Physician Liaison Program Brings Improvement

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by Valerie Wilson, RRA, Juanita Hammer, CCS, and Daniel Washburn, MD

St. Mary's Mercy Hospital is a 277-bed acute care facility in northwestern Oklahoma. Serving as a regional referral center, the facility provides acute medical and surgical services, critical care, neurosurgical services, inpatient rehabilitation, a skilled nursing unit, ambulatory surgery, outpatient cardiac rehabilitation, and several other outpatient services. Our coding staff includes one CCS, an RRA/CCS, and two non-credentialed coders.

Targeting the Issues

Since the early 1990s, the St. Mary's coding staff has monitored coding and DRG assignments for appropriateness. This began as an effort to improve processes within the HIM department. In 1992, we implemented a program designed to help us better understand the clinical issues related to the assignment of DRGs (i.e., the diagnoses and procedures that have an impact on DRG assignment and the clinical conditions that may be interrelated, which would create some confusion in selecting principal diagnoses). As we worked with this program, we identified two key elements in our ability to appropriately code the medical record: the documentation (or lack thereof) in the medical record, and the lack of clinical knowledge among coding staff members.

We decided that the coding process required more clinical input. Furthermore, we needed to recruit a physician to act as liaison between case management and the medical staff. This physician also could provide clinical input for the coders. In 1994, Daniel Washburn, MD, was selected to serve in this role. He first became involved with coding and utilization issues through the Oklahoma Peer Review Organization (PRO) in the mid-1980s. He also served on the Medicare relations committee for the Oklahoma Society of Internal Medicine. Since becoming physician liaison, he has worked with the coding section on a daily basis.

Implementing the Process

When the hospital established the physician liaison position, the job description included working with case management staff to promote more appropriate utilization of services and providing assistance with coding questions and issues for the coding staff. Washburn was trained in coding and classification systems, DRG reimbursement, and other case management issues. His experience reviewing charts for the PRO also taught him to look for information in places besides dictation and progress notes, including nurses' notes, anesthesia records, and graphic sheets. When he first began this position, 60 percent of his time was allocated to coding and 40 percent to case management. As our case management staff gained experience, the ratio changed to approximately 80 percent coding and 20 percent case management. Washburn averages 21 hours per month in his physician liaison position.

Another important quality for the physician liaison is a good working relationship with the medical staff. The physicians respond positively to his phone calls and informal letters asking for clarification of a critical issue—a response that has evolved over time. When Washburn discusses his role in the HIM department with physicians, he stresses the HIM department's desire for accurate coding. Often he finds that physicians are caring for critically ill patients, but have not documented the severity of the illness. He explains the need for complete documentation to the medical staff, not only for coding purposes, but also for its impact on patient care. He encourages them to document all of their thoughts in the chart.

The physician liaison also works to educate coders. Washburn looks at coding quality reviews, which reveal the educational needs of the coders. To improve and maintain coders' skills, Washburn presents a disease process each month in an educational program. The topic may be based on the results of the coding quality review or implementation of new services. This gives the coders better insight into what they need to look for in the medical record, which, in turn, leaves them better equipped to obtain clarification from the physicians. From the coders' viewpoint, the physician liaison program is as much an educational tool as it is an aid in appropriate DRG assignment.

The actual work with the physician liaison starts with assignment of the final DRG. If the coders have issues about the appropriateness of the DRG assignment, the chart goes to the physician liaison for review. If the coder has questions that require clarification from someone with more clinical expertise, that chart also is referred to Washburn. The physician liaison reviews charts on a daily basis. He discusses them with the coders, particularly focusing on any recommended changes in coding or sequencing, or he leaves his input on a note placed with the chart. If additional information is needed from the attending physician, he writes a note to that physician. These notes are usually requests for clarification of a diagnostic statement, additional information about a diagnosis or condition, or additional documentation to substantiate a diagnosis identified in the record.

Overall, the impact on our case mix index has been beneficial. Physicians have learned to document more thoroughly, which has led to more appropriate code assignments based on the care they provide to their patients. We have also identified that coding changes, as a result of Washburn's intervention, do not always result in an increase in reimbursement. We believe that the efforts of the physician liaison program result in more appropriate DRG assignments.

In the next millennium, coding will continue to become much more sophisticated and challenging. The role of the physician liaison will continue to evolve along with it.

Valerie Wilson*, RRA, is director of health information management,* ***Juanita Hammer****, CCS, is senior coder, and* ***Daniel Washburn****, MD, is physician liaison at St. Mary's Mercy Hospital, Enid, OK.*

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