to coded numbers—the basics upon which our profession was founded. May we all have the clarity and insight to support each other as we grow into new challenges. May we keep the vision our professional forbearers left to us. May data integrity, coding compliance, and record and information management continue to guide us as a profession. Go HIM! ⊞

EDITOR'S NOTE
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One year of ICD-10: First half 2016 data shows coding trends and impacts

by Eileen Dano Tkacik

One year following the official implementation of ICD-10, the coding industry is beginning to report valid results regarding accuracy, productivity, and denial trends. While some of these facts and figures are self-reported by HIM directors and anecdotal in nature, other findings are grounded in hard, fast coding performance data. Such is the case with the results from Central Learning *(www.centrallearning.com)*, a web-based system that electronically assesses coder knowledge using real medical record cases and expert-verified answer keys.

This article summarizes coder performance data as measured across 50 health systems and 300 coders as of June 30, 2016. It compares these findings with other industry reports and extrapolates key findings for HIM directors and revenue cycle executives. Since coding and diagnosis-related group (DRG) assignment are the major drivers behind health system revenue streams, consistent data analysis helps to ensure accurate coding and reimbursement.

ICD-10 coding accuracy on the rise
According to Central Learning data, coding accuracy is *slightly* increasing after nine months under ICD-10 for both experienced coders and coders-in-training. While the industry overall still lags behind the 95% accuracy benchmark achieved in ICD-9, we're getting closer in all three major patient types: inpatient, outpatient, and emergency services.

Fifty health systems are represented in the data, providing a broad-based assessment. We compared

coder accuracy from Q1 (January 1–March 31) with Q2 (April 1–June 30) to identify recent, timely trends in code quality. The figure on p. 13 lists the most current benchmark of our status through June 30, 2016.

We expect the uptick in coder accuracy to continue as coders and health systems engage in more targeted education and training for ICD-10. Actively monitoring code quality through monthly coding audits, combined with coder knowledge assessments, helps prevent denials and mitigates compliance risk. This two-pronged approach to coding management is critical, as payer denials and Recovery Auditor audits are expected to increase later in 2016.

Education and communication are the keys to making continued improvements in coder accuracy over time. This is especially true for the five identified areas of coding accuracy concern.

Current Benchmarks

Coding Type	Q1 Average Accuracy	Q2 Average Accuracy
Inpatient coding	83.1%	84.2%
Ambulatory coding	80.8%	83%
Emergency services coding	85.6%	88.3%

Source: Data from Central Learning, a product of AVIANCE Suite.

Five areas of coding accuracy concern

A closer look at Central Learning data from June 30, 2016, identified five coding categories where accuracy remains below acceptable levels (ranging between 65%–75% accuracy). With concentrated training efforts in these specific areas, coders can see a marked improvement in the quality of their work. For example, the coding of injury, poisoning, and other external causes ranked third lowest in Q1, but only sixth worst for coding quality in Q2 with a 12.6% improvement in coding quality following focused educational efforts.

HIM directors and coding managers can use these nationwide benchmarks to compare coding quality across internal teams and identify specific areas for coding risk.

Other ICD-10 coding quality data results

Alongside these specific Central Learning data reports, AHIMA recently conducted interviews to benchmark coding accuracy and productivity in ICD-10. The survey was conducted by the AHIMA Foundation in May 2016 *(http://journal.ahima. org/2016/06/13/survey-coding-productivity-dipped-after-icd-10-implementation)*. In the self-reported survey results, "respondents noted they experienced a 14.15% decrease in productivity, yet only a 0.65% decrease in accuracy."

With such a dramatic variation between AHIMA's self-reported results and system-generated data from Central Learning, it is evident that continued coder assessments and monitoring are essential. Solid coding data drives performance transparency—a critical component of revenue cycle preparation and denial prevention in ICD-10.

Putting ICD-10 coding data to work

Practices and health systems are smart to flag specific areas of coding concern based on their areas of challenge to introduce targeted education and training. This is especially true for specific diagnoses and procedures frequently used by providers.

Coding performance data analysis is also a first step to develop follow-up performance measures for coding teams, coding audits, and coding compliance programs. Positive trends in high coding quality should be accelerated, while poor performance areas should be targeted for risk mitigation.

A great starting place is to identify your coding team's top five most and least accurate code categories during coding audits or coder knowledge assessments. This will bring your strengths and weaknesses to the forefront so you can conduct appropriate training.

Once you've identified these categories, use your data to answer these five important questions:

1. How accurate is the code assignment methodology used for high-risk service lines within these code categories?
2. What are the specific coder knowledge gaps by diagnosis, procedure, and coder?
3. Is clinical documentation accurate, complete, and as specific as possible?
4. Are payers paying high-risk service lines correctly?
5. How much revenue, if any, is lost due to incorrect coding?

Coders are using training tools, such as AHIMA seminars and the Central Learning training tool, to enhance their knowledge and experience with ICD-10. The result should be continual improvement in coding accuracy.

High Risk Coding Accuracy Categories

Q1 Rank/Accuracy	Category/Description	Q2 Rank/Accuracy	% Change
1 51.1%	V00-Y99 – External causes of morbidity	1 65.3%	+14%
2 58.0%	R00-R99 – Symptoms, signs & abnormal findings	2 69.3%	+11.3%
3 63.6%	S00-T88 – Injury, poisoning and other external	6 76.2%	+12.6%
4 65.2%	Q00-Q99 – Congenital malformations	4 71.3%	+6.1%
5 65.2%	D50-D89 – Diseases of the blood & organs	5 74.2%	+8.1%

Source: Data from Central Learning, a product of AVIANCE Suite.

The impact of accurate coding on the revenue cycle, compliance, and accurate reimbursement becomes more obvious as we get further down the ICD-10 road.

Correlation between coding and revenue stream

High levels of coding accuracy are essential in both fee-for-service and value-based reimbursement models. So far, the payment trends under ICD-10, to the surprise of many, have been positive. There has been a steady decrease in claims processing and payment velocity. Also, the deluge of claims denials has not yet happened—but may occur after October 2016 when the one-year grace period for code specificity concludes.

The following data was collected in a recent year-over-year six-month period (October 1, 2015–March 31, 2016), compared to the same six-month period from a year ago (October 1, 2014–March 31, 2015) according to RemitDATA, a healthcare claims clearinghouse company:

- Average staff processing time has shown a steady de-

crease during the year, with average staff processing time of 17 days in January to an average of eight days in May
- Average payer processing time has decreased throughout the year, with an average of 15 days in January to 12 days in May
- Total claims processing time was reduced by nearly 60%, with total processing time of 32 days in January to 12 days in June

Coding certainly has played a big role in this trend. Precise coder accuracy measurement and analysis of coding data are the first steps to making this transition. ◫

JC quarterly update
The Joint Commission deletes 225 standards

by Jean S. Clark, RHIA, CSHA

The May 2016 issue of *Perspectives* outlined 225 hospital requirements from the accreditation manual—nine from the Information Management (IM) chapter and five from the Record of Care, Treatment and Services (RC) chapter—that have been deleted. This initiative is part of the Joint Commission's project REFRESH and improving the survey process. Deletions fell into three categories:

1. Those that were duplicative of or implicit in the element of performance
2. Those that were a routine part of operations or clinical care processes
3. Those that were adequately addressed by external requirements

The largest number of deletions fell into those that were a routine part of operations or clinical processes. The good news is that we now have fewer standards/elements of performance to contend with. The bad

news is that the majority of the IM and RC chapter deletions fell into the duplicative category, so we still have to be compliant in other standards. Let's take a look at what was deleted and where requirements can now be located.

As you can see, the majority of the deletions are duplicative, which means the standards did not go away entirely. My advice is to review the deletions and compare your compliance with the referenced standard or requirement. Don't become complacent just because some standards have been removed! And take time to review the other standards identified in the May 2016 issue of *Perspectives*, especially the Provision of Care deletions. The good news here is that all hospitals, regardless of deemed status, will be using the CMS restraints and seclusion requirements. ◫