Outpatient Clinical Documentation Improvement Specialist

INDUSTRY FACTS

What do outpatient clinical documentation improvement specialists do?

Clinical documentation improvement specialists perform concurrent reviews of patient health records to ensure complete, accurate, and specific clinical documentation. They have a comprehensive understanding of CMS Coding Guidelines and are responsible for clarifying conflicting, incomplete, or imprecise documentation by actively seeking answers and educating active providers.

Their daily routines probably include the following responsibilities:

- Reviewing overall quality and completeness of clinical documentation.
- Reviewing patient records with an emphasis on improving documentation.
- Applying comprehensive knowledge of medical terminology, anatomy and physiology, disease processes, treatment modalities, diagnostic tests, medications, and procedures to ensure proper code selection.
- Adhering to accepted coding practices, guidelines, and conventions.
- Assisting facility staff with documentation requirements to completely and accurately reflect the patient care provided.

Where do they work?

More often than not, an outpatient clinical documentation improvement specialist will work in a physician's office, clinic, or surgery center. Since this role requires either a prospective or concurrent review, it is beneficial for the specialist to be onsite in their role. Working from home is becoming increasingly more common and could be a possibility, depending upon the needs of the organization.

How much do they earn?

According to PayScale.com, Clinical Documentation Specialists make just over $77,000 a year.*

How's the job outlook?

Advancement in technology has impacted the industry with trends in inpatient, surgical, specialties, and physician coding roles are on the rise. CDI Specialists are an integral part of compliance and documentation improvement.

*PayScale. "Average Clinical Documentation Specialist Salary" Payscale.com. Accessed April 25, 2023.

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JENNIFER, CAREERSTEP LEARNER
JULY, 2019

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PROGRAM DETAILS

Prepare For A Better Job

Train affordably without sacrificing quality. This program's comprehensive training was developed by industry professionals with years of experience – specifically designed to help you prepare for the Certified Documentation Expert Outpatient (CDEO) and Certified Electronic Health Records Specialist (CEHRS) certification exams.

Learn Your Way (From Home)

With online training, you can absorb more knowledge and learn more skills—fast.

- Train on a schedule that fits your life
- Progress at a pace that matches your learning style
- Adjust the time and effort you devote to your coursework each day

Receive Coaching and Guidance

When you train with CareerStep, we back you every step of the way—from signup through course completion.

- Learner support
- Technical support

Get Certified

We'll help you prepare to take nationally recognized exams so you can explore greater opportunities in your area.

- **Certified Documentation Expert Outpatient (CDEO)**
- **Certified Electronic Health Records Specialist (CEHRS)**

Program Outline

Courses
Program Orientation: Clinical Documentation Improvement—Outpatient 2023
Introduction to Healthcare
Digital Technology
Comprehensive Medical Terminology
Law, Liability and Ethics for Healthcare
Anatomy and Physiology Essentials
Health Information Management
Comprehensive Pharmacology
Comprehensive Electronic Health Records
Outpatient Coding
Clinical Documentation Improvement - Outpatient
Program Completion: Clinical Documentation Improvement—Outpatient 2023