Clinical Documentation Improvement

Clinicalation Improvement

The Clinical Documentation Improvement Specialist's Handbook, Second EditionThe Documentation Improvement Guide to Physician E/MThe Clinical Documentation Improvement Specialist's Complete Training GuideClinical Documentation Improvement for Outpatient CareClinical Documentation ImprovementThe Physician Advisor's Guide to Clinical Documentation ImprovementBridging the Gap Between Coding and Clinical Documentation Improvement (CDI)The Physician Advisor's Guide to Clinical Documentation ImprovementClinical Documentation Reference Guide - First EditionThe Clinical Documentation Improvement Specialist's Guide to ICD-10Clinical Documentation Improvement (CDI) Made Easy, 2nd EditionFirst Steps in Outpatient CDIICD-10-CM Clinical Documentation Improvement Desk Reference 2018Clinical Documentation Improvement Desk Ref for ICD-10-CM & Procedure CodingThe Clinical Documentation Improvement Specialist's Guide to ICD-10, Second EditionClinical Documentation ImprovementClinical Documentation Improvement Specialist's HandbookICD-10-CM Clinical Documentation Improvement Desk Reference 2019Clinical Documentation Improvement Desk Reference for ICD-10-CM & Procedural CodingThe Essential Guide to Supporting Quality Care Measures Through Documentation Improvement Heather Taillon Glenn A. Krauss Laurie L. Prescott Pamela Carroll Hess Rn Phn Nkwuaku, Msn Cphq Trey La Charité Anneleah Williams Bridges Trey La Charité AAPC Glenn Krauss Anthony Nkwuaku Anny Pang Yuen Jennifer Avery Ruthann Russo Colleen Garry LAURIE L. PRESCOTT

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the clinical documentation improvement specialist s handbook second edition marion kruse mba rn heather taillon rhia ccds get the guidance you need to make your cdi program the best there is the clinical documentation improvement specialist s handbook second edition is an all inclusive reference to help readers implement a comprehensive clinical documentation improvement cdi program with in depth information on all the essential responsibilities of the cdi specialist this edition helps cdi professionals incorporate the latest industry guidance and professional best practices to enhance their programs co authors heather taillon rhia and marion kruse mba rn combine their cdi and coding expertise to explain the intricacies of cdi program development and outline the structure of a comprehensive multi disciplinary program in this edition you will learn how to adhere to the latest

government and regulatory initiatives as they relate to documentation integrity prepare for successful icd 10 transition by analyzing your cdi program step up physician buy in with the improved education techniques incorporate the latest physician query guidance from the american health information management association ahima table of contents chapter 1 building the cdi program chapter 2 cdi and the healthcare system chapter 3 application of coding guidelines chapter 4 compliant physician queries chapter 5 providing physician education chapter 6 monitoring the cdi program what s new in the second edition analysis of new industry guidance including ahima s managing an effective query process and guidance for clinical documentation improvement programs cms guidance from new ipps regulations mln matters articles quality improvement organizations and the recovery audit contractor rac program among others strategies to help you incorporate the guidance into your cdi program tools to help you interpret mac initiatives and rac focus areas to enhance your cdi program and help prevent audit takebacks new sample queries forms tools and industry survey data bonus tools this book also includes bonus online tools you can put to use immediately sample query forms sample job descriptions for cdi managers and cdi specialists sample evaluation form for cdi staff sample pocket guide of common documentation standards

give physicians a crash course in the documentation of e m services physicians who provide e m services must document the necessary clinical information to support their medical decision making this is where cdi specialists play an important role and the documentation improvement guide to physician e m can help this reference guide helps cdi specialists explain to physicians how complete and accurate documentation benefits their e m payments prevents medical necessity denials and provides the information they need to document correctly this handbook offers the perfect portable reference guide for cdi specialists to educate physicians about e m documentation this handbook is provided in packs of 10 so cdi specialists can distribute copies to physicians during documentation improvement education sessions or in response to physician questions and requests for additional information this reference guide will help cdi specialists better understand the complex guidelines that affect physician payment for e m services explain the importance of documentation to physicians beyond hospital reimbursement clarify the purpose of queries and how responding to them benefits physicians payments and public profiles encourage physicians to provide adequate documentation that will reduce the number of denials for lack of documented medical necessity access a comprehensive list of additional online resources to further aid them in their important role take a look at the table of contents chapter 1 e m documentation chapter 2 components of e m chapter 3 chief complaint chapter 4 history of present illness chapter 5 review of systems chapter 6 past family and social history chapter 7 physical examination chapter 8 medical decision making chapter 9 amount and complexity of data chapter 10 critical care chapter 11 medical necessity and clinical documentation appendix

your new cdi specialist starts in a few weeks they have the right background to do the job but need orientation training and help understanding the core skills every new cdi needs don t spend time creating training materials from scratch acdis acclaimed cdi boot camp instructors have created the clinical documentation improvement specialist s complete training guide to serve as a bridge between your new cdi specialists first day on the job and their first effective steps reviewing records the clinical documentation improvement specialist s complete training guide is the perfect resource for cdi program managers to help new cdi professionals understand their roles and responsibilities it will get your staff trained faster and working quicker this training guide provides an introduction for managers with suggestions for training staff and guidance for manual use sample training timelines test your knowledge questions to reinforce key concepts case study examples to illustrate essential cdi elements documentation challenges associated with common diagnoses such as sepsis pneumonia and copd sample policies and procedures

clinical documentation improvement for outpatient care design and implementation is an all inclusive guide to establishing and enhancing cdi programs for the outpatient amd professional fee setting

clinical documentation improvement cdi made easy is a great resource and reference that every clinical documentation improvement specialist professional cdis cdip coder physician champion advisor and others involved in the cdi must have the book is a compendium of sound clinical knowledge and experience clinical documentation expertise and quality which will help the cdis cdip and others maximize their potentials in performing their core duties whether you are a new cdis trying to learn cdi or an experienced cdis hoping to stay current with cdi world or involved in the cdi this book will be very valuable to you remember accurate and quality documentation is a reflection of great patient care if it wasn t documented and documented accurately it never happened this book clearly explained various query opportunities by major disease classifications mdcs with some sample queries it defines and analyses different disease processes creates cdis awareness and what to look for under various mdcs icd 10 cm pcs explained current cms pay for performance p4p and the cdi responsibility under p4p explained some pertinent coding guidelines 2016 official coding guidelines for coding and reporting ahima acdis practice brief for queries and compliance and much more i have no doubt in my mind that this book is a concise but a comprehensive tool and reference that anyone involved in cdi should always have at his her side the author anthony o nkwuaku rn phn msn cphq ccds is very knowledgeable and experienced as a clinician clinical instructor and clinical documentation improvement specialist

the physician advisor s guide to clinical documentation improvement physician advisors are not just needed for case management anymore icd 10 cm pcs and the changing landscape of healthcare reimbursement make their input invaluable in the realm of cdi and coding too this book will help your physician advisors quickly understand the vital role they play and how they can not only help improve healthcare reimbursement but also reduce claims denials and improve the quality of care overall this book will provide job descriptions and sample roles and responsibilities for cdi physician advisors outline the importance of cdi efforts in specific relation to the needs and expectations of physicians highlight documentation improvement focus areas by major diagnostic category review government initiatives and claims denial patterns providing physician advisors concrete tools to sway physician documentation

physicians play vital roles in the overall quality of patient care however him professionals and clinical documentation improvement specialists also share essential roles in the healthcare system as guardians of phi and advocates for continuity of care through consistent documentation and accurate code assignment clinical documentation improvement specialists cdis are responsible for the communicative aspects of the process often serving as a liaison between the provider and the coder the cdis ensures that the medical record is complete there is clinical validation to support diagnoses and that the medical record is consistent without conflicting or obscure documentation him professionals share some of the responsibility of cdis in addition to abstracting data from the medical record and assigning the appropriate codes to accurately report the patient s clinical picture without the two teams working hand in hand to improve the medical record s documentation billing errors could ensue and the quality of patient care is at risk the process is very detailed and requires a clinical and coding mind to work efficiently more organizations are calling for their cdis to learn the fundamentals of coding and for their coders to review the medical record with clinical eyes which is whythisresource proves invaluable whether you re already skilled in him but want to add cdi expertise to your resume or an existing cdis looking to update your coding skillset this publication will be of good use to you

it s not the quantity of clinical documentation that matters it s the quality is your clinical documentation improvement cdi program identifying your outliers does your documentation capture the level of icd 10 coding specificity required to achieve optimal reimbursement are you clear on how to fix your coding and documentation shortfalls providing the most complete and accurate coding of diagnoses and site specific procedures will vastly improve your practice s bottom line get the help you need with the clinical documentation reference guide this start to finish cdi primer covers medical necessity joint shared visits incident to billing preventative care visits the global surgical package

complications and comorbidities and cdi for emrs learn the all important steps to ensure your records capture what your physicians perform during each encounter benefit from methods to effectively communicate cdi concerns and protocols to your providers leverage the practical and effective guidance in aapc s clinical documentation reference guide to triumph over your toughest documentation challenges prevent documentation deficiencies and keep your claims on track for optimal reimbursement understand the legal aspects of documentation anticipate and avoid documentation trouble spots keep compliance issues at bay learn proactive measures to eliminate documentation problems work the coding mantra specificity specificity specificity avoid common documentation errors identified by cert and racs know the facts about emr templates and the pitfalls of auto populate features master documentation in the emr with guidelines and tips conquer cdi time based coding for e m the clinical documentation reference guide is approved for use during the cdeo certification exam

take charge of icd 10 documentation requirements the implementation of icd 10 brings with it new documentation requirements that will have a significant impact on the work of your cdi team the higher degree of specificity of information needed to code accurately will have a direct correlation to reimbursement and compliance cdi specialists need a firm understanding of the new code set and the rules that govern it to obtain the appropriate level of documentation from physicians the clinical documentation improvement specialist s guide to icd 10 is the only book that addresses icd 10 from the cdi point of view written by cdi experts it explains the new documentation requirements and clinical indicators of commonly reported diagnoses and the codes associated with those conditions you ll find the specific documentation requirements to appropriately code conditions such as heart failure sepsis and copd learn from your peers the clinical documentation improvement specialist s guide to icd 10 includes case studies from two hospitals that have already begun icd 10 training so you can use their timelines as a blue print to begin your organization s training and implementation icd 10 implementation happens in 2013 it s not too soon to start developing the expertise and comfort level you ll need to manage this important industry change and help your organization make a smooth transition benefits tailored exclusively for cdi specialists side by side comparison of what documentation is necessary now v what will be required starting october 1 2013 timelines to train physicians in new documentation requirements to ensure readiness by implementation date strategies and best practices to ensure physician buy in

the book provides clear guides on how to perform the vital duties required in obtaining accurate quality complete and specific documentation from the providers so as to reflect the quality of care severity of illness and risk of mortality of admitted patients during their encounter to the hospital or inpatient rehab the book is a must have for every cdis or anyone involved in clinical documentation the book has current icd 10 cm pcs update with pertinent information on the 2018 official coding guidelines for coding and reporting coding clinic advice pay for performance sample queries various disease processes by mdcs cdi strategy for success in inpatient rehab rehab impairment group codes and categories list of all the surgical and ms drgs and much more remember if it was not documented and documented accurately it never happened

first steps in outpatient cdi tips and tools for building a program anny p yuen rhia ccs ccds cdip page knauss bsn rn lnc acm cpc cdeo find best practices and helpful advice for getting started in outpatient cdi with first steps in outpatient cdi tips and tools for building a program this first of its kind book provides an overview of what outpatient cdi entails covers industry guidance and standards for outpatient documentation reviews the duties of outpatient cdi specialists and examines how to obtain backing from leadership accurate documentation is important not just for code assignment but also for a variety of quality and reimbursement concerns in the past decade outpatient visits increased by 44 while hospital visits decreased by nearly 20 according to the medicare payment advisory commission however just because physicians are outside the hospital walls doesn t mean they re free from documentation challenges for these reasons cdi programs are offering their assistance to physician practices ambulatory surgical centers and even emergency rooms this book will explore

those opportunities and take a look at how others are expanding their record review efforts in the outpatient world this book will help you target the outpatient settings that offer the greatest cdi opportunities understand the quality and payment initiatives affecting outpatient services understand the coding differences between inpatient and outpatient settings identify data targets incorporate physician needs to ensure support for program expansion assess needs by program type

clinical documentation improvement cdi is not about how to code in icd 10 cm or cpt cdi is knowing what to look for in medical records as well as how to ask for clarification and get ongoing changes to the notes and comments provided by physicians important note the greater number of icd 10 cm diagnostic codes means an even bigger need for detailed clinical documentation making the right code selection requires having adequate clinical detail and under icd 10 cm clinician s documentation willmore than evertranslate into reimbursement gained or lost

the clinical documentation improvement specialist s guide to icd 10 second edition now in its second edition the clinical documentation improvement specialist s guide to icd 10 is the only guide to address icd 10 from the cdi point of view written by cdi experts and icd 10 boot camp instructors it explains the icd 10 documentation requirements and clinical indicators of commonly reported diagnoses and the codes associated with those conditions in it you ll find the specific documentation requirements to appropriately code a variety of conditions the clinical documentation improvement specialist s guide to icd 10 second edition not only outlines the changes coming in october 2014 it provides detailed information on how to assess staffing needs training requirements and implementation strategies the authors an icd 10 certified coder and cdi specialist collaborated to create a comprehensive selection of icd 10 sample queries that facilities can download and use to jumpstart their icd 10 documentation improvement efforts develop the expertise and comfort level you need to manage this important industry change and help your organization make a smooth transition the clinical documentation improvement specialist s guide to icd 10 second edition is part of the library of products and services from the association of clinical documentation improvement specialists acdis acdis members are cdi professionals who share the latest tested tips tools and strategies to implement successful cdi programs and achieve professional growth member benefits include a quarterly journal members only site quarterly networking conference calls discounts on conferences and more what s new completely revised to accommodate changes in icd 10 implementation dates dozens of targeted icd 10 physician queries updated icd 10 benchmarking reports benefits sample icd 10 queries specificity requirements and clinical indicators by disease type and body system staff training and assessment tools table of contents chapter 1 icd 10 primer chapter 2 conventions and guidelines chapter 3 physician queries chapter 4 cdi target areas chapter 5 icd 10 cm pcs provider education

cover title includes subtitle achieving excellence

improving documentation is no easy task cdi professionals have never had one easy to read inclusive reference to help them implement a cdi program understand the fundamentals of icd 9 cm coding query physicians and encourage interdepartmental communication in theory physicians should document their entire thought process including ruling conditions in and out but it s not that simple and in light of ms drgs it requires significant physician education and retraining you need a blueprint for success your blueprint has arrived at last here is a guide for cdi specialists the clinical documentation improvement specialist s handbook is your essential partner for creating a cdi program staffing your program querying physicians and understanding how documentation affects code selection and data quality as a cdi specialist you need answers now in light of medicare severity drgs ms drg detailed documentation and accurate capture of complications and comorbidities ccs has made the cdi specialist s role more important and more demanding than ever this handbook will enhance your ability to gather the right information the first time and every time author colleen garry rn bs has compiled case studies that document best practices and reference several different cdi models so that you can select the one that s right for your hospital s cdi success

in addition you ll be privy to an executive summary of hcpro s exclusive cdi survey that solicited more than 800 responses learn how other hospitals are handling cdi and choosing the model that works best for them work with physicians to obtain detailed appropriate documentation maintain compliance when performing physician queries convey return on investment for a cdi program customizable cd rom included your copy of the clinical documentation improvement specialist s handbook includes a cd rom loaded with all of the working tools you ll find in the book among them

clinical documentation improvement cdi is not about how to code in icd 10 cm or cpt cdi is knowing what to look for in medical records as well as how to ask for clarification and get ongoing changes to the notes and comments provided by physicians important note the greater number of icd 10 cm diagnostic codes means an even bigger need for detailed clinical documentation making the right code selection requires having adequate clinical detail and under icd 10 cm clinician s documentation willmore than evertranslate into reimbursement gained or lost

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