# Healthcare Documentation Improvement Certification (HDIC®)

Curriculum and Program Overview *(Confidential)*

***About AAPC***

*AAPC was founded in 1988 as a National Trade Association and is currently the leading credentialing authority and training provider for Health Information Management professionals.*

*Today AAPC has over 250,000 members in 50 countries and is recognized by employers, association groups and governments around the world as the gold standard in medical coding and health information management.*

*AAPC offers over 30 professional credentials and certification programs recognized worldwide as a means of establishing standards to measure and ensure professionals meet a baseline level of qualification. Each year AAPC conducts over 60,000 certification exams across 3,700 locations world-wide with the goal of preparing working professionals with the specialized skills and expertise needed to be successful in today's complex healthcare system.*

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# Program Overview

The objective of the HDIC® program is to provide and deliver an efficient and sustainable training program that will give physicians, Billers, insurance specialists and medical coders the specific jobs skills and knowledge requirements necessary to be successful in basic clinical documentation improvements concepts. The program draws from experienced clinical documentation integrity specialists to establish criteria for competency in the broad and multidisciplinary bodies of knowledge critical to the role of clinical documentation integrity specialists. These include knowledge of healthcare and coding regulations; anatomy, physiology, pharmacology, and pathophysiology; proficiency in medical record review; communication and physician query techniques; relevant regulatory policy and payment methodologies; and data mining and reporting functions.

The main aim of this course is to provide and deliver an efficient and sustainable comprehensive clinical documentation training and certification program to improve quality of care by correctly capturing: The patient clinical complexity levels of illness (PCCL), Episode of clinical complexity levels(ECCL),risk of mortality (ROM), average length of stay (ALOS), Standardized medical data, Improve the Case Mix Index of the Hospitals, Minimizes Claims Rejections and Suitable Hospital/Clinic reimbursements for the level of care. The goal is to elevate the professional standing of CDI specialists. The program draws from experienced clinical documentation integrity specialists to establish criteria for competency in the broad and multidisciplinary bodies of knowledge critical to the role of clinical documentation integrity specialists. These include knowledge of healthcare and coding regulations; anatomy, physiology, pharmacology, and pathophysiology; proficiency in medical record review; communication and physician query techniques; relevant regulatory policy and payment methodologies; and data mining and reporting functions.

The purpose of becoming a HDIC® is to recognize that those individuals who perform the role of a CDI specialist have a diverse set of concurrent, prospective, and retrospective medical record review skills, clinical knowledge, and knowledge of documentation, coding, and reimbursement rules and regulations.

The HDIC® program follows a highly effective and proven vocational skills training approach to prepare students for their respective job roles. The following provides an overview of the curriculum and training methods developed for this program:

The course is devised into 10 modules and there is no pre-requisite to take the course.

**Training Methods**

The curriculum has been developed to be highly flexible so that it can accommodate a variety of training methods depending on the students or training institutions requirements.

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|  | Classroom Training | Instructor lead training in classroom settings. |
|  | Online Self-Paced Training | 100% online course where students are independent and follow their own schedule with no instructor intervention. |
|  | Online Hybrid Training | Independent learning with a little extra help. Students can take the online program but follow a set schedule with weekly live review sessions by instructors. |
|  | Live Virtual Training | Students attend live classes online where they participate in lectures and interact with instructor and classmates virtually. |

**Instructional Method**

The program was developed utilizing the best international practice standards for classroom and online learning to ensure effective and impactful teaching methods including:

Instructional Design

- Content is organized by lesson goals using logical sequencing. Lessons include overviews describing learning objectives, activities, and assessments that provide multiple learning opportunities for content mastery.
- The program provides users with multiple mediums such as video, animation, and graphics to engage users in a variety of ways.
- The program design provides explicit communication / activities that confirm if users are engaged and progressing.

User Assessments

- Program structure incorporates evaluation methods to assess user's mastery of the content.
- The Program uses ongoing and frequent assessments to provide real-time feedback.
- Assessment tools and program design give users continuous awareness of their progress in the program and mastery of the content.

Technology

- For online, virtual and hybrid training methods the programs utilize the latest technology tools and a simple and easy to use LMS interface.
- Rich media is provided in multiple formats.
- Minimal technology requirements are needed which allows use from any computer and internet connection.

The Program is devised into 10 modules and there is no pre-requisite to take the course.

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| Healthcare Documentation Improvement Certification - (HDIC®) | 40 course Hours | Required for all students |

The curriculum includes various assessments and activities at each module level to engage students through the following methods:

- Module Lectures**:** Including interactive online learning modules. This comprises of common conditions and ICD-10-AM documentation overview
- ICD-10 Documentation Overview (Lectures)
- Common Conditions (Lectures)
- Reading Assignments: Course eBook (Training Manual)
- Module Quizzes: Online quizzes after each module to help assess student comprehension.
- Practical Application Work Assignments: Case studies mirroring real life scenarios.
- Final Exam: Final Program exam to pass the course, also helps prepare students for the Certification Credential Exam.

# Healthcare Documentation Improvement Certification-KSA Overview

The Clinical Documentation Integrity program includes lectures, reading assignments, practice exercises, module review tests and a final exam. Students must complete a passing score of 70% or more for all module review tests and an overall score of 70% or higher for the final exam.

Students who successfully complete this course will also be eligible to take AAPC's credentialing exam to obtain the professional credential of HDIC® (Healthcare Documentation Improvement Certification)).

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|---|---|
| Skill Level | Beginner to Advanced |
| Program Hours | 40 Program Hours<br>*(Course hours account for time spent in lecture and does not include time spent outside of class for study and homework.)* |
| Time to Complete | Depending on the training schedule students typically complete this course within 10 weeks |
| Target Audience | Physicians, Medical Coders, Auditors, Billers, Physicians, Nurses and Mid-level Providers |
| Summary | The main aim of this course is to provide and deliver an efficient and sustainable comprehensive clinical documentation training and certification program to improve quality of care by correctly capturing: The patient severity of illness (SOI), Clinical complexity levels (CCL),risk of mortality (ROM), average length of stay (ALOS), Standardized medical data, Improve the Case Mix Index of the Hospitals, Minimizes Claims Rejections and Suitable Hospital/Clinic reimbursements for the level of care. |
| Program Outline | The program is comprised of 10 modules.<br>• Module 1- The Purpose and importance of Inpatient Clinical Documentation Improvement<br>• Module 2- Documentation Requirements<br>• Module 3- Provider Communication and Compliance<br>• Module 4- Quality Measures<br>• Module 5- Inpatient Payment Systems<br>• Module 6- Introduction to ICD-10-AM and ACS<br>• Module 7- Clinical Conditions and Diagnosis Coding Part 1: ICD-10-AM Chapters 1-11<br>• Module 8- Clinical Conditions and Diagnosis Coding Part 2: ICD-10-AM Chapters 12-22<br>• Module 9- Introduction to ACHI, ACS and SBS<br>• Module 10- Inpatient Coding and Documentation Review (CDI Cases)<br><br>• **End of Unit Test (100 questions / 4 hours to complete)**<br>• **Practice Exam (50 Questions/ 2 Hours to complete)**<br>• **Credential Certification Exam: (100 questions / 4 hours to complete); Two attempts** |

# Assessment and Examination Requirements

Students must successfully complete each module of the training to progress through the course. Successful completion requires passing module quizzes, practical application modules and then a final program exam:

**Quizzes**

- **10** quiz questions per module
- Students have multiple attempts along with rationales
- Quiz questions will vary upon each attempt
- 70% minimum score is required.

**Review exam**

- **25** questions per module
- Students have two attempts along with rationales.
- 70% minimum score is required.

**End of Unit Test**

- 100 questions / 4 hours, 70% score to pass)
- 80 multiple questions
- 20 case studies

Upon completion of the course requirements and successfully passing End of Unit Test, students will have completed the training program and receive a certificate of course completion.

**Practice Exam**

Before attempting the final credential exam, students can take the online practice exam mirroring the testing environment, exactly like the credential exam.

- 50 questions / 2 hours, 70% score to pass)
- 40 multiple questions
- 10 case studies (Focused on CDI)

**Certification Exam**

Once students have successfully completed the training program, they will have the skills and knowledge necessary to challenge the professional certification exam administered by AAPC. Students who successfully pass this certification exam will be recognized with a HDIC® (Healthcare Documentation Improvement Certification) credential.

Professional certification is an important step as it is used to validate coders knowledge, skills and expertise against an established industry standard recognized around the world to ensure professionals meet a baseline level of qualifications.

**Certification Exam Requirements:**

- 90 multiple choice questions
- 10 case studies (Case analysis mix of various medical reports with CDI issues)
- The exam must be completed within 4 hours
- Passing score of 70% or higher