

Ahima Documentation Guidelines

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

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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

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Managers of health information

have a professional stake in

understanding the legal

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requirements designed to safeguard health care information. This comprehensive book covers all legal aspects of the Health Information Management field including the legal principles that govern patient information. Actual cases related to health care underscore the relationship between the law and health information. The first chapters introduce the American legal system, legal procedures and principles of liability. Subsequent chapters build on this information by presenting information on patient record requirements, access to health information, confidentiality, computerized records, and other areas.

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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

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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

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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

Certified Documentation Improvement Practitioner (CDIP)
Exam Preparation
2021 CDI Pocket Guide
Health Care Fraud and Abuse

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ICD-9-CM Official Guidelines for
Coding and Reporting
Ethical Health Informatics

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

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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*

CPT(R) 2022 Professional Edition is

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the definitive AMA-authored resource to help healthcare professionals correctly report and bill medical procedures and services.

ACDIS Answers: Clinical

Documentation Improvement FAQs

ACDIS Answers: Clinical

Documentation Improvement FAQs is a quick reference guide for the most common questions faced by CDI specialists. Organized by Major Diagnostic Categories and broken down into specific topics of concern, ACDIS Answers provides information not only on documentation needs but also on issues related to the CDI profession. This compendium of commonly asked CDI questions is an essential reference book and office

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companion, valuable for new CDI specialists as well as those experienced in concurrent medical record review. Whether you're wondering about sequencing guidelines, staff productivity, escalation policies, diabetes coding, or documentation requirements for acute kidney injury, ACDIS Answers provides quick, easily understandable information from respected experts in CDI, including ACDIS' own Boot Camp instructors and Advisory Board members.

*A Guide to Hospital Outpatient Issues
CPT 2021 Professional Edition
Clinical Documentation Improvement
Guidelines Regarding Maintenance
and Disclosure of Health Information*

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Made Easy: a Professional Guide
ICD-10-CM 2018: The Complete Official Codebook provides the entire updated code set for diagnostic coding. This codebook is the cornerstone for establishing medical necessity, determining coverage and ensuring appropriate reimbursement.

This book covers documentation procedures in acute care settings specific topics include health record law and Hippa regulations, nursing documentation, and documentation for specialty care. This book replaces Ahima's documentation requirements for the acute care patient record.

CPT® 2021 Professional Edition is

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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

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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,

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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,

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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

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set section and subsection

Documentation Guidelines for
Evaluation and Management
Services

Legal Aspects of Health Information
Management

Acdis Answers

Long Term Care Health Information
Practice and Documentation
Guidelines

The Complete Guide to CDI
Management

Health Administration

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

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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

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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

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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 HCPPro'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

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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

Stepped-up efforts to ferret out health care fraud have put every provider on the alert. The HHS, DOJ, state Medicaid Fraud Control Units, even the FBI is on the case -- and providers are in the hot seat! in this timely volume, you'll learn about the types of provider activities that fall under federal fraud and abuse prohibitions as defined in the Medicaid statute and Stark legislation. And you'll discover

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what goes into an effective corporate compliance program. With a growing number of restrictions, it's critical to know how you can and cannot conduct business and structure your relationships -- and what the consequences will be if you don't comply.

Concepts, Principles, and Practice

Conditions of Participation for Hospitals

The Physician Advisor's Guide to Clinical Documentation

Improvement

Release and Disclosure

Sixth Edition: Concepts, Principles, and Practice

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Ethical Informatics is an invaluable resource for HIM, the healthcare team (nursing, physical therapy, occupational therapy et al.), information technology (IT) students (associate, baccalaureate and graduate) and practitioners. Each chapter includes ethical “real life” scenarios, a discussion of the issues, and a decision-making matrix for each scenario that facilitates an understanding of ethical ways to respond to the problem and actions that

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would not be considered ethical.

Clinical Documentation Improvement for Outpatient Care: Design and Implementation is an all-inclusive guide to establishing and enhancing CDI programs for the outpatient and professional fee setting.

ICD-10-CM 2022: The Complete Official Codebook provides the entire updated code set for diagnostic coding, organized to make the challenge of accurate coding easier. This codebook is the

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cornerstone for establishing medical necessity, correct documentation, determining coverage and ensuring appropriate reimbursement. Each of the 22 chapters in the Tabular List of Diseases and Injuries is organized to provide quick and simple navigation to facilitate accurate coding. The book also contains supplementary appendixes including a coding tutorial, pharmacology listings, a list of valid three-character codes and additional information on

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Z-codes for long-term drug use and Z-codes that can only be used as a principal diagnosis.

Official 2022 coding guidelines are included in this codebook. FEATURES

AND BENEFITS Full list of code changes. Quickly see the complete list of new, revised, and deleted codes affecting the CY2022

codes, including a conversion table and code changes by specialty. QPP symbol in the tabular section. The symbol

identifies diagnosis codes associated with Quality Payment Program (QPP)

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measures under MACRA. New and updated coding tips. Obtain insight into coding for physician and outpatient settings. Chapter 22 features U-codes and coronavirus disease 2019 (COVID-19) codes Improved icon placement for ease of use New and updated definitions in the tabular listing. Assign codes with confidence based on illustrations and definitions designed to highlight key components of the disease process or injury and provide better understanding of complex

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diagnostic terms. Intuitive features and format. This edition includes color illustrations and visual alerts, including color-coding and symbols that identify coding notes and instructions, additional character requirements, codes associated with CMS hierarchical condition categories (HCC), Medicare Code Edits (MCEs), manifestation codes, other specified codes, and unspecified codes. Placeholder X. This icon alerts the coder to an important ICD-10-CM

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convention--the use of a "placeholder X" for three-, four- and five-character codes requiring a seventh character extension. Coding guideline explanations and examples. Detailed explanations and examples related to application of the ICD-10-CM chapter guidelines are provided at the beginning of each chapter in the tabular section. Muscle/tendon translation table. This table is used to determine muscle/tendon action (flexor, extensor, other), which is a component of

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codes for acquired conditions and injuries affecting the muscles and tendons

Index to Diseases and Injuries. Shaded guides to show indent levels for subentries.

Appendices. Supplement your coding knowledge with information on proper coding practices, risk-adjustment coding, pharmacology, and Z-codes.

The Clinical Documentation Improvement Specialist's Guide to ICD-10

Exam Preparation

First Steps in Outpatient CDI

Health Information

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*Management Technology
Journal of AHIMA*

"Creates a blueprint for success in the health information management (HIM) field. Chapter content is expanded in the fifth edition to prepare students for transitional and changing roles in an electronic health information environment. All chapters are updated to reflect current HIM trends, practices, standards, and legal issues. Written by distinguished leaders in

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the field, this book guides students through two-year academic programs in preparation for the Registered Health Information Technician (RHIT) certification exam and beyond"--

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

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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.

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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

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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

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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

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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

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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

Basic ICD-10-CM and
ICD-10-PCS Coding 2020

Pocket Glossary of
Health Information

Management and

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Technology
An Applied Approach
Management of a
Strategic Resources
Package

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

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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

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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

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**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**

**Commissioned by the Department
of Health and Human Services,
Key Capabilities of an Electronic
Health Record System provides
guidance on the most significant
care delivery-related capabilities
of electronic health record (EHR)**

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systems. There is a great deal of interest in both the public and private sectors in encouraging all health care providers to migrate from paper-based health records to a system that stores health information electronically and employs computer-aided decision support systems. In part, this interest is due to a growing recognition that a stronger information technology infrastructure is integral to addressing national concerns such as the need to improve the safety and the quality of health care, rising health care costs, and matters of homeland security related to the health sector. Key

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Capabilities of an Electronic Health Record System provides a set of basic functionalities that an EHR system must employ to promote patient safety, including detailed patient data (e.g., diagnoses, allergies, laboratory results), as well as decision-support capabilities (e.g., the ability to alert providers to potential drug-drug interactions). The book examines care delivery functions, such as database management and the use of health care data standards to better advance the safety, quality, and efficiency of health care in the United States.

This workbook/textbook package

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accompanies the main text *Health Information: Management of a Strategic Resource* (ISBN 0-7216-5132-1).

**Health Information Management
Documentation for Acute Care
Design and Implenation
Registered Health Information
Administrator (RHIA)
Tips and Tools for Building a
Program**

*Documentation for Health
RecordsClinical
Documentation Improvement
Specialist's HandbookHC Pro,
Inc.*

*First Steps in Outpatient
CDI: Tips and Tools for
Building a Program Anny P.
Yuen, RHIA, CCS, CCDS, CDIP*

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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

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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

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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

*Documentation for Health Records
Health Information
Letter Report
Key Capabilities of an*

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*Electronic Health Record
System
CPT Professional 2022*