



# Benchmarking Coding Quality using a specialised scoring System---

Dr. Med. Johannes Peiseler & Dr.med. Michael Wilke

Annual Meeting of Society of Clinical Coders  
Tylösand, March 23<sup>th</sup> 2007

# Agenda

- Introduction
- The German Health System
- Background & objectives
- The scoring system in detail
- Sample Results



# Dr. med. Michael Wilke

- Consultant in HealthCare
- Head of Competence Center Health Management
- Physician in Surgery, Anesthesia, intensive care, emergency medicine
- Since 1997 involved in DRG - projects
- Head of DRG Competence Center in Munich Schwabing hospital
- Member of Casemix advisory committee in the German Ministry of Health
- Member of „Patient Classifications International“ (PCS/I) scientific committee
- Coding audits in app. 30 hospitals
- Over 140 publications and lectures for DRG - topics



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# German health system

Germany has a compulsory health insurance system for app. 88% of the population (12% privately insured)

- Currently app. 250 insurance companies in the compulsory system
  - Coverage of all healthcare service expenditures
  - Financing via percentage of wages (50% employer, 50% employee), avg. fee is ca. 14,2%
- Accidents at work covered by special accident insurance
- App. 150 private companies
- Investments are covered by the states, but due to bad financial situation, many states suffer severe investment jam.



# German health system

The most important difference to the Nordics

- Strictly different financing mechanisms and budget proportions between the different sectors:
  - Outpatient
  - Inpatient
  - Rehabilitation
  - Prevention

# Healthcare expenditures 2005

- In 2005 there was a total of € 250 Bill. of healthcare expenditures
- App. € 144 Bill. Were covered by the compulsory system (see details right)
- Private companies covered app. 9% of the expenditures

<b>Services</b>	<b>Expenditure in Bill. €</b>	<b>%</b>
Doctors fees	21,6	15,04
Dental care	7,52	5,24
Dental prosthetics	2,45	1,7
Medication (from pharmacy and others)	23,65	16,47
Orthopedic aides and others	8,18	5,7
Hospital services	49,01	34,12
Sickness funding	5,86	4,08
Transportation	2,8	1,95
Prevention and Rehabilitation	2,38	1,66
Homecare	1,93	1,34
Administrative costs	8,05	5,61
Other	10,18	7,09
<b>Total expenditures (compulsory only)</b>	<b>143,61</b>	<b>100</b>

# The hospital sector

- Hospitals are in ownership of:
- States or communities (app. 40%)
- Social and religious welfare organizations (app. 30%)
- Private companies (app. 30%)

## Funding:

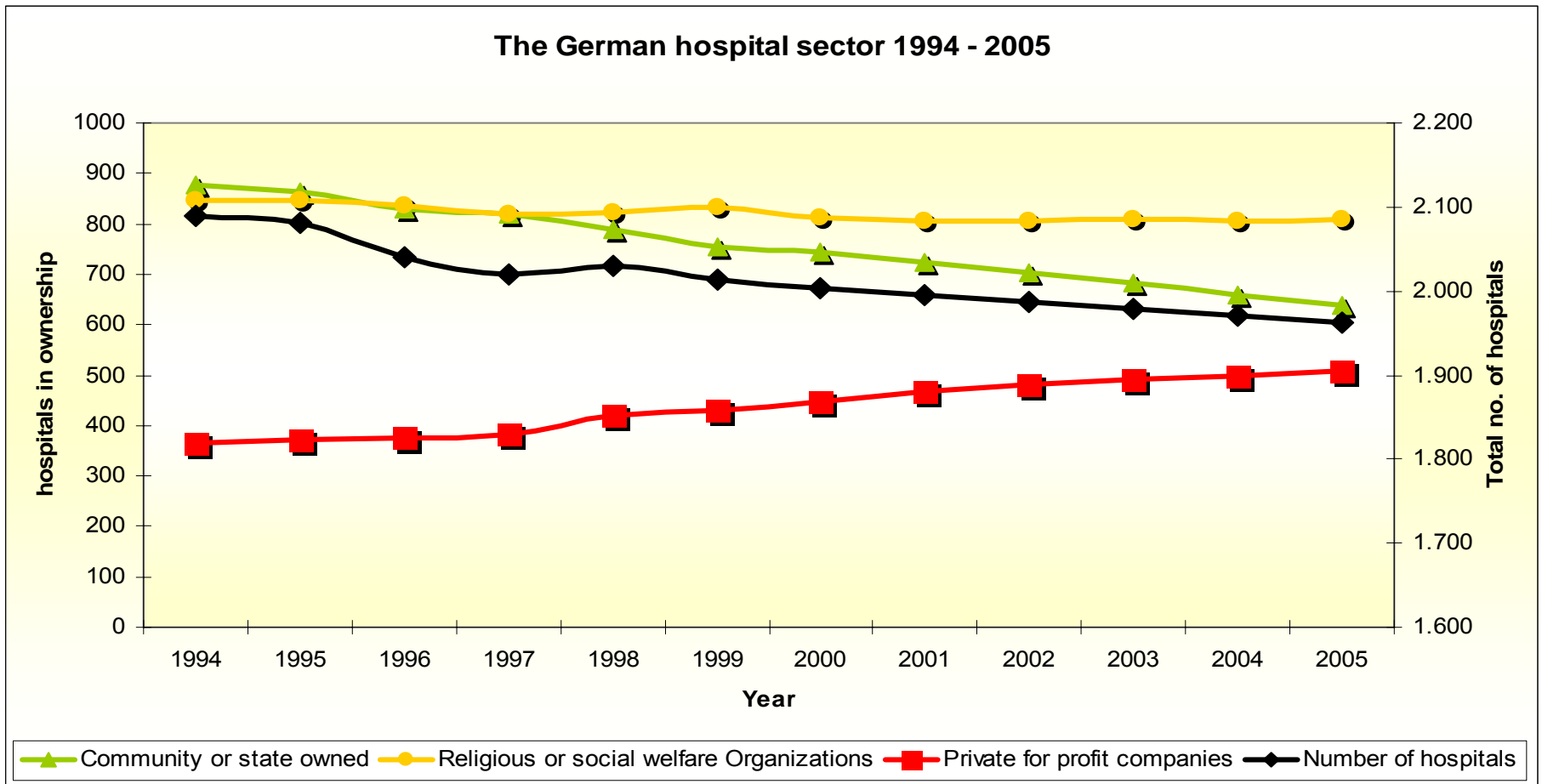
- Buildings and technical equipment → regional state (except private hospitals)
- Medical treatment → insurance (public, private, other)
- All companies contract to the same conditions with each hospital!!

# Hospital financing

The hospital system is heavily regulated by federal and state laws

- Since 1993 continuous budget cap
  - Budget can only grow accordant to cash inflow on insurer's side
  - Insurers income dependent on wage – level
- Since 2000 step-by-step introduction of prospective payment system via DRGs (Diagnoses related groups)  
→ shifting cost risks in treatment from insurance to hospital!
- As introduction is adjusted to relative sloth of public sector, private companies can easily make profits

# Hospital sector in constant shift to private ownership and reduction of total number



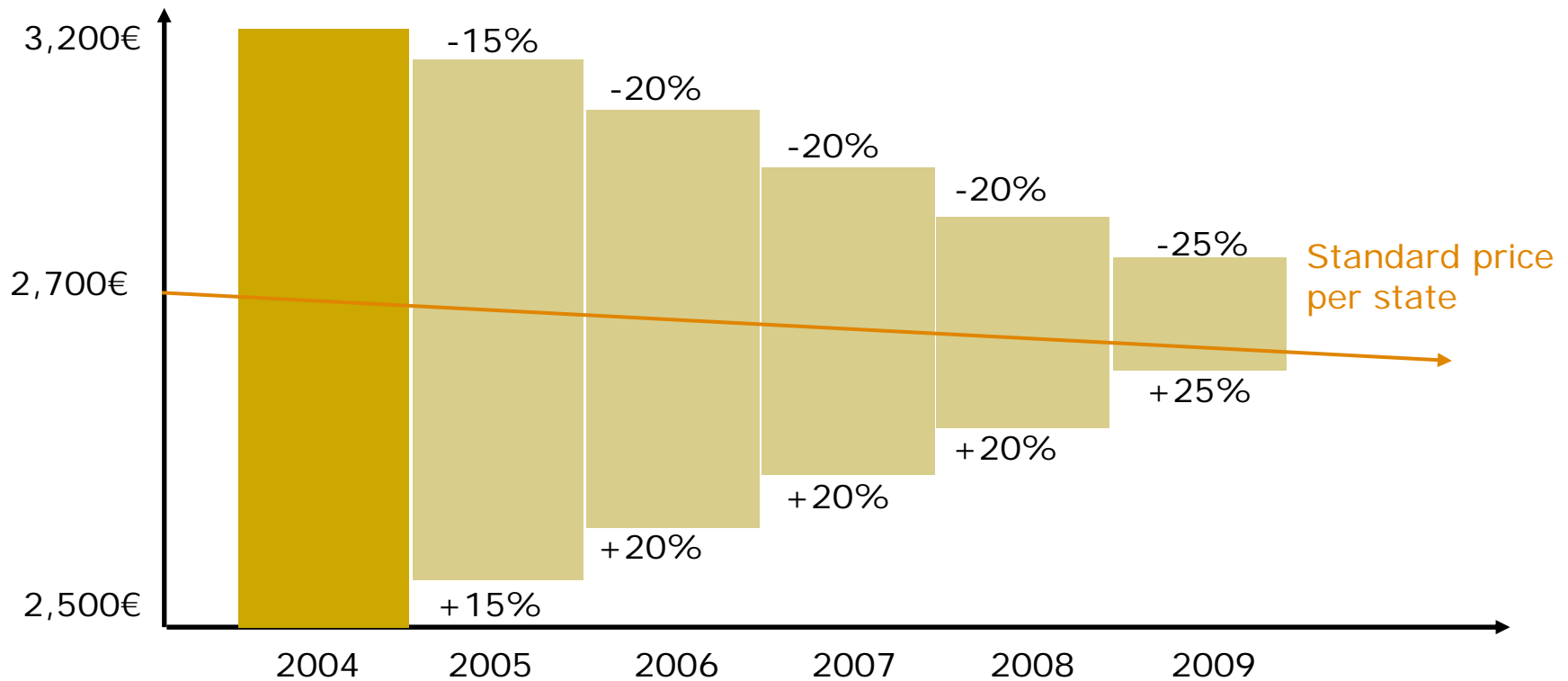
# DRG introduction in Germany

Step-by-step adjustment of hospital income from historical budget to activity based payment → *convergence*

- Expensive hospitals loose budget, cheaper ones get more
- Adjustment happens on state level
- DRG – System does not yet explain all cost differences → if special risks are not paid, the hospitals treating those have a significant market disadvantage (e.g. complicated hospital infections)
- The ***goal*** in Germany is ***100% activity-based payment!***

# ‘Convergence’ – price adjustment

Base price for standard patient (cost weight 1.0)



# Risk adjustment

To prevent taking budget away from the ,wrong' hospitals, the following measures were taken

- Continuous improvement of accuracy (and complexity) of the DRG – payment system
- DRGs for individual negotiation (long-term care for spine injuries, etc.)
- Co-payments (mainly expensive drugs and prosthesis)
- Extra budgets for special tasks (e.g. burn unit, infectious disease isolation unit)

Nevertheless budgets shifts occur mainly from big (university or tertiary) hospitals to smaller ones (with less differentiated treatment)!

# Co-payments

Mainly expensive drugs

- Antifungals
- Chemotherapy
- Intensive care
- Blood and blood products

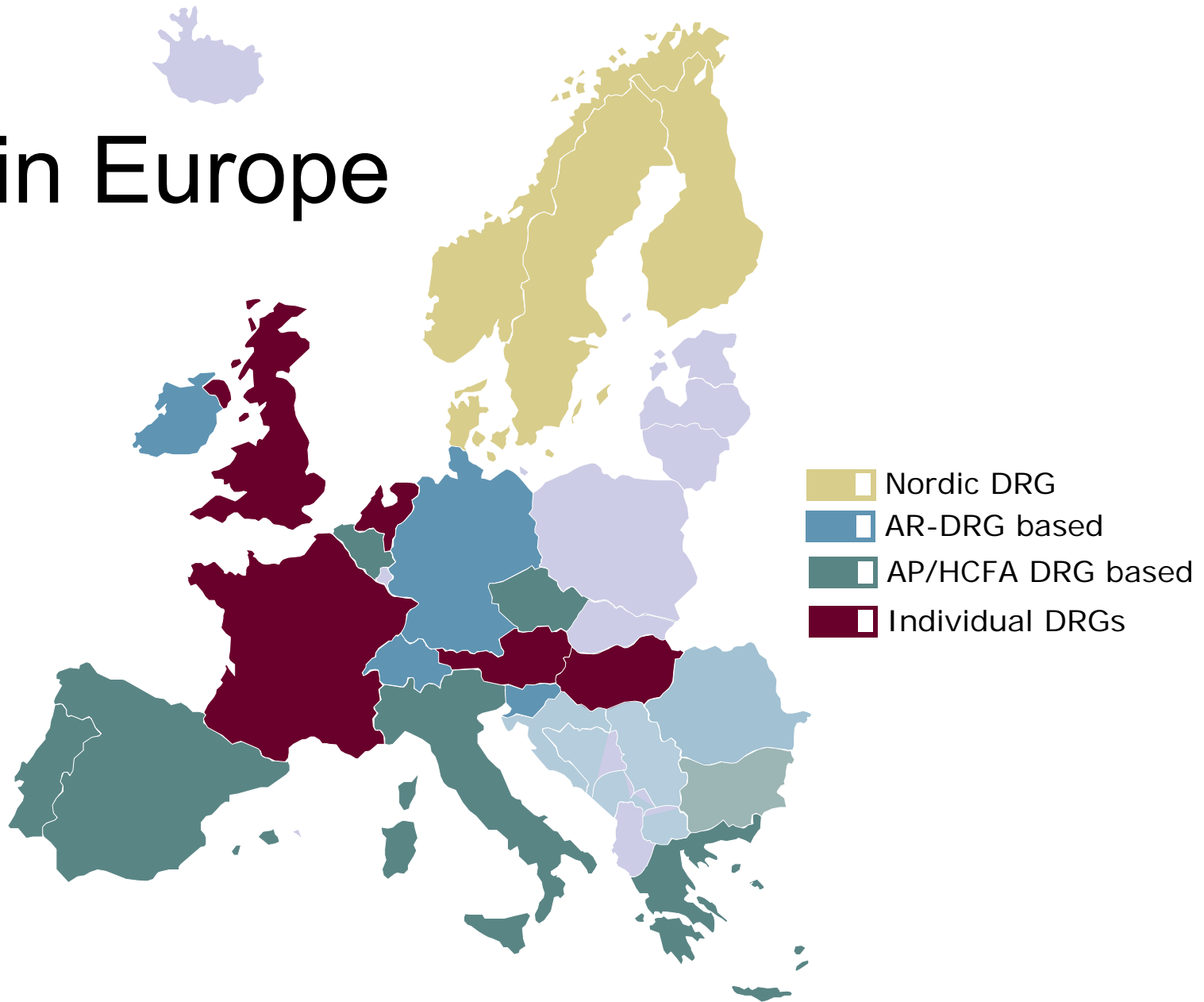
Special opportunity: ‚NUB – payments‘ for NEW diagnostic and therapeutic methods (not older than 3 years, only from year to year, hospitals have to file for individually)

# Outlook 2007 – 2009: Health system financing

Coming changes (health reform effective 04/2007):

- Building up a national healthcare fund
  - Insurance companies get money out of it correspondent to the morbidity of their members
  - Government gives money for unemployed, children, etc.
  - If one company does not collect enough money from the fund, co-payments from the members
- Private companies have to include more members without formal health check before
- Selective contracting will be possible
- Most important: Better possibilities of transsectoral collaboration and building up e.g. population based service structures

# DRG in Europe



# Why DRG?

DRGs are the most common instrument for activity based hospital financing systems in industrial nations worldwide

However, there are the Paradigms of DRG – reimbursement:

- Principally excellent idea, because reimbursement is directly bound to diseases and their related cost
- Moreover it is patient-related
- But: The bigger proportion of the hospital budget to be financed via DRG the more complex they have to be

Additional challenge in Germany: >300 payors

# The German Solution

In Germany the Australian Refined DRG System (AR-DRG) was taken as starting point and then adapted, key features:

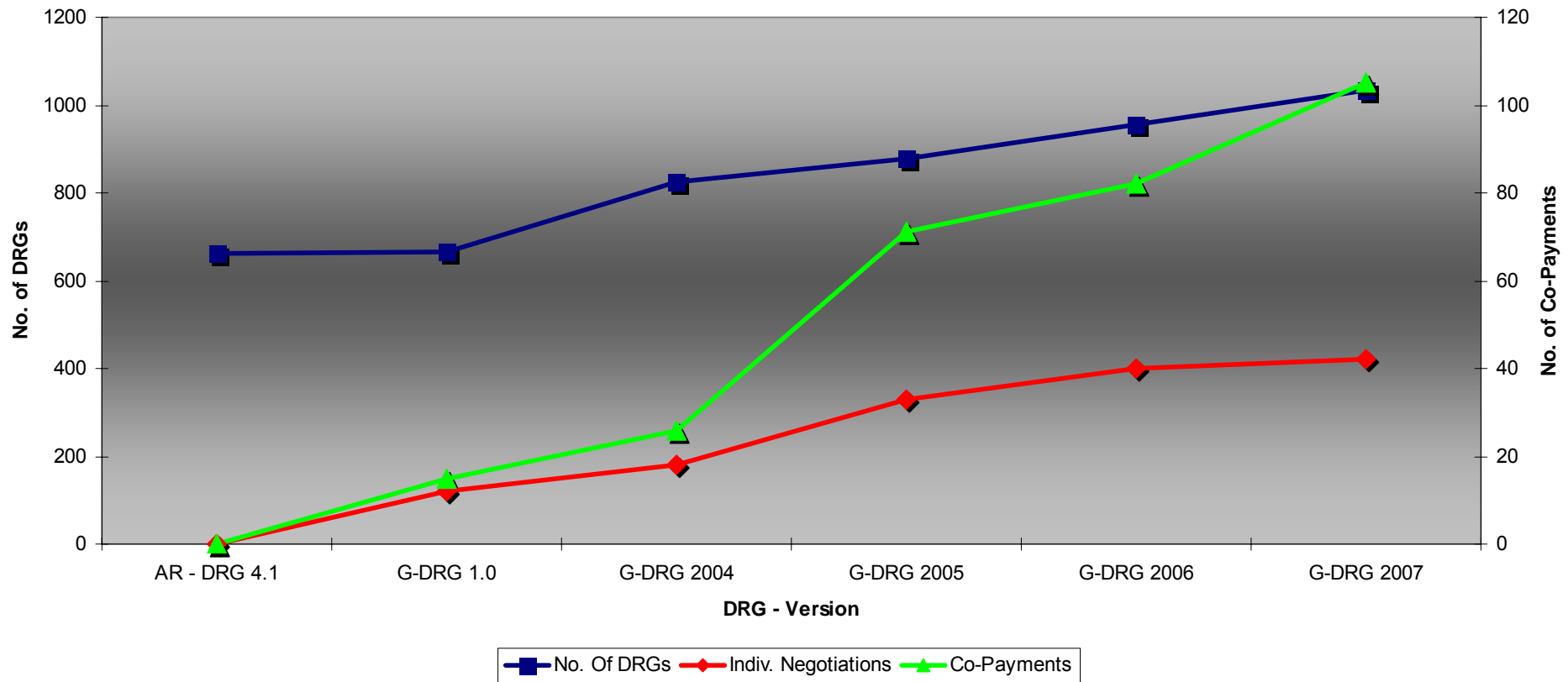
- Strong relation to clinical entities
- Excellent respectation of co-morbidities via CCL/PCCL system
- Logical, hierarchical nomenclature instead of mere *numbers*

Additional features:

- Hours of mechanical ventilation trigger expensive DRGs
- Age and birthweight as further discriminators
- Length of stay is taken into account for short- and long stay outliers

# The German solution II

## *The "Evolution" of G - DRG*





# The German Solution III

G-DRG Version 2007 in brief:

- 1035 DRGs with nationwide cost weights
- 47 DRGs for individual negotiation or same-day
- 105 co-payments
- App. 100 NUB-payments

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# Background

- „The coding represents the bill“ (Dr. B. Rochell, German Medical Association):
- Coding errors lead to wrong DRG - results
- Wrong DRG results lead to wrong bills
- Wrong bills lead to rejection
- Rejection leads to more work and financial problems
- A preliminary project with the German MDK showed lots of action areas

# Goals

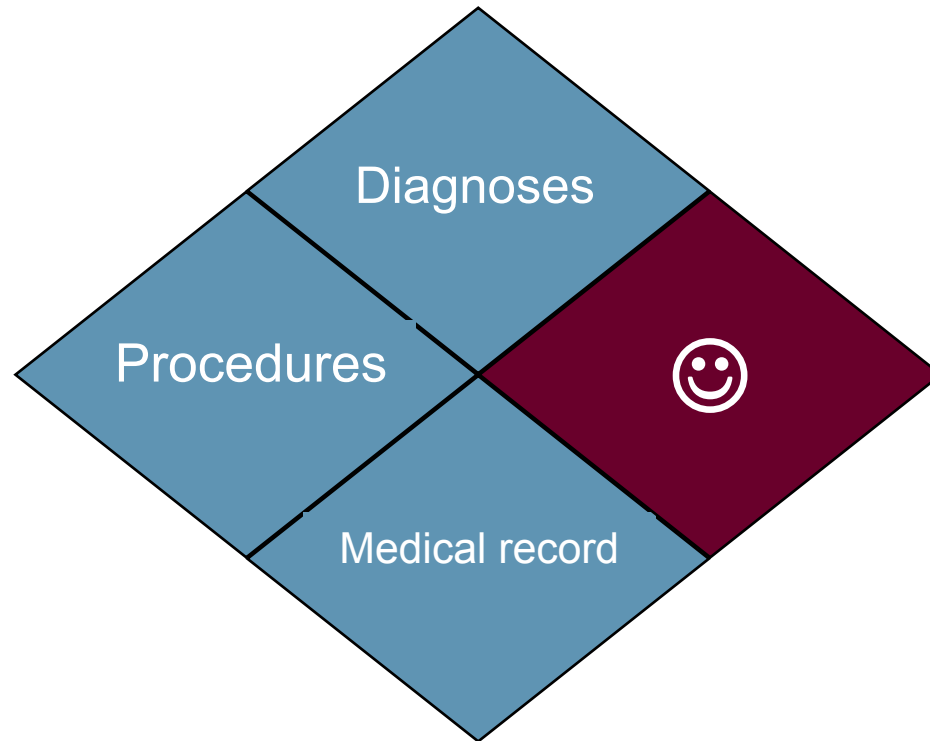
- The development of our „Audit & Fokus“ system aimed at:
- Providing a reliable tool for the measurement of coding quality
- Giving the possibility of benchmarking Coding quality not Casemix points!
- Identifying the areas of interest → where can we improve?
- Measuring financial consequences

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# The scoring system



# Scoring system - diagnoses

<b>Principle diagnosis</b>	wrong			0
	right, but not exact		15	
	right	20		
<b>correctness of sec. Dx</b>	all wrong or not coded			0
	lt. 50% right			2
	mt. 50% right		3	
	all right	5		
<b>Completeness of sec. Dx</b>	no coded, although there were			-5
	lt. 50% coded			-3
	mt. 50% coded		3	
	all coded	5		
<b>Up Coding</b>	n x -1			-X

# Scoring system - procedures

<b>correctness of procedures</b>	all wrong or not coded				<b>0</b>
	lt. 50% right			<b>2</b>	
	mt. 50% right		<b>3</b>		
	all right	<b>5</b>			
<b>completeness of procedures</b>	no coded, although there were				<b>-5</b>
	lt. 50% coded			<b>-3</b>	
	mt. 50% coded		<b>3</b>		
	all coded	<b>5</b>			
		<b>45</b>			

# Scoring system – medical record

<b>Completeness of lab results</b>	incomplete		0		
	complete	2			
<b>Orders for treatment</b>	missing often		0		
	nearly complete	2			
<b>Order in the record</b>	no order, lose stack of paper			-1	
	results often in wrong order		0		
	neat record, good order	1			

# The scoring system – coding quality

<b>Overall coding quality</b>	correct = everything correct				
	some errors = errors without DRG relevance				
	major errors = errors with DRG relevance or wrong PDX				

# Audit & Fokus – The audit process

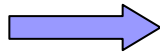
- Drawing a data driven sample (eventually representative = bigger sample)
- Analyzing discharge reports
- Analyzing medical report
- Assessment = Scoring
- Patient report
- Department report → Same day dialogue with the responsables
- Complete report
- Presentation

# „Audit & Fokus“ database

- MS – Access database with import functionality for patient records
- Scoring page to document the results by clicking
- Some functions for summaries

# The 'Audit & Fokus' IT - Tool

Patient-  
Selection



**Patienten wählen**

*Audit-Zentrale*

Krankenhaus: \*  
Fachabteilung: \*

**Patienten:**

44001513	Amler	Sigrid
44001378	Glavic	Ivan
44001243	Koller	Christian
44001163	Schubert	Erna
44001120	Samara	Despoina
44001119	Rosenthal	Edith
44001111	Jauss	Gertrud
44001109	Wamsler	Anneliese
44001091	Gittinger	Erna
44001080	Wieber	Peter
44001067	Bachmann	Hartmut
44001054	Altun	Günay
44001045	Krayl	Elise
44001032	Schäfer	Johanna
44001024	Linkert	Alma
44001023	Diel	Gertrud
44001016	Fortomaris	Pantelis
44001015	Evren	Fatma
44001012	Hees	Oskar
34001199	Horn	Karl-Heinz

**Kumulativer  
Abteilungsbericht**

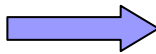
**Gesamtauswertung**

**Patient laden**

**Schließen**

# The 'Audit & Fokus' IT - Tool

Patient-  
summary



**Dokumentationsaudit**

Datei Bearbeiten Ansicht Einfügen Format Datensätze Extras Fenster ?

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**Patient**

Patientennummer: 14010533 Krankenhaus: LB Aufgenommen am: 04.02.2004 Pruefdatum: 20.04.2004 Heute  
 Name: Lindenberger Hauptabteilung: 1700 Entlassen am: 24.02.2004 Prüfer: Dr. Peiseler  
 Vorname: Max MDC: 08 DRG: I10B Rg: 1.443 PCCL: 0 VWD: 20  
 Text: Andere Eingriffe an der Wirbelsäule ohne äußerst schwere CC ugvd: 3 mvd: 11 ogvd: 21  
 DRG-Version: 2.0 MDC neu: DRG neu: PCCL neu: 0 RG Neu: 0

**Diagnosen**

pat	Hauptdia	Code	Titel	dia_status
14010533	0	E66.0	Adipositas durch übermäßige Kalorienzufuhr	korrekt
14010533	1	M51.1	Lumbale und sonstige Bandscheibenschäden mit Radikulopathie	korrekt
*				

**Prozeduren**

pat	proc_nr	Code2004	Titel	proc_korrekt
14010533	1	3-203	Native Computertomographie von Wirbelsäule und Rückenmark	korrekt
14010533	2	5-032.10	Zugang zur Lendenwirbelsäule, zum Os sacrum und zum Os coccygis:	korrekt
14010533	3	5-032.30	Zugang zur Lendenwirbelsäule, zum Os sacrum und zum Os coccygis:	korrekt
14010533	4	5-037.1	Operationen an intraspinalen Blutgefäßen: Präparation und Destruktion	korrekt
14010533	5	5-831.0	Exzision von erkranktem Bandscheibengewebe: Exzision einer Bandscheibe	korrekt
14010533	6	5-832.4	Exzision von erkranktem Knochen- und Gelenkgewebe der Wirbelsäule:	korrekt
14010533	7	5-984	Mikrochirurgische Technik	korrekt

**Bemerkung:**  
 Kodierung der 5-037.1 - Operationen an intraspinalen Blutgefäßen nur verwenden, wenn es sich um einen selbständigen Eingriff handelt.

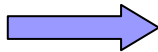
**Score:**  
 16

Bericht drucken Audit öffnen  
 Berichtsvorschau Schließen

Formularansicht FLTR

# The 'Audit & Fokus' IT - Tool

Audit-  
documentation



**Dokumentationsaudit**

File Edit View Insert Format Data Sets Extras Window ?

Tahoma 8 F X U

**Audit & Fokus**

### Checkliste

Patientenidentifikation: 4010538  
Name: Lindenberger  
Vorname: Max  
Krankenhaus: LB  
Abteilung: 1700

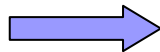
<b>Ordnung in der Akte</b> <ul style="list-style-type: none"><li><input type="radio"/> Keine erkennbare Ordnung</li><li><input type="radio"/> Befunde häufig falsch eingeordnet</li><li><input checked="" type="radio"/> Weitgehend einheitliche Ordnung</li></ul>	<b>Vollständigkeit Befunde</b> <ul style="list-style-type: none"><li><input type="radio"/> Unvollständig</li><li><input checked="" type="radio"/> Vollständig</li></ul>	<b>AEP Beurteilung</b> <ul style="list-style-type: none"><li><input checked="" type="radio"/> Korrekt 2</li><li><input type="radio"/> Diskussionsbedarf 1</li><li><input type="radio"/> Keine Stat. Behandlung 0</li></ul>
<b>Hauptdiagnose</b> <ul style="list-style-type: none"><li><input type="radio"/> Zuordnung falsch -3</li><li><input type="radio"/> Diagnose richtig, aber falsch kodiert 1</li><li><input type="radio"/> Diagnose richtig, aber zu ungenau kodiert 2</li><li><input checked="" type="radio"/> Diagnose richtig 3</li></ul>	<b>Richtige Kodierung von Nebendiagnosen</b> <ul style="list-style-type: none"><li><input type="radio"/> Alle ND falsch oder nicht kodiert 0</li><li><input type="radio"/> Weniger als 50% aller kodierten ND richtig kodiert 1</li><li><input checked="" type="radio"/> Mindestens 50% aller kodierten ND richtig kodiert 2</li><li><input type="radio"/> Alle kodierten ND richtig kodiert/Keine ND vorh. 3</li></ul>	<b>Vollständigkeit relevanter ICD</b> <ul style="list-style-type: none"><li><input type="radio"/> Keine relevanten ND kodiert, obwohl vorhanden 0</li><li><input type="radio"/> Weniger als 50% relevanter ND kodiert 1</li><li><input type="radio"/> Mindestens 50% relevanter ND kodiert 2</li><li><input checked="" type="radio"/> Alle relevanten ND kodiert oder keine vorhanden 3</li></ul>
<b>Richtige Kodierung der Prozeduren</b> <ul style="list-style-type: none"><li><input type="radio"/> Alle angegebenen Proz. falsch oder nicht kodiert 0</li><li><input type="radio"/> Weniger als 50% aller Prozeduren richtig kodiert 1</li><li><input checked="" type="radio"/> Mindestens 50% aller Prozeduren richtig kodiert 2</li><li><input type="radio"/> Alle Prozeduren richtig kodiert/Keine Proz. vorh. 3</li></ul>	<b>Vollständigkeit durchgef. Prozeduren</b> <ul style="list-style-type: none"><li><input type="radio"/> Keine Prozeduren kodiert obwohl vorhanden 0</li><li><input type="radio"/> Weniger als 50% aller Prozeduren kodiert 1</li><li><input checked="" type="radio"/> Mindestens 50% aller Prozeduren kodiert 2</li><li><input type="radio"/> Alle Prozeduren kodiert/Keine Prozeduren vorh. 3</li></ul>	<b>DRG Differenz</b> <ul style="list-style-type: none"><li><input type="radio"/> Ja</li><li><input checked="" type="radio"/> Nein</li></ul> <b>RG Differenz</b> <ul style="list-style-type: none"><li><input type="radio"/> Ja</li><li><input checked="" type="radio"/> Nein</li></ul> <b>Liegedauer</b> <ul style="list-style-type: none"><li><input checked="" type="radio"/> in GVD</li><li><input type="radio"/> &lt; untere GVD</li><li><input type="radio"/> &gt; obere GVD</li></ul>
<b>Kodierqualität</b> <ul style="list-style-type: none"><li><input type="radio"/> Korrekt 2</li><li><input checked="" type="radio"/> Kleinere Beanstandungen 1</li><li><input type="radio"/> Gravierende Beanstandungen 0</li></ul>	<b>Bemerkung:</b> Kodierung der 5-037.1 - Operationen an intraspinalen Blutgefäßen nur verwenden, wenn es sich um einen selbständigen Eingriff handelt.	

**Schliessen**

Formularansicht

# The 'Audit & Fokus' IT - Tool

Patient report



Dokumentationsaudit - [rptPatAudit : Bericht]

Datei Bearbeiten Ansicht Extras Fenster ?

100% Schließen

**Checkliste Audit**

Krankenhaus: LB                      Abteilung: 1700

Patientenidentifikation: 14010533                      Prüfdatum: 20.04.2004

Name: Lindenberger                      Vorname: Max                      Prüfer: Dr. Peisler

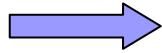
<b>Ordnung in der Akte</b> <ul style="list-style-type: none"><li><input type="radio"/> Keine erkennbare Ordnung</li><li><input type="radio"/> Befunde häufig falsch eingeordnet</li><li><input checked="" type="radio"/> Weitgehend einheitliche Ordnung</li></ul>	<b>Vollständigkeit Befunde</b> <ul style="list-style-type: none"><li><input type="radio"/> Unvollständig</li><li><input checked="" type="radio"/> Vollständig</li></ul>	<b>AEP Beurteilung</b> <ul style="list-style-type: none"><li><input checked="" type="radio"/> Korrekt</li><li><input type="radio"/> Diskussionsbedarf</li><li><input type="radio"/> Keine Stat. Behandlung</li></ul>
<b>Hauptdiagnose</b> <ul style="list-style-type: none"><li><input type="radio"/> Zuordnung falsch</li><li><input type="radio"/> Diagnose richtig, aber falsch kodiert</li><li><input type="radio"/> Diagnose richtig, aber ungenau kodiert</li><li><input checked="" type="radio"/> Diagnose richtig</li></ul>		
<b>Richtige Kodierung von Nebendiagnosen</b> <ul style="list-style-type: none"><li><input type="radio"/> Alle ND falsch oder nicht kodiert</li><li><input type="radio"/> Weniger als 50% aller kodierten ND richtig kodiert</li><li><input checked="" type="radio"/> Mindestens 50% aller kodierten ND richtig kodiert</li><li><input type="radio"/> Alle kodierten ND richtig kodiert/Keine ND vorh.</li></ul>	<b>Vollständigkeit relevanter ND</b> <ul style="list-style-type: none"><li><input type="radio"/> Keine relevanten ND kodiert, obwohl vorhanden</li><li><input type="radio"/> Weniger als 50% relevanter ND kodiert</li><li><input type="radio"/> Mindestens 50% relevanter ND kodiert</li><li><input checked="" type="radio"/> Alle relevanten ND kodiert oder keine vorhanden</li></ul>	
<b>Richtige Kodierung der Prozeduren</b> <ul style="list-style-type: none"><li><input type="radio"/> Alle angegebenen Proz. falsch oder nicht kodiert</li><li><input type="radio"/> Weniger als 50% aller Prozeduren richtig kodiert</li><li><input checked="" type="radio"/> Mindestens 50% aller Prozeduren richtig kodiert</li></ul>	<b>Vollständigkeit durchgef. Prozeduren</b> <ul style="list-style-type: none"><li><input type="radio"/> Keine Prozeduren kodiert obwohl vorhanden</li><li><input type="radio"/> Weniger als 50% aller Prozeduren kodiert</li><li><input checked="" type="radio"/> Mindestens 50% aller Prozeduren kodiert</li></ul>	

Seite: 1

Bereit

# The 'Audit & Fokus' IT - Tool

Entry for  
Department report



**Dokumentationsaudit**

File Edit View Insert Format Data Sets Extras Window ?

MS Sans Serif 8 F X U

### Fachabteilungsauswertung

Kategorie	Unterkategorie	Fälle
Beurteilung nach AEP-Kriterien	Keine stat. Behandlung	1
Beurteilung nach AEP-Kriterien	Disk	
Beurteilung nach AEP-Kriterien	Korre	
Korrektheit der Hauptdiagnose	Zuon	
Korrektheit der Hauptdiagnose	Diagn	
Kodierqualität	Grav	
Kodierqualität	Klein	
Kodierqualität	Korre	
Nebendiagnosen komplett	Keine	
Nebendiagnosen komplett	Weni	
Nebendiagnosen komplett	Minde	
Nebendiagnosen komplett	Alle r	

**Kommentar**  
Krankenhaus:  Abteilung:   
**Beurteilung**  
Lange Latenz zwischen Aufnahme und OP - Termin.  
Aufnahmegrund im Abschlussbericht selten erwähnt.  
In einem Fall Wiederaufnahme / Fallzusammenführung.

**Empfehlung**  
Optimierung des Abschlussberichts.  
Überprüfung der präoperativen Vorlaufzeiten.  
5-037.1 (Eingriff an spinalen Gefäßen) nur in begründeten Fällen zu kodieren, nicht als Beschreibung von Elektrokoagulation.

Datensatz: 1 von 21

Formularansicht

# The 'Audit & Fokus' IT - Tool

cumulative  
Department report



**Dokumentationsaudit - [rptKategorieFab]**

Abteilungsreport Audit & Fokus Datum: 05.05.2004

*Beteiligte*

Funktion	Name
Prüfer	Dr. Peiseler
Medizincontrolling	Fr. Dr. Keller

*Abteilung* Neurochirurgie

*Beurteilung nach AEP-Kriterien*

Ausprägung	Nennungen
Diskussionsbedarf	3
Korrekt	10
Keine stat. Behandlung	1

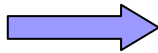
*Kodierqualität*

Ausprägung	Nennungen
Kleinere Beanstandungen	11
Korrekt	1
Gravierende Beanstandungen	2

Seite: 1  
Bereit

# The 'Audit & Fokus' IT - Tool

Report  
sample



**Dokumentationsaudit - [rptKategorie]**

File Edit View Extras Window ?

100% Schließen

*Gesamtauswertung Audit & Fokus* Datum: 05.05.2004

Krankenhaus	Kategorie	Subkategorie	Fälle
BI			
	Beurteilung nach AEP-Kriterien	Diskussionsbedarf	9
	Beurteilung nach AEP-Kriterien	Keine stat. Behandlung	11
	Beurteilung nach AEP-Kriterien	Korrekt	39
	Kodierqualität	Gravierende Beanstandungen	14
	Kodierqualität	Kleinere Beanstandungen	23
	Kodierqualität	Korrekt	22
	Korrektheit der Hauptdiagnose	Diagnose richtig	42
	Korrektheit der Hauptdiagnose	Diagnose richtig, aber zu ungenau kodiert	4
	Korrektheit der Hauptdiagnose	Zuordnung falsch	13
	Korrektheit der Nebendiagnosen	Alle kodierten ND richtig kodiert / Keine ND vorhanden	29
	Korrektheit der Nebendiagnosen	Alle ND falsch oder nicht kodiert	4
	Korrektheit der Nebendiagnosen	Mindestens 50% aller kodierten ND richtig kodiert	15
	Korrektheit der Nebendiagnosen	Weniger als 50% aller kodierten ND richtig kodiert	11
	Korrektheit der Prozeduren	Alle angegebenen P roz. Falsch oder nicht kodiert	2
	Korrektheit der Prozeduren	Alle Prozeduren richtig kodiert / Keine Prozeduren v	54

Seite: 1/1

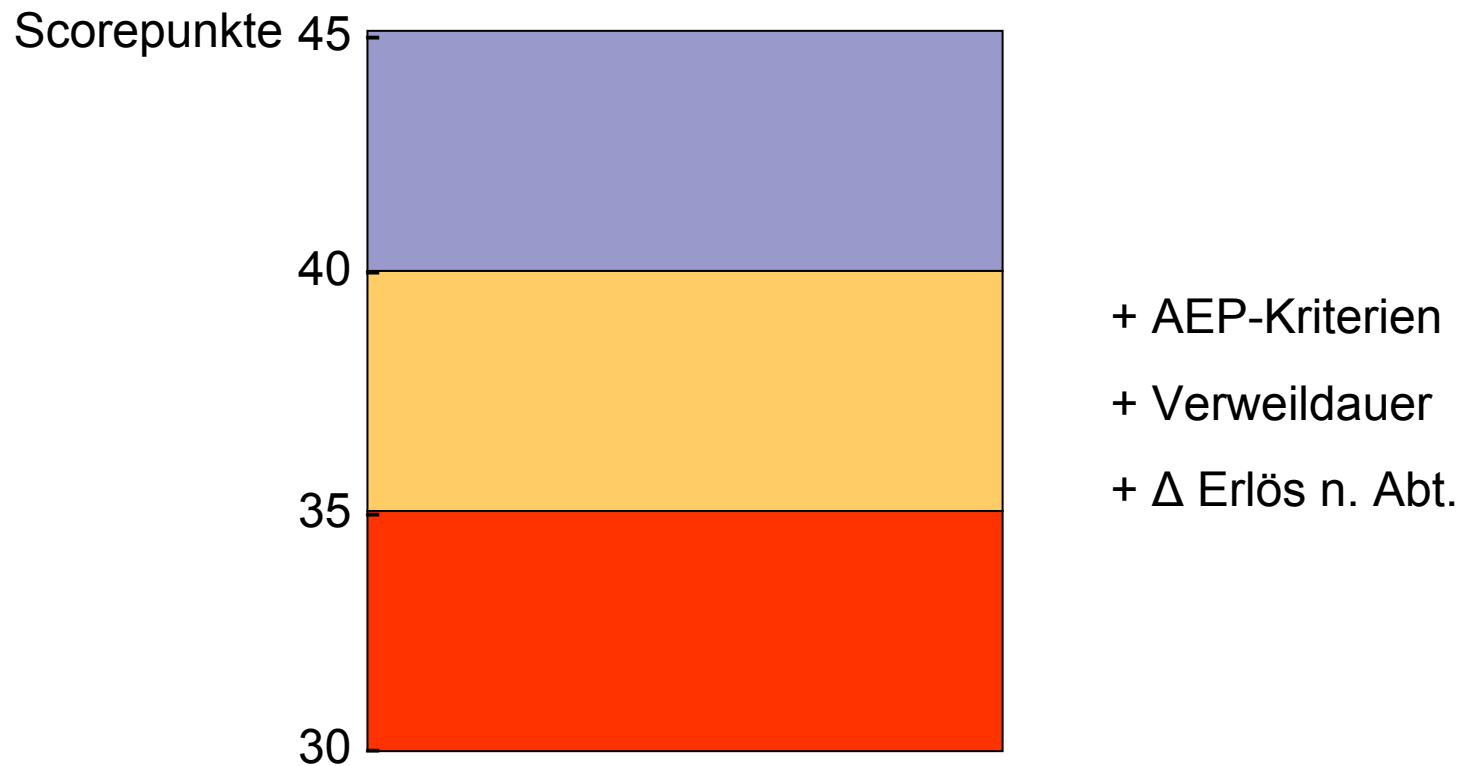
Bereit

# Agenda

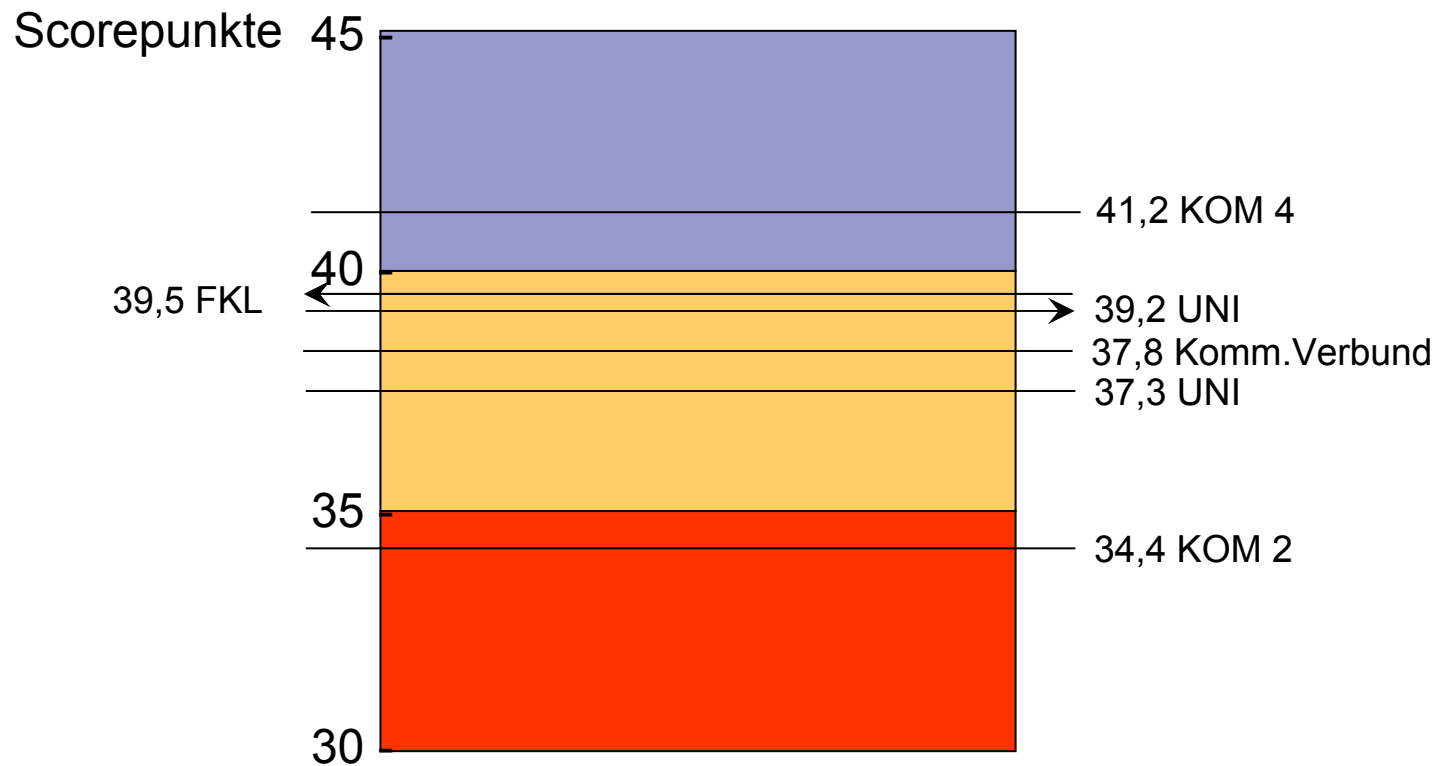
- Introduction
- The German Health System
- Background & objectives
- The scoring system in detail
- Sample Results



# Audit & Fokus Interpretation

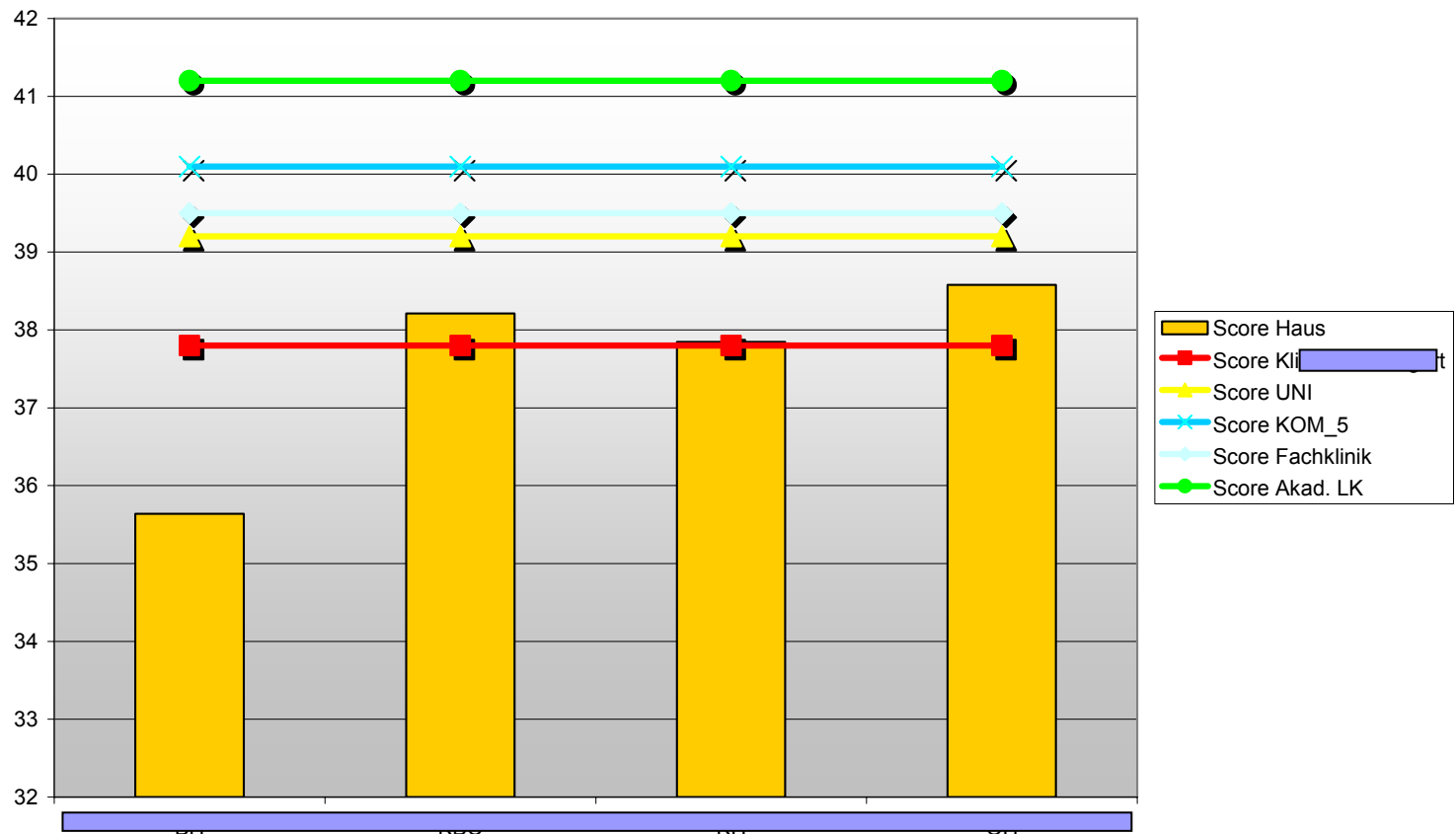


# Audit & Fokus Results I



# Audit & Fokus Sample Results II – Benchmarking Coding Scores

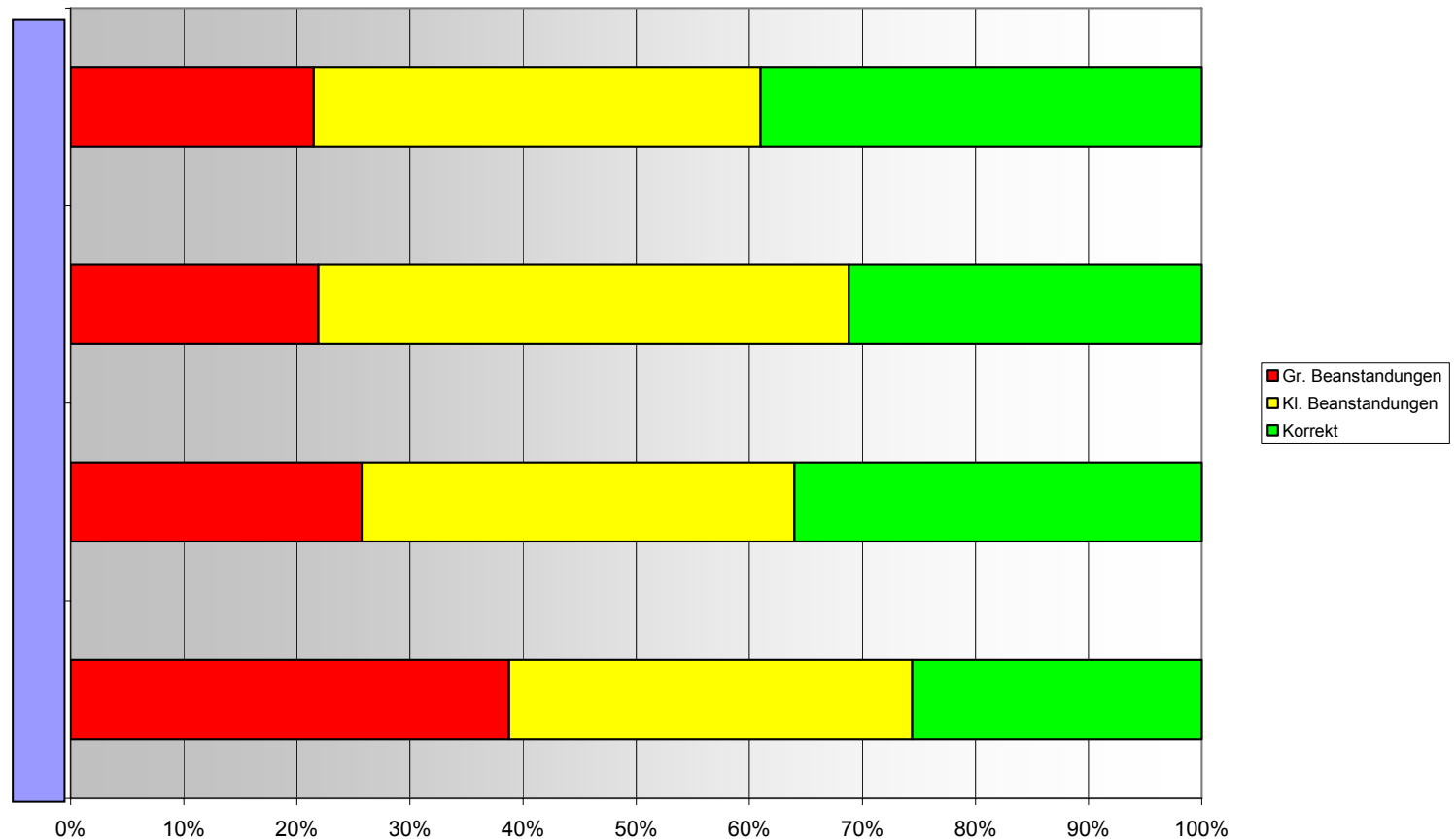
"Der MDK ist da!" Audit & Fokus [redacted]  
Dokumentations-Score (max = 45) & Benchmark (Datenbasis: n= 861)



# Audit & Fokus Sample Results III

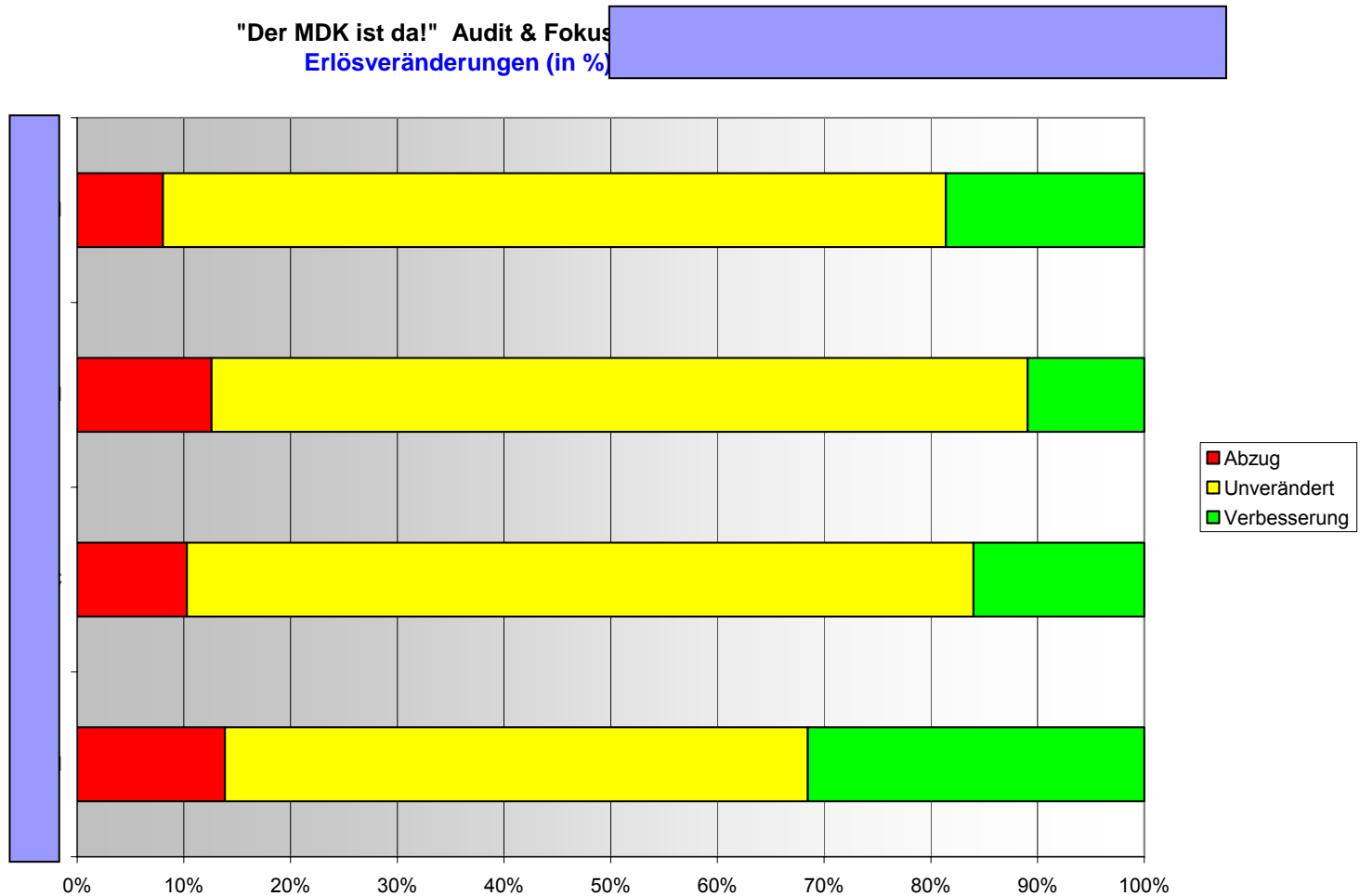
## – Coding Quality

"Der MDK ist da!" Audit & Fokus Klinikur  
(Anteile in %) pro Kra



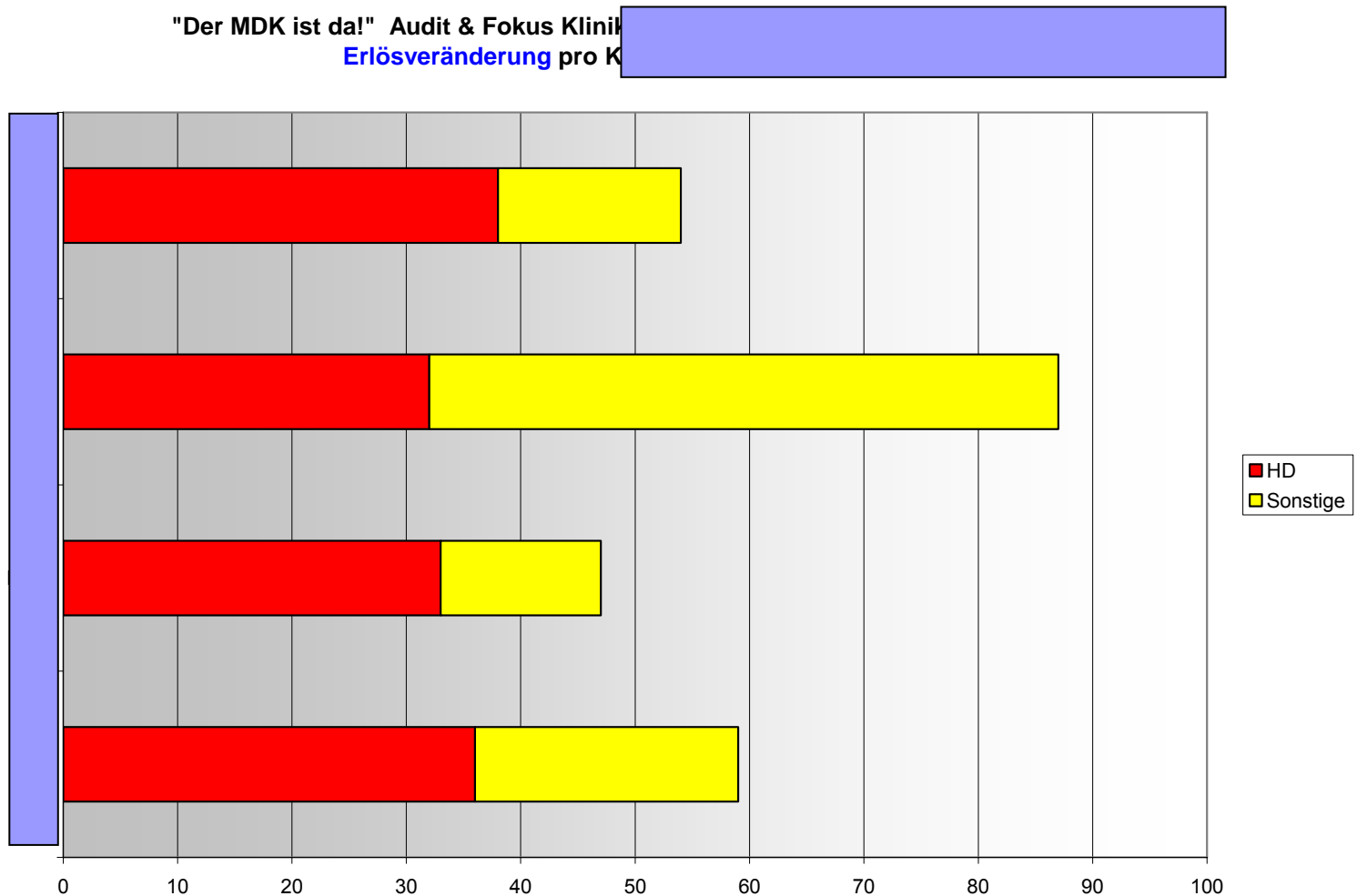
# Audit & Fokus Sample Results IV – Financial consequences

"Der MDK ist da!" Audit & Fokus  
Erlösveränderungen (in %)



# Audit & Fokus Sample Results V- Reasons for DRG - change

"Der MDK ist da!" Audit & Fokus Klinik  
Erlösveränderung pro K



# Conclusions - I

- Pro's:
- Scoring system gives good and representative results to assess coding quality
- Especially structural problems are easily unveiled
- Repetitive use can show developments
- Benchmarking between similar departments in different hospitals is feasible

# Conclusions - II

- Limitations:
- Due to sample size limited predictive value for CaseMix impact of whole department/hospital
- High scores often reflect „easy“ patients



# So, in the end:

***„There are no simple answers to complex questions!“***

(Don Hindle, 2001)

***BUT***

***„The path is the goal“***

(various philosophers)

**Thank you very much for your  
attention!**



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