Power of Clinical Document Specialists: New Role Combines Clinical, Coding Knowledge to Improve Documentation

by Christina Mayer Duggan

Incomplete documentation is a fact of life in healthcare facilities. With more than 20 years of experience in HIM, Kathy Sauer, MBA, BS, RHIA, agrees. “Absolutely-across the board!” says Sauer, HIM director at Mount Sinai Hospital in Chicago, IL. “I’ve been a director at several facilities, and it’s always an issue.”

Mount Sinai addressed the age-old challenge by creating a new role that bridges the clinical and coding professions: clinical document specialists (CDSs).

“You need the clinical side, someone who can talk to physicians, like an RN,” says Sauer, who helped create the program. “You also need someone like an RHIA or RHIT who knows about coding, guidelines, and what documentation coders need in the charts. Those are two different thought processes. It’s a great combination.” The CDSs are members of the HIM department and report to Sauer.

Combining Clinical and Coding Knowledge

The CDSs don’t code; instead, they identify diagnoses and diagnostically related groups, find out about lab work, review charts during patients’ stays, query physicians, and use a worksheet to stay organized. “They abstract information from the chart and write a query to the physician if necessary. Clinically, they know the information coders need to see in the chart so coders can code correctly,” explains Sauer.

Since these professionals were hired two years ago, Sauer has noticed many benefits. “We’ve increased our case mix and increased our reimbursements. The first year, we realized about $1.5 million in additional reimbursements. The second year, it was about $.9 million. We saw results right away.”

Revenue cycles were also enhanced. “Better documentation means better coding, which means cleaner bills. We get bills out faster, and there’s less need to redo them. It’s a good way of doing business.” In addition, other payers like Medicare, Medicaid, Blue Cross/Blue Shield, HMOs, and insurance companies also benefit from the improved documentation process. “It’s good continuity of care,” says Sauer.

Better Communication, Better Care

The benefits go beyond finances, however. “There’s an open line of communication between the coders and the CDSs; there’s mutual respect. They know each others’ needs. When we first implemented this program, the CDSs were excited and said, ‘We can do this!’ It’s been successful.”

Physicians are also becoming accustomed to the process, and new residents are taught what to do and why it’s important. “They know we won’t go away,” she says, smiling.

Gathering complete information is crucial for Sauer, as it is for all HIM professionals. “HIM people are in the business of documentation; it’s what we’re all about. Coders convert written material into codes; they need specific documentation to do that. If documentation is missing, they can’t code diagnoses to the highest specificity.” Clearly, the CDSs are improving the documentation process.

Excellent patient care, though, is always the bottom line. “Hospitals must continue to focus on problematic documentation and coding issues” Sauer says. “When we document better, we give the patient better care.”

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Article citation:
Duggan, Christina Mayer. "Power of Clinical Document Specialists: New Role Combines Clinical, Coding Knowledge to Improve Documentation" *Journal of AHIMA* 78, no.1 (January 2007): 92-.