Much like concurrent CDI reviews, the concurrent coding process necessitates that the coding professional follow the chart throughout the patient’s admission and code it at intervals. The hope is that this process limits the number of clarifications needed after discharge, allowing the organization to send the final bill sooner rather than later. According to a recent ACDIS survey, 47.51% of the 603 respondents currently have a concurrent coding program.

The mechanics of the concurrent coding process can cause headaches for both CDI and coding professionals alike. Plus, one could argue that CDI’s presence itself limits the number of necessary post-discharge clarifications without the process of concurrent coding.

So, why should CDI programs get involved with this process? Accurate real-time reporting

Since coded data is used for so many things now, the accuracy of that data has never been more important. The practice of concurrent coding ensures the data is accurate, in real time, with the patient’s stay.

Plus, as the chart is coded concurrently, the CDI specialists are able to immediately see where coding difficulties may arise, says Diana Ortiz, JD, RN, CCDS, CDI product owner at 3M Health Information Systems in Murray, Utah.

“I don’t want to say things were more accurate [with a concurrent coding process in place], but things were accurate quicker,” Ortiz says of implementing a concurrent coding program at her previous facility. “It also helps with the back-end reconciliation process.”

And knowing how the chart will code out concurrently doesn’t only help CDI, Ortiz adds. According to the ACDIS survey, 53.05% of respondents say that the goal of their concurrent coding program is to improve coding of potential quality indicators during the patient’s stay.

“A lot of the time, the quality team is looking at the [more] basic coding that CDI specialists are [traditionally] doing concurrently. Because coders are more in tune with coding guidelines than CDI specialists, there may be differences in final coding versus working codes,” she says. “Following those quality measures more concurrently from a better [clinical and coding] truth perspective is a good thing.”
In fact, the accuracy of quality measures may be the exact thing a new concurrent program focuses on. That’s the case for CentraState Medical Center in Freehold, New Jersey, which only performs concurrent coding on charts suspected to include a hospital-acquired condition (HAC) or a Patient Safety Indicator (PSI), says Christine Butka, RN, MSN, CCDS, CDI manager at CentraState.

In such situations, CDI staff refer the case to Butka for review. If she comes to the same conclusion as the original reviewer, she turns it over to the coding manager, who assigns the chart to a coding professional to perform concurrent coding.

“CDI doesn’t always know the specificities of a procedure, so the coders help us understand the real codes that are going to appear on the chart and if they trigger a quality measure,” she says.

If the coding team agrees that the situation could trigger a PSI or HAC, Butka and her team have an opportunity to re-review the chart to ensure any conditions that might “exclude” the case from PSI or HAC measures get documented accurately before the chart is final coded and the bill is dropped.

Even if the case does ultimately fall into a HAC or PSI, she says the process still saves the CDI staff time in the long run and allows the chart to be billed in a timelier manner.

“It helps us get the patients out of the PSI or HAC, if we can, during the stay or it helps us understand if we’ve triggered it so we don’t have to do that work of figuring it out on the back end,” says Butka.

The process also makes things a bit easier on the physicians. Since the clarifications all happen concurrently, it eliminates the strain of post-discharge queries once physicians have moved on to other cases and concerns.

“If you try to get the quality piece figured out after the fact, the doctor probably doesn’t want to hear it since the patient was discharged the month before,” she says.

Better communication between CDI and coding

CDI professionals have always served as a bridge between the clinical and coding worlds, but concurrent coding can broaden and diversify that avenue of communication.

“The collaboration between coding and CDI is a huge benefit,” says Ortiz. “Both teams should come together and try to figure things out quicker.”

Since the coding professional and the CDI specialist are both concurrently in the record, there are more opportunities to communicate about the case and share coding and clinical concepts as their expertise allows, Ortiz says.

“Ideally, responsibility for the code set should be with the coding team,” she says. “It really makes sense for CDI to own all the queries, all the clinical side of things, and the physician education piece.”

The division of labor plays to each group’s strengths rather than asking everyone to be an expert in everything.

“We really wanted to lean on the expertise of the coders to help us,” says Butka. Even when CDI professionals come from an HIM/coding background, their skill set will shift since their CDI role doesn’t have them coding charts daily.

Having a coding professional in the record with the CDI professional will illuminate any misunderstandings and ensure that the documentation is sufficient for both painting the clinical picture and translating it into codes.

Advice for concurrent coding implementation

Of course, the relationship between CDI and coding isn’t necessarily smooth sailing. In fact, according to 41.78% of the survey respondents, the main barrier to implementing a concurrent coding program is a lack of CDI/coding collaboration. To eliminate that barrier, Ortiz suggests administrators provide clear goals to focus concurrent efforts.

Those starting a concurrent coding program should “figure out exactly what they want to achieve for their organization,” she says. “There’s lots of benefits, but what’s the benefit for you?”

“The collaboration between coding and CDI is a huge benefit. Both teams should come together and try to figure things out quicker.”

Diana Ortiz, JD, RN, CCDS
Without a clear focus, it will be difficult to get people on board with the project and keep the ball rolling as time goes on. Once you’ve set your goals, it’s time to plan the implementation process, Butka adds.

“I think you have to get the process down from a CDI and from a coding perspective. You can’t just say, ‘Hey, code this chart’ and walk away,” she says. “You have to figure out the step-by-step process.”

Though that process will ultimately make the project go smoother, implementation will probably have some hiccups. “I won’t say it didn’t come without pain, but we really had to start by looking at the process,” Ortiz says.

For Ortiz and her team at the time, they started with some “super users” from both the CDI and coding teams—people who knew the technology and workflow inside and out and were comfortable with learning new processes in the system.

“Best practice should include documentation of the final process so it remains adaptable and can be scaled,” she says.

Once the process is documented, the workflow can be tweaked along the way. According to Ortiz, determining the best rollout method for an organization is critical to avoid negative impact to the discharged-not-final-billed list (DNFB).

If the goal of an organization is to decrease the DNFB, implementing concurrent coding across all service lines or all payers can introduce an element of risk—if the new process fails, there’s a danger of administrators eliminating the experiment. Rolling out by service line, payer, or facility allows the CDI staff to identify obstacles, adjust, and make changes ahead of the next phase of implementation.

“While there is an opportunity to implement organizationwide, all at once, an organization has to decide whether they are willing to take that risk,” says Ortiz.

Since Butka’s facility uses a hybrid medical record, their approach was a bit different. They started with education—namely, where to find documents in the medical record when they haven’t been scanned into the EHR yet.

“We had to have the coders come up on the floor with us and see the whole process,” says Butka. “They’re used to having everything scanned in the EHR, so they had to be trained in knowing where everything would be in the chart to concurrently code it.”

While the CDI specialists were used to being on the floor and finding things in the chart, the coding team wasn’t, Butka says. Then, CDI had to help the coding team understand the process and purpose of the project, she says.

“One of the difficulties was having the coders understand that they have to code everything in the chart during this process,” says Butka. “It’s hard for them to code something that’s incomplete. What if this code I’m putting in is ruled out five days from now?”

This educational process can be summed up as “change management,” says Ortiz—meaning the process by which people are prepared for upcoming changes.

“There’s a human component to it, and you have to have buy-in from people,” Ortiz adds. “At least philosophically, you can’t spend enough time on the change management.”

One way to prepare the coding and CDI teams for the change, according to Butka, is to do some practice runs before the program goes live.

“I’d recommend having the coders practice concurrent coding before they’re actually doing it so they’re used to the process and where everything is in the chart,” she says. That way, you’re not asking coding professionals to do something out of the blue with no process instruction or guidelines.

Once you’ve done your homework, set goals for the program, and developed a process for the project, the concurrent program can go live. However, that doesn’t mean it’ll stay the same for the rest of time, Ortiz says. You have to do what works best for your CDI and coding staff, as well as what’s best for the organization, she says.

“Just because you set out on a path doesn’t mean it won’t change and evolve. You have to stay open,” she says. “It’s really just the beginning of further expanding collaboration to improve clinical documentation.” 🌟