Certificate in Clinical Documentation Improvement

This certificate is designed for adult learners who already have a minimum of an Associate's degree OR one of the following credentials: RN, LPN, RHIA, RHIT, CCS, CCS-P, CPC, COC, CIC, CPMA. In special cases, someone without these requirements may be granted permission from the Health Science and Technology Program Associate for admission into the program. The certificate was created for those who want a specialized certificate to increase their opportunities for employment in CDI. This certificate equips students with a working knowledge of clinical documentation improvement (CDI) tasks, procedures, policies, philosophy, and value. A focus will be placed on mastering documentation concepts as it relates to reimbursement and medical necessity. Courses will immerse students in real-world scenarios and processes, giving the student experience that simulates work experience in the field. A case study practicum is the final course and will require students to demonstrate high-level CDI knowledge and skills.

This Certificate is 33 credits and 15 of these credits must be completed at Charter Oak. All courses must be completed with a grade of 'C' or better.

Certificate Core Prerequisites

BIO 212: Anatomy and Physiology	3cr
BIO 215: Pathophysiology	3cr
HCA 105: Medical Terminology	3cr
HIM 205: Reimbursement Methodologies	3cr
HIM 210: Clinical Classification Systems I	3cr
HIM 211: Clinical Classification Systems II	3cr

Certificate Core Courses

HIM 371: Revenue Cycle and CDI	3cr
HIM 373: CDI Operational Process	3cr
Mastering Documentation	3cr
Compliance and Medical Necessity	3cr
CDI Case Study Practicum	3cr
Total	**33cr**

The Clinical Documentation Improvement Certificate Program is in Candidacy Status, pending accreditation review by the Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM).

Student Learning Outcomes

Students who complete a certificate in Clinical Documentation Improvement will be able to:

1. analyze coded diagnoses and procedures related to reimbursement methodologies and billing;
2. analyze patient health records in the current EHR environment for documentation that meets accepted coding guidelines;
3. query physicians for documentation clarification and interpretation;
4. identify ethical, legal, and compliance issues as they relate to documentation, coding and reimbursement;
5. evaluate the relationship between financials and clinical documentation that drives the operational revenue cycle performance;
6. utilize the principles of chart review and clinical documentation improvement tools within the EHR;
7. relate medical necessity to the criteria for quality documentation and communication of patient care and bidirectional clinical indicators;
8. demonstrate the ability to communicate, interact, and engage providers in the standards of documentation as an integral part of the practice of medicine.