Clinical Documentation Specialist

INTEGRIS Health
Job Location: Houston, TX
Full Time, Remote

JOB SUMMARY:

This job can work remotely from the following States - GA, WA, FL, TN and TX

At Houston Methodist, the Clinical Documentation Specialist is responsible for improving the overall quality and completeness of clinical documentation. This position analyzes medical records for DRG's, complications, and comorbidities; identifies trends; and notes observations and recommendations for documentation improvement. This role also facilitates modifications to clinical documentation through extensive interaction with physicians, nursing staff, other patient care givers, and medical records coding staff to ensure that appropriate reimbursement is received for the level of service rendered to all patients. Additional duties include supporting the accuracy and completeness of the clinical information used for measuring and reporting physician and hospital outcomes and educating all members of the patient care team on an ongoing basis.

REQUIREMENTS:

Job responsibilities labeled EF capture those duties that are essential functions of the job.

PEOPLE - 20%

1. Improves the overall quality, completeness and accuracy of clinical documentation by performing open record reviews using clinical documentation guidelines. Supports the accuracy and completeness of clinical information used for measuring and reporting physician and medical outcomes. (EF)

SERVICE - 25%

1. Seeks additional information regarding clinical condition from appropriate clinical personnel and follows up as necessary. Tracks responses and trends completion of DRG/Documentation worksheets as pertinent to scope of department. (EF)
2. Conducts follow-up reviews of clinical documentation to ensure points of clarification have been recorded in the patient's chart. (EF)

QUALITY/SAFETY - 25%

1. Demonstrates knowledge of DRG payor issues, optimization strategies, clinical documentation requirements and referral policies and procedures. Requests clarification and/or correction from physicians for unclear diagnoses, complications, procedures, and clinical information. Helps identify appropriate ICD10 codes for diagnoses or procedures related to projects or studies being conducted as needed. (EF)

FINANCE - 20%

1. Promotes clarification to clinical documentation to ensure that appropriate reimbursement is received for the level of service rendered to all patients. Identifies diagnoses and procedures performed and comorbidities and complications. Impacts discharges by updating the DRG worksheet to reflect any changes in status, procedures/treatments, conferring with physician to finalize diagnosis as necessary. (EF)

GROWTH/INNOVATION - 10%

1. Educates all internal customers on clinical documentation opportunities, coding, and reimbursement issues, as well as performance improvement methodologies. (EF)

QUALIFICATIONS:

EDUCATION REQUIREMENTS

- Associate's or bachelor's degree in nursing; OR
- Medical School graduate where Western Medicine is practiced

EXPERIENCE REQUIREMENTS

- For RN - At least five years of recent clinical experience caring for adults in an acute care hospital setting is required; coding and utilization review experience preferred
- For Medical School graduate - One year of clinical experience preferred

CERTIFICATIONS, LICENSES AND REGISTRATIONS REQUIRED

- For RN - Texas RN license or temporary TX RN license, should obtain permanent license within 90 days. Compact license acceptable according to current Board of Nursing requirements.
- For Medical School graduate - Must have one of the following certifications:
    - Certified Clinical Documentation Specialist (CCDS) through the Association of Clinical Documentation Improvement Specialists
    - Certified Documentation Improvement Practitioner (CDIP) through the American Health Information Management Association
    - Certified Coding Specialist (CCS) through the American Health Information Management Association

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED

- Demonstrates the skills and competencies necessary to safely perform the assigned job, determined through on-going skills, competency assessments, and performance evaluations
- Sufficient proficiency in speaking, reading, and writing the English language necessary to perform the essential functions of this job, especially with regard to activities impacting patient or employee safety or security
- Ability to effectively communicate with patients, physicians, family members and co-workers in a manner consistent with a customer service focus and application of positive language principles
- Demonstrates knowledge of DRG payor issues, appropriate DRG assignment alternatives, clinical documentation requirements, and referral policies and procedures
- Demonstrates accountability and professional development
- Requires excellent observation skills, analytical thinking, problem solving, plus good verbal and written communication
- Regular significant contacts with other personnel throughout the institution (including but not limited to - physicians and their staff, mid-level providers, mid-level staff, coders, Case Managers). Contacts may be in person, by telephone, or through correspondence. Requires assertiveness while being even tempered, with a pleasing personality and the ability to communicate easily with others.

FOR MORE INFORMATION/TO APPLY:

https://www.houstonmethodistcareers.org/job/clinical-documentation-specialist-3-000-sign-on-bonus-fulltime-remote-him-medical-records-corporate-5-25922/