Coders and Physician Liaisons: a Winning Combination

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by Starla Stavely, RHIA (formerly RRA)

Never have so many HIM professionals had so much to worry about in the area of coding. Combine the need to keep an eye on case mix and a vigilant effort to prevent fraud and abuse, throw in a lack of physician documentation, increasingly stiff competition for the chart on nursing units, and constant audits, and you have a first-class headache.

In response to these pressures, coders have had to develop strategies to ensure compliance and accuracy on every level. One of these strategies is a physician liaison (or physician advisor) program.

Is There a Doctor in the House?

Since 1995, a Mississippi Baptist Medical Center program has paired physicians and coders, creating a unique coding environment that promotes good documentation and accurate coding. Working through a consulting firm, the program provides coders with clinical feedback from physicians. This program has allowed the medical center, the 650-bed flagship of Baptist Health Systems Inc. in Jackson, MS, to address some key issues affecting physician communication and timely coding of inpatient charts.

Prior to the creation of the physician liaison program, inpatient coders were concurrently coding on each nursing unit, then returning to the department to abstract and enter data. This process was slowed considerably by limited and unpredictable access to the charts on the units and little or no physician response to coder inquiries.

To address the issue of physician inquiries, a program was developed that would place a specially trained physician in the HIM department at least one hour each day. This physician would provide detailed clinical information, review charts referred by coders, and communicate with physicians directly for documentation issues.

The Physicians: Gaining New Understanding

The physicians selected for this project were varied in their specialties and backgrounds -- commitment being a key qualification. Additional requirements included an even temperament, good reputation with peers, and good documentation habits.

Each physician went through a two-day intensive training session and continued to be monitored for up to a year. Additionally, the physicians were joined by a DRG coordinator or coder during their weekly visits to the department. Quarterly coding/documentation updates were provided as well.

The dual chart reviews yielded a terrific opportunity for coders and physicians alike, as each gained a new perspective from the other. The physician liaisons came to understand the importance of complete documentation and the impact of coding guidelines, while the coders gained invaluable clinical insights to supplement their training. Soon, the liaisons were the medical record department's most vocal champions, eager to work with staff physicians to improve coding.

Three months into this project, a significant increase in the case mix was noted and directly attributed to this joint effort. The increase was attributed to the physician/coder efforts because significant improvements in documentation were noted by the coding staff during regular chart audits, and responses to coder inquiries increased dramatically. The physician advisors were instrumental in contacting physicians for more complete documentation and speaking to their peers about the importance of good documentation.

The Coders: Getting Respect

Despite some anxiety about the role physicians would play in their daily work, the coding staff soon realized the advantages of the collaboration. Their interaction with the liaisons enhanced their own expertise and earned them a measure of respect from the medical staff they had not previously enjoyed.

One of the success factors was a policy that allowed any coder to refer any chart to a physician liaison for any reason. Although a target list of DRGs is used as a guide, any question or inquiry is addressed promptly. The coders' position has been strengthened, and their comfort level with physicians has dramatically increased as a result of this collaboration.

The Process: Who Does What

Although concurrent coding is not performed by inpatient coders on the units, the function of concurrent coding is intact. In addition to their traditional duties, case managers abstract the diagnosis/procedure information into a shared database via wireless laptops. The DRG coordinators then follow up and enter ICD-9 codes, pending DRG, ALOS, and relative weight. This ensures that the data is available facility-wide within 12 hours of admission. These reviews continue until discharge.

When a chart reaches coders after discharge, much of the chart has already been abstracted and codes entered. Their responsibility is to review and confirm the data. At this point, they may refer the chart to a physician liaison for review/opinion or they may go ahead and drop the bill. Charts referred to the liaisons are located in a central area so the physician scheduled to review that day has quick access.

Typically, a coder will communicate some concern about documentation or make a clinical inquiry. If a disagreement occurs between the physicians and coders, the case is referred to the DRG coordinator/team leader for opinion. On rare occasions, the case could be referred to a consultant for a final ruling. Each physician advisor spends roughly four to five hours per week in the department, and their findings are tracked by the team leader and reported monthly to hospital administration.

The Results: Better Communication and Processes

In addition to an increase in net reimbursement, the best outcome of the project has been in the area of compliance. By the time a bill is dropped, most charts have been through a multi-level review for documentation and accuracy:

- the initial review by the case managers (RNs)
- a second review by the DRG coordinators
- a third by the inpatient coders
- a fourth by the physician liaisons
- in some cases, a fifth by a consultant

We have also noticed a trend among the medical staff to document more completely without prompting from the coders or liaisons. The medical staff are more knowledgeable about the importance of documentation as it relates to coding and the impact of poor documentation both from a compliance and a reimbursement standpoint. The department is enjoying a much higher profile in the physician community, the reputation and recognition of the coding staff has soared, and the coders are gaining in-depth clinical knowledge on a daily basis. Establishing these links of communication has had an impact on every area of the department in a positive way and continues to strengthen our relationship with our medical staff.

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