Clinical Documentation Coordinator

Position Summary: : The role of the Clinical Documentation Coordinator is, at its core, that of an educator, who is able by virtue of exceptional interpersonal skills to successfully and pro-actively work with all members of the healthcare team to achieve the most timely and accurate patient record possible, prior to discharge.The Clinical Documentation Improvement Specialist, in consultation with the HIM Director and others as appropriate and consistent with the AHA Coding Clinic, is responsible for daily concurrent review of inpatient medical records to identify opportunities for improving the quality of medical record documentation for reimbursement, severity of illness, and risk of mortality. Opportunities include identification of cases where diagnoses and procedures are either absent, not stated in appropriate terminology, or are not appropriately recorded. Opportunities may also be identified through focused audits as requested by the CMO, CFO, AVP, or a service or specialty. The CDIS interacts in a positive and productive manner on a daily basis with physicians and providers, other clinical professionals, and the coding team regarding documentation clarification, in accordance with prevailing guidelines published by the Association of Clinical Documentation Improvement Specialists (ACDIS). The CDIS collects statistics from the reviews and maintains accurate records of review activities (scorecard) to document cost/benefits and to identify patterns and trends affecting the case mix index. The CDIS's goal is to achieve a complete medical record by the time of patient discharge in order to facilitate the coding and DRG assignment process. Educational Requirements/ Qualifications:Education: RN with current New York State license preferred; RHIA will be considered. Bachelor’s degree in healthcare field preferred. CCS Certification preferred; required within three years of hire. Experience: Previous CDI experience in an acute care setting preferred. Minimum of 2 years acute care clinical experience required. Experience with electronic medical records required. Experience with 3-M Coding and reimbursement programs a plus and will be required within 3 months of hire. Experience with MS-Office suite, Excel and PowerPoint expertise in particular required.Skills: Demonstrates excellent interpersonal skills to develop relationships necessary to effectively influence physician/clinical documentation accuracy and timeliness in a positive and pro-active manner. Demonstrates analytic skills necessary to clinically assess medical records in the context of prevailing coding standards and regulations. Demonstrates excellent prioritization and organizational skills. Demonstrates outstanding public speaking and formal presentation skills; and the ability to successfully provide education to a wide variety ofadult learners. Demonstrates Intellectual curiosity and willingness to accept feedback in a

positive manner. Demonstrates flexibility to adapt to challenging work situations and varied styles. Demonstrates ability to consistently and effectively work under pressure while meeting compliance targets and maintaining positive demeanor.Knowledge: Current working knowledge of published ACDIS and AHIMA Clinical Documentation Improvement practices, guidelines and metrics required. Current working knowledge of ICD-10 coding principles and guidelines or willingness to obtain this knowledge within six months of hire required. Current working knowledge of MS-DRG’s and APR-DRG’s. Working knowledge of federal, state, and payer-specific regulations and policies pertaining to documentation, coding, and reimbursement required.