Table 7

Task Frequency and Importance Average Weightings

Domain	Task Items	Frequency and Importance Average
Clinical & Coding Practice		
1	Use reference resources for code assignment	3.367
1	Identify the principal and secondary diagnoses in order to accurately reflect the patient's hospital course	3.361
1	Use coding software	3.326
1	Assign and sequence ICD-9-CM codes	3.313
1	Use coding conventions	3.230
1	Display knowledge of payer requirements for appropriate code assignment (e.g., CMS, APR, APG)	3.016
1	Assign appropriate DRG codes	2.824
1	Communicate with the coding/HIM staff to resolve discrepancies between the working and final DRGs	2.740
1	Participate in educational sessions with staff to discuss infrequently encountered cases	2.655
1	Assign CPT and/or HCPCS codes	2.630
1	Communicate with coding/HIM staff to resolve discrepancies in documentation for CPT assignment	2.563
Leadership		
2	Maintain affiliation with professional organizations devoted to the accuracy of diagnosis coding and reporting	2.876
2	Promote CDI efforts throughout the organization	2.692
2	Foster working relationship with CDI team members for reconciliation of queries	2.677
2	Establish a chain of command for resolving unanswered queries	2.662
2	Develop documentation improvement projects	2.480
2	Collaborate with physician champions to promote CDI initiatives	2.331
2	Establish consequences for noncompliance to queries or lack of responses to queries in collaboration with providers	2.297
2	Develop CDI policies and procedures in accordance with AHIMA practice briefs	2.085

Record Review & Document Clarification		
3	Identify opportunities for documentation improvement by ensuring that diagnoses and procedures are documented to the highest level of specificity	3.200
3	Query providers in an ethical manner to avoid potential fraud and/or compliance issues	3.072
3	Formulate queries to providers to clarify conflicting diagnoses	2.945
3	Ensure provider query response is documented in the medical record	2.929
3	Formulate queries to providers to clarify the clinical significance of abnormal findings identified in the record	2.896
3	Track responses to queries and interact with providers to obtain query responses	2.785
3	Interact with providers to clarify POA	2.567
3	Identify postdischarge query opportunities that will affect SOI, ROM, and ultimately case weight	2.561
3	Collaborate with the case management and utilization review staff to effect change in documentation	2.525
3	Interact with providers to clarify HAC	2.327
3	Interact with providers to clarify the documentation of core measures	2.287
3	Interact with providers to clarify PSI	2.260
3	Determine facility requirements for documentation of query responses in the record to establish official policy and procedures related to CDI query activities	2.154
3	Develop policies regarding various stages of the query process and time frames to avoid compliance risk	2.113
CDI Metrics & Statistics		
4	Track denials and documentation practices to avoid future denials	2.276
4	Trend and track physician query response	2.270
4	Track working DRG (CDS) and coder final code	2.265
4	Perform quality audits of CDI content to ensure compliance with institutional policies and procedures or national guidelines	2.232
4	Trend and track physician query content	2.214
4	Trend and track physician and query provider	2.181

4	Trend and track physician query volume	2.115
4	Measure the success of the CDI program through dashboard metrics	1.969
4	Track data for physician benchmarking and trending	1.964
4	Compare institution with external institutional benchmarks	1.948
4	Track data for CDI benchmarking and trending	1.945
4	Track data for specialty benchmarking and trending	1.901
4	Use CDI data to adjust departmental workflow	1.880
Research & Education		
5	Articulate the implications of accurate coding	3.106
5	Educate providers and other members of the healthcare team about the importance of the documentation improvement program and the need to assign diagnoses and procedures, when indicated, to their highest level of specificity	2.625
5	Articulate the implications of accurate coding with respect to research, public health reporting, case management, and reimbursement	2.582
5	Monitor changes in the external regulatory environment in order to maintain compliance with all applicable agencies	2.535
5	Educate the appropriate staff on the clinical documentation improvement program including accurate and ethical documentation practices	2.441
5	Develop educational materials to facilitate documentation that supports severity of illness, risk of mortality, and utilization of resources	2.174
5	Research and adapts successful best practices within the CDI specialty that could be utilized at one's own organization	2.102
Compliance		
6	Apply AHIMA best practices related to CDI activities	2.720
6	Apply regulations pertaining to CDI activities	2.651
6	Consult with compliance and HIM departments regarding legal issues surrounding CDI efforts	2.278

Note: ICD-9-CM, International Classification of Diseases, Ninth Revision, Clinical Modification; CMS, Centers for Medicare and Medicaid Services; APR, All Patient Refined; APG, Ambulatory Patient Groups; DRG, diagnosis-related group; HIM, health information management; CPT, Current Procedural Terminology; HCPCS, Healthcare Common Procedural Coding System; CDI, clinical documentation improvement; AHIMA, American Health Information Management Association; POA (present on admission); SOI, severity of illness; ROM (risk of mortality); HAC, hospital-acquired conditions; PSI (patient safety indicators); CDS (clinical documentation specialist).