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In sub-Saharan Africa, older people make up a relatively small fraction of the total population and are supported primarily by family and other kinship networks. They have traditionally been viewed as repositories of information and wisdom, and are critical pillars of the community but as the HIV/AIDS pandemic destroys family systems, the elderly increasingly have to deal with the loss of their own support while absorbing the additional responsibilities of caring for their orphaned grandchildren. Aging in Sub-Saharan Africa explores ways to promote U.S. research interests and to augment the sub-Saharan governments' capacity to address the many challenges posed by population aging. Five major themes are explored in the book such as the need for a basic definition of "older person," the need for national governments to invest more in basic research and the coordination of data collection across countries, and the need for improved dialogue between local researchers and policy makers. This book makes three major recommendations: 1) the development of a research agenda 2) enhancing research opportunity and implementation and 3) the translation of research findings.

AAPC's CPMA® Certification Study guide is specifically designed to help individuals prepare for the CPMA® exam. Five chapters will guide you through a review of medical record standards and documentation guidelines, coding and documentation compliance, coding and reimbursement concepts, audit scope and statistical sampling methods, medical record audit abstraction, and category risk analysis and communication. The study guide covers all the content sections found on the exam and will also provide you with testing tips for taking the AAPC's CPMA® exam. The study guide is not an introduction to coding but a review of coding concepts. Key Features: - Practical Examples - Testing Techniques for CPMA® exam - Questions designed to mimic the CPMA® certification exam - Each chapter includes ten review questions geared to test important concepts - Study guide written by same task force who wrote the CPMA® exam - 50 Test your Knowledge questions with answers and rationales - 50 question practice test with answers and rationales AAPC's CPMA® Online Practice Exams are highly recommended to supplement this study guide. These online practice exams will add an additional 150 questions to your preparation. Accurately report supplies and services for physician, hospital outpatient, and ASC settings with the Ingenix HCPCS Level II Expert. Nearly 400 code updates went into effect for 2009. Be prepared for several more changes on January 1, 2010, with updated, comprehensive information for the HCPCS code set in a reference that focuses on management of reimbursement. This user-friendly book will guide any coder confidently through current modifiers, code changes, additions and deletions with information as dictated by the Centers for Medicare and Medicaid Services (CMS).

Get ready for the CCDS exam The 2012 study guide has been updated to prepare candidates for the Certified Clinical Documentation Specialist (CCDS) exam. It follows the content outline established by the advisory board that created the exam. Each chapter reviews clinical documentation improvement program principles and contains sample questions for self-testing. To learn more about prerequisites for taking the exam or to apply, visit www.cdiassociation.com/certification. The CCDS Exam Study Guide will: * Help candidates determine whether they are ready to take the CCDS exam * Give qualified candidates the confidence they need for success * Provide sample questions for self-assessment * Deliver proven test-taking strategies

A guide to the medication reconciliation process for healthcare facilities.

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

Develop the skills you need to effectively and efficiently document patient care for children and adults in clinical and hospital settings. This handy guide uses sample notes, writing exercises, and EMR activities to make each concept crystal clear, including how to document history and physical exams and write SOAP notes and prescriptions.

2021 Official HCPCS Level II Expert Code Book An essential key to quality measures, durable medical goods, injectable drugs, outpatient surgery, Medicaid, Blue Cross/Blue Shield, and many other codes. Complete with supplementary information for each code, it's designed for clinical coders as both an easy-to-use office guide and the preferred choice to prepare for all AAPC certification exams. AAPC's difference means these features: HCC Reporting Guide Receive expert advice regarding HCC reporting in 2021 Tabs - Simply flip to the chapter you need, saving you time during your exam or in the office Comprehensive 2021 Code Updates - Stay up to date. AAPC code books will notify you about new, deleted, and changed codes modifiers. More Brand Name Drugs in Table of Drugs - Pairing drugs with codes can be difficult. Simplify the process with easy to understand tables and tips. Modifiers Easier to Find and Use - Modifiers are easy to use and handy to find with a front cover fold-out flap that contain the modifier information you need to code accurately Additional Information for Each Chapter - Included information will help you meet your quota or pass your exam APC Status Indicators and ASC Designation Symbols - Find the codes payable through OPSS, and we'll help you do it accurately DMEPOS Icon - AAPC books make billing DME easier with supplemental information. In-depth Illustrations - View the various items associated with codes, along with anatomical illustrations. AHA Coding Clinic for HCPCS References - AHA Coding Clinic® not only helps you report supplies and services accurately; it helps you stand up to challenges User-friendly Appendixes - Appendixes have the extra information you want, including the relevant parts of Medicare's Pub 100 Color-coded Bars and Icons - Ask around, no HCPCS Level II books are as color-coded and easy to use as this. With Pub. 100 references, age and sex edits, quantity alerts, new/deleted/revised code changes, and government coverage and rules for each code, the 2021 Official HCPCS Level II Expert Code Book is an essential key.

For a better understanding of the latest revisions to the CPT(R) code set, rely on the CPT(R) Changes 2022: An Insider's View.

Get the insider's perspective into the annual changes in the CPT code set directly from the American Medical Association.

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

Principles of CPT Coding, ninth edition, is a best-selling resource that provides education on CPT billing and guidelines. It offers valuable training on how to code correctly with CPT.

Completely updated to the 2017 ICD-10-CM and ICD-10-PCS coding guidelines and packed with practical applications, Bowie's UNDERSTANDING ICD-10-CM AND ICD-10-PCS Update: A Worktext, 3E delivers a comprehensive presentation of the ICD-10-CM and ICD-10-PCS diagnostic and procedural coding system. Extremely hands-on, this unique workbook offers detailed coverage that engages readers. Numerous learning tools thoroughly review and reinforce understanding of the materials presented in each chapter. Readers can immediately begin putting what they learn into real-world practice through numerous timely exercises, meaningful coding assignments, and case studies. Vivid color illustrations emphasize how knowledge of anatomy and disease processes can positively impact coding accuracy. This edition provides the ideal resource to assist today's practicing professionals and healthcare organizations smoothly transition from ICD-9-CM to ICD-10-CM and ICD-10-PCS. This updated printing of the third edition includes new 2017 ICD-10 codes. Important Notice: Media content referenced within the product description or the product text may not be available in the ebook version.

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

Have you started your ICD-10 training? If you haven't, the time to start is right now! Nationally recognized coding expert, Joan L. Usher, BS, RHIA, COS-C, ACE, will help you begin training with her new, comprehensive ICD-10 coding training manual. Specific to home health, this manual gives detailed coding training and how-to guidance for the top diagnoses in the homecare setting and breaks down some of the biggest changes that are featured in ICD-10. When ICD-10 goes into effect, home health agencies must include ICD-10 coding on their claims to prove medical necessity of their services per Medicare coverage guidelines. ICD-10 coding is complex and even the most seasoned ICD-9 coder will need education and training to code correctly under this new system due to the significant increase in codes and specificity required with coding. ICD-10 Coding for Home Health: A Guide to Medical Necessity and Payment will provide coding tutorials, as well as, analysis and guidance on the most common diagnoses and most challenging coding situations within the homecare setting. The book also features an exam to test your knowledge and ensure coder proficiency. ICD-10 Coding for Home Health: A Guide to Medical Necessity and Payment is a companion resource to Beacon Health's ICD-10 Essentials for Homecare: Your Guide to Preparation and Implementation. Together, these resources will help your agency remain profitable and compliant under the ICD-10 coding system. This book provides: - Coding how-to for the most common diagnoses in the homecare setting - An overview of OASIS-C1 and how it will accommodate ICD-10 codes - Guidance on how to properly document and code in ICD-10 to ensure proper Medicare payment

CPT(R) 2022 Professional Edition is the definitive AMA-authored resource to help healthcare professionals correctly report and bill medical procedures and services.

CPT® 2021 Professional Edition is the definitive AMA-authored resource to help health care professionals correctly report and bill medical procedures and services. Providers want accurate reimbursement. Payers want efficient claims processing. Since the CPT® code set is a dynamic, everchanging standard, an outdated codebook does not suffice. Correct reporting and billing of medical procedures and services begins with CPT® 2021 Professional Edition. Only the AMA, with the help of physicians and other experts in the health care community, creates and maintains the CPT code set. No other publisher can claim that. No other codebook can provide the official guidelines to code medical services and procedures properly. FEATURES AND BENEFITS The CPT® 2021 Professional Edition codebook covers hundreds of code, guideline and text changes and features: CPT® Changes, CPT® Assistant, and Clinical Examples in Radiology citations -- provides cross-referenced information in popular AMA resources that can enhance your understanding of the CPT code set E/M 2021 code changes - gives guidelines on the updated codes for office or other outpatient and prolonged services section incorporated A comprehensive index -- aids you in locating codes related to a specific procedure, service, anatomic site, condition, synonym, eponym or abbreviation to allow for a clearer, quicker search Anatomical and procedural illustrations -- help improve coding accuracy and understanding of the anatomy and procedures being discussed Coding tips throughout each section -- improve your understanding of the nuances of the code set Enhanced codebook table of contents -- allows users to perform a quick search of the codebook's entire content without being in a specific section Section-specific table of contents -- provides users with a tool to navigate more

effectively through each section's codes Summary of additions, deletions and revisions -- provides a quick reference to 2020 changes without having to refer to previous editions Multiple appendices -- offer quick reference to additional information and resources that cover such topics as modifiers, clinical examples, add-on codes, vascular families, multianalyte assays and telemedicine services Comprehensive E/M code selection tables -- aid physicians and coders in assigning the most appropriate evaluation and management codes Adhesive section tabs -- allow you to flag those sections and pages most relevant to your work More full color procedural illustrations Notes pages at the end of every code set section and subsection

Torture, Psychoanalysis and Human Rights contributes to the development of that field of study called 'psycho-social' that is presently more and more committed to providing understanding of social phenomena, making use of the explicative perspective of psychoanalysis. The book seeks to develop a concise and integrated framework of understanding of torture as a socio-political phenomenon based on psychoanalytic thinking, through which different dimensions of the subject of study become more comprehensible. Monica Luci argues that torture performs a covert emotional function in society. In order to identify what this function might be, a profile of 'torturous societies' and the main psychological dynamics of social actors involved – torturers, victims, and bystanders – are drawn from literature. Accordingly, a wide-ranging description of the phenomenology of torture is provided, detecting an inclusive and recurring pattern of key elements. Relying on psychoanalytic concepts derived from different theoretical traditions, including British object relations theories, American relational psychoanalysis and analytical psychology, the study provides an advanced line of conceptual research, shaping a model, whose aim is to grasp the deep meaning of key intrapsychic, interpersonal and group dynamics involved in torture. Once a sufficiently coherent understanding has been reached, Luci proposes using it as a groundwork tool in the human rights field to re-think the best strategies of prevention and recovery from post-torture psychological and social suffering. The book initiates a dialogue between psychoanalysis and human rights, showing that the proposed psychoanalytic understanding is a viable conceptualisation for expanding thinking of crucial issues regarding torture, which might be relevant to human rights and legal doctrine, such as the responsibility of perpetrators, the reparation of victims and the question of 'truth'. Torture, Psychoanalysis and Human Rights is the first book to build a psychoanalytic theory of torture from which psychological, social and legal reflections, as well as practical aspects of treatment, can be mutually derived and understood. It will appeal to psychoanalysts, psychoanalytic psychotherapists and Jungians, as well as scholars of politics, social work and justice, and human rights and postgraduate students studying across these fields.

AAPC's CDEO® Certification Study guide is specifically designed to help individuals prepare for the CDEO® exam. Ten chapters will guide you through provider communication and compliance, clinical conditions and diagnosis coding, documentation requirements associated with E/M services and CPT coding. This study guide covers each section found on the exam, plus it will provide you with testing tips for taking AAPC's CDEO® exam. If you have coding or auditing experience or have successfully completed documentation training, this study guide will optimize your exam preparation. This study guide is not an introduction to clinical documentation, but a review of documentation concepts. Key Features: Practical Examples Testing Techniques for CDEO® exam Questions designed to mimic the CDEO® certification exam Each chapter includes ten review questions geared to test important coding concepts Study guide written by same task force who wrote the CDEO® exam Practice exam with 50 multiple choice questions with answers and rationales AAPC's CDEO® Online Practice Exams highly recommended to supplement this study guide. These online practice exams will add an additional 60 multiple choice questions and 10 fill-in-the-blank coding cases to your preparation.

This all-in-one resource focuses on the most important CPT(R) and HCPCS codes for general surgery and gastroenterology, plus medicine and ancillary services codes chosen by experts who have taken into consideration utilization, denial risk and complexity. 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 why this resource 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 #1 Drug Guide for nurses & other clinicians...always dependable, always up to date! Look for these outstanding features: Completely updated nursing-focused drug monographs featuring 3,500 generic, brand-name, and combination drugs in an easy A-to-Z format NEW 32 brand-new FDA-approved drugs in this edition, including the COVID-19 drug remdesivir—tabbed and conveniently grouped in a handy "NEW DRUGS" section for easy retrieval NEW Thousands of clinical updates—new dosages and indications, Black Box warnings, genetic-related information, adverse reactions, nursing considerations, clinical alerts, and patient teaching information Special focus on U.S. and Canadian drug safety issues and concerns Photoguide insert with images of 439 commonly prescribed tablets and capsules

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. You'll find the specific documentation requirements to appropriately code a variety of conditions. The CDI Specialist's Guide to ICD-10, 2nd 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 facilities can download and use to jumpstart ICD-10 documentation improvement efforts. Develop the expertise and comfort level you'll 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, 2nd ed. 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 Web 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

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

2021 Official ICD-10-CM Expert for Providers and Facilities ESSENTIAL! For new, 2021 codes and guidelines, AAPC's Official ICD-10-CM Expert for Providers and Facilities is a must-have resource for clinical coders. When it comes to ease-of-use, usable content and accuracy, there is no substitute. AAPC's ICD-10-CM was written by medical coding experts and custom-tailored as an easy, essential reference for use in the office, medical facilities, classrooms, and for exams. New 2021 codes and guidelines are supported by helpful information for every coder, biller, and other professional dealing in healthcare revenue. Color coding and illustrations make the material easy to navigate, digest and remember. AAPC's difference includes these features: New for 2021! 2021 new, changed, and deleted codes updates assure you will have the codes you need at work and during your examination 2021 Official Guidelines in the front of the book build the foundation for your documentation of medical necessity and accuracy Additional character icons help make your book a one-stop, easy-to-use resource Expanded online updates and tips to help you succeed at work or in your exam Yellow-highlighted orientation lines - Index to Diseases and Injuries include highlights that are like maps to the correct indentation, meaning you can easily find the right code categories Highlighted codes - Easily find MACRA quality measure-related diagnosis codes Adhesive tabs - Save time by adding custom tabs Symbols/alerts with Z codes - Conveniently Identify primary Dx for this code chapter Age and Gender icons - Save yourself from embarrassing mistakes Primary Diagnosis indicators - Take any guesswork out of which code to report Manifestation codes - Add the information needed to make codes more payable Detailed illustrations - Understand the geography and pathology in the codes Extension symbols - Identify encounter, recovery stage, or laterality Spiral binding - Lay your book open and flat for an easy-to-use coding reference Lists over 1,500 of the latest and most common FDA-approved drugs, including information on drug action, dosage, interactions, contraindications, and guidelines for administration.

Official 2022 ICD-10-CM Expert Code Book Do you ever struggle with the level of ICD-10-CM code specificity required for successful claim submissions? The struggle ends here. The ICD-10-CM Expert 2022 will not only get you up to speed with 2022 updates but will also help you check your coding for medical necessity. Color coding and illustrations make the material easy to navigate, digest and remember. Developed for students and professionals alike, the ICD-10-CM Expert 2022 is designed for coders by coders. It is custom-tailored as an easy, essential reference for use in the office, medical facilities, classrooms, and for exams. Key Features and Benefits: Complete 2022 ICD-10-CM code set with new codes, new text, revised codes, and revised text 2022 ICD-10-CM Official Guidelines for Coding and Reporting with expanded Quick View Flow Charts for quick and accurate information AAPC exclusive! Monthly email coding updates to keep you informed and keep your claims on track Symbols indicating "additional character required" to ensure valid coding Age and gender icons showing which codes have patient-based restrictions Symbols for unacceptable principal diagnosis, code exempt from diagnosis present on admission requirement, complication or comorbidity, CC/MCC exclusion, questionable admission, and HAC alert Code first indicators, plus "code also" and "use additional code" notes Manifestation code alerts to properly assign codes representing manifestations of an underlying disease Extension symbols to identify encounter, recovery stage, or laterality Highlighted codes to recognize conditions related to MACRA quality measures HCC and RxHCC symbols to alert you to HCC and RxHCC diagnoses Full-color anatomical illustrations of anatomy and conditions throughout the Tabular List to help you to understand how to assign specific codes Colored vertical lines throughout the Alphabetic Index to easily recognize subterms and codes to cross reference Preprinted adhesive tabs for quick, easy reference to frequently used sections and codes Spiral binding allows book to lay flat for easy coding and scanning

The Complete Guide to CDI Management Cheryl Ericson, MS, RN, CCDS, CDIP Stephanie Hawley, RN, BSN, ACM Anny Pang Yuen, RHIA, CCS, CCDS, CDIP Managing a CDI department can be a daunting task for new and seasoned managers alike. The Complete Guide to CDI Management provides CDI program managers and directors with insight into the most common issues associated with implementing, staffing, running, and growing a CDI department. The book also covers core skills such as auditing and metrics, and it provides strategies for overcoming challenges related to electronic records, changing regulatory landscapes, and resource limitations. The Complete Guide to CDI Management incorporates the deep expertise of multiple authors with varied backgrounds who have come together to share their firsthand knowledge. From reporting structures and productivity measurement to defining a mission and physician engagement, this definitive resource addresses the wide array of issues facing CDI managers and directors in today's hospital environment. Table of Contents About the Authors Introduction Chapter 1: An Introduction to CDI for the New Manager History of Coded Data The Medical Coder The Prospective Payment System Adding "Severity" Into the DRG Methodology CDI Basics Summary Chapter 2: Growing a CDI Department The Traditional Role of CDI CDI Review Population Principal Diagnosis Assignment Types of DRG Reviews Quality Focus Summary Chapter 3: Developing Relationships Sharing the Mission Physician Engagement Obstacles to Developing a Physician Relationship Leveraging Queries as an Educational Tool The Art of Clinical Validation The Query Format Query Templates Fostering a Relationship With Coding Networking Summary Chapter 4: Department Structures and Staffing Expectations Department Structures Staffing/Hiring Physician Advisor Creating a Career Ladder Continuing Education CDI Department Meetings Evaluations Credentialing Initialing vs. Revitalizing Summary Chapter 5: Demonstrating the Return on Investment Measuring Success Productivity and Sample Metrics Summary Chapter 6: Challenges and How to Overcome Them Organization Issues Resource Issues Summary Appendixes Appendix A: Resources

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

Your shortcut to accurate assessment and compliant documentation The quick and easy way to document quality resident care! The "Long-Term Care Clinical Assessment and Documentation Cheat Sheets" is the ultimate blueprint for how to provide resident-centered care for any symptom or condition. Available on CD, this electronic-only resource provides nurses with a thorough list of what to check and what to document during every shift, based on the specific circumstances of a given resident. Best of all, the new electronic format of this content enables long-term care clinicians to easily search for the condition they need to treat and access the appropriate checklist within seconds. Each checklist can be downloaded and printed to fit directly into the resident's record to ensure thorough, focused, and regular assessments and documentation. "Long-Term Care Clinical Assessment and Documentation Cheat Sheets" is the most convenient way to guarantee your residents receive the proper care and your facility maintains compliant documentation."Long-Term Care Clinical Assessment and Documentation Cheat Sheets"will help you: Save time finding the correct guidelines for a resident's condition with the searchable, electronic checklists Maintain complete and accurate clinical records for each resident to authenticate that physician orders were followed and residents were provided with the highest quality of care Ensure consistency of care across each nurse's shift by including the relevant checklist in each resident record Assess and document resident status, including cardiovascular, hematologic, and neurological conditions with more than 190 guidelines, tools, and cheat sheets Avoid survey citations, lost reimbursement, and legal implications arising from improper documentation Minimize nurses' stress by providing them with reliable guidance and data for each resident, in an easy-to-use format that fits seamlessly in their everyday work flow What's New Electronic, searchable checklists, which enable you to upload the information to the resident's EHR or print to file in their paper record! Special chapter covering the most frequent diagnoses for hospital readmissions and strategies for how to prevent them.

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