NYC HEALTH+ HOSPITALS

Human Resources
Office of Classification & Compensation Administration
55 Water Street, 26th Floor
New York, NY 10041

Position Title	*Title Code(s)*	*Effective*	*Reissued*	*Revision*
Clinical Documentation Specialist				
Level I	342750	4/12/2019		
Level II	342760			

Purpose of Position:

Under the direction of the Director of Clinical Documentation, Director of Health Information Management or a designee for revenue management and recovery, facilitates and obtains appropriate physician documentation for clinical conditions or procedures to support the appropriate severity of Illness, expected risk of mortality, and complexity of patient care and to optimize reimbursement, ensuring patient-centered quality care, optimal utilization of resources, service delivery and compliance with NYC Health + Hospitals, hospital, and all relevant regulatory policies, procedures, and standards of care for better outcomes and improved patient experience. Demonstrates effective communication, planning, and organizational skills and keeps current knowledge in the clinical documentation field and of all applicable regulations. There are two (2) Assignment Levels within this class of positions; all personnel perform related work and may perform tasks remotely, as authorized.

Assignment Level I

Under supervision, performs assigned duties related to reviewing, reporting, processing and quality assurance of clinical documentation. The following are typical tasks for Assignment Level I:

Examples of Typical Tasks:

1. Facilitates improvement in the overall quality, completeness, accuracy, specificity and timeliness of physician clinical record documentation through extensive medical record review, query process, and effective communication with appropriate clinical and coding staff, and by utilizing computer programs and systems.

2. Obtains appropriate physician documentation for clinical conditions or procedures through extensive on-going interaction with physicians, other patient caregivers, and medical records coding staff to ensure the clinical documentation properly captures information describing patients' acuity, severity of illness, and risk of mortality. Reflects the level of service delivered to patients is appropriate, complete, and accurate and supports appropriate reimbursement for the level of service rendered to all patients.

3. Completes concurrent and retrospective reviews of patient records for a specified patient population to evaluate documentation to assign the principal diagnosis, pertinent secondary diagnoses, post-admission complications and procedures for accurate Diagnosis-Related Group (DRG) assignment and Case Mix Index (CMI), risk of mortality, and severity of illness.

4. Queries physicians for incomplete, inconsistent, unclear or conflicting health record documentation to clarify and resolve conflicting information in patient's medical record prior to patient's discharge; maintains a record of review and query activities and other appropriate records.

Examples of Typical Tasks: (continued)

5. Provides feedback and completes follow-up review of patient medical record, to ensure points of clarification have been addressed and recorded in the patient's chart, and to assign a working/updated or final DRG upon patient discharge and before final coding and quality reporting submissions, as necessary.

6. Identifies and reports areas of weakness that may impact financial opportunities, and works with Finance or other appropriate staff in resolution of problems.

7. Participates in the analysis and trending of statistical data for specified patient populations to identify opportunities for improvement.

8. Assists with preparation and presentation of clinical documentation monitoring/trending reports for review with physicians and hospital leadership.

9. Assists in the orientation and training of new staff members, and provides continual guidance and mentoring, as required.

10. Educates providers on proper clinical documentation and coding guidelines and practices, and compliance and reimbursement issues on an ongoing basis. Advises on the impact of provider documentation on accurate reporting of a patient's clinical information and reimbursement.

11. Attends and/or participates in staff, departmental and interdisciplinary meetings, LEAN efficiency/ process improvement events, training and quality assurance/performance improvement (QA/PI) activities.

12. Performs other related work, as assigned.

Assignment Level II

Under general supervision, coordinates and supports the daily activities and services in an assigned department(s), unit(s) or area of service. In addition to performing the duties of Assignment Level I at a more difficult and responsible level, also performs the following:

Examples of Typical Tasks:

1. Contributes to the strategic planning and process improvement initiatives and activities related to clinical documentation, by providing expert-level review and assessment, and effective recommendations or solutions for improvement.

2. Assists in the development of policies, procedures, and guidelines, or a review and/or revision of existing ones, to support best practices for clinical documentation program and staff and ensures all compliance and regulatory standards are met.

3. Serves as lead Clinical Documentation Specialist, providing guidance to other Clinical Documentation Specialists and handles more difficult cases.

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Examples of Typical Tasks: (continued)

4. Acts as a liaison and key resource for medical and other staff on interpretation and application of clinical documentation, ethical reporting and documentation standards and other related actions and matters. Actively monitors clinical documentation requests and responds to questions submitted and provides complete follow-through on all requests for clarification.

5. Provides direction, training, and education to reporting and other assigned staff on performance of duties. Supervises accuracy and timeliness of work, work processes, and overall workload responsibilities.

Qualification Requirements:

For Appointment to Assignment Level I:

1. Valid New York State license and current registration to practice as a Registered Professional Nurse (RN) issued by the New York State Education Department (NYSED); and Bachelor of Science in Nursing degree from an accredited college or university; and four (4) years of acute care experience; or

2. Valid New York State license and current registration to practice as a Nurse Practitioner (NP) issued by the NYSED; and two (2) years of experience, as described in "1" above; or

3. Valid New York State license and current registration to practice as a Physician Assistant (PA) issued by the NYSED; and two (2) years of experience, as described in "1" above; or

4. Foreign Medical Graduate; and, two (2) years of medical records review or utilization and case management experience; or

5. Successful completion of education that leads to a medical degree; and two (2) years of experience, as described in "4" above.

For Appointment to Assignment Level II:

1. Two (2) years of experience serving in Assignment Level I; and

2. Holds and maintains a Certified Clinical Documentation Specialist (CCDS) Certification issued by the Association of Clinical Documentation Improvement Specialists (ACDIS).

Note:

Incumbent employees currently functioning in Clinical Documentation Specialist roles will be reclassified to the title of Clinical Documentation Specialist Level I or II, as appropriate, effective April 12, 2019. All **new** employees entering the Clinical Documentation Specialist title on or after April 12, 2019 must meet the qualification requirements for the appropriate level, indicated above, at the time of appointment.

Direct Line of Promotion:

None. This class of positions is classified in the non-competitive class.