Certified Documentation Integrity Practitioner (CDIP) Eligibility Requirements (Effective Date: 06/01/2023)

Candidates must meet *one* of the following eligibility requirements to sit for the CDIP examination:

- Hold an associate's degree or higher; or
- Hold a CCS®, CCS-P®, RHIT®, or RHIA® credential

While not required, the following are recommended:

- Minimum of two (2) years of clinical documentation integrity experience
- Associate's degree or higher in a health care or allied health care discipline
- Completion of coursework in the following topics:
    - Medical terminology
    - Human anatomy and physiology
    - Pathology
    - Pharmacology

Certified Documentation Integrity Practitioner (CDIP) Exam Content Outline (Effective Date: 06/01/2023)

Domain 1 – Clinical Coding Practice (15-18%)

Tasks:

1. Use reference resources for code assignment
2. Identify the principal and secondary diagnoses in order to accurately reflect the patient's hospital course
3. Assign and sequence diagnosis and procedure codes
4. Apply coding conventions and guidelines related to diagnosis and procedure codes
5. Understand the assignment of the working and final DRG
6. Communicate with the coding/HIM staff to resolve discrepancies between the working and final DRGs, and to ensure coding and reimbursement updates are incorporated into practice

Domain 2 – Education and Leadership Development (21-26%)

Tasks:

1. Promote CDI efforts throughout the organization and health system, including administration
2. Create and nurture working relationships to support collaboration across multi-disciplinary teams
3. Develop documentation improvement projects
4. Collaborate with physician champions to promote CDI initiatives
5. Develop CDI policies and procedures in accordance with AHIMA practice briefs
6. Determine facility requirements for documentation of query responses in the record to establish official policy and procedures related to CDI query activities
7. Recognize a chain of command for resolving unanswered queries
8. Facilitate clinical documentation integrity by identifying educational topics and delivery methods for effective learning for an audience
9. Articulate the implications of accurate documentation and coding with respect to research, public health reporting, case management, and reimbursement

Domain 3 – Record Review & Document Clarification (27-33%)
Tasks:

1. Demonstrate comprehension of clinical documentation in health records
2. Identify and prioritize cases as part of the CDI review process
3. Identify gaps in documentation that may impact patient quality of care, code assignment, or reimbursement (e.g., command of disease process, clinical concepts, clinical validation opportunities, etc.)
4. Apply industry current best practices pertaining to query development and query processes
5. Identify strategies for obtaining query responses from providers and ensure provider query response is documented in the health record
6. Interact with providers to clarify documentation opportunities within the health record (e.g., patient quality indicators, Present on Admission (POA), acuteness/chronicity, complications, etc.)
7. Identify post-discharge query opportunities

Domain 4 – CDI Metrics & Statistics (8-11%)
Tasks:

1. Identify common dashboard metrics and monitor CDI departmental performance
2. Perform quality audits of CDI content to ensure compliance with institutional policies & procedures or national guidelines
3. Track metrics and interpret trends related to the physician query process (e.g., CDI perspective vs provider perspective)
4. Track and interpret data for physician benchmarking and trending
5. Compare institution with external institutional benchmarks
6. Identify common key performance metrics for CDI professionals
7. Use CDI data to adjust departmental workflow

Domain 5 – Compliance (18-23%)
Tasks:

1. Apply AHIMA and other industry standards in support of ethical CDI best practices
2. Monitor changes in the regulatory environment applicable to CDI activities to maintain compliance with all applicable agencies
3. Identify risks associated with technology (e.g., electronic health records, natural language processing (NLP), computer-assisted coding, etc.)
4. Identify situations when second level reviews are appropriate
5. Understand and appropriately use clinical validation queries
6. Identify and address non-compliant queries as part of a CDI workflow
7. Apply policies regarding various stages of the query process and time frames, including retention of queries, to avoid compliance risk