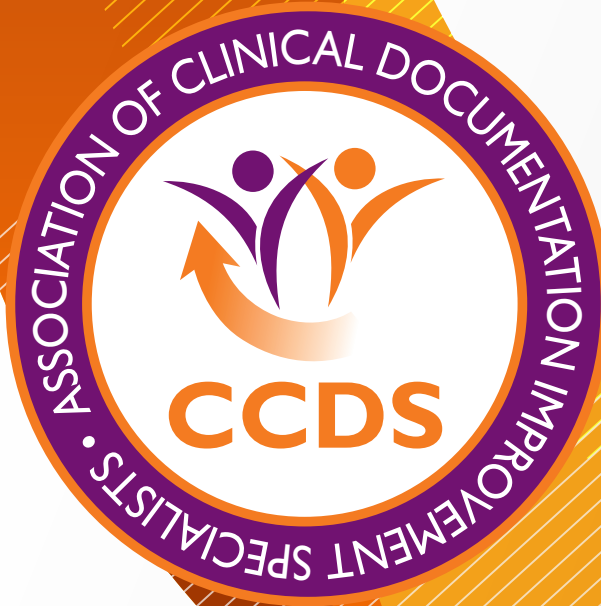


CCDS

Certified Clinical Documentation Specialist Candidate Handbook

The standard of excellence for clinical documentation
specialists by clinical documentation specialists



2016 CANDIDATE HANDBOOK

About the Association of Clinical Documentation Improvement Specialists

The Association of Clinical Documentation Improvement Specialists (ACDIS) is a diverse community of professionals whose backgrounds include nursing, HIM/coding, case management, quality, and more. Members of ACDIS share the latest tested tips, tools, and strategies to implement successful CDI programs and achieve professional growth. ACDIS' mission is to bring CDI specialists together.

ACDIS offers its members a bi-monthly journal, quarterly conference calls, news updates, a forms and tools library, a talk group, a job board, and discounts on selected products. Members can network with their colleagues and peers through member publications, working groups, local chapter meetings, and the option of attending the ACDIS annual conference.

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January 2016

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Note to candidates

It is your responsibility to read and understand the contents of this handbook before applying for certification.

This handbook contains current information about the criteria and process for applying to be a **Certified Clinical Documentation Specialist (CCDS)**. Please refer to the contents of this handbook for any questions you may have regarding the certification program.

Additional information is available at the **ACDIS** Web site at www.acdis.org. If you cannot find the information you require or have further questions, you may also contact:

Penny Richards
ACDIS Member Services Specialist
prichards@acdis.org

or call **ACDIS** Customer Service at 877-240-6586

Mission statement

The mission of the CCDS credential is to elevate the professional standing of clinical documentation specialists. The program draws from experienced clinical documentation specialists in the field to establish criteria for competency in the broad and multidisciplinary bodies of knowledge clinical documentation specialists must possess. These include knowledge of healthcare and coding regulations; anatomy, physiology, pharmacology, and pathophysiology; proficiency in medical record review; communication and physician query techniques; and data mining and reporting functions.

Affiliation

Work on the CCDS credential began in 2008 as a service of **ACDIS** to answer the demand amongst its members for a nationally recognized mark of distinction and professionalism specific to clinical documentation specialists.

ACDIS appointed an advisory board to help develop the CCDS certification. The board's multidisciplinary membership comes from diverse backgrounds, including HIM/coding, nursing, case management, quality, and compliance.

The following are members of the CCDS certification board

- **Deborah Biskner, MBA, RHIA, CCS, CCDS**, Manager, Health Information Services, Port Huron Hospital, Port Huron, MI
- **Margi Brown, RHIA, CCS, CCS-P, CPC, CCDS**, independent consultant, Orlando, FL
- **Karen L. Bridgeman, MSN, RN, CCDS**, CDI Educator, Medical University of South Carolina
- **Sharme Brodie, RN, CCDS**, AHIMA approved ICD 10 CM/PCS Trainer, CDI Education Specialist, HCPro, Inc.
- **Gary David, PhD**, associate professor, department of sociology, department of information design and corporate communication, Bentley University, Waltham, MA (public member)
- **Cheryl Ericson, MS, RN, CCDS, CDI-P**, AHIMA Approved ICD-10-CM/PCS Trainer, CDI Education Director, ezDI
- **Tamara A. Hicks, RN, BSN, MHA, CCS, CCDS**, AHIMA Approved ICD-10-CM/PCS Trainer Certified Six Sigma Green Belt, ACM Manager, Care Coordination, Wake Forest Baptist Health, Winston-Salem, NC
- **Fran Jurcak, RN, MSN, CCDS**, Senior Director CDI Solution, Huron Healthcare, Chicago, IL
- **Kathy Kerfoot, LPN, CPHQ, CCDS**, Quality Manager, St. Mary's Regional Medical Center, Enid, OK
- **Melinda Matthews, RN, BSN, CCDS**, Supervisor, Clinical Documentation, Wake Forest Baptist Health, Winston-Salem, NC
- **Mary McGrady, MSN, RN, CCDS**, Director of CDI, NYU Langone Medical Center
- **Laurie Prescott, MSN, RN, CCDS, CDIP**, and an AHIMA ICD-10 CM/PCS Trainer, CDI Education Director, HCPro, Inc.
- **Irina Zusman, RHIA, CCS, CCDS**, AHIMA-Approved ICD-10-CM/PCS Trainer, Director of HIM Coding and CDI Initiative, NYU Langone Medical Center

Statement of nondiscrimination

The opportunity to become a CCDS is available to all eligible candidates who meet the exam prequalifications as identified in the handbook. **ACDIS** does not discriminate on the basis of age, gender, race, religion, national origin, marital status, sexual preference, or disability.

If special accommodations are required for the examination, notify the program at 800-650-6787.

Certified Clinical Documentation Specialist overview

The purpose of becoming a CCDS is to recognize that those who perform the role of a clinical documentation specialist possess a diverse set of concurrent medical record review skills, clinical knowledge, and knowledge of coding and reimbursement regulations under the Inpatient Prospective Payment System.

Because the CCDS credential was developed to recognize individuals with a proven ability to work as a clinical documentation specialist, candidates for the CCDS designation are required to have at least two years of experience in the profession. Additionally, candidates must have some college-level education (see "Certification eligibility requirements" below.) Successful candidates must achieve a passing score on the certification examination, which tests the candidate's ability to abide by documentation and coding regulations and apply his or her experience and knowledge to typical scenarios that clinical documentation specialists encounter in their profession.

The certification program is not designed to determine who shall serve as a clinical documentation specialist. That is the responsibility of the leadership team for each hospital. Instead, the goal is to establish a baseline of competency in professionals who serve as clinical documentation specialists, be they from nursing, HIM/coding, case management, quality, or other healthcare-related backgrounds.

The CCDS program is a service provided in conjunction with **ACDIS** specifically to help those professionals with baseline levels of education and experience as a clinical documentation specialist achieve a mark of distinction and professionalism. The required experience and education ensures that only clinical documentation specialists with proven ability to perform their functions can achieve this certification.

Certification eligibility requirements

The candidate for the Certified Clinical Documentation Specialist (CCDS) exam will meet one of the following three education and experience standards and currently be employed as either a concurrent or retrospective Clinical Documentation Improvement Specialist:

- An RN, RHIA, RHIT, MD or DO and two (2) years of experience as a concurrent or retrospective documentation specialist in an inpatient acute care facility using the United States IPPS system.
- An Associate's degree (or equivalent) in an allied health field (other than what is listed above) and three (3) years of experience as a concurrent or retrospective documentation specialist in an inpatient acute care facility using the United States IPPS system. The education component must include completed college-level course work in medical terminology and human anatomy and physiology.
- Formal education (accredited college-level course work) in medical terminology human anatomy and physiology, medical terminology, and disease process, or the AHIMA CCS or CCS-P credential, and a minimum of three (3) years of experience in the role as a concurrent or retrospective documentation specialist in an inpatient acute care facility using the United States IPPS system.

A year of experience is defined as full-time employment or greater than 2,000 hours worked during that year

Experience documenting in a medical record as a clinician, resident or equivalent foreign medical graduate does not meet the experience requirement.

What is a documentation specialist?

- The *concurrent* documentation specialist conducts daily reviews of medical records for patients who are currently hospitalized
- The *retrospective* documentation specialist reviews medical records daily of post discharge, pre-bill records

Both concurrent and retrospective documentation specialists also:

- Works collaboratively using real-time conversation with physicians and medical team members caring for the patient
- Uses his or her clinical knowledge to evaluate how the medical record will translate into coded data, including reviewing provider and other clinical documentation, lab results, diagnostic information and treatment plans

- Communicates with providers, whether in verbal discussion or by query, for missing, unclear or conflicting documentation
- Educates providers about optimal documentation, identification of disease processes to ensure proper reflection of severity of illness, complexity, and acuity and facilitate accurate coding

Allowable resources

Examination takers for the CCDS will be allowed to bring the following two books with them into the examination:

- *DRG Expert*, published by OPTUM
- One of the following standard drug reference guides:
 - Mosby's Nursing Drug Reference
 - Nurse's Pocket Drug Guide
 - Physicians' Desk Reference
 - PDR Nurse's Drug Handbook
 - Nursing Drug Handbook/Lippincott's

Books will be checked for additional pages or loose notes inserted or attached inside. These are not allowed to be brought into the testing room. Handwritten notes previously written in the margins of books are permitted, but candidates may not write in their books during the exam.

About the certification examination

To become a CCDS, a candidate must pass the examination. This examination is offered once annually via paper-and-pencil at the **ACDIS** annual conference. The CCDS examination is also offered by computer at approximately 190 AMP Assessment Centers located throughout the United States. There are no application deadlines, and a candidate who meets eligibility requirements may submit an application and fee at any time. The examination is administered by appointment only Monday through Saturday at 9:00 a.m. and 1:30 p.m. Candidates are scheduled on a first-come, first-serve basis. The examination is not offered on the following holidays:

- New Year's Day
- Martin Luther King Day
- Presidents' Day
- Good Friday
- Memorial Day
- Independence Day (July 4)
- Labor Day
- Columbus Day
- Veterans' Day
- Thanksgiving (and the following Friday)
- Christmas Eve Day
- Christmas Day
- New Year's Eve Day

Examination fee

The fee for the certification application process and examination is \$255 for ACDIS members and \$355 for non-members. Payment may be made by credit card, personal check, or money order for the total amount, payable to HCPro, Inc. All fees are non-refundable.

If you do not pass the exam, you may submit a new application to schedule a reexam (see "Applying for the examination" on p. 11 of the handbook). ACDIS will discount the exam fee to \$125 for one retake only. Subsequent attempts to pass the exam will be at full price (\$355 or \$255 for ACDIS members). There is a mandatory ninety (90) day waiting period between exam attempts.

Management and examination services

The Association of Clinical Documentation Improvement Specialists contracts with Applied Measurement Professionals, Inc., (AMP) to provide management and examination services. AMP provides administrative support for the certification process, including examination development, validation, and administration. AMP carefully adheres to industry standards for development of practice-related, criterion-referenced examinations to assess competency.

AMP offers a full range of services, including practice analyses and development of examination specifications, psychometric guidance to committees of content experts during examination question writing, development of content, valid examination instruments, publishing, examination administration, scoring, and reporting examination results.

Applied Measurement Professionals, Inc.
18000 West 105th Street
Olathe, KS 66061-7543
Tel: 913-895-4600 • Fax: 913-895-4650
E-mail: info@goAMP.com • Web site: www.goAMP.com

ACDIS maintains records, handles finances, and processes examination applications, certification materials, and requests for continuing education approvals.

Assessment Center locations

A current list of Assessment Centers can be viewed at www.goAMP.com. Specific address information will be provided when a candidate schedules an examination appointment.

Applying for the examination

All candidates may review the application process on the ACDIS Web site at www.acdis.org.

- Download and complete the application (PDF document), which is available online at www.acdis.org by clicking the Certification link. Print the application and handwrite your responses. Please use black ink, write legibly, and complete all fields.
- Submit the application by mail, fax, or e-mail, with your payment instructions. Mail:
HCPro, a division of BLR
CCDS Certification Program
35 Village Road, Suite 200
Middleton, MA 01949
Fax: 978-560-0934
E-mail: prichards@hcpro.com

ACDIS and HCPro will process the application and will send a confirmation notice including a Web site address and toll-free telephone number to contact AMP to schedule an examination appointment. To request special accommodations, please complete the *Request for Special Examination Accommodations* form, and contact AMP at 888-519-9901.

Scheduling an examination appointment

After you have registered for the examination and received notification of your eligibility by e-mail and/or letter, you may schedule the examination by one of the following methods:

1. **Schedule online:** Schedule a testing appointment online at any time by using AMP's Online Application/Scheduling service at www.goAMP.com. To use this service follow these steps:
 - Go to www.goAMP.com and select "Schedule/Apply for an Exam".
 - Follow the simple step-by-step instructions to choose your examination program and register for the examination.

2. **Schedule by phone:** Call AMP toll-free at 888-519-9901 to schedule an examination appointment from 7 a.m. – 9 p.m. (Central Time) Monday through Thursday, 7 a.m. to 7 p.m. on Fridays, and 8:30 a.m. to 5 p.m. on Saturdays.

When you contact AMP to schedule an appointment, please be prepared to confirm a date and location for testing and to provide your name and CD candidate number (from AMP's email scheduling notice). Note: Your Social Security number is required for unique identification. All individuals are scheduled on a first-come, first-served basis. Refer to the following chart.

| If you call AMP by 3:00 p.m. Central time on | Depending on availability, your examination may be scheduled |
|--|--|
| Monday | Wednesday |
| Tuesday | Thursday |
| Wednesday | Friday/Saturday |
| Thursday | Monday |
| Friday | Tuesday |

You will be notified of the time to report to the assessment center; please make a note of it since you will not receive an admission letter. Unscheduled candidates (walk-ins) will not be admitted to the assessment center.

Special arrangements for candidates with disabilities

AMP is interested in ensuring that no individual with a disability is deprived of the opportunity to take the examination solely by reason of that disability. AMP will provide reasonable accommodations for candidates with disabilities.

1. Wheelchair access is available at all established assessment centers. Candidates must advise AMP at the time of registration that wheelchair access is necessary.
2. Candidates with visual, sensory, or physical disabilities that would prevent them from taking the examination under standard conditions may request special accommodations and arrangements. Please inform AMP of your need for special accommodations by completing the *Request for Special Examination Accommodations* form, and contacting AMP at 888-519-9901.
3. Verification of the disability and a statement of the specific type of assistance needed must be made in writing to AMP at least 45 calendar days prior to your desired examination date by completing the *Request for Special Examination Accommodations* form. AMP will review the submitted forms and will contact you regarding the decision for accommodations.

Telecommunication devices for the deaf

AMP is equipped with Telecommunication Devices for the Deaf (TDD) to assist deaf and hearing-impaired candidates. TDD calling is available 8:30 a.m.—5 p.m. (Central Time) Monday through Friday at 913-895-4637. This TDD phone option is for individuals equipped with compatible TDD machinery.

Examination and appointment changes

Candidates may reschedule their appointment for a future date **on one occasion per examination fee paid**. Candidates who wish to change their appointments must call AMP at 888-519-9901 at least two business days prior to the examination. Candidates who wish to change their appointments within two days of the examination will not be refunded their examination fee and will be required to pay the entire examination fee for any future examinations.

Missed appointments/cancellations

A candidate will forfeit the examination registration and all fees paid under the following circumstances:

- The candidate wishes to reschedule an examination but fails to contact AMP at least two business days prior to the scheduled testing session.
- The candidate wishes to reschedule a second time.
- The candidate appears more than 15 minutes late for an examination.
- The candidate fails to report for an examination appointment.

Inclement weather/power failure/other emergency

In the event of inclement weather or unforeseen emergencies on the day of an examination, AMP will determine whether circumstances warrant the cancellation, and subsequent rescheduling, of an examination. The examination will usually not be rescheduled if the Assessment Center personnel are able to open the Assessment Center.

You may visit AMP's website at www.goAMP.com prior to the examination to determine if AMP has been advised that any Assessment Centers are closed. Every attempt is made to administer the examination as scheduled; however, should an examination be canceled at an Assessment Center, all scheduled candidates will receive notification following the examination regarding rescheduling or reapplication procedures.

For computer based examinations, if power to an Assessment Center is temporarily interrupted during an administration, your examination will be restarted. The responses provided up to the point of interruption will be intact, but for security reasons the questions will be scrambled.

Cancellations

Candidates who fail to arrive at the assessment center on the date and time they are scheduled for examination will not be refunded any portion of their examination fees and must reregister; examination fees may not be transferred to another appointment. Candidates who arrive more than 15 minutes late for an appointment will not be admitted, will forfeit their examination fee, and must reregister.

A candidate's application is valid for 120 days (4 months) from the date the name is submitted to the exam company, during which the candidate must schedule an appointment to test on the computer and take the examination.

A candidate who fails to take the exam within the eligibility period forfeits the application and all fees paid to take the examination. A complete application and examination fee are required to reapply for examination. A candidate is allowed to take only the examination for which application is made and a confirmation notice is received. Unscheduled candidates (walk-ins) are not eligible to take the exam.

Examination content

The examination is based upon seven major content areas. Each of the content areas is briefly described and followed by an outline of the topics included in the area. In addition, the number of examination questions devoted to each major content area is noted.

The examination is composed of 140 multiple-choice questions.

Each question on the examination is categorized by a cognitive level that a candidate would likely use to respond. These categories are:

- **Recall:** The ability to recall or recognize specific information.
- **Application:** The ability to comprehend, relate, or apply knowledge to new or changing situations.
- **Analysis:** The ability to analyze and synthesize information, determine solutions, and/or evaluate the usefulness of a solution.

The test is designed to contain approximately 40% recall questions, 40% application questions, and 30% analysis questions.

Examination content outline

The CCDS exam will cover the following core competencies:

I. Healthcare regulations, reimbursement, and documentation requirements related to the Inpatient Prospective Payment System (IPPS): 15 items

(Recall 10, application 3, analysis 2)

- a. Define the IPPS and the process by which it is updated and revised.
- b. Demonstrate a knowledge of Medicare Severity Diagnostic Related Groups (MS-DRGs)
- c. Demonstrate an understanding of the responsibilities of medical staff (i.e., providers) for documentation necessary for appropriate IPPS reimbursement.
- d. Demonstrate an understanding of the responsibilities of clinical staff for documentation necessary for appropriate IPPS reimbursement.
- e. Explain how documentation impacts reimbursement under the IPPS through diagnosis and procedure assignment.
- f. Explain the relationship between documentation and medical necessity of setting
 - Demonstrate an understanding of criteria to support an inpatient admission (i.e., CMS 2-Midnight Rule)
 - Demonstrate an understanding of the relationship between principal diagnosis assignment and medical necessity of setting
- g. Define and recognize a complication/comorbidity under the MS-DRG system.
- h. Define and recognize a major complication/comorbidity under the MS-DRG system.
- i. Define case mix index and its relevance to CDI programs.
- j. Explain the role of Medicare Contractors, including Recovery Auditors (RA), Medicare Administrative Contractors (MACs), Comprehensive Error Rate Testing (CERT) contractors, and the Office of Inspector General (OIG), and their impact on CDI efforts.
- k. Recognize coding and billing practices that are vulnerable to denial.

2. Anatomy and physiology, pathophysiology, pharmacology, and medical terminology: 23 items (Recall 0, Application 12, Analysis 11)

- a. Identify and apply clinical indicators and query opportunities typically targeted by CDI professionals related to common medical conditions, such as those listed below by Major Diagnostic Category (MDC):

- i. MDC 1- Diseases and Disorders of the Nervous System
 - Examples include: acute CVA, encephalopathy, seizures, cerebral edema, coma
- ii. MDC 4 - Diseases and Disorders of the Respiratory System
 - Examples include: pulmonary embolism, respiratory neoplasms, pleural effusions, COPD, respiratory infections, pneumonia, respiratory failure (acute/chronic), ventilation support
- iii. MDC 5 – Diseases and Disorders of the Circulatory System
 - Examples include: acute myocardial infarction, heart failure, hypertension, cardiac arrhythmia, syncope and collapse, angina pectoris, chest pain
- iv. MDC 6- Diseases and Disorders of the Digestive System
 - Examples include: esophageal disorders, peritoneal infections, digestive malignancy, GI hemorrhage, ulcer, obstruction
- v. MDC 7- Diseases and Disorders of the Hepatobiliary System
 - Examples include: cirrhosis, hepatitis, malignancy, pancreatic disorders, disorders of the liver and the biliary tract
- vi. MDC 8 - Diseases and Disorders of the Musculoskeletal system
 - Examples include: Fractures, osteomyelitis, bone diseases
- vii. MDC 9 - Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast
 - Examples include: debridement procedures, skin ulcers, malignant disorders, cellulitis, trauma
- viii. MDC 10 - Endocrine, Nutritional and Metabolic Disease and Disorders
 - Examples include: Diabetes, dehydration, obesity, malnutrition
- ix. MDC 11 -Diseases and Disorders of the Kidney and Urinary Tract
 - Examples include: renal failure (acute/chronic), urinary tract infections, urosepsis, urinary stones
- x. MDC 16 - Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders
 - Examples include: Red blood cell disorders- anemia, coagulation disorders, sickle cell disease
- xi. MDC 17- Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms
 - Examples include: Lymphoma, leukemia, neoplasms
- xii. MDC 18 - Infectious and Parasitic Diseases

- Examples include: postoperative infections, bacterial infections, viral infections, sepsis
- xiii. MDC 19 - Mental Diseases and Disorders
 - Examples include: psychoses, developmental disorders, dementia, behavioral disorders
- xiv. MDC 20- Alcohol/Drug Use and Alcohol/Drug Induced Organic Brain Disorders
 - Examples include: alcohol/drug abuse, dependence
- xv. MDC 21- Injuries, Poisonings and Toxic Effects of Drugs
 - Examples include: traumatic injuries, poisoning and toxic effects of drugs, complications of treatment, adverse reactions
- xvi. MDC 25 - HIV Infections
 - Examples include: HIV related and major related conditions as differentiated within the *DRG Expert*
- b. Recognize pharmaceuticals commonly used in the inpatient setting and the disease process (es) they treat.
- c. Demonstrate ability to interpret medications as a clinical indicator.
- d. Identify diagnostic tests (e.g., labs, radiology, etc.) as possible clinical indicators to support documentation clarification opportunities
- e. Recognize standard medical abbreviations used in the healthcare setting.

3. Medical record documentation: 23 items (Recall: 6, Application 11, Analysis 6)

- a. Explain which elements of the health record can be used for diagnosis and/or procedure code assignment.
- b. Explain how the role of the provider in relation to the patient (i.e., attending physician vs. radiologist, pathologist, or other) affects diagnosis code assignment.
- c. Identify documentation in need of clarification for accurate code assignment.
- d. Demonstrate an understanding of when a physician query is warranted.
- e. Explain the different types of physician queries (i.e., concurrent, retrospective, verbal, etc.)
- f. Demonstrate an understanding of the different physician query formats (i.e., open ended, multiple choice, and yes/no) and their proper application
- g. Define the concept of clinical indicator(s).
- h. Demonstrate an understanding of how to translate clinical indicators in the health record (i.e., laboratory results, imaging reports, orders, etc.) into a compliant query.

- i. Differentiate compliant from non-compliant queries.
- j. Describe situations in which queries are not appropriate (i.e., diagnosis was not evaluated/treated/monitored, etc.).
- k. Demonstrate an understanding of current professional guidance including the AHIMA-ACDIS practice brief, *Guidelines for Achieving a Compliant Query Practice*
- l. Explain proper mechanisms to address diagnoses in the medical record without clinical support

4. Healthcare facility CDI program analysis: 10 items (Recall 3, Application 4, Analysis 3)

- a. Demonstrate the ability to analyze data and evaluate a CDI program's trends.
 - i. CDI specialist productivity metrics
 - ii. Provider response rates
 - iii. Case mix index (CMI)
- a. Demonstrate the ability to create forecasting data to predict the direction of a CDI program.
- b. Recognize the importance of the following metrics/methodologies for evaluating CDI program performance:
 - i. CMI
 - ii. CC/MCC capture
 - iii. Severity of Illness/Risk of Mortality
 - iv. Hospital Value Based Purchasing measures
 - v. Patient Safety Indicators
 - vi. Monitoring of high frequency DRGs
- g. Identify methods for measuring physician performance related to documentation.
- h. Demonstrate an ability to track and trend data to measure individual physician performance over time.
- i. Demonstrate basic computer skills and basic software applications (e.g., basic Excel spreadsheet functions).
- j. Demonstrate an ability to identify and apply hospital specific financial data.
- k. Identify performance standards used to evaluate individual CDI specialists' performance.
- l. Demonstrate an ability to track and trend data to measure hospital performance over time.
- m. Demonstrate an ability to track and trend data to measure department-specific performance over time.

- n. Explain how physician documentation impacts publicly reported data (e.g., Leapfrog, Healthgrades).
- o. Demonstrate a working knowledge of a PEPPER (Program for Evaluating Payment Patterns Electronic Report) data

5. Communication skills: 11 items (Recall: 3, Application 6, Analysis 2)

- a. Identify methods for creating physician education forms and tools.
- b. Demonstrate the ability to produce basic educational presentations specific for departments/services, including physicians, nurse practitioners, and administration.
- c. Demonstrate the ability to communicate with physicians in an effective, non-confrontational manner.
- d. Describe the roles and responsibilities of a documentation specialist.
- e. Describe the roles and responsibilities of a coder working in conjunction with a CDI department.
- f. Demonstrate the ability to reconcile discrepancies between working DRG assignments assigned by CDI staff and final, coded DRGs.
- g. Identify situations in which verbal, personal communications with physicians are more favorable than written communication.

6. Official Guidelines for Coding and Reporting: 17 items (Recall 6, Application 8, Analysis 3)

- a. Explain when *Official Guidelines for Coding and Reporting* are updated and where to obtain official information.
- b. Explain the role of *AHA Coding Clinic* in code assignment.
- c. Define and apply the principles of principal diagnosis assignment.
- d. Apply coding guidelines when selecting a principal diagnosis.
- e. Define and apply the principles of secondary diagnosis assignment.
- f. Explain how discharge dispositions and the location to which the patient is transferred impact payment.
- g. Identify which conditions are considered hospital acquired conditions by CMS.
- h. Define the basics of the present on admission indicator assignment and explain its impact on payment.
- i. Explain how to assign a working DRG when a patient has multiple diagnoses in play.

7. Professionalism, ethics, and compliance: 11 items (Recall 4, Application 4, Analysis 3)

- a. Maintain confidentiality of the medical record and other information relevant to the practice of CDI.
- b. Identify initiatives that ensure DRG compliance.
- c. Identify areas of potential DRG creep as identified by the Office of Inspector General (OIG).
- d. Demonstrate what constitutes a leading query to the physician.
- e. Explain the goals and objectives of a clinical documentation department beyond reimbursement.
- f. Identify potential compliance risks identified in a PEPPER report

8. Impact of Reportable Diagnoses on Quality of Care: 10 items Recall: 3, Application 3, Analysis 4)

- a. Demonstrate knowledge of the significance of documentation and code assignment upon mortality index (Severity of Illness/Risk of Mortality)
- b. Demonstrate knowledge of mortality reviews and interpreting observed/expected ratios
- c. Define how quality data is acquired through both record abstraction and claims data
- d. Explain the significance of these different types of quality metrics used by CMS:
 - i. Hospital Value Based Purchasing (HVBP)
 - ii. Hospital Acquired Condition (HAC) Reduction Program
 - iii. Hospital Readmissions Reduction Program
 - iv. 30-day Mortality Measures
- e. Analyze the financial impact of the Hospital Inpatient Quality Reporting Program on an organization, and the role of CDI regarding this CMS quality initiative
- f. Demonstrate an understanding of CDI impact on documentation and code assignment in relation to Hospital Value Based Purchasing (HVBP)
- g. Identify components of Patient Safety Indicator (PSI) 90 and its impact as a quality measure:
 - i. PSI 03—Pressure Ulcer Rate
 - ii. PSI 06—Iatrogenic Pneumothorax Rate
 - iii. PSI 07—Central Venous Catheter Related Bloodstream Infection Rate
 - iv. PSI 08—Postoperative Hip Fracture Rate

- v. PSI 12—Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate
 - vi. PSI 13—Postoperative Sepsis Rate
 - vii. PSI 14—Postoperative Wound Dehiscence Rate
 - viii. PSI 15—Accidental Puncture or Laceration Rate
- i. Identify other Patient Safety Indicators beyond or in addition to PSI 90 and their impact as a quality measure(s)
 - j. Identify coded data elements that can impact the reporting of Patient Safety Indicators (PSIs) in regards to Medicare claims
 - k. Compare and contrast Hospital Acquired Infections (HAI) from documentation that supports the assignment of a “complication code”

CCDS sample exam questions

Sample question 1: Which of the following medications is commonly prescribed to stimulate appetite in patients with neoplasm or HIV-related cachexia?

- A. Meridia®
- B. Namenda®
- C. Megace®
- D. Synthroid®

Answer: C

Sample question 2: When there is conflicting clinical documentation in the medical record, clarification must be provided by the

- A. physician assistant.
- B. consulting physician.
- C. attending physician.
- D. emergency physician.

Answer: C

Sample question 3: Which of the following is considered a major complication/comorbidity (MCC)?

- A. chronic obstructive pulmonary disease
- B. bacteremia
- C. congestive systolic heart failure
- D. severe protein-calorie malnutrition

Answer: D

Sample question 4: A patient was admitted with shortness of breath, swelling in the lower extremities, severe weakness, elevated BNP of 1,000, and EF=25%. The patient's history and physical includes history of heart failure. The echocardiogram report states left ventricular dysfunction. Which of the following should the clinical documentation specialist consider when querying the practitioner for the appropriate documentation?

- A. combined diastolic and systolic heart failure
- B. congestive systolic heart failure
- C. acute and chronic systolic heart failure
- D. acute and chronic diastolic heart failure

Answer: C

Sample question 5: Various methods exist for measuring how well physicians participate in CDI programs. Which of the following metrics indicates a lack of physician engagement?

- A. volume of queries generated
- B. volume of non-responses
- C. volume of "agree" responses
- D. volume of "disagree" responses

Answer: B

Sample question 6: It is important for the clinical documentation specialist to discuss a concurrent query with the physician when

1. only part of the query is answered.
2. there is conflicting documentation.
3. the physician documents a probable diagnosis.
4. the physician refuses to acknowledge or respond to the query.

- A. 1, 2, and 3 only
- B. 1, 2, and 4 only
- C. 1, 3, and 4 only
- D. 2, 3, and 4 only

Answer: B

Sample question 7: Which of the following is classified by CMS as a hospital-acquired condition (HAC) when not present on admission (POA) to the hospital?

- A. Fat embolism
- B. Kidney disease
- C. Pneumonia
- D. Fractured ulna

Answer: D

Sample question 8: Aplastic anemia is a condition that:

- A. Is hereditary and can only be sequenced as the principal diagnosis
- B. Is defined as bone marrow failure causing a reduction in white blood cells, red blood cells, and platelets
- C. Is chronic and easily treated
- D. Qualifies as a comorbid condition (CC)

Answer: B

Sample question 9: If the documentation indicates that the patient was admitted with fever, shortness of breath, chest pain, and nonproductive cough, and the chest x-ray confirms a pleural effusion, which type of effusion is most suspicious for this patient?

- A. Malignant
- B. Transudative
- C. Exudative
- D. Serosanguinous

Answer: C

On the day of your examination

On the day of your examination appointment, report to the Assessment Center no later than your scheduled time. Once you enter the building, look for the signs indicating AMP Assessment Center Check-In. **A candidate who arrives more than 15 minutes after the scheduled examination time will not be admitted.**

To gain admission to the assessment center, you must present two forms of identification. The primary form must be government issued, current and include your name, signature and photograph. No form of temporary identification will be accepted. You will also be required to sign a roster for verification of identity.

- Examples of valid primary forms of identification are: driver's license with photograph; state identification card with photograph; passport; military identification card with photograph.
- The secondary form of identification must display your name and signature for signature verification (e.g., credit card with signature, social security card with signature, employment/student ID card with signature).
- If your name on your registration is different than it appears on your identification, you must bring proof of your name change (e.g., marriage license, divorce decree or court order).

Candidates must have proper identification to gain admission to the Assessment Center. Failure to provide appropriate identification at the time of the examination is considered a missed appointment. There will be no refund of examination fees.

After your identification has been confirmed, you will be directed to a testing carrel. You will be prompted on-screen to enter your Social Security number. Your photograph will be taken and it will remain on-screen throughout your examination session. This photograph will also print on your score report.

Security

AMP administration and security standards are designed to ensure all candidates are provided the same opportunity to demonstrate their abilities. The Assessment Center is continuously monitored by audio and video surveillance equipment for security purposes.

The following security procedures apply during the examination:

- Examinations are proprietary. No cameras, notes, tape recorders, pagers or cellular/smart phones are allowed in the testing room. Possession of a cellular/smart phone or other electronic devices is strictly prohibited and will result in dismissal from the examination.
- No calculators are allowed, nor is one required for the examination.
- No guests, visitors or family members are allowed in the testing room or reception areas.
- Candidates may be subjected to a metal detection scan upon entering the examination room.

Personal Belongings

No personal items, valuables or weapons should be brought to the Assessment Center. Only wallets and keys are permitted. Large coats and jackets must be left outside the testing room. You will be provided a soft locker to store your wallet and/or keys with you in the testing room. The proctor will lock the soft locker prior to you entering the testing room. You will not have access to these items until after the examination is completed. Please note the following items will not be allowed in the testing room except securely locked in the soft locker:

- watches
- hats
- wallets
- keys

Once you have placed your personal belongings into the soft locker, you will be asked to pull out your pockets to ensure they are empty. If you bring personal items that will not fit in the soft locker, you will not be able to test. The site will not store or be responsible for your personal belongings.

If any personal items are observed or heard (such as cellular/smart phones, alarms) in the testing room after the examination is started, you will be dismissed and the administration will be forfeited.

Examination Restrictions

- Pencils will be provided during check-in.
- You will be provided with one piece of scratch paper at a time to use during the examination, unless noted on the sign-in roster for a particular candidate. You must return the scratch paper to the proctor at the completion of testing or you will not receive your score report.
- No documents or notes of any kind may be removed from the Assessment Center.
- No questions concerning the content of the examination may be asked during the examination.
- Eating, drinking or smoking is not permitted in the Assessment Center.
- You may take a break whenever you wish, but you will not be allowed additional time to make up for time lost during breaks.

Misconduct

If you engage in any of the following conduct during the examination you may be dismissed, your scores will not be reported and examination fees will not be refunded. Examples of misconduct are when you:

- create a disturbance, are abusive or otherwise uncooperative;
- display and/or use electronic communications devices such as pagers, cellular /smart phones;
- talk or participate in conversation with other examination candidates;
- give or receive help or are suspected of doing so;
- leave the Assessment Center during the administration;
- attempt to record examination questions or make notes;

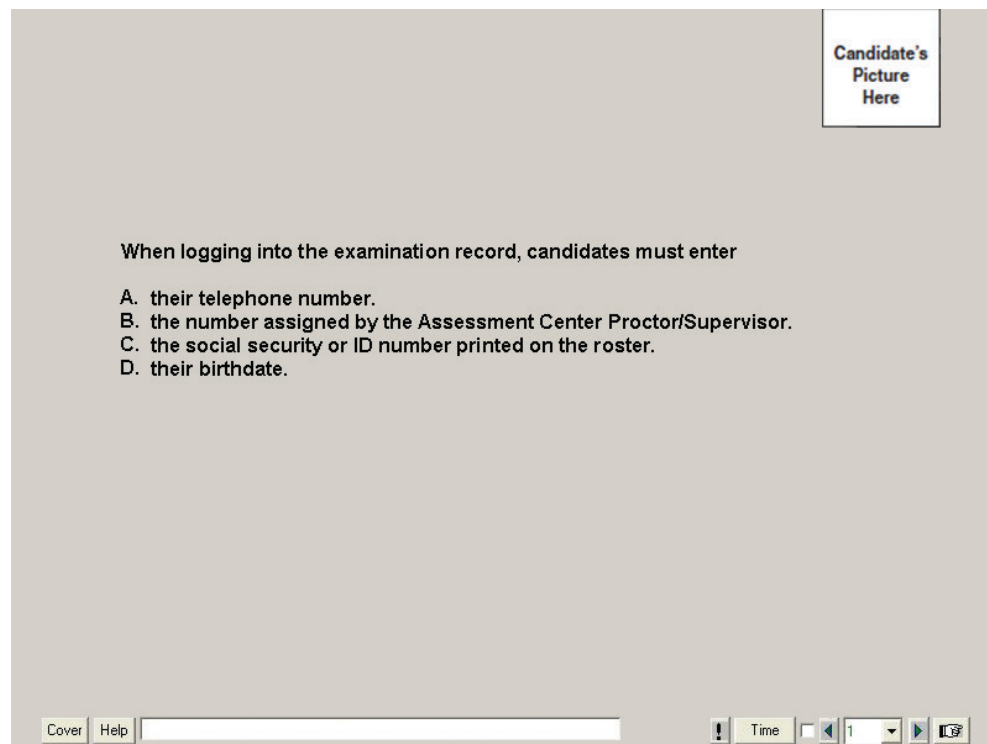
- attempt to take the examination for someone else;
- are observed with personal belongings, or
- are observed with unauthorized notes, books or other aids.

Practice examination

Prior to attempting the timed examination, you will be given the opportunity to practice taking an examination on the computer. The time you use for this practice examination is not counted as part of your examination time. When you are comfortable with the computer testing process, you may quit the practice session and begin the timed examination.

Timed examination

Following the practice examination, you will begin the timed examination. Before beginning, instructions for taking the examination are provided on-screen. The examination contains 140 questions. Three hours are allotted to complete the examination. The following is a sample of what the computer screen will look like when candidates are attempting the examination:



The computer monitors the time you spend on the examination. The examination will terminate if you exceed the time limit. You may click on the “Time” button in the lower right portion of the screen to monitor your time. A digital clock indicates the time remaining for you to complete the examination. The time feature may also be turned off during the examination.

Only one examination question is presented at a time. The question number appears in the lower right portion of the screen. The entire examination question appears onscreen (i.e., stem and four options labeled: A, B, C, and D). **Indicate your choice by either entering the letter of the option you think is correct (A, B, C, or D) or clicking on the option using the mouse.** To change your answer, enter a different option by pressing the A, B, C, or D key or clicking on the option using the mouse. You may change your answer as many times as you wish during the examination time limit.

To move to the next question, click on the forward arrow (>) in the lower right portion of the screen. This action will move you forward through the examination question by question. If you wish to review any questions, click the backward arrow (<) or use the left arrow key to move backward through the examination.

A question may be left unanswered for return later in the examination session. Questions may also be bookmarked for later review by clicking in the blank square to the right of the Time button. Click on the hand icon to advance to the next unanswered or bookmarked question on the examination. To identify all unanswered and bookmarked questions, repeatedly click on the hand icon or press the NEXT key. When the examination is completed, the number of questions answered is reported.

If not all questions have been answered and there is time remaining, return to the examination and answer those questions. Be sure to answer each question before ending the examination. **There is no penalty for guessing.**

Online comments may be entered for any question by clicking on the button displaying an exclamation point (!) to the left of the Time button. This opens a dialog box where comments may be entered. Comments will be reviewed, but individual responses will not be provided.

Failing to report for an examination

A candidate who fails to report for an examination forfeits the application and all fees paid to take the examination. A completed application and examination fee are required to reapply for examination.

Following the examination

After completing the examination, candidates are asked to complete a short evaluation of their examination experience. Then, candidates are instructed to report to the examination proctor to receive their score report. Scores are reported in written form only, in person or by U.S. mail. Scores are not reported over the telephone, by electronic mail, or by facsimile.

Your score report will indicate “pass” or “fail.” Additional detail is provided in the form of raw scores by major content category. A raw score is the number of questions you answered correctly. Your pass/fail status is determined by your raw score.

The methodology used to set the minimum passing score is the Angoff method, in which expert judges estimate the passing probability of each examination question. These ratings are averaged to determine the minimum passing score (i.e., the number of correctly answered questions required to pass the examination).

If you pass the examination

If you pass the examination, you are allowed to use the designation CCDS. Passing candidates will receive a certificate and lapel pin by the end of the month following the examination month.

If you do not pass the examination

If you do not pass the examination, you may schedule a reexamination appointment by submitting a new application form (see “Applying for the examination” on p. 10 of the handbook). ACDIS will discount the exam fee to \$125 for the first retake only. Subsequent attempts to pass the exam will be at full price (\$355, or \$255 for **ACDIS** members). There is a waiting period of ninety (90) days between examination attempts.

Appeals

Because the performance of each question on the examination that is included in the final score has been pretested, there are no appeal procedures to challenge individual examination questions, answers, or a failing score. The CCDS Certification Program will always apply the same passing score (“cut score”) and the same answer key to all candidates taking the same form of the exam.

Appeals may be made on the following grounds:

- Candidate eligibility

- Revocation of the CCDS credential
- Inappropriate examination administration procedures or environmental testing conditions severe enough to cause a major disruption of the examination process

All appeals must be submitted in writing to ACDIS, attention Certified Clinical Documentation Specialist Program, at 35 Village Road, Suite 200, Middleton, MA 01949, or by e-mail to prichards@acdis.org The candidate or certificant must explain in detail the following:

1. The nature of the request and the specific facts and circumstances supporting the request
2. All reasons why the action or decision should be changed or modified. The candidate or certificant must also provide accurate copies of all supporting documents.

Eligibility and revocation appeals must be received within thirty (30) days of the initial action. Appeals for alleged inappropriate administration procedures or severe adverse environmental testing conditions must be received within sixty (60) days of the release of examination results.

The CCDS Certification Program will respond within thirty (30) days of receipt of the appeal. If this decision is adverse, the candidate may file a second-level appeal within thirty (30) days. A three-member panel of the CCDS Certification Board will review the initial decision and respond with a final decision within forty-five (45) days of receipt.

Scores cancelled by ACDIS or AMP

ACDIS is responsible for the integrity of the scores it reports. On occasion, occurrences such as computer malfunction or misconduct by a candidate may cause a score to be suspect. ACDIS is committed to rectifying such discrepancies as expeditiously as possible. ACDIS may void examination results if, upon investigation, violation of its regulations is discovered.

Copyrighted examination questions

All examination questions are the copyrighted property of ACDIS. It is forbidden under federal copyright law to copy, reproduce, record, distribute, or display these examination questions by any means, in whole or in part. Doing so may subject you to severe civil and criminal penalties.

Confidentiality

Information about candidates' examination results are considered confidential; however, **ACDIS** reserves the right to use information supplied by or on behalf of a candidate in the conduct of research. Studies and reports concerning candidates will contain no information identifiable with any candidate, unless authorized by the candidate.

ACDIS recognizes the achievement of all individuals who successfully complete the CCDS examination on the **ACDIS** Web site or in *CDI Journal*. Applicants may decline this option on the application form.

Duplicate score report

Candidates may purchase additional copies of their score reports at a cost of \$25 per copy. Requests must be submitted to AMP, in writing, within 12 months of the examination. The request must include the candidate's name, mailing address, telephone number, date of examination, and examination taken. Submit this information with the required fee payable to AMP. Duplicate score reports will be mailed within approximately five business days after receipt of the request and fee.

Recertification

The recertification process for the CCDS ensures that clinical documentation improvement professionals stay abreast of changing government and private-payer regulations, documentation and coding requirements, and important developments in the field of CDI.

Individuals who hold the CCDS must apply for recertification every two years from the date on which they passed the CCDS exam. CCDS certification holders must submit 30 Continuing Education Units (CEUs) relevant to the field of CDI by using the *CCDS Recertification Application* found on the ACDIS web site. Re-taking the CCDS examination is not necessary. Please review the document *CEU Qualifying Activities* for examples of acceptable CE activities. ACDIS sends email reminders as an individual's recertification due date approaches but it not responsible for late recertification because of undelivered or ignored email. It is the individual's responsibility to update address and email changes with the ACDIS office. Individuals who fail to recertify in a timely manner may have their certification revoked.

ACDIS does not issue a new certificate for recertification, but sends a letter and wallet card. Replacement certificates can be purchased for \$25.

Although ACDIS strongly recommends submitting 30 CEUs by the two-year examination anniversary date, CCDS certification holders are extended a 45-day grace period to submit their CEUs. Failure to submit CEUs within this 45-day grace period will result in revocation of the CCDS credential. A former credential holder may recertify by reapplying for and successfully passing the CCDS exam.

A percentage of participants will be audited to ensure that they have met the CEU requirements. Individuals who hold the CCDS should keep a record of participation in all of their CEU qualifying activities in the event of an audit.

Certification maintenance fees

ACDIS members pay a certification maintenance fee of \$100 when submitting their *CCDS Recertification Application*. The fee for non-ACDIS members is \$200.

Please send your completed form to:

HPro, a division of BLR

CCDS Certification Program

35 Village Road, Suite 200, Middleton, MA 01949

Or fax to 978-560-0934, Attention: Certification Program Manager

Failure to renew

A certificant who fails to renew his or her certification is no longer considered certified and may not use the credential awarded for certification in professional communications, such as on letterhead, stationery and business cards, in directory listings, or in signature.

Disciplinary policy

The CCDS Certification Board is an independent and autonomous body within **ACDIS** that has been established to oversee and manage the Certified Clinical Documentation Specialist (CCDS) certification program. In order to maintain and enhance the credibility of the CCDS certification program the CCDS Certification Board has adopted the following administrative procedures to allow individuals to bring complaints concerning CCDS certificants' conduct to the CCDS Certification Board.

The CCDS Certification Board shall undertake sanctions against applicants, candidates, or individuals relating to failure to meet requirements for initial certification or recertification, or misrepresentation/misuse of the CCDS certification. The CCDS certification program

is a voluntary process, not required by law for employment in the field. Monitoring and evaluating actual job performance is beyond the scope of the CCDS Certification Board or **ACDIS**.

Applications may be refused, candidates may be barred from future examinations, or candidates or individuals already certified may be sanctioned, including revocation of the CCDS designation, for the following reasons:

1. Attesting to false information on the CCDS application, recertification documents, or during random audit procedures of both forms
2. Giving or receiving information to or from another candidate during the examination
3. Removing or attempting to remove examination materials or information from the testing site
4. Possessing or distributing unauthorized official testing or examination materials
5. Representing oneself falsely as a CCDS

The CCDS Certification Board notes that the **ACDIS** Code of Ethics applies to **ACDIS** members as well as professionals possessing the CCDS who are not **ACDIS** members.

Contact us

If you have questions regarding the CCDS exam or its requirements, please contact:

Penny Richards, ACDIS Member Services Specialist
prichards@acdis.org

You may also contact:
HCPro, a division of BLR
CCDS Certification Program
35 Village Road, Suite 200
Middleton, MA 01949
Tel: 877-240-6586
Fax: 978-560-0934
E-mail: customerservice@hcpro.com
Web site: www.acdis.org







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