

Clinical Documentation Improvement

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The Leader's Guide to Hospital Case Management Foundations of Health Information Management - E-Book Clinical Documentation Improvement The Clinical Documentation Improvement Specialist's Handbook, Second Edition The Clinical Documentation Improvement Specialist's Guide to ICD-10 Bridging the Gap Between Coding and Clinical Documentation Improvement (CDI) The Physician Advisor's Guide to Clinical Documentation Improvement The Documentation Improvement Guide to Physician E/M Document Document Clinical Documentation Improvement The Clinical Documentation Improvement Specialist's Complete Training Guide FAO Documentation Clinical Documentation Reference Guide - First Edition The Physician Advisor's Guide to Clinical Documentation Improvement City Document Legislative Document Documentation de la FAO. Basic Employment Law Manual for Managers and Supervisors City document Stefani Daniels Nadinia A. Davis Rn Phn Nkwaku, Msn Cphq Heather Taillon Glenn Krauss Anneleah Williams Bridges Trey La Charité Glenn A. Krauss Boston (Mass.) Pamela Carroll Hess Laurie L. Prescott Food and Agriculture Organization of the United Nations. Documentation Center AAPC Trey La Charité Providence (R.I.) Alabama. Legislature Paul C. Gibson Worcester (Mass.)

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this text will address the role of the hospital case manager from a business perspective rather than a nursing perspective will engage all areas that are involved with the health care system in pursuit of global objectives on behalf of every stakeholder

selected for doody's core titles 2024 with essential purchase designation in health information management foundations of

health information management 6th edition is an absolute must for anyone beginning a career in him by focusing on healthcare delivery systems electronic health records and the processing maintenance and analysis of health information this engaging easy to understand text presents a realistic and practical view of technology and trends in healthcare it readies you for the role of a registered health information technician who not only maintains and secures accurate health documentation but serves as a healthcare analyst who translates data into useful quality information that can control costs and further research this edition is organized by cahim competencies to prepare you for the rhit credentialing exam as well as ehr samples critical thinking exercises and expanded coverage of key issues in him today clear writing style and easy reading level make reading and studying more time efficient organized for cahim competencies to assure that you are prepared to sit for the exam competency check in exercises at the end of every main section in each chapter encourage you to review and apply key concepts competency milestone feature at the end of each chapter hosts ample assessments to ensure your comprehension of the cahim competencies ethics challenge links topics to professional ethics with real world scenarios and critical thinking questions critical thinking questions challenge you to apply learning to professional situations mock rhit exam provides you with the opportunity to practice taking a timed objective based exam specialized chapters including legal statistics coding and performance improvement and project management support in depth learning professional profile highlights key him professionals represented in chapter discussions patient care perspective illustrates the impact of him professionals on patients and patient care career tip boxes instruct you on a course of study and work experience required for the position chapter summaries and reviews allow for easy review of

each chapter's main concepts simchart and simchart for the medical office ehr samples demonstrate electronic medical records in use

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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

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

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

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

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

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