Outpatient Clinical Documentation Improvement Specialist

LEARNING OBJECTIVES

Our 423-hour program is divided into 12 easy-to-digest courses that cover a variety of topics, including outpatient coding, pharmacology, health information best practices, professional communication, and time management.

Program Orientation: Clinical Documentation Improvement—Outpatient

- Initiate the Outpatient Clinical Documentation Improvement Program.

Introduction to Healthcare

- Identify health information management concepts common to allied health professionals.
- Describe characteristics of health care delivery and settings in the United States.
- Delineate career opportunities for health information management professionals.

Digital Technology

- Have a basic understanding of the internet and evaluated hardware.
- Understand and be able to use various programs and apps.
- Be able to explain privacy and digital security in digital technology.
- Describe the fundamentals of input and output.
- Have an understanding of network devices.
- Use technology to help you find a career.

Comprehensive Medical Terminology

- Analyze how medical terms are built using common word parts.
- Properly spell, define, and pronounce medical terms associated with each of the major body systems.
- Identify and define the word parts most frequently associated with the major body systems.
- Interpret common abbreviations used in medical terminology and cautions to remember when using them.

Law, Liability, and Ethics for Healthcare

- Describe the structure of the healthcare industry and how it relates to the medical office profession.
- Identify law and regulations related to the healthcare workplace.
- Describe how law flows from the constitution to the courtroom.
- Identify criminal acts and intentional torts.
- Recognize what makes a contract and who can contract.
- Identify medical malpractice and other lawsuits.
- Explain the characteristics, ownership, and confidentiality of the health record.
- Recognize the importance of the laws and ethics of patient confidentiality.
- Explain professional ethics and how they apply to patients.
- Recognize ethical issues surrounding the beginning of life.
- Recognize ethical issues surrounding death and dying.

Anatomy and Physiology

- Identify the structures, locations, and functions of major body systems and the organs that comprise them.
- Explain how the organs of the major body systems interact and maintain homeostasis.
- Compare various risk factors leading to high mortality and morbidity.
- Describe the components of cell structure and their functions.
- Summarize how infectious agents affect cellular growth and function.
- Define basic anatomical terms.

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Health Information Management

- Explain the role of health information management in patient care documentation and medical coding and billing.
- Identify types of health records and the documentation requirements, data sources, collection tools, and potential issues associated with each type.
- Discuss the evolution of the electronic health record (EHR) and its administrative and clinical applications.
- Describe records storage and retrieval processes, including numbering and filing systems and record storage and circulation methods.
- Explain health record maintenance through the use of the master patient index and data collection, indexes, and registers.
- Identify the principles, professional practice standards, and regulations related to the use of the health record as a legal business record.
- Describe the processes and legal requirements for the release of personal health information.

Comprehensive Pharmacology

- Define basic pharmacology terminology.
- Identify U.S. drug laws and explain their importance in patient care and health services documentation.
- Differentiate among drug classifications, routes of entry, mechanisms of action, and therapeutic treatments related to specific body systems and disease conditions.
- Identify medication side effects, precautions, contraindications, and interactions.
- Identify major drug standards, legislation, legal responsibilities of the health care practitioner when dispensing medications.
- Identify the major drug classification systems and differentiate among the various types of drug names with examples.
- Evaluate the standard and online pharmacological references in use today.
- Classify the sources of drugs, examine their pharmacokinetic processes, and analyze the variables that affect drug actions and effects.
- Analyze various drug forms, routes of delivery, and the supplies and techniques necessary for safe and appropriate administration.
- Identify commonly used medications and their characteristics.
- Identify the sources, mechanism of action, and indications for specific drug therapies.
- Analyze the side effects, precautions, contraindications, and interactions for specific medications.
- Assess the factors that influence the absorption and effectiveness of drugs.
- Analyze the physiological effects of prolonged drug use and discuss the responsibilities of a health care practitioner in addressing and treating drug abuse.
- Investigate recent actions taken by the government and by manufacturers for specific drugs.
- Identify the key factors involved in considering drug therapies for older adults.

Comprehensive Electronic Health Records

- Demonstrate how patient records are used and regulated.
- Complete tasks required for scheduling patient appointments.
- Clinical information reporting.
- Apply basic coding for reimbursement claims.
- Revenue cycle and financial reporting.

Outpatient Coding

- Understanding of ICD-10-CM format, symbols, punctuation, and instructional notations (domain 1).
- Accurately assign and sequence ICD-10-CM diagnostic codes for inpatient, outpatient, and physician services according to the official coding guidelines.
- Employ both manual and electronic resources to accurately code and sequence information from patient health records using the ICD-10-CM classification system.
- Describe the impact of reimbursement policies on individuals and healthcare providers.

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- Differentiate reimbursement systems for various programs, including private insurance and contacts, managed care, Medicare, Medicaid, Workers' Compensation, and other disabilities.
- Understand the difference between CPT, ICD, and HCPCS coding systems and identify their appropriate use in health records.
- Identify local, state and federal statutes and regulations surrounding the control and use of health information.
- Describe the key elements of the Healthcare Insurance Portability and Accountability Act (HIPAA) and its impact on healthcare professionals.
- Explain the Outpatient Prospective Payment System (OPPS).
- This course provides the foundational understanding and application of ICD-10-CM and CPT coding systems.
- Provides the foundational understanding and application of ICD-10-CM, CPT, and HCPCS coding systems and includes a focus on using Official Coding Guidelines to accurately assign diagnosis codes using ICD-10, along with coding rules for CPT and HCPCS coding systems.

Clinical Documentation Improvement - Outpatient

- Demonstrate knowledge of healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for Coding and Reporting (OCG), the Outpatient Prospective Payment System (OPPS), and provider coding and billing.
- Identify and apply diseases and disease processes to the clinical chart review.
- Demonstrate an ability to develop proper provider education tools.
- Describe critical performance indicators and data elements that monitor the impact of Clinical Documentation Improvement (CDI) specialist efforts.
- Demonstrate knowledge of quality, regulatory and health initiatives.

Program Completion: Clinical Documentation Improvement—Outpatient

- Prepare to take next steps for program completion.

Total Hours: 423

Coursework, Simulations, and Experiential