

## CLINICAL DOCUMENTATION ANALYST

### Definition

Under direction, to review medical record documentation to achieve accurate inpatient coding and physician queries to increase the quality of documentation; to provide feedback and education to medical providers on documentation and coding and to serve as institutional subject matter expert and resource for interpretation and application of coding rules and regulations.

### Distinguishing Characteristic

Clinical Documentation Analysts are required to work with minimal supervision to educate members of the patient care team regarding specific documentation requirements and coding and reimbursement issues identified through daily documentation reviews.

The Clinical Documentation Analyst differs from the Health Information Technician series in that the Clinical Documentation Analyst has an in-depth understanding of the substantive contents of a medical record including comprehensive knowledge of a wide variety of specialized medical terminology, testing and treatment relationships and sequences, and has the ability to write physician documentation queries to improve the quality of documentation. Clinical Documentation Analysts provide guidance to physicians, clinicians and other coding specialists regarding documentation requirements.

### Typical Tasks

- Completes admission reviews of patients records within 24 hours of admission to evaluate and analyze documentation in order to assign the principal diagnosis, pertinent secondary diagnoses, and procedures for accurate and optimal MS-Diagnostic Related Group (MS-DRG) assignment;
- Initiates and performs concurrent documentation reviews of selected inpatient records to clarify conditions/diagnoses and procedures where inadequate or conflicting documentation exists and conducts follow up reviews as necessary;
- Communicates with and serves as a resource for physician or medical staff departments to facilitate complete and accurate documentation of the inpatient record; queries physician regarding missing, unclear, or conflicting medical record documentation and obtains additional documentation within the medical record when needed;
- Analyzes a wide variety of operative, diagnostic, monitoring and life-sustaining medical procedures for abstracting and coding purposes;
- Codes a wide variety of procedures and primary and secondary diagnoses according to the latest adaptation of the International Classification of Diseases (ICD-9-CM) and Concurrent Procedure Terminology (CPT) coding systems;
- Collaborates with case managers, nursing staff, and other ancillary staff regarding interaction with physicians on documentation and to resolve physician queries prior to patient discharge;
- Abstracts and prepares pertinent data from medical charts according to criteria established by the Office of State Wide Hospital Planning and Development (OSHPD) and the Medical Audit Committee or individual physicians for various studies, statistical indexing and preparation of summary reports to various agencies;

- Monitors and evaluates coding outcomes and provides status to hospital departments and committees at designated intervals;
- Maintains accurate records of review activities to comply with departmental and regulatory agency guidelines;
- Collects data for performance improvement and reports findings and outcomes;
- Prepares narrative, statistical, and graphic reports for hospital use or for outside agencies;
- Provides liaison for data collection agencies, both regulatory and private;
- Participates in the analysis and trending of statistical data for specified patient populations to identify opportunities for improvement;
- Participates in revenue cycle meetings, providing data and information on reimbursement concerns;
- Improves coding specificity by educating physicians, clinicians, and other involved parties regarding the necessity of providing complete and clear documentation of the care provided throughout a patient's stay;
- Educates and answers coding questions, either one-on-one or in small groups, members of the patient care team regarding specific documentation needs as they relate to coding and reimbursement issues required for appropriate billing and reimbursement purposes;
- Serves as an institutional subject matter expert and resource for interpretation and application of coding rules and regulations;
- Maintains confidentiality and security levels to protect medical/legal patient care documentation;
- Maintains a library of information beneficial to coding and documentation;
- Maintains established hospital and departmental policies and procedures, objectives, performance improvement program, safety, environmental and infection control standards;
- May be assigned as a Disaster Service Worker, as required;
- Performs related duties as required.

#### Employment Standards

Sufficient education, training and experience to demonstrate possession and direct application of the following knowledge and abilities:

Possession of a Certified Coding Specialist (CCS) credential issued by the American Health Information Management Association.

#### Experience Note:

The required knowledge and abilities would typically be acquired by obtaining a credential as a Registered Health Information Technician (RHIT) by the American Health Information Management Association (AHIMA), **OR** a credential as a Registered Health Information Administrator (RHIA).

In addition to the credential, education, experience and training equivalent to a Bachelor's Degree from an accredited college in Health Information Technology or Health Information Management, AND four (4) years of work experience coding and abstracting in a medical record department or nursing department of an acute care facility. With possession of an Associate's Degree in Health Information Technology or Health Information Management, two (2) additional years of experience can substitute for up to two (2) years of related education.

**OR**

Possession of a Registered Nurse license or Bachelors Degree in Nursing AND two (2) years of experience in nursing or other clinical area coding, process improvement, or utilization review/case management in an acute care facility

Knowledge of:

- Coding, abstracting, and terminology systems such as: International Classification of Diseases, Clinically Modified (ICD), current Concurrent Procedure Terminology (CPT) coding systems;
- Comprehensive medical terminology covering a wide variety of medical specialties, including anatomy and physiology, the disease process, pharmacology, and pathophysiology;
- Documentation Standards for Acute Care Clinical Records;
- Components and format of a medical record, including but not limited to laboratory findings, special tests, medications, surgical procedures, therapy systems, reports, history and progress notes, and consent documentation;
- Medical services, and patient treatment interrelationships and sequences of a comprehensive teaching hospital;
- Abstract for patient data fields, abstracting and coding techniques and statistical methods;
- Office of State Wide Hospital Planning and Development (OSHPD) reporting requirements;
- English grammar, punctuation, spelling, and general English usage;
- Effective methods of using audio/visual equipment and other training aids or materials;
- Computerized patient data systems.

Ability to:

- Read, analyze, interpret, and comprehend the technical elements of a medical chart;
- Analyze, code, and abstract complex technical data from medical records covering a wide variety of medical specialties utilizing an encoder and electronic abstracting system;
- Recognize missing elements, infer procedural and treatment relationships, and properly sequence information for coding and abstracting data from a medical record;
- Prepare clear and concise narrative, statistical, and graphic reports;
- Set work priorities and work independently, exercising considerable independent judgment;
- Communicate clearly, both verbally and in writing, with the public, patients, medical/nursing staff, technical staff, and legal counsel;
- Conduct training and development sessions, perform the role of facilitator, and effectively instruct individuals or groups in specific documentation needs as they relate to coding and reimbursement issues;
- Skillfully and tactfully resolve complex requestor problems and complaints;
- Follow- guidelines for coding and documentation to ensure physician and hospital compliance;
- Generate reports from computer or manual systems;
- Establish and maintain effective professional working relationships with those contacted in the course of work.

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