# CCDS-O content outline

1. **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**
    a. Demonstrate knowledge of the OCG for ICD-10-CM
        i. Identify core concepts of a first-listed diagnosis
        ii. Identify core concepts of additional/secondary diagnoses
        iii. Identify documentation from non-providers that can be used for code assignment, as described in Section 1, B14 of the OCG
        iv. Explain relevant concepts from Section I of the OCG including chapter-specific guidelines
        v. Identify relevant coding principles from Section IV of the OCG including uncertain diagnoses, chronic diseases, and codes that describe signs and symptoms
        vi. Define criteria of what constitutes a reportable diagnosis, as defined in Section IV of the OCG including first-listed and co-existing conditions.
    b. Explain the role of *AHA Coding Clinic/CPT Assistant* in code assignment.
    c. Demonstrate knowledge of the OPPS
        i. Identify services covered under the OPPS
        ii. Identify code sets used in the OPPS
        iii. Identify methodologies used in OPPS reimbursement including Ambulatory Payment Classifications (APC)
        iv. Demonstrate an understanding of the responsibilities of providers and other clinical staff for documentation necessary for appropriate OPPS reimbursement.
        v. Explain core concepts related to patient status, including inpatient vs. observation
    d. Explain professional billing concepts and their application, including:
        i. Current Procedural Terminology (CPT) codes, specifically Evaluation and Management (E/M) and relevant CMS Documentation Guidelines, and where documentation may be obtained from the medical record
        ii. Understand the basic concepts of the documentation necessary for professional fee reimbursement under the Medicare Physician Fee Schedule, including the relationship of CPT and ICD-10-CM for medical necessity, claims submission, and reimbursement.
        iii. Unspecified diagnoses

2. **Diseases and disease processes, and application to the clinical chart review**
    a. Identify and apply clinical indicators and query opportunities related to common medical conditions, abnormal findings, external causes, and other factors influencing health status, as outlined within the Tabular List of Diseases and Injuries, including the following:
        i. Infectious and Parasitic Diseases (A00-B99)
        ii. Neoplasms (C00-D49)

iii. Diseases of the Blood & Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism (D50-D89)
iv. Endocrine, Nutritional and Metabolic Diseases (E00-E89)
v. Mental, Behavioral and Neurodevelopmental Disorders (F01-F99)
vi. Diseases of the Nervous System (G00-G99)
vii. Diseases of the Circulatory System (I00-I99)
viii. Diseases of the Respiratory System (J00-J99)
ix. Diseases of the Digestive System (K00-K94)
x. Diseases of the Skin and Subcutaneous Tissue (L00-L99)
xi. Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
xii. Diseases of the Urinary System (N00-N99)
xiii. Pregnancy, childbirth and the Puerperium (O00-O99)
xiv. Certain Conditions Originating in the Perinatal Period (P00-P96)
xv. Congenital Malformations, Deformations and Chromosomal Abnormalities (Q00-Q99)
xvi. Symptoms, Signs and Abnormal Clinical and Laboratory Findings (R00-R99)
xvii. Injury, poisoning and Certain Other Consequences of External Causes (S00-T88)
xviii. Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

b. Identify opportunities for clarification typically presented in primary care visits
c. Demonstrate ability to perform prospective case reviews
    i. Application to case scenarios with clarification opportunities
d. Demonstrate an ability to perform retrospective case reviews
    i. Application to case scenarios with clarification opportunities
e. Recognize common pharmaceuticals and medications and the disease process(es) they treat.
f. Identify diagnostic tests (e.g., labs, radiology, etc.), elements of consult notes, and medications without a corresponding diagnosis, as possible clinical indicators to support documentation clarification opportunities
g. Recognize standard medical abbreviations used in healthcare settings.

**3. Risk adjustment models and impact of documentation and coding**

a. Explain the concept of risk adjustment and its relationship to medical record documentation
    i. Explain health record elements that impact risk scores, beyond diagnoses
    ii. Recognize and define common risk adjustment methodologies including those used by Medicare, Medicaid, and commercial payers
b. Explain fundamentals of the CMS Hierarchical Condition Category (HCC) risk adjustment model
    i. Describe the principles of the Medicare Advantage program including capitated payments
    ii. Demonstrate an understanding of Medicare risk adjustment factor (RAF) scoring, including how RAF scores are calculated
    iii. Define the following concepts within the CMS-HCC model:
        1. Hierarchies

2. Disease interactions
3. Beneficiary demographics (community and institutional)

iv. Explain parameters and requirements of compliant CMS-HCC reporting
v. Identify diagnoses that qualify as CMS-HCCs and risk adjust, principally outpatient but also inpatient

**4. CDI program concepts: Department metrics and provider education**

a. Demonstrate an ability to develop succinct, effective provider education
   i. Identify methods for creating provider education forms and tools
   ii. Demonstrate the ability to produce basic educational presentations specific for departments/services, including providers, clinical staff, and administration
   iii. Demonstrate the ability to communicate with providers in an effective, non-confrontational manner
b. Describe critical performance indicators and data elements that monitor the impact of CDI specialist efforts, including:
   i. Productivity of outpatient chart reviews, query rates, and provider educational sessions conducted
   ii. Rates of diagnoses captured as coded data as a result of CDI intervention
c. Demonstrate an ability to track and trend data to measure organizational performance over time.
d. Demonstrate the ability to analyze data and evaluate outpatient CDI department performance, including:
   i. HCC reporting, including HCCs that are dropped, recaptured, and/or newly added over prior year
   ii. Risk adjustment factor (RAF) scoring, including progression over baseline and trending
   iii. Accountable Care Organization (ACO) and Medicare Shared Savings Program (MSSP) impact, including quality scores and performance payments
e. Identify physician performance metrics, including:
   i. RAF scores
   ii. E/M billing
   iii. Risk adjusted diagnosis capture rates
   iv. Denial rates for medical necessity of care
   v. Unspecified code use
   vi. Provider engagement metrics including query response rates, query agreement rates, and problem list updates
f. Explain how physician documentation impacts publicly reported data (e.g., Hospital Compare, Merit-based Incentive Payment System).
g. Demonstrate a baseline of inpatient CDI knowledge, including basic differences between inpatient and outpatient coding guidelines

**5. Quality, regulatory, and health initiatives**

a. Demonstrate knowledge of the concepts of population health, including areas of CDI collaboration with utilization review and care coordination

b. Define the operations of the Medicare Shared Savings Program (MSSP)
    i. Describe Accountable Care Organizations (ACOs) and next generation ACO models
c. Describe the basic functions of the Medicare Access and CHIP Reauthorization Act (MACRA), including knowledge of:
    i. Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)
    ii. Quality reporting including the CMS Quality Payment Program and its measures
    iii. Explain how RAFs impact quality scores and cost-efficiency metrics
    iv. Demonstrate an understanding of CDI impact on documentation and code assignment as it relates to quality reporting
d. Explain the role of Medicare Contractors, including Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) contractors
e. Demonstrate a grounding in regulatory and association/best practice compliance documents and initiatives
    i. Demonstrate how to develop a compliant query to the provider, as defined by *Queries in Outpatient CDI: Developing a Compliant, Effective Process*
    *ii.* Demonstrate what constitutes a leading query to the provider, as defined by *Queries in Outpatient CDI: Developing a Compliant, Effective Process*
    iii. Demonstrate an understanding of acceptable provider query formats (i.e., open ended, multiple choice, and yes/no) and their proper application
    iv. Describe situations in which queries are not appropriate (i.e., diagnosis was not evaluated/treated/monitored, etc.) and proper management of diagnoses that lack clinical support, including process of clinical validation
    v. Define the goals and objectives of the Medicare Risk Adjustment Data Validation (RADV) Program
    vi. Identify compliance concerns regarding maintenance of the problem list
    vii. Identify areas of potential noncompliance as identified by the Office of Inspector General (OIG) in its *Work Plan*.
    viii. Maintain confidentiality of the medical record and other information relevant to the practice of CDI, including core tenets of HIPAA