There is a poster that I’ve seen in several hospital departments around the country: “TEAM: Together Everyone Achieves More.”

The problem, as I see it, is that developing a team takes more than just a poster. It takes collaboration, patience, and trust. These three qualities are often in short supply when facilities drive coders’ and CDI specialists’ workloads by productivity standards and financial considerations rather than accurate data and compliance.

Coders are accountable for every code they assign. They must make sure to use the correct specific code and that the record supports the condition for the code they assigned. When they review a record that contains nonspecific terminology, vague wording, or inconsistencies, they may feel that the CDI specialist has not done his or her job, as many new CDI programs are “sold” to the coding staff with the premise that it will reduce or eliminate the need for retrospective queries, thus making the coder’s job easier.

On the other hand, many CDI program leaders tell documentation specialists to focus on reviewing those records.
‘TEAM’ approach
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that have “opportunity” as defined by records with the potential for increasing revenue, minimizing audit risk, or improving documentation in a specific service line.

Seldom does facility leadership instruct CDI specialists to focus on overall compliant documentation, regardless of the reimbursement or data quality. This differing set of expectations divides the team. It makes getting the two groups to work together a momentous challenge.

The following steps describe the suggested blueprint for fostering increased collaboration among CDI specialists and coding staff members.

Step 1: Define clear expectations

Building a strong CDI/coding team needs to start with a straightforward description of goals. These should be clear and definable so that success is measurable. Examples of CDI program expectations might be that all physician queries will be resolved prior to final coding and billing. This type of expectation ensures that the coders’ goals are met (i.e., questionable documentation will be clarified prior to coding).

Defining the process for accomplishing this goal depends on input and agreement from the executive team as well as the coders and documentation specialists. The coders need to know that holding a record from final billing will not result in criticism. The documentation specialists need to know that the executive team supports their work in identifying opportunities to clarify documentation as a valuable component of accurate data reporting.

Step 2: Meet on a regularly scheduled basis

Both groups should have the opportunity to meet regularly. It may be daily, weekly, or monthly, depending on how long the documentation program has been in place, but management should support this time and view it as an integral part of the documentation improvement process, not time away from work.

Teams must interact to be successful. Regularly scheduled meeting times allow team members to collaborate on ongoing documentation initiatives, take part in ongoing education, discuss issues, and develop solutions.

Today, many coders work off-site and communicate primarily via e-mail or telephone. Often, CDI specialists have limited access to the coders due to administratively imposed restrictions. Lack of ongoing communication limits the team’s problem-solving ability.

It is inefficient for coders to receive random calls throughout their day; therefore, it is important to provide a designated process for communicating questions and answers, which benefits both groups without affecting the productivity of either.

This process may include designating one person (e.g., a DRG analyst) to respond to CDI specialists’ questions during a specific time frame, either via e-mail or telephone. This may take place in the morning or the afternoon, depending on work schedules.

The coders need assurance that CDI specialists will consider records held for additional documentation a priority. If the documentation specialist owns a query until a physician response is received, a defined process for obtaining a response should be developed by the coders and documentation specialists with input and support from the program leaders and, wherever possible, the facility’s executive team.

Step 3: Implement conflict resolution processes

When conflict arises between a coder and documentation specialist, the team should have a mechanism for conflict resolution. Is it a question of whether the record supports a diagnosis or whether the documentation is sufficient for code assignment? The CDI team should consider designating a staff member as the deciding authority, a person whose determination will be
considered final. For clinical issues, this may be a physician advisor/champion or the chief medical officer. If it’s a coding issue, it may be the HIM director (see “Try this CDI conflict resolution” below).

Avoid, at all costs, procedures that eliminate one of the parties from the process, such as:

» “I asked another coder and he/she agreed with me, so I dropped the bill.”

» “I reviewed the record and the query was answered, so you have to code it.”

If the same situation arises frequently, it indicates problems with the current process and additional team discussion or process revision may be necessary to meet everyone’s goals.

A common problematic situation is when CDI team members report to different levels of administration. For example, HIM often reports to finance and the CDI specialists often report to case management who then reports to nursing or quality. If the directors of these groups do not present a united approach, conflict between the coders and documentation specialists will be difficult to resolve.

To address this problem, have the CDI team report up through the same administrator or implement an executive steering committee responsible for defining goals and expectations.

Step 4: Have patience and perseverance

Patience and trust are the most difficult qualities to achieve and the easiest to lose. Well-defined program expectations and adherence to agreed processes and procedures will build trust. All team members require patience. New CDI programs experience growing pains, such as the long learning curve for new CDI specialists. Even a good didactic program doesn’t address every documentation issue; the CDI specialists learn on the job, and patient feedback from the coders will speed this process.

Effective teams are not built overnight, but with patience, collaboration, and trust, everyone can achieve the desired goal of obtaining the most accurate information for inclusion in the patient’s medical record.

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Try this CDI conflict resolution

The following is an example of a conflict that typically occurs between coding and CDI staff and a recommendation for a conflict resolution.

The conflict

A physician documents “renal insufficiency” in the progress notes and H/P. Based on the serum creatinine values, the CDI specialist generates a physician query for additional clarification (i.e., “acute renal failure?”). The attending physician documents “acute renal failure” in the next progress note, but subsequent notes provided by the attending physician’s partner state “renal insufficiency.” The diagnosis is not documented in the discharge summary.

Since the condition “acute renal failure” was documented only once in the record, the coder feels that the record does not adequately support code assignment. However, the CDI specialist feels that the lab values and treatment plan do support the code and notes that it’s the only MCC for the case. Omitting this code results in a lower-weighted DRG assignment.

A discussion between the coder and the CDI specialist results in a standoff: The coder feels that coding the condition would be upcoding, and the CDI specialist feels that her efforts were not successful.

The solution

The case is referred to the team’s physician advisor, who reviews the record from a clinical perspective. Based on the patient’s condition and treatment plan, she feels that “acute renal failure” accurately describes the circumstance and meets the clinical definition of acute renal failure. She then contacts the patient’s attending physician and discusses the case. A retrospective query is generated to the attending physician, who then adds an addendum to the progress notes and the discharge summary.