COOK COUNTY HEALTH

Standard Job Description

Job Code: 9366
Grade: 23
HCWR: N

Job Title	**Department**
Clinical Documentation Improvement Manager	Health Information Management

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

Job Summary

The Clinical Documentation Improvement Manager will complete timely documentation reviews to assign principal diagnosis and pertinent secondary diagnoses for inpatients admitted emergently, urgently and electively and outpatient services for completeness. Works collaboratively with the Clinical Documentation Improvement (CDI) Staff to facilitate documentation within the medical record that supports patient's severity of illness and risk of mortality utilizing strong communication skills with physicians, case managers, utilization reviewer, nurse, or other healthcare professionals, utilizing appropriate querying tools to capture needed documentation. Manages audits for external Centers for Medicare & Medicaid Services (CMS) Recovery Audit Tracker (RAC) Audit results. Reviews monthly audits of all internal coders for accuracy. Using broad knowledge and understanding of the Medical Severity (MS) Diagnosis-Related Group (DRG) system, complication or comorbidity (CC)/major complexity or comorbidity (MCC), impact on quality, and CMI as well as ICD-10-CM/PCS coding systems and the guidelines related to CDI.

General Administrative Responsibilities

Collective Bargaining

- Review applicable Collective Bargaining Agreements and consult with Labor Relations to generate management proposals
- Participate in collective bargaining negotiations, caucus discussions and working meetings

Discipline

- Document, recommend and effectuate discipline at all levels
- Work closely with labor relations and/or labor counsel to effectuate and enforce applicable Collective Bargaining Agreements
- Initiate, authorize and complete disciplinary action pursuant to CCH system rules, policies, procedures and provision of applicable collective bargaining agreements

Supervision

- Direct and effectuate CCH management policies and practices
- Access and proficiently navigate CCH records system to obtain and review information necessary to execute provisions of applicable collective bargaining agreements

General Administrative Responsibilities

Management

- Contribute to the management of CCH staff and CCH' systemic development and success
- Discuss and develop CCH system policies and procedures
- Consistently use independent judgment to identify operational staffing issues and needs and perform the following functions as necessary; hire, transfer, suspend, layoff, recall, promote, discharge, assign, direct or discipline employees pursuant to applicable Collective Bargaining Agreements
- Work with Labor Relations to discern past practice when necessary

Typical Duties

- Completes timely documentation reviews to assign principal diagnosis and pertinent secondary diagnoses for inpatients admitted emergently, urgently and electively and outpatient services for completeness.
- Uses broad knowledge of quality medical documentation and regulatory directives, coordinates point of care and/or retrospective documentation improvement to address severity of illness and risk of mortality and to be further used for patient care, quality of care and performance measurement, and reimbursement. The multi-disciplinary process requires excellent communication and interactive skills with members of the healthcare team.
- Serves as a resource to physicians and administration regarding issues related to the appropriateness of Inpatient DRG assignments.
- Works collaboratively with the CDI Staff to facilitate documentation within the medical record that supports patient's severity of illness and risk of mortality utilizing strong communication skills with physicians, case managers, utilization reviewer, nurse or other healthcare professionals, utilizing appropriate querying tools to capture needed documentation.
- Managing individual(s) including, but not limited to, interviews, trainings, assigns work, manages and evaluates performance, conducts professional development plans. Ensures that the productivity and actions of that group meet/support the overall operational goals of the department as established by department leadership.
- 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
- Completes initial reviews of outpatient health records within 24 to 48 hours for a specified population to evaluate documentation to assign the principle diagnosis and pertinent secondary diagnosis for severity of illness and risk of mortality to meet the CMS two midnight rule.
- Demonstrates a thorough understanding of the Medicare Severity (MS)-DRG system, CCs/MCCs, impact on quality, and CMI as well as ICD-10-CM/PCS coding systems and the guidelines related to Clinical Documentation Improvement.
- Maintains CDI Dashboard and reports monthly analysis to the CDI Staff.

Typical Duties

- Attends Monthly CCH Utilization Review Committee Meetings and coordinate any assignments related Clinical Documentation.
- Attends coding/financial educational programs and regulatory educational programs and updates as necessary to maintain expert knowledge base.
- Quarterly review of AHA Official Coding and Reporting Guidelines, CMS and other agency directives for ICD-10-CM/PCS.
- Attends Coding Updates and all coding conference calls as well as required CDI education.
- Prepares weekly team performance reports including weekly production, quality assessments and coding inventory reports, i.e., coding queries and submit to the manager for review.
- Mentors the CDI in building effective relationships with the providers they support.
- Coordinate employee's schedules, including vacation/sick request to ensure adequate coverage.
- Lead weekly team meetings with CDI staff.
- Fosters an environment of teamwork and service excellence within the department.
- 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 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
- Meets with the HIMS Coding Staff on a regular basis to participate in post-discharge coding reviews to ensure the most accurate DRG has been assigned and to identify opportunities for clinical documentation improvement for future cases.
- Performs other duties as assigned

Minimum Qualifications

- Bachelors degree from an accredited college of university

Minimum Qualifications

- Licensed as a Registered Professional Nurse in the State of Illinois, Registered Health Information Technician (RHIT), OR a Registered Health Information Administrator (RHIA)
- Four (4) years of experience in acute care nursing, as a Registered Health Information Technician (RHIT), and/or as a Registered Health Information Administrator (RHIA)
- Two (2) year of experience within the last five (5) years working in Clinical Documentation Improvement
- Two (2) years of experience supervising and/or managing staff
- Two (2) years 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
- Certified Documentation Improvement Practitioner (CDIP), or Certified Clinical Documentation Specialist (CCDS)
- Must be detail oriented for clinical documentation review
- Must be familiar with electronic health record systems, i.e., Cerner or Siemens

Preferred Qualifications

- Licensed as a Registered Professional Nurse in the State of Illinois
- 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
- Four (4) 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 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
- Broad knowledge of quality medical documentation and regulatory directives
- 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

Knowledge, Skills, Abilities and Other Characteristics

- 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.