Clinical Documentation Improvement Specialist

Jennie Stuart Health
Job Location: Hopkinsville, KY
Full Time/Regular

JOB SUMMARY:

The Clinical Documentation Integrity (CDI) specialist is responsible for facilitating the improvement in the overall quality and completeness of provider-based clinical documentation in the medical record. This position will be responsible for assisting treating providers to ensure that documentation in the medical record accurately reflects the severity of illness of the patient as well as the level of services rendered. The CDI Specialist assesses clinical documentation through extensive review of the medical record, interaction with physicians, nursing staff, other patient care givers, and Health Information Management (HIM) coding specialists to ensure that appropriate reimbursement is received for the level of services rendered to patients and the clinical information utilized in profiling and reporting outcomes is complete and accurate.

PRINCIPAL DUTIES AND RESPONSIBILITIES:

- Facilitate clinical documentation to support appropriate diagnosis coding and to ensure the level of service rendered to all patients is recorded.
- Collaborate with HIM coding specialists and Case Management to promote complete and accurate clinical documentation and correct negative trends.
- Communicate with physicians, nurse practitioners, case managers, coding specialists and other members of the care team to facilitate comprehensive medical record documentation to reflect treatment, acuity and decision-making in compliance with government and other regulations for all patients.
- Assign a working DRG and severity level using coding rules and guidelines with follow up reviews as required by LOS criteria.
- Analyze clinical information to identify areas within the chart for potential gaps in physician documentation.
- Query providers on a concurrent basis. Work with providers to clarify documentation in the medical record.
- Formulate credible and compliant clinical documentation clarifications to improve specificity of principal diagnosis, co-morbidities, present on admission (POA), quality core measures, and patient safety indicators (PSI).
- Conduct concurrent and retrospective reviews for comparative analysis of working and final DRG and severity level assignment.
- Develop and conduct ongoing education for new staff, including new CDI Specialists, physicians and nursing, utilizing educational material and tools relative to documentation improvement practices for individual practitioners and groups of clinicians presented as handouts, PowerPoint, etc.
- Utilize software systems (including DRG encoder) to collect, track, and report outcomes. Requires proficiency in abstracting and data entry into all databases used for clinical documentation. Maintain integrity of data collection

REQUIRED SKILLS:

- Scope of practice requires the knowledge of theories, principles, and concepts typically acquired through completion of a Bachelor's Degree in Nursing or Health Information Management.
- Work requires superior interpersonal communication skills and demonstrated ability to communicate effectively with physicians is essential.
- Electronic medical record experience with Paragon applications, OneContent, 3M strongly preferred
- Experience in a fast paced, metric driven operational setting.
- In-depth knowledge of Medicare/Medicaid regulations, including compliance, coding and documentation requirements.
- Understanding of the application of authoritative guidance to the interpretation and analysis of documentation, coding, and queries.

- Ability to build and maintain effective relationships with internal stakeholders.
- Demonstrated willingness to consistently provide superior customer service and the ability to react with a professional demeanor.
- This role requires a focus on detail and accountability, and the ability interpret and apply coding guidelines.

REQUIRED EXPERIENCE:

- Minimum of five years recent, broad-based clinical or coding experience in an inpatient setting required.
- 3+ years' experience in Clinical Documentation Improvement in acute hospital setting.
- RN or MD
- CCDS, CDIP or CCS certification required
- BSN degree preferred

FOR MORE INFORMATION/TO APPLY:

https://jobs.silkroad.com/JSMC/JennieJobs/jobs/2494?source=ONLINE