Appendix A

WORK PROCESS SCHEDULE

AND

RELATED INSTRUCTION OUTLINE

Clinical Documentation Improvement Specialist Apprenticeship

O*NET-SOC CODE: 29-2071.00
RAPIDS CODE: 2026CB
Type of Training: Competency-based

APPENDIX A

Sample Work Process Schedule and Related Instruction Outline

Clinical Documentation Improvement Specialist Apprenticeship
O*NET-SOC CODE: 2026CB
RAPIDS CODE: 2026CB

This schedule is attached to and a part of these Standards for the above identified occupation.

1. TYPE OF OCCUPATION

☐ Time-based ☒ Competency-based ☐ Hybrid

2. TERM OF APPRENTICESHIP

The term of the occupation shall be competency-based supplemented by a minimum of 144 hours of related instruction.

3. RATIO OF APPRENTICES TO JOURNEYWORKERS

Two (2) apprentice(s) to **One (1)** journeyworker/mentor/trainer.

4. APPRENTICE WAGE SCHEDULE

Apprentices may be paid a progressively increasing schedule of wages based on a percentage of the current Clinical Documentation Improvement Specialist wage rate of $_____.

1 Year Term (example):
1st 1000hrs = $_____
2nd 1000hrs + CDIP =$_____

5. WORK PROCESS SCHEDULE (See below Work Process Schedule)

(Customized at point of hire by the Employer and Sponsor)

The Employer may modify the work processes to meet local needs prior to submitting these Standards to the appropriate Registration Agency for approval.

6. RELATED INSTRUCTION OUTLINE (See below Work Process Schedule)

(Customized at point of hire by the Employer and Sponsor)

Position Description:

The Clinical Documentation Improvement Specialist (CDIS) will be responsible for demonstrating competency in coordinating and performing day to day operations, providing concurrent/retrospective review, and improving documentation of all conditions, treatments, and care plans to ensure highest quality care is provided to the patient. In addition, CDIS should be able to educate clinical staff in appropriate documentation criteria. The CDIS will ensure that documentation reflects Medicare Severity Diagnosis Related Groups (MS-DRG), case mix index, severity of illness, risk of mortality, physician profiling, hospital profiling, and reimbursement rules. Monitoring changes in laws, rules, regulations, and code assignments that impact documentation and reimbursement is implicit. Knowledge and skills on Microsoft Access database management and ability to present information effectively and clearly is essential. An Associate's degree in a healthcare related field with a Registered Health Information Administrator (RHIA), Registered Health Information Technician (RHIT), Certified Coding Specialist (CCS) credential or Registered Nurse (RN) license is required. Clinical Documentation Improvement Practitioner (CDIP) and Certified Clinical Documentation Specialist (CCDS) credentials are preferred.

WORK PROCESS SCHEDULE

COMPETENCY	***MEASURED BY***	***Score***	***COMMENTS***
Use reference resources for code assignment including coding software	Demonstrates understanding in use and application of resources, encoder and grouper software	1 2 3 4 5 N/A	1 – Below expectation in the use of coding resources and software 2 – Needs improvement in the use of coding resources and software 3 – Satisfactorily demonstrates accuracy in the use of coding resources and software 4 – Demonstrates proficiency in the use of coding resources and software 5 – Exceeds expectations in the use of coding resources and software
Identify principle and secondary diagnoses in order to accurately reflect the patient's hospital course utilizing ICD-10	Reviews indicate appropriate code and sequencing	1 2 3 4 5 N/A	1 – Below expectation in the application of inpatient coding guidelines, conventions and regulations

COMPETENCY	MEASURED BY	Score	COMMENTS
with appropriate application of coding conventions and guidelines.	use following regulations, coding conventions and guidelines		2 – Needs improvement in the application of inpatient coding guidelines, conventions and regulations 3 – Demonstrates basic understanding of inpatient coding guidelines, conventions and regulations 4 – Demonstrates proficiency in inpatient coding guidelines, conventions and regulations 5 – Excels in application of inpatient coding guidelines, conventions and regulations
Ensure accuracy of diagnostic/procedural groupings such as DRG (Diagnosis Related Group), MSDRG (Medicare Severity), APC (Ambulatory Payment Classification), etc. Communicate with the Coding/HIM staff to resolve discrepancies between the working and final DRGs.	Reviews indicate accuracy of MS-DRG and APC assignment	1 2 3 4 5 Inpatient Outpatient Both	1 – Below expectation in the accuracy of DRG/MSDRG/APC assignment 2 – Needs improvement in the accuracy of DRG/MSDRG/APC assignment 3 – Demonstrates basic understanding of DRG/MSDRG/APC assignment 4 – Demonstrates proficiency in DRG/MSDRG/APC assignment 5 – Excels in application of DRG/MSDRG/APC assignment
Assign Current Procedural Terminology [CPT] and/or Healthcare Common Procedure Coding System [HCPCS] codes	Reviews indicate accuracy of procedural coding	1 2 3 4 5 Audit score	1 – Below expectation in the accuracy of applying procedure codes 2 – Needs improvement in the accuracy of applying procedure codes 3 – Satisfactorily demonstrates accuracy in the application of procedure codes

COMPETENCY	***MEASURED BY***	***Score***	***COMMENTS***
			4 – Demonstrates proficiency in the application of procedure codes 5 – Exceeds expectations in the accuracy of applying procedure codes
Promote Clinical Documentation Improvement [CDI] efforts throughout organization. Collaborate with physician champions to promote initiatives.	Demonstrates collaboration with peers to support CDI efforts	1 2 3 4 5 Audit score	1 – Below expectation in supporting CDI efforts and initiatives 2 – Needs improvement in the support of CDI efforts and initiatives 3 – Satisfactorily demonstrates support of CDI efforts and initiatives 4 – Demonstrates proficiency in support of CDI efforts and initiatives 5 – Exceeds expectations in the support of CDI efforts and initiatives
Foster working relationship with CDI team members for reconciliation queries. Track responses to queries and interact with providers to obtain query responses. Establishes "chain of command" and consequences for resolving unanswered queries	Identifies correct coding nomenclature for patient type and location	Meets or Does not meet	Comment on **Does Not Meet**
Query providers in ethical manner to avoid potential fraud and/or compliance issues. Formulate queries to providers to clarify conflicting diagnoses. Ensure provider query	Creates compliant physician queries	1 2 3 4 5 N/A	1 – Queries reviewed did not meet facility criteria 2 – Queries reviewed met facility criteria at least 25% of the time

COMPETENCY	MEASURED BY	Score	COMMENTS
response is documented in the medical record.			3 – Queries reviewed met facility criteria at least 50% of the time 4 – Queries reviewed met facility criteria at least 80% of the time 5 – Queries reviewed met all facility criteria for compliance 100% of the time
Interact with providers to clarify Present on Admission (POA), hospital acquired conditions (HAC), public safety indicators (PSI), and documentation of core measures.	Communicates effectively with providers on documentation issues	Meets or Does not Meet	Comment on **Does Not Meet**
Develop CDI policies and procedures to include (but not limited to): query process, education and training, performance of reviews, etc.	Reviews CDI process and develops policies as needed	Meets or Does not Meet	Comment on **Does Not Meet**
Track and trend CDI data to include physician query, denials, documentation practices, working DRG, and physician/CDI benchmarking	Track and trend CDI data for continuous program improvement	1 2 3 4 5	1 – Not compliant with tracking and trending CDI data 2 – Needs improvement in monitoring of CDI data 3 – Satisfactorily monitors CDI data 4 –Proficient in the monitoring of CDI data 5 – Proactive in tracking and trending CDI data

COMPETENCY	***MEASURED BY***	***Score***	***COMMENTS***
Develop training and educate providers and other members of the healthcare team about the importance of the documentation improvement program, severity of illness, risk of mortality and the need to assign diagnoses and procedures when indicated, to their highest level of specificity. Articulates the implications of accurate coding with respect to research, public health reporting, case management and reimbursement.	Communicates effectively with all members of the healthcare team	1 2 3 4 5	1 – Does not communicate effectively with healthcare team 2 – Needs improvement in effective communication 3 – Satisfactorily communicates with healthcare team 4 –Proficient in communication with healthcare team 5 – Proactive in communication with healthcare team
Monitor changes in the regulatory environment in order to maintain compliance with all applicable agencies. Apply regulations to pertinent CDI activities.	CDI program meets regulatory requirements	Meets or Does not Meet	Comment on **Does Not Meet**

Note: ***On the job competencies will be evaluated as competency-based achievements. Each of the competencies will have objectives and all competencies will be verified and signed off by assigned journeyworker/mentors/trainers/supervisors.***

All related instruction and supplementary training will be structured in accordance with Certified Documentation Improvement Professional (CDIP) certification domains.

RELATED INSTRUCTION OUTLINE

Clinical Documentation Improvement Specialist Immersion Training (Related Instruction) Outline

Item	Type	Content	Approx. Hours
Program orientation	WebEx	Program overview	1
VLab tutorial	WebEx	VLab training	1
Pre-immersion assessment	Online assessment	Questions from CDIP exam domains	4
Read Chapters 1, 2, 3 and 4 in *Clinical Documentation Improvement, Principles and Practices* textbook. Complete online assessments.	Online and self-directed	Fundamentals of clinical documentation, translation of clinical documentation into coded data, and impact of classification systems on reimbursement	24
Complete course: Clinical Documentation Improvement – Recognize ICD-10 Documentation Requirements	Online in the AHIMA Academy	Identify areas in ICD that include specific terminology, define areas in ICD that enable improved data capture, discuss training methods for physicians on documentation opportunities.	2
Read Chapter 5 in *Clinical Documentation Improvement, Principles and Practices* textbook. Complete online assessments.	Online and self-directed	Importance of clinical documentation assessment, performing concurrent and retrospective reviews.	6
Complete course: Clinical Documentation Improvement Issues	Online in the AHIMA Academy	Review CDI role and skill sets, discuss essential coding skills and MS-DRG system, evaluate physician communication methods, review necessity of clear concise documentation, and identify best practices in CDI.	2
Read Chapters 6 through 14 in *Clinical Documentation Improvement, Principles and Practices* textbook. Complete online assessments.	Online and self-directed	Implementing a CDI program, physician training, documentation review and physician query process, reporting on program data, CDI program compliance and best practices for CDI programs.	50
Complete course: Clinical Documentation Improvement Success	Online in the AHIMA Academy	Discuss key team players and factors in design of CDI program, review communication barriers, describe concurrent review process and query methods.	2
Read Chapters 15 through 19 in *Clinical Documentation Improvement, Principles and Practices textbook.* Complete online assessments.	Online and self-directed	Meaningful use incentive programs, CDI technology, growing CDI programs in all patient care areas, and critical thinking in healthcare.	30
Complete course: Clinical Documentation Improvement Quality Measures and Documentation Standards	Online in the AHIMA Academy	Relationship of CDI programs to quality measures, differentiate various documentation standards, how coded data affects quality outcome report cards, and examine best practices in CDI	2

Item	Type	Content	Hours
Common employability modules	Online self-directed	Common employability skills to include: • Communication skills • Analysis and problem-solving • Behavioral characteristics • Business knowledge • Teamwork	10
Post-immersion assessment	Online assessment	Questions from CCS-P exam domains	4
Meetings with Coding Trainers	WebEx	Review activities, provide feedback and instruction	6
Total Immersion Training/Related Instruction hours			**144**

TOTAL MINIMUM HOURS **144**