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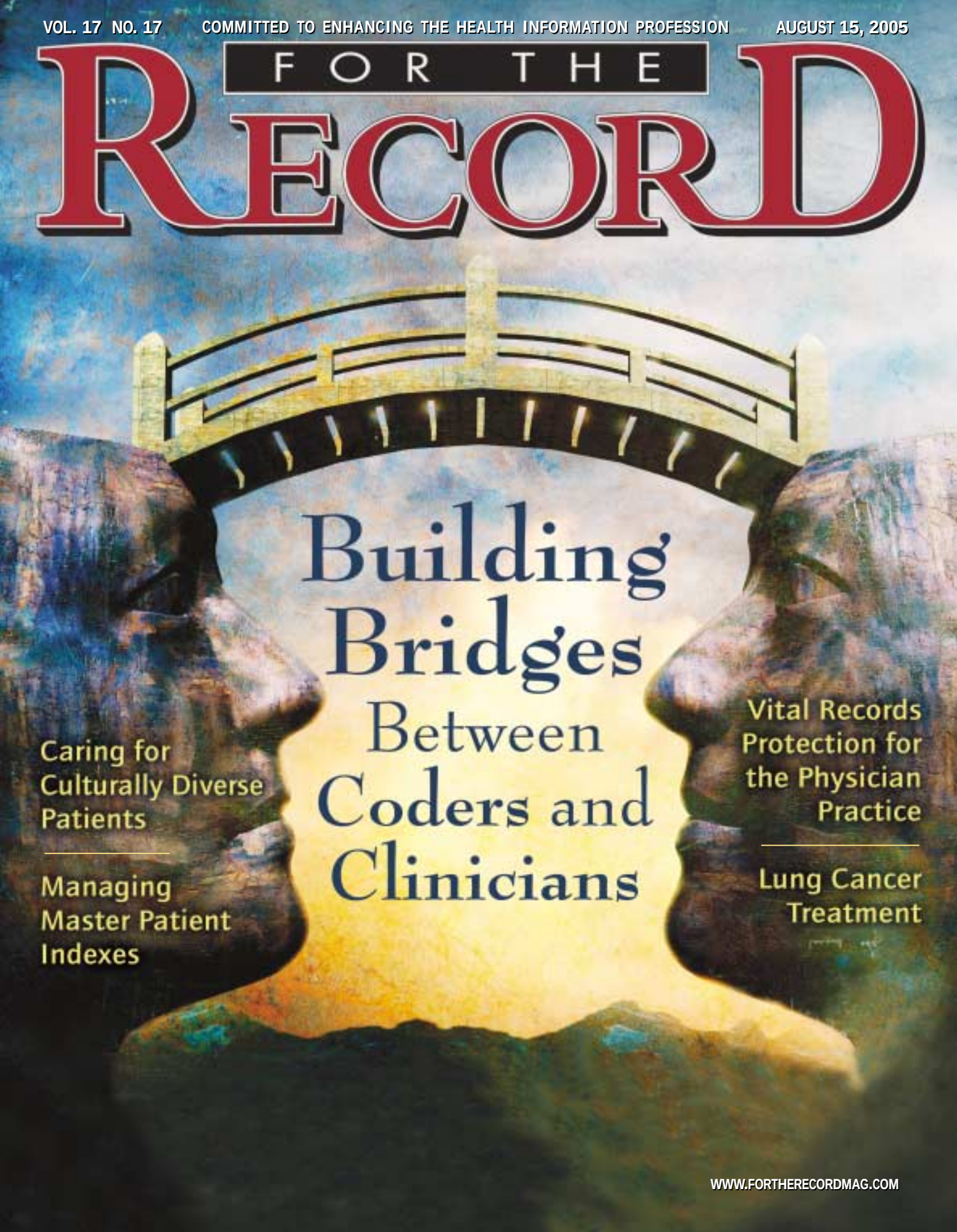
FOR THE RECORD



Building Bridges Between Coders and Clinicians

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Building Bridges Between Coders and Clinicians

By Michael von Grey, BSc, MBA

For The Record
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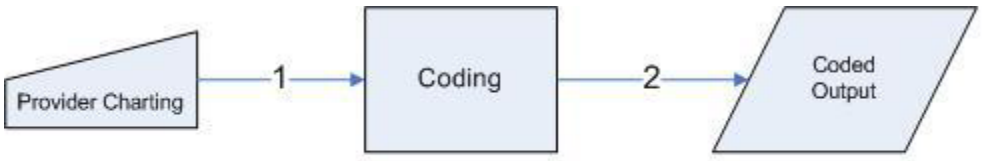
Coding quality depends on timely, thorough clinical documentation. One healthcare provider has raised compliance and improved revenue by connecting coders with doctors.

The medical coding profession in the United States exists because the complexity of coding rules require specialized staff with a deep knowledge base and continuous learning to stay abreast of evolving policies. Physicians and nurses are not trained as coders and would find it difficult to master the time-consuming and technically tricky coding function while also performing their caregiving roles.

Coding accuracy is a lynchpin for both regulatory compliance and hospitals' financial health. Yet there is a built-in contention between staff delivering care and those who ultimately "keep score" of what care is delivered and whether it is medically necessary. This article explores the nature of the contention and innovative ways in which coders and clinicians can integrate their activities more fully—with resulting benefits for the provider organization.

Conventional Information Flow

The information flow from treatment to bill tends to be unidirectional in most provider settings. Specifically, doctors and nurses complete their charting activities, with the patient record flowing to the coder for code assignment and onward to the billing department for bills to be sent. The flow of information can be illustrated as follows:



Unidirectional (Traditional) Data Flow

Under this arrangement, the avenues for coders to positively affect revenue and compliance are limited. Coders can seek to apply codes accurately based on what has been documented, but they are constrained by the quality of documentation they receive in the first place. Although a coder may spot circumstances where charting was ambiguous or potentially incomplete, there is rarely an avenue for this feedback to make its way back to the clinician for effective follow-up.

The traditional information flow impedes the ability of a provider organization to actively improve its compliance and reimbursement outcomes. If doctors and nurses do not receive routine feedback about ways documentation can be improved—not just relating to clinical relevance, but also to compliance and reimbursement consequences—they are destined to continue their historical habits, locking the provider organization into a cycle of unclaimed revenue or worse.

Coding can be viewed as a form of "information manufacturing." Various disparate documents (face sheet, physicians' dictation, nursing notes, insurance records, etc) start the process. Once these components are all assembled, the patient record goes through a series of value-added steps—assembly, analysis, deficiency handling, coding, edits—to yield a

set of "manufactured" diagnostic and procedure codes. The codes, in turn, populate a billing or abstracting system to yield the patient's bill.

Many other industries follow a comparable value-added manufacturing process. Yet it would be rare to see so little feedback between the processing stages. For example, if a worker assembling automobile components finds that substandard parts are causing downstream quality problems, the manufacturer typically takes great care to ensure that the worker understands the established channels for communicating such problems upstream for speedy resolution. In the healthcare coding market, such feedback mechanisms are rare.

Current Attempts to Improve Documentation

To mitigate the "garbage in, garbage out" phenomenon on its coding outcomes, some hospitals and physician groups have attempted various approaches to improve the standard of clinical documentation. Here are two fairly conventional approaches:

Educational Sessions

Hospitals may ask doctors or nurses to attend periodic educational seminars to discuss ways of improving their charting, with an eye toward improved revenue and compliance. The typical paradigm is to herd clinicians into a conference room, provide broad guidance about the downstream implications of charting problems, and hope that these lessons will ultimately result in modified charting behavior.

This type of educational process is doomed almost from the start. Given the fast-paced and time-pressured work environment of a hospital or clinic, getting doctors and nurses to carve out time for routine educational sessions is impractical. The main training themes tend to be fairly general in nature and can often be too abstract to apply reliably. Training has little connection with current patients, so it is hard to associate the learning with actual cases that the clinicians can still recall having documented.

As a result of these factors, holding formal classroom-oriented educational sessions is generally ineffective.

Documentation Coaches

Some hospitals or clinics have hired specialist "coaches," who pair with a given doctor or nurse for a period of time, assisting the clinician in real time with ways of improving clinical documentation. This approach has the benefit of immediacy—each lesson is underscored by a relevant and current example, but it also has drawbacks. First, it is expensive. Educating a single physician can cost upward of $5,000. Second, many hospitals report that the behavior changes resulting from this educational approach are temporary. Without the constant reinforcement offered during the peering process, clinicians eventually settle back into their old documentation habits.

Aside from being expensive and impermanent, the coaching approach to education is not well-suited to dynamic learning. For example, new regulations or policies frequently arise that require modified charting habits. Hospitals may contract with a specific payor, resulting in a new and different set of coding guidelines. In these circumstances, the clinician's documentation habits may be anchored to a set of policies taught during coaching that could be months old. It's simply impractical to use coaches for each new policy nuance that arises.

Feedback from various hospitals and clinics generally indicate that education from documentation coaches is superior to classroom training, but still has drawbacks.

A New Feedback Model

What if coders and clinical staff could interact more fluidly and iteratively, with a low-cost and rapid ability to offer advice and commentary to one another? What tools would be required to facilitate this sort of interaction? What roles would each party play in that process? The recent experiences of a large multispecialty clinic may provide some answers.

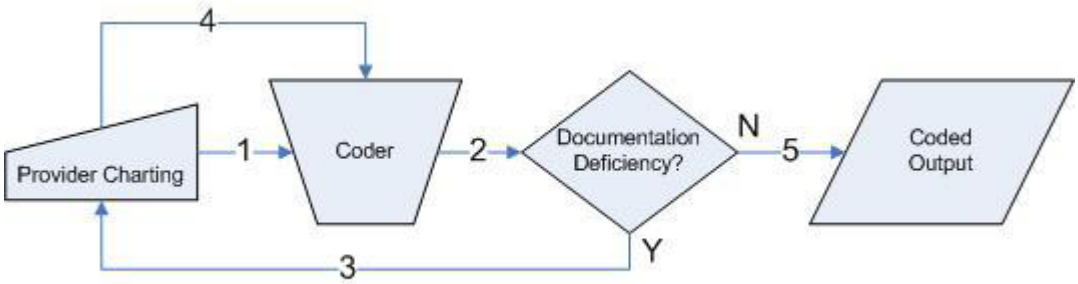
A large integrated delivery network in the Southeast operates from 11 locations, with hundreds of doctors and nurses. Administration identified the opportunity for improved physician education and anticipated that this could improve compliance and revenue outcomes. It partnered with an external coding vendor to bring its vision to reality. This vision included several components:

- Seeking a systematic way of connecting coders with physicians and nurse practitioners. Given the physical separation of the various clinic locations, it appeared that electronic communication would be the best approach.
- Training coders to think about what was not contained in a given patient chart (but probably should have been). This is a novel and unconventional behavior for coders, who have traditionally been trained to accept physician documentation as absolute and code accordingly.
- Affording clinicians an easy way of looking at a digital image of charts so coder feedback could be absorbed while referring to live "case studies."
- Educating physicians on the probable benefits of such education, thereby avoiding any defensive or negative reaction to coder feedback.

Beginning in early 2004, clinic administration began working with an outsourced medical coding company to help engineer the solution. By using chart scanning technology, plus Internet-based workflow software, the vendor offered an attractive way for key constituents—the vendor's coders, the clinic's coding manager, and individual nurses and doctors—to enjoy shared digital access to each patient record. Relying on paper charts would have made such sharing impossible.

Workflow technology was a key component to the deployment, allowing charts from certain providers to be routed to a nominated group of coders familiar with each clinician's charting habits. This workflow technology could also provide the basis for bidirectional feedback between coder and clinician.

The work processes agreed after this redesign looked like this:



Bi-Directional (New) Data Flow

This new solution works as follows:

1. Clinical staff treat patients and chart the results.
2. Each chart is quickly scanned into a digital imaging system.
3. Secure Internet workflow routes each chart and various demographics to a pool of preassigned coders.
4. A coder reviews each chart for completeness—both relating to traditional "assembly and analysis" functions and also determining whether the documentation could be improved from a financial or compliance perspective.
5. If the coder identifies a deficiency, the chart is electronically pended and a deficiency note routed to the clinician.
    a. Some notes are prospective, such as "Does any documentation exist to describe the patient condition that required this procedure?"
    b. Other notes are retrospective, such as "The doctor failed to dictate a full Review of Systems. This case would have justified a Level 3 E&M [evaluation and management], but has only been coded as a Level 2 because of this oversight."
6. Once doctors or nurses receive a deficiency note, they can immediately view a digital image of the chart through a Web browser.
7. If the chart requires an addendum, the clinician can provide this. When the additional documentation arrives, the chart is automatically released from its pended status and coded—liberating more (justifiable) revenue than would have been possible without such communication.

The results of the reengineered process have exceeded the provider's expectations. The average increase in achieved, per-case revenue has been 400% higher than the cost of the vendor's full coding service (including use of the document imaging and workflow technologies). In parallel, this clinic has improved its compliance posture by consistently working to improve the standard of chart thoroughness. The entire solution was implemented in less than 60 days.

For the most part, clinical staff have demonstrated clear, lasting improvements to their standard of documentation within 60 to 90 days of commencing the feedback process. The clinicians also report that they feel substantially more informed and intuitively knowledgeable about the coding consequences of their documentation.

Enablement and Consequences

This novel approach to connect coders and clinical staff would be possible in the operations of most healthcare providers, but making it work requires a thoughtful approach to preparation. Considerations include the following:

- Coder education: Coders need to learn a skill that is different from traditional coding. Specifically, they need to develop a capacity for critical thought that no longer asks "What care was documented?" but rather "What care was likely to have been delivered? Has this care been adequately documented?"
- Physician receptivity: This will be a new process for the doctors and nurses. It is important for hospital or clinic leaders to explain to the clinical leadership what benefits can arise from this process and therefore understand its objectives. Clinicians will also need to tolerate a period of learning and refinement as they and the coders find the right balance in what coder feedback proves most useful.
- Tracking progress: As with any re-engineered process, it is important to set objectives and monitor progress using an agreed set of metrics. Relevant metrics for this kind of project include billable revenue per case, E&M distributions, reports from compliance staff, and the number of coder deficiency comments trended over time.
- Workflow and communications technology: While this type of feedback could, in theory, be administered via paper-based processes, such manual approaches could be tedious to administer. This doesn't mean the technique requires expensive technology; even using a ubiquitous, inexpensive tool such as e-mail can work.
- Chart access: Feedback carries more impact if the clinician is able to view the chart while absorbing coder comments. This implies the need for either a chart imaging system or close cooperation with the HIM department to provide timely retrieval of charts.

Conclusions

The traditional flow of information from clinicians to coders has made it structurally difficult for these key constituencies to collaborate. Coders are only able to apply codes for diagnoses and procedures that are clearly documented by clinicians. Therefore, unless providers can find creative, effective ways of improving chart completeness, they are destined to bill less revenue than they are legitimately due.

This article has described a practical and sustainable approach to building communications bridges between coders and clinicians that has delivered great benefits in one provider's operations. Given the right tools and preparation, this process should be repeatable in most provider settings.

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