Clinical Documentation Specialist Job Description

Duties and Responsibilities:

- Collect information about patients' diagnoses and upload on computer databases
- Assess patient's medical documents to ensure accuracy
- Educate medical coders and billers on standard procedures that must be followed when composing medical documents
- Recommend strategies for improving record keeping processes
- Ensure all clinical documents are in compliance with federal laws in terms of composition and secure storage
- Apply knowledge of medical terminology and procedures to properly evaluate clinical documents
- Prepare written reports for public health officials who evaluate health care facilities
- Interpret clinical reports to identify health related issues and assist in addressing patient health problems
- Train information specialists on proper methods of documentation and maintenance of medical records
- Promote continuity on specific clinical documentation throughout the record
- Accurately report and describe the severity of patient's illness so as to make known the action required
- Facilitate complete discharge summaries.

Clinical Documentation Specialist Requirements – Skills, Knowledge, and Abilities

- Education and Training: To become a clinical documentation specialist requires a bachelor's degree in health information technology or at least an associate's degree in applied science

- IT Skill: Clinical documentation specialists must have excellent computer skills and knowledge of software for database maintenance and electronic health record storage
- Communication Skill: They must have excellent communication skill, both written and verbal applied in the provision of accurate information to healthcare staff
- Interpersonal Skill: They should be able to relate and work with others in the clinical setting so as to create an air of understanding among all units.