CDEO™ Clinical Documentation Improvement Training Course Syllabus

Prerequisites: Minimum of two years coding experience and coding certification strongly recommended.

Clock Hours: 20 (*Note:* 20 clock hours accounts only for time spent in the online course, and does not include time spent outside the course or study time. Study time will vary widely per individual.)

Course Length: To be completed at student's own pace within a 3-month period or less. Enrollment date begins at date of purchase. Monthly course extensions may be purchased.

Class Hours: Days/Times Per Week: Online course, independent self-study, no classroom meetings; student may login to course at their own time schedule, no specific login times.

Certificate of Completion Issued: Yes

CEUs: 20 CEUs upon completion (AAPC certified prior to enrollment; some certifications excluded – see AAPC website for more details.)

Course Description: The student will learn principles of clinical documentation improvement. In addition, there will be discussion of benefits of clinical documentation improvement (CDI) programs, documentation requirements, quality measures, payment methodologies, and clinical conditions including common signs and symptoms, typical treatment, documentation tips and coding concepts. This course is recommended for anyone who is preparing for a career in clinical documentation improvement and strongly recommended for anyone who is preparing for AAPC's Certified Documentation Expert-Outpatient (CDEO) certification examination.

Course Objectives:

- Define benefits of clinical documentation improvement programs
- Explain the impact of the OIG Work Plan and Corporate Integrity Agreements (CIAs)
- Define the proper use of queries and effective provider communication.
- Identify National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) risk areas
- Explain the HIPAA privacy rule, including details on protected health information, minimum necessary, sharing of information, and enforcement
- Identify medical record documentation standards and record retention standards
- Identify common errors found in documentation for evaluation and management, minor surgery, radiology, pathology and laboratory, and medicine services
- Explain aggregate analysis and when it is useful
- Explain the importance of discussing audit findings with the provider
- Provide practical application of auditing operative reports and evaluation and management services

Course Content:

- Purpose of Clinical Documentation Improvement
    - Requirements of medical documentation
    - Benefits of CDI
    - Best practices of CDI
- Documentation Requirements
    - HIPAA requirements
    - Signature requirements
    - Electronic Health Records deficiencies
        - Cloning
        - Copy Paste
        - Carry forward

    - Proper use of templates
    - Proper procedure for correcting errors
    - Documentation to support billing and coding
    - Documentation required for ancillary services
    - Documentation required for minor procedures
    - Selecting diagnosis codes for pick lists
    - Management of problem lists
    - Abbreviations
    - Timely completion of a medical record
- Provider communication and compliance
    - HIPAA compliance
    - OIG Work plan and audit results
    - Provider queries
- Quality Measures
    - Understand and identify HEDIS measures
    - Know the requirements for meaningful use
    - Identify PQRS measures and proper documentation for support
    - Demonstrate knowledge of quality measures and other value-based payment systems
    - Understand strategies for capturing quality measures within documentation
    - Understand the purpose of the Stars rating and the domains.
- Payment Models
    - Demonstrate understanding of fee-for-service payment models
        - RVUs
        - NCCI edits
        - Global days
- Explain how the HCC Risk adjustment model can determine areas of CDI focus
- Explain how documentation affects HCC risk adjustment and patient RAF scores
- Understand new payment models and documentation requirements
    - MACRA
        - MIPS
        - Advanced payment models
    - Bundled payments
- Clinical Conditions and Diagnosis Coding Part I: Chapter 1-11
    - Define the condition, signs and symptoms, testing, treatments, coding concepts, coding guidelines for the following conditions
        - Congenital versus acquired conditions (General)
        - HIV/AIDS
        - Sepsis
        - Neoplasms
        - Adjuvant therapy
        - Active versus history of neoplasm
        - Metastatic
        - Anemia (blood loss) polycythemia
        - Diabetes
        - Malnutrition
        - Morbid obesity and BMI
        - Drug Dependence
        - Major Depression
        - Epilepsy
        - Neuropathy
        - Parkinson's disease
        - Common conditions of the ear
        - Aortic aneurysm
        - Aortic stenosis/sclerosis

        - CAD
        - Cardiomyopathy
        - Cardiac conduction conditions – A-fib, sick sinus syndrome
        - CVA vs. TIA
        - Deep Vein Thrombosis
        - Heart failure
        - Hemiplegia
        - Hypertension
        - Hypoxia
        - Myocardial infarction
        - Peripheral vascular disease
        - Venous stasis ulcers
        - Chronic Obstructive Pulmonary Disease– bronchitis, asthma
        - Pneumonia
        - Crohn's disease
        - Cirrhosis

- Clinical Conditions and Diagnosis Coding Part II: Chapters 12-21
    - Define the condition, signs and symptoms, testing, treatments, coding concepts, coding guidelines for the following conditions
        - Pressure ulcers
        - Rheumatoid arthritis
        - Pathological osteoporosis fractures
        - Chronic Kidney Disease
        - Common conditions in pregnancy
        - Common conditions in the perinatal period
        - Burns
        - Fractures
        - Head injury
        - Amputation
        - Artificial openings
        - Transplant status
- Procedure Coding
    - Evaluation and Management Coding
        - Review the key components
            - History
            - Exam
            - Medical decision making
                - Determine how analysis of data applied to the complexity of medical decision making
                - Review documentation to determine the complexity of medical decision making
                - Utilize the table of risk to determine MDM
        - Nature of the presenting problem
        - Time based E/M coding
    - Demonstrate the ability to determine when an E/M code can be billed in addition to a minor procedure in the office
    - Determine when a sick visit can be billed on the same date as a preventive visit
    - Apply CPT® Assistant guidance related to procedure coding
    - Apply NCD/LCD policies related to procedure coding and medical necessity
- Final Exam

Methods of Evaluation:

The instructional methods used include reading assignments, interactive audio/video lectures with quizzes included, chapter review exams, and a final exam. To receive a certificate of completion, students must successfully complete the course within the allotted time frame of 3 months or less (monthly extensions may be purchased).

Successful course completion includes:

- A passing score of 70% or higher on all chapter review exams
- A passing score of 70% or higher on the final exam
- An overall final course score of 70% or higher

No reduced hours in the course or tuition discount for previous education or training will be granted.

Included Reading Material:

1. Clinical Documentation Improvement Training: CDEO™ 2019; AAPC; AAPC publisher; (available online only in PDF format, no textbook will be issued with this course)

Required Code Books (Not Included):

1. CPT® Professional Edition code book (2019 year), AMA publisher
2. ICD-10-CM code book (2019 year), any publisher
3. HCPCS Level II code book (2019 year), any publisher

Required code books may be purchased through AAPC or any major bookseller.

Computer Requirements: High-speed Internet connection with Blackboard supported Operating System & Web browser (see Course Requirements tab: https://www.aapc.com/training/medical-documentation-course.aspx) Adobe Flash Player; Adobe Acrobat Reader. For best experience, use of a mobile device is not recommended.

Course Enrollment Fee: Payment is due in full at time of enrollment. Fees listed do not include any required or recommended textbooks/supplies or computer requirements, which are to be purchased separately by the student. Prices are variable and subject to change, see AAPC website for most current enrollment fees: https://www.aapc.com/training/cdeo-complete-training-package.aspx.