CDEI™ Clinical Documentation Improvement – Inpatient Training Course Syllabus

Prerequisites: Minimum of two years inpatient 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 for inpatient facility documentation. In addition, there will be discussion of benefits of clinical documentation improvement (CDI) programs, documentation requirements, 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-Inpatient (CDEI) certification examination.

Course Objectives:
- Define benefits of clinical documentation improvement programs.
- Describe the implementation of a clinical documentation improvement program for inpatient facilities.
- 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.
- Define the proper use of queries and effective provider communication.
- Describe quality measures and how they apply to clinical documentation.
- Summarize inpatient payment systems.
- Apply ICD-10-CM and ICD-10-PCS guidelines to clinical documentation.
- Identify documentation deficiencies and resolutions in clinical documentation cases.

Course Content:
- The Purpose of Inpatient Clinical Documentation Improvement Programs
    - Understand the importance of medical documentation
    - Master the documentation process
    - Implement a CDI program
- Documentation Requirements
    - Understand the medical record
    - Identify ownership and access to the medical record
    - Summarize HIPAA
    - Identify and summarize regulatory guidance for the medical record
    - List the components of the medical record
- Provider communication and compliance
    - Identify regulations such as the False Claims Act, Exclusion Statute, and Civil Monetary Penalties Law
    - Describe the OIG and identify publications of the OIG
    - Summarize Recovery Audit Contracts (RACs)

    - List types of physician queries
    - Describe how to write a compliant query
    - Explain the mindset of a physician for effective communication
- Quality Measures
    - Demonstrate knowledge of the Hospital Value-Based Purchasing Program
    - Describe patient safety and quality indicators
    - Explain the hospital readmission reduction program
    - Explain Vizient
- CMS and Inpatient Payment Systems
    - List common inpatient payment system reimbursement methodologies
    - Define inpatient stays
    - Explain the discharge status disposition
    - Describe Diagnostic Related Groups (DRGs) and how they affect reimbursement
    - Define rules affecting inpatient admissions, such as the 72-hour rule and the two-midnight rule
    - Identify hospital acquired conditions
    - Explain the Hospital Inpatient Quality Reporting Program
    - Define Major Diagnostic Categories (MDCs), Medicare Severity-Diagnoses Related Groups (MS-DRGs), and All Patients Refined – Diagnosis Related Groups (APR-DRGs)
    - List the steps to determine the MS-DRG
- Introduction to ICD-10-CM
    - Describe how to look up an ICD-10-CM code
    - Apply ICD-10-CM coding guidelines
- 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 12-22
  - 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
    - COVID-19
    - Vaping-related disorders
- ICD-10-PCS Coding and Guidelines
  - Identify the structure of the ICD-10-PCS code book.
  - Determine how to use the ICD-10-PCS code book to determine code selection based on documentation.
  - Describe ICD-10-PCS Official Guidelines.
- Inpatient Coding and Documentation Review
  - Determine the principal diagnosis, admitting diagnosis, and additional diagnosis code sequencing
  - Define and apply present on admission (POA) indicators
  - Review documentation dissection and query writing example
- Final Exam

<u>Methods of Evaluation:</u>

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:

- An attempt on all required assignments and quizzes
- 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.

<u>Included Reading Material:</u>

1. Clinical Documentation Improvement – Inpatient Training: CDEI™ 2024 – eBook; AAPC; AAPC publisher

Required Code Books (Not Included):

1. ICD-10-PCS code book (2024 year), any publisher
2. ICD-10-CM code book (2024 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 Acrobat Reader. For best experience, use of a mobile device and Blackboard app 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.