COOK COUNTY HEALTH

Standard Job Description

Job Code: 6350
Grade: 23
HCWR: N

Job Title	**Department**
Clinical Documentation Specialist	Medical Records Administration

This position is exempt from Career Service under the CCH Personnel Rules.

Job Summary

The Clinical Documentation Specialist conducts concurrent and retrospective medical documentation reviews on inpatient medical records to identify clinical indicators to support appropriate severity of illness, expected risk of mortality and complexity of care of the patient. The Specialist facilitates comprehensive medical record documentation to reflect clinical treatment, diagnoses and decisions from physicians to bridge gaps in clinical documentation which address patient care and regulatory compliance. Under supervision, the Specialist completes timely documentation reviews to assign principal diagnosis and pertinent secondary diagnoses for inpatients admitted emergently, urgently and electively and outpatient services for completeness. Audits external Centers for Medicare & Medicaid Services (CMS) Recovery Audit Tracker (RAC) Audit results. Performs monthly audits of all internal coders for accuracy. Using broad knowledge of quality record medical documentation and regulatory directives, the Specialist coordinates point of care and/or retrospective documentation improvement to address severity of illness and risk mortality; and, for further use with patient care, quality of care and performance measurement, and reimbursement.

Typical Duties

- Completes initial reviews of inpatient health records within 24-48 hours of admission and outpatient health records for a specified patient population to evaluate documentation to assign the principal diagnosis and pertinent secondary diagnoses for severity of illness and risk of mortality
- Queries physicians regarding missing, under, or conflicting health record documentation and obtains additional documentation within the health record when needed
- Conducts follow-up reviews of patients every 2-3 days to support documentation adequacy upon patient discharge, as necessary
- Follows Cook County Health & Hospitals System (CCHHS) Clinical Documentation Program Guidelines in carrying out position functions; works accurately within the hospital's designated clinical documentation system
- Educates physicians and key healthcare providers regarding clinical documentation Improvement and the need for accurate and complete documentation in the health record
- Demonstrates an understanding of medical necessity, severity of Illness, complications, comorbidities, risk of mortality, case mix, secondary diagnoses, and procedures, and is able to impart this knowledge to physicians and other members of the interdisciplinary healthcare team
- Collaborates with the physician advisor, case managers, nursing staff, and other ancillary staff regarding interaction with physicians on documentation and to resolve physician queries prior to patient discharge
- Participates in the analysis, interpretation and trending of statistical data for specified patient

Typical Duties

populations to identify opportunities for clinical documentation and process Improvement
- Assists with preparation and presentation of clinical documentation monitoring and trending reports for review with physicians and hospital leadership
- Educates members of the patient care team regarding specific documentation needs and reporting and reimbursement issues Identified through daily and retrospective documentation reviews and aggregate data analysis
- Facilitates change processes required to capture needed documentation, such as forms and screen design
- Partners with the coding professionals to ensure adequate coding understanding to support clinical documentation necessary to determine a working severity of illness
- Reviews and clarifies clinical issues In the health record With the coding professionals that would support accurate and specific diagnoses and procedural coding
- Assists in appeal process resulting from third-party reviews
- Performs other duties as assigned

Minimum Qualifications

- Valid license as a Registered Professional Nurse in the State of Illinois OR a Registered Health Information Technician (RHIT) OR a Registered Health Information Administrator (RHIA)
- Three (3) years of experience in acute care nursing or as a registered health information technician or as a registered health information administrator OR a combination of the three totaling three (3) years of experience
- One (1) year of experience within the last five (5) years working in Clinical Documentation Improvement
- One (1) year of experience working with Case Mix, ICD 10 coding, principal and secondary diagnoses, procedures, complications, comorbidities, severity and patient mortality risk
- Current experience with federal, state, and other payers' regulatory requirements and criteria including, but not limited to, Medicare and Medicaid
- Prior experience working in a hospital or health care environment
- Must be detail oriented for clinical documentation review
- Must be familiar with electronic health record systems, i.e. Cerner or Siemens

Preferred Qualifications

- Five (5) years of acute care nursing experience or as a registered health information administrator
- Two (2) years of experience within in the last three (3) years working in Clinical Documentation Improvement
- Two (2) years of experience working with Case Mix, ICD 10 coding, principal and secondary diagnoses, procedures, complications, comorbidities, severity and patient mortality risk
- Two (2) years of experience with federal, state, and other payers' regulatory requirements and criteria including, but not limited to, Medicare and Medicaid
- Current experience with InterQual and/or Milliman Care guidelines
- Certified Documentation Improvement Practitioner (CDIP), or Certified Clinical

Preferred Qualifications

Documentation Specialist (CCDS)

- Certified Coding Specialist (CCS), Certified Coding Specialist - Physician-based (CCSP), or Certified Professional Coder (CPC)
- Registered Health Information Administrator (RHIA)

Knowledge, Skills, Abilities and Other Characteristics

- Knowledge and application of AHIMA, and/or ACDIS Ethical Standards
- Knowledge of, but not limited to, current CMS coding guidelines and methodologies, MS-DRGs, APR-DRGs, HCCs; ICD-10-CM/PCS and AMA CPT coding guidelines and conventions · Interpersonal, verbal, written communication skills in dealing with inter and intradepartmental activities
- Critical thinking skills with the ability to assess, evaluate, and teach
- Organizational and analytical thinking skills
- Ability to develop and maintain supportive, collaborative relationships with Physicians and other clinical professional
- Ability to provide concise reports of activities and results.
- Ability to work independently in performing duties with minimal supervision with a high degree of self-motivation
- Ability to teach in a large group setting to educate healthcare providers about current documentation standards
- Ability to track activities and communication across multiple physician services and forums
- Ability to work with clinical manager, case management, and physicians to make clinical documentation improvements, i.e. change clinical documentation processes
- Ability to analyze problems and issues and understand the regulatory and reimbursement impact of those decisions
- Ability to become adaptable and self-motivated by staying abreast of CMS rules and regulations and incorporating those changes into daily practice
- Proficiency in Microsoft Office Suite (Word, Excel, and PowerPoint)

Physical and Environmental Demands

This position is functioning within a healthcare environment. The incumbent is responsible for adherence to all hospital and department specific safety requirements. This includes but is not limited to the following policies and procedures: complying with Personal Protective Equipment requirements, hand washing and sanitizing practices, complying with department specific engineering and work practice controls and any other work area safety precautions as specified by hospital wide policy and departmental procedures.

The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not intended to be construed as an exhaustive list of all responsibilities, duties and skills required of the personnel so classified.

For purposes of the American with Disabilities Act, "Typical Duties" are essential job functions.