Oroville Hospital	Job Description for Clinical Documentation Analyst	Department:	**Hospital Information Management**
		Dept.#:	**8700**
		Last Updated:	**02/10/12** Position Status: Non-Exempt

Reports To

Director of Health Information Management/Chief Operating Officer

Job Summary

Facilitates and obtains appropriate physician documentation for any clinical conditions or procedures to support the appropriate severity of illness, expected risk of mortality, and complexity of care of the patient. Exhibits a sufficient knowledge of clinical documentation requirements, DRG assignment, and clinical conditions or procedures. Educates members of the patient care team regarding documentation guidelines, including physicians, allied health practitioners, and nursing. Also responsible for utilization review and resource management of the case based on clinical documentation found in the patient record.

Duties:

- Completes initial reviews of patient records to: (a) evaluate documentation to assign the principal diagnosis, pertinent secondary diagnoses, and procedures for accurate DRG assignment, risk of mortality, and severity of illness; and (b) initiate a review worksheet.
- Conducts follow-up reviews of patients to support and assign a working or final DRG assignment upon patient discharge, as necessary.
- Queries physicians regarding missing, unclear, or conflicting health record documentation by requesting and obtaining additional documentation within the health record when needed.
- Educates physicians and key healthcare providers regarding clinical documentation improvement and the need for accurate and complete documentation in the health record.
- Collaborates with discharge planners, nursing staff, and other ancillary staff regarding interaction with physicians on documentation to resolve physician queries prior to patient discharge.
- Educates members of the patient care team regarding specific documentation needs and reporting and reimbursement issues identified through daily and retrospective documentation reviews.
- Facilitates change processes required to capture needed documentation by communicating with department leadership
- Uses effective relationship management, coordination of services, resource management, education, patient advocacy and related interventions to:
    - promote improved quality of care
    - promote cost effective medical outcomes
    - promote decreased length of hospital stays when appropriate
    - assure appropriate levels of care are received by patients

Qualifications

Education & Licensure:

- High School Graduate or equivalent
- Computer skills required

Certifications:

- Coding or clinical documentation certification preferred

Knowledge & Experience:

- Healthcare professionals with a clinical and/or coding background
- At least 2 years inpatient coding experience and/or 2 years acute care experience required

Additional Qualifications:

- Must be detailed oriented, have excellent analytical and problem solving skills, and the ability to manage workload and competing priorities in order to complete tasks in a timely manner
- The ability to read and interpret clinical information and resolve issues with providers, learn new software and latest technologies
- A working knowledge of operational and system workflows and Microsoft products
- Demonstrates outstanding written and verbal communication skills with proven track record in prior positions
- Must have the ability to prioritize work to meet the needs of all customers
- Must have the proven ability to maintain confidentiality
- Must demonstrate excellent customer service and communication skills
- Must be flexible, dependable, and demonstrate the ability to adapt to change

Work Environment

Work area is well lighted and ventilated.

Dress Code

Complies with hospital and departmental dress code. Wears name badge with job title and credentials clearly visible.

Physical Abilities

See attached Job Task Analysis