

# **Ahima Clinical Documentation Improvement Toolkit**

**Ruthann Russo** 

## **Ahima Clinical Documentation Improvement Toolkit:**

The Clinical Documentation Improvement Specialist's Handbook, Second Edition Heather Taillon, 2011-01-21 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 gueries 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 guery forms Sample job descriptions for CDI managers and CDI specialists Sample evaluation form for CDI staff Sample pocket guide of common documentation standards Legal and Ethical Standards for Nurses, 4th Edition Sheryl Feutz-Harter, 2012-05 To practice nursing effectively today requires a sound understanding of the legal system and the laws specifically affecting nurses Legal and Ethical Standards for Nurses is filled with practical information covering topics such as delegation documentation professional liability insurance regulatory issues advance directives and many others While these are exciting and challenging times for nurses clinically they are equally challenging legally It is therefore increasingly important that each nurse learn how to protect herself and her nursing license The 4th Edition includes an expanded discussion of healthcare fraud and the False ClaimsTo practice nursing effectively today requires a sound understanding of the legal system and the laws specifically affecting nurses Legal and Ethical Standards for Nurses is filled with practical information covering topics such as delegation documentation professional liability insurance regulatory issues

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The Physician Advisor's Guide to Clinical Documentation Improvement Trey La Charité, James S. Kennedy, 2014

Bridging the Gap Between Coding and Clinical Documentation Improvement (CDI) Anneleah Williams Bridges, 2020-02-14 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 whythis 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 Essential Guide to Supporting Quality Care Measures Through Documentation Improvement LAURIE L. PRESCOTT, Sharme Brodie, 2017-06 Resource added for the Health

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Garry, 2014-05-14 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 Specialists Complete Training Guide** Laurie L. Prescott (R. N.),2014 Clinical Documentation Reference Guide - First Edition AAPC, 2020-03-12 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

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