CCDS-O prerequisites

Candidates for the Certified Clinical Documentation Specialist-Outpatient (CCDS-O) exam must:

- List their documentation specialist experience. Applications may be audited to verify work history and educational background, credentials, and licensure.
- Have at least two years of experience as an outpatient documentation specialist, **OR** one year in an inpatient setting **AND** an additional year of outpatient CDI experience. Once a candidate has accumulated the time, it does not expire.
- Meet the work experience requirements prior to submitting their application.

Candidates must meet one of the following two education and experience standards:

1. A clinical licensure (RN, MD, DO) or coding certification (RHIA, RHIT, CCS, CPC, CRC, COC) and two (2) years of experience as an outpatient documentation specialist using United States reimbursement systems.
2. A clinical licensure (RN, MD, DO) or coding certification (RHIA, RHIT, CCS, CPC, CRC, COC), one (1) year of experience as an inpatient clinical documentation specialist, and one (1) year of experience as an outpatient documentation specialist using United States reimbursement systems.

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

What essential functions define an outpatient documentation specialist? Outpatient documentation specialists:

- Conduct reviews of medical records for patients in a variety of outpatient settings including but not limited to physician offices, physician and hospital-owned clinics, ambulatory surgery centers, and hospital emergency departments.
- Collaborate with physicians and medical team members caring for the patient to clarify clinical documentation
- Apply their clinical knowledge to evaluate how the medical record will translate into coded data, including reviewing provider and other clinical documentation, chronic disease processes, medications and their indications, diagnostic information, and treatment plans
- Communicate with providers, whether in verbal discussion or by query, for missing, unclear or conflicting documentation
- Educate providers about optimal documentation and identification of disease processes to ensure proper reflection of severity of illness, complexity, and acuity, and facilitate accurate coding and billing
- Understand risk adjusted payment methodologies, professional coding and billing, and outpatient facility coding and billing, and share this knowledge with providers and members of the healthcare team