 5.6 and 6.8 percent depending on credentials, according to the American Association of Professional Coders' 2010 Salary Survey⁴ of 10,000 members. Backing this are projections from the Bureau of Labor Statistics⁵ that put job growth at levels far above average: 20 percent from 2008 to 2018. Between 2011 and 2013 alone, Economic Modeling Specialists Inc. project growth to be at 8 percent⁶.

An experienced medical coder brings not only enhanced productivity due to application of appropriate codes, but also knowledge of the diagnosis/procedure coding proclivities used by an organization’s healthcare professionals, potential red flags and other nuances that can affect reimbursement. While the current volume of coders in aggregate may be sufficient to address healthcare needs — particularly since the recent flood of coding schools/programs — it is experienced coders who are most in demand and most difficult to find and retain.

The value brought by coders reinforces Manpower’s research on emerging world of work trends, namely, that having the right talent in the right place at the right time will become the defining competitive edge for organizations⁷. In this new “Human Age,” human potential is the major agent of economic growth, even more than access to capital. To succeed, each organization will need to better understand the composition, competencies and desires of the individuals who comprise the workforce. This view is directly relevant to coding staff as demand for them, as well as demands put upon them, continue to increase.

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According to the 2009 JustCoding.com survey⁸ of 500 medical coders, the profile is:

Median age:	41 – 50
Median length of time in current position:	3 – 5 years
Median number of years of coding experience:	11 – 15
Median hours per week worked:	31 – 40
Median of most recent raise (within last 12 months):	3 – 4%

The American Association of Professional Coders (AAPC) notes that 28 percent of their 100,000+ members are over 50 years; only 5 percent are age 25 or younger. The majority are between 26 and 50 years of age.

Most coders have some advanced schooling and this is positively correlated with pay levels.

Education	Split	Salary: Certified	Salary: Non-Certified
Some High School	0.3%	\$39,167	\$27,500
High School	11.8%	\$41,272	\$36,764
Technical School	13.4%	\$41,017	\$33,413
Some college	36.7%	\$45,038	\$36,409
Associates degree	19.6%	\$43,868	\$35,807
Bachelor’s degree	15.3%	\$51,389	\$47,421
Master’s degree+	2.9%	\$64,807	\$50,929

AAPC 2010 Salary Survey⁴

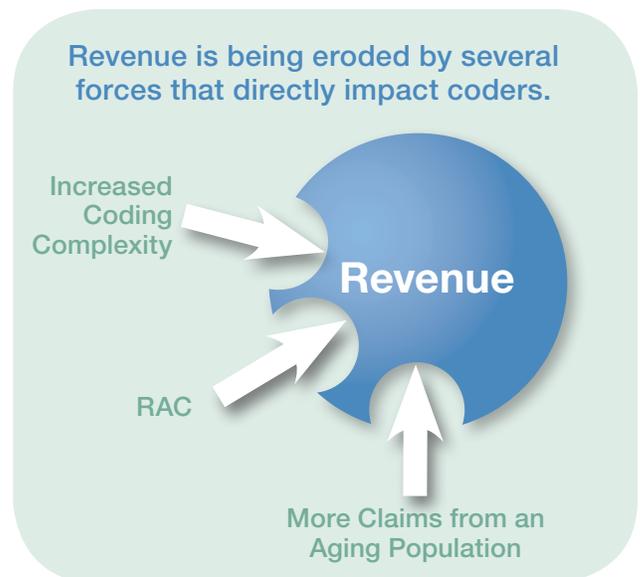
Across all educational levels, those working for Payers (e.g., insurance companies) realize the highest salaries at \$54,100 for certified coders; salaries paid by Providers are lower. Hospital pay for certified coders averages \$47,848 (inpatient hospitals) and \$45,005 (outpatient hospitals). The lowest paying organizations are home health care organizations (\$37,965), long term care facilities (\$39,881), solo practitioners (\$40,430) and other outpatient facilities (\$41,242)⁴. The same general pattern exists for non-certified coders.

This data becomes particularly relevant in understanding the experience levels and options coders may have to shift either to organizations that offer higher pay, or that offer slightly lower pay but fewer coding complexities.

The Coding Environment: The Perfect Storm

According to the Healthcare Information and Management Systems Society (HIMSS)⁹, the changes required by ICD-10 will likely result in:

- Increased provider queries
- Decreased coder productivity
- Increased delays in processing authorizations
- Increased claim rejections and denials
- Improper reimbursement
- Slowed and/or reduced cash flow



The multi-year, costly process of ICD-10 implementation comes at a time when many healthcare organizations are already grappling with financial issues. According to the 2010 American Hospital Association (AHA) survey¹⁰, the majority of respondents say the recession has reduced their operating margins and increased the percentage of patients covered by Medicaid, CHIP or other programs.

Revenue is also being impacted by the Centers for Medicare and Medicaid (CMS) Recovery Audit Contractor (RAC) Program. The program uses an automated system to detect improper payments and live reviews for more complex cases. More than 50 percent of respondents to the 2011 HealthLeaders Survey say RAC will have a negative or strongly negative impact on their organization over the next three years¹.

To understand the impact of RAC and assist members in addressing it, in January 2010 the American Hospital Association (AHA) set up RACTrac—an online system hospitals access to log their experiences with RAC. The AHA's February 2011 report¹¹ on 2010 activity showed that 1,454 general medical/surgical acute care hospitals, long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals reported an aggregate of \$86 million in claims denied via RAC. Approximately 90 percent of the \$86 million in claims went through the live review process and the most

prominent reason given for denial was incorrect coding/coding errors. These findings underscore the need for proper training and support of coders who are central to the coding process.

Billing issues will also grow as the care provided to the aging population grows and more individuals move to government-supported programs. From 2011 on, 10,000 baby boomers will turn 65 every day for the next 19 years.¹² According to the AHA, Medicare and Medicaid cover more than half of patients but the reimbursement received under these categories “pays substantially less than the cost of caring for these patients.”¹⁰

Coder Challenges/Incentives to Remain

These governmental, environmental and financial issues converge on coders. Focusing on the challenge of ICD-10 alone, coders will need to:

- Accommodate major technological changes resulting from ICD-10.
- Learn an entirely new way to do their jobs. The CMS has provided General Equivalency Mapping between ICD-9 and ICD-10 codes; however, it is estimated that only five percent of the diagnosis and procedures codes have a direct one-to-one match underscoring the pivotal role of the system and the coder.¹³
- Interact differently with other healthcare providers, such as physicians and nurses, as these professionals will likely need to alter the way information is documented to ensure compliance under the new ICD-10 rubric.
- Manage a dual reporting system for a period of time to accommodate care and claims that occurred prior to October 1, 2013 or the organization’s ICD-10 start date.
- Manage losses in individual productivity and increasing organizational demands to maintain reimbursement levels. It is estimated that providers will experience coding productivity losses of 10 – 25 percent as organizations transition to ICD-10.¹⁴
- Contend with losses in morale due to a confluence of the above factors.

The question arises if ICD-10 and other organizational pressures will result in a significant coder exodus or in early retirements, particularly since about 3 in 10 coders are over the age of 50. Attrition/retirement is of course a possibility, but other factors may temper it.

According to research conducted by the Pew Research Center in 2009¹², over 50 percent of full-time workers age 50 – 64 say the recession has caused them to postpone thoughts of eventual retirement. Sixteen percent say they never plan to retire. Of those who do plan to retire, 66 years of age is the retirement benchmark most commonly given, which is four years older than current retirees had predicted they would stop working.

In addition to economic considerations, the knowledge acquired by medical coders is very industry specific. While the general competencies of organization, efficiency, and keen attention to detail translate to a variety of positions, specific coding knowledge — their key vocational differentiator—is less transferable.

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While coders may remain in the field, the increasing demands of ICD-10 in particular may cause some to transfer to other types of healthcare facilities that, while paying less, are less complex in their coding requirements e.g., outpatient facilities or long-term care facilities.

To understand the strengths of their coding teams, some organizations have begun to look more closely at not only productivity levels, but also additional competencies related to managing large amounts of data.

Engaging/Retaining Coders

ICD-10 represents a dramatic change in the volume of information coders will need to learn and the systems/processes they will need to access to do their jobs well. To drive coder satisfaction, productivity and engagement, organizations should consider:

Involvement

- Bring coders into the project plan to invite buy-in. Ensure they understand the ultimate benefits of ICD-10 such as improved patient care and safety provided by the enhanced data granularity. As suggested by James H. Braden, corporate director of HIM at HealthQuest health system in Poughkeepsie, NY, “Managing the transition will play a greater role in job satisfaction than coder salaries.”⁸

Evaluation

- To understand the strengths of their coding teams, some organizations have begun to look more closely at not only productivity levels, but also additional competencies related to managing large amounts of data. This type of information can be useful in bolstering skills or determining if changes need to be made.

Training

- The AAPC recommends 70 – 80 hours of coding-related training. For those coding leaders responsible for implementation, the AAPC believes that training should have begun in 2010. It is recommended that coding staff undergo anatomy training in 2011, and code set training in 2012 (B. Erickson, VP, AAPC, personal communication February 28, 2011). Note: Training on the specific technologies implemented by the organization will also need to be factored in.
- The question of when and how this training will occur is critical. According to the Justcoding.com survey⁸, 58 percent of respondents work 31 – 40 hours to week; 40 percent work 41 – 70. Considering the average age range of coders, they are likely to have additional responsibilities outside of work and may not have large pockets of extra time to accommodate training. Working with your coding team now to determine how training will occur can reinforce the pivotal role coders play and the organization’s desire to partner with coders to ensure success.

Quality/Support

- Leading up to launch and post-launch, coders may need additional support systems to ensure appropriate quality control measures. It may be desirable to include additional checks prior to submission to reduce the risk of claim rejection. In addition, some coding departments may find it useful to identify team leaders, in addition to the manager, who can serve as “subject matter experts” for content or process questions.

Fixed/Flexible Staffing Models

- Assuming an estimated decrease in coder productivity of 10 – 25 percent¹⁴, an increase in training time, and limited coder capacities for overtime, most organizations will need

to plan for an influx of temporary staff prior to and post-launch. Since there is already a shortage of experienced coders, organizations will need to do advance planning to ensure the availability of talent and how these individuals will fold into existing structures.

Working with Other Stakeholder Groups to Create Seamless Processes

- A coder can more accurately assign codes when the organization's healthcare professionals are defining diagnoses and procedures within the ICD-10 framework. In some cases, for example, enhanced specificity will be required from these professionals. Ensuring appropriate training for providers can expedite the release of accurate claims.

Recognition

- In any role, recognition for work well done can serve to engage and retain good employees. Knowing that enhanced demands will be placed on this critical group of healthcare staff, how can the organization provide meaningful evidence of its appreciation? This can come through tactics such as program updates, training opportunities and accommodations, and personal thanks from hospital leaders. The recognition pieces that will be most meaningful will depend on the organization, its policies and its brand.

In Conclusion

Collecting payment for services rendered is essential to the solidity of any healthcare organization and coders are key drivers in that process. Experienced and productive coders will be in even greater demand as the challenges of claim submission and reimbursement driven by ICD-10 draw near. To retain and engage these professionals, organizations need to plan now for ways to involve, train, support and recognize them. Doing so early will limit the risk of attrition/retirement, enhance claim acceptance rates and mitigate the inevitable operational gaps that will result from the monumental shift of ICD-9 to ICD-10.

About ManpowerGroup

A world leader in innovative workforce solutions, ManpowerGroup creates and delivers services that enable its clients to win in the changing world of work. With over 60 years' experience, ManpowerGroup offers employers a range of solutions and services for the entire employment and business cycle including permanent, temporary and contract resourcing; employee assessment and selection; training; outplacement; outsourcing and consulting. ManpowerGroup's worldwide network of 4,000 offices in 82 countries and territories enables the company to meet the needs of its 400,000 clients per year, including small and medium size enterprises in all industry sectors, as well as the world's largest multinational corporations. The ManpowerGroup suite of solutions is offered through ManpowerGroup Solutions, Experis, Manpower and Right Management. Learn more at www.manpowergroup.com



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