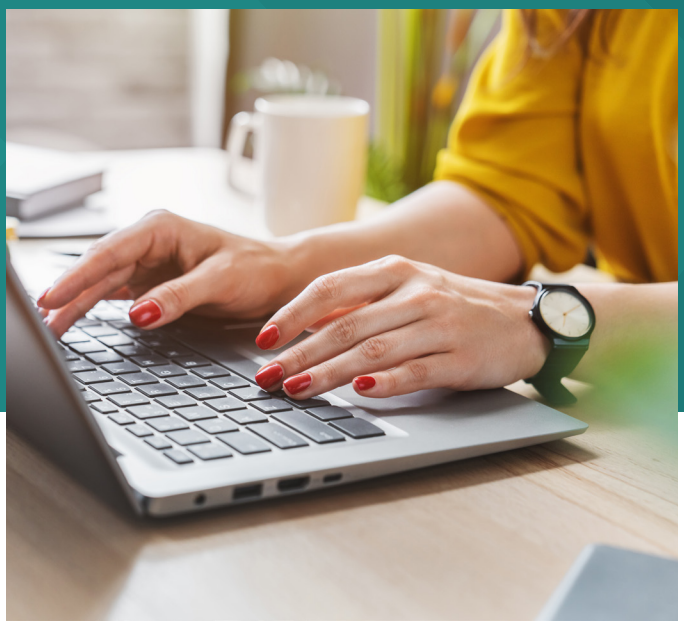
Inpatient Clinical Documentation Improvement Specialist

INDUSTRY FACTS



What do inpatient 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?

Inpatient clinical documentation improvement specialists are often onsite as they complete concurrent reviews. This allows them to have real-time dialog with the provider as they review patient charts and records. Remote work is becoming more common for this role, however that would depend upon the individual needs of the organization.

How much do they earn?

By leveling up and expanding your knowledge, you have the opportunity to significantly increase your job salary—the average income for Learners in this career, according to Burning Glass, is just over $68,000 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.

"I have truly enjoyed my experience with CareerStep. Their programs allow you to work on your studies on your own time, which is fantastic for busy moms like myself. If I have ever run into problems with anything, all I have to do is text someone from learner support and they are there to help me."

JENNIFER, CAREERSTEP LEARNER

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PROGRAM DETAILS

Improve Your Life

When it comes to career training, you'll find a lot of posers out there. Con artists that'll try to impress you with fancy hyperbole. But through all the noise, the distinct sound of success can be heard. Your success. All it takes is a little push. A nudge in the right direction—and your whole life could change. New doors opened. New worlds discovered. New opportunities explored.

Prepare For A Better Job

Clinical Documentation Improvement (CDI) is the process of elevating healthcare records to ensure better patient outcomes, data quality, and accurate reimbursement. If you have relevant coding and/or clinical experience—and you're looking to take the next steps in your career—brushing up on your clinical documentation improvement skills is a surefire way to get noticed within the industry.

Our 383-hour program is divided into 13 easy-to-digest courses that cover a variety of topics, including inpatient coding, pharmacology, health information best practices, professional communication, and time-management.

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 throw in 1 free voucher for the Certified Documentation Improvement Practitioner (CDIP) exam offered by the American Health Information Management Association (AHIMA). This is a high-level certification, and AHIMA requires all Learners to hold an associate's degree (or higher), or hold one of the following credentials: CCS®, CCS-P®, RHIT®, or RHIA®.

- **Certified Documentation Improvement Practitioner (CDIP)**

Program Outline

Course
Program Orientation: Clinical Documentation Improvement—Inpatient
Computer Fundamentals
Comprehensive Medical Terminology
Law, Liability, and Ethics for Healthcare
Introduction to Healthcare
Comprehensive Electronic Health Records
Anatomy and Physiology
Comprehensive Pharmacology
Health Information Management
Inpatient Coding
Inpatient Clinical Documentation Improvement
Career Success in Healthcare
Program Completion: Clinical Documentation Improvement—Outpatient

TOTAL HOURS: 383
Coursework, Simulations, and Experiential