

Position Title: Clinical Documentation Improvement Specialist
Department: Health Information Management
Pay: Dependent on experience

Job Summary: The Clinical Documentation Specialist works to improve the overall quality and completeness of clinical documentation by facilitating modifications to clinical documentation through extensive interaction with physicians, nursing staff, other patient caregivers, and health information coding staff to help ensure that appropriate reimbursement is received for the level of service rendered to patients. Manages and coordinates the day to day activities of the clinical documentation improvement area; develops, maintains, interprets and evaluates procedures and processes to ensure that activities are carried out in an effective manner. Works with Case Management, HIM and Medical Staff in facilitating appropriate documentation of care. Provides education to physicians and other patient caregivers on regulatory / reimbursement changes.

Qualifications:

The following qualifications, or equivalent, are the minimum requirements necessary to perform essential functions of this job.

Education and formal training:

Preferred: RN, BSN, LPN, RHIT, RHIA or CCS

Work Experience:

Preferred: 3 to 5 years experience as an RN, BSN, LPN, RHIT, RHIA or CCS

Knowledge, skills, and abilities required:

- Strong background in ICD-9/CPT Coding;
- Documentation review experience;
- Experience with 3-M coding and reimbursement systems, MS4 recommended but not required
- Experience with Word, Excel, and Windows;
- Excellent interpersonal skills for communications with medical staff, nursing, other clinical staff, and coding

Physical Requirements:

- Ability to see written word and computer screen
- Ability to lift and carry 20 pounds
- Ability to hear for communication with physicians and others
- Ability to sit, stand and walk, occasionally for extended durations