

Becoming A Clinical Documentation Specialist

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

CDI Mail: Ongoing Physician Training - CD-ROM/Downloadable Online Cathy Farraher, RN, BSN, MBA, CCM, CCDS Finding effective ways to continuously remind physicians of ways to improve their documentation can be an arduous task for CDI managers and directors. To support this effort, ACDIS has developed "CDI Mail, " a compilation of 52 separate easy-to-use, customizable email reminders that CDI managers can send to physicians and other providers that document in the health record. Each reminder provides focused education and documentation tips on a common CDI problem area, allowing managers to distribute user-friendly education quickly and easily across multiple departments. These email reminders will provide continuous CDI education, reinforce training, and provide effective, ongoing education necessary now and in advance of ICD-10. "CDI Mail: Ongoing Physician Training: " Supplies messages that are ready-made for CDI managers to provide to their staff, but customizable as necessary Provides ongoing CDI education for an entire year Reinforces training for new and/or veteran physicians Provides ICD-10 education in preparation for 2015 implementation Table of Contents Overview CDI and Quality Measures Present on Admission Coding From Physician, PA, and NP Only Respiratory Failure Malnutrition Sepsis Severity of Illness/Risk of Mortality Example Diabetes Lab Values vs. Diagnoses CHF Specificity Principal Diagnosis vs. Signs and Symptoms Functional Quadriplegia Coding Accuracy and Queries Encephalopathy CKD Stage and Linkage Severity of Illness/Risk of Mortality Example Substance Use, Abuse, and Dependence Anemia Midline Shift Postoperative Pulmonary Insufficiency Acute Non-Cardiogenic Pulmonary Edema AKI and ATN Pneumonia Severity of Illness/Risk of Mortality Example Suspected or Presumed Diagnoses Drug-Induced Delirium Pancytopenia 2/2 Chemotherapy Late Effect of CVA PMH vs. Chronic Condition Procedural Complication vs. Unavoidable or Expected End of Life Comfort Care Fracture Specificity Severity of Illness/Risk of Mortality Example Septic Joint Ischemic Stroke Hemorrhagic Stroke CHF vs. Respiratory Failure as PDx Asthma Morbid Obesity Shock Severity of Illness/Risk of Mortality Example Organ Failure Specificity HIV/AIDS Psychiatric Diagnoses Radiology Findings Cause and Effect: Linkage Neoplasm Admission Decision Dementia With Behavioral Disturbance Excisional vs. Non-Excisional Debridement Resolved and Resolving Diagnoses Consistency vs. Conflicting Record Careers in Health Information Management & Technology such as Medical Coders, Clinical Documentation Specialist, and Auditors have expanded in the past years. Having the correct tools will enhance your opportunities in finding the career path for you. As a Health Information Professional with over 30 years of experience I'm here to guide you!

Lined Notebook Journal Clinical Documentation Specialist Because Freakin' Awesome Is Not an Official Job Title

The CDI Director's Cut: a Guide for Effective Program Management

The Lined Notebook Contains 120 Pages (6 X9) a Perfect Gift for Future Clinical Documentation Specialist Title Working Cover:

Book, Passion, Task Manager, Over 120 Pages 6 X9

Ongoing Physician Training

Made Easy: a Professional Guide

*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*

*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*

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.

Principles and Practice

Clinical Documentation Reference Guide - First Edition

A Guide for Physicians, Nurses and Clinical Documentation Specialists

The CCDS Exam Study Guide

Cdi Mail

This innovative text uses a simulation approach to give readers interested in healthcare documentation and medical transcription careers a working knowledge of medical reports common in both acute and chronic care settings. Readers have access to transcription of 107 patient medical reports, including 56 new reports exclusive to the Eighth Edition. This edition also features 20 new speech recognition technology/medical editing (SRT) reports, as well as information on electronic health records (EHRs), quality assurance (QA), and scribes to keep readers up-to-date on the latest advances in the field. Organized by body system, the text includes full-color anatomy and physiology illustrations to make medical terminology easier to master. In addition, the authors have included a review of proper formatting, grammar, and style in accordance with the AHDI's BOOK OF STYLE, and a master glossary list compiles key terms in one section for convenient study and quick reference. Important Notice: Media content referenced within the product description or the product text may not be available in the ebook version.

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.

The CDI Director's Cut: A Guide for Effective Program Management is the most comprehensive resource designed for CDI managers and directors to help them successfully lead and grow their departments. This book provides guidance on everything from onboarding new hires to working with vendors to managing remote CDI staff. It also offers hands-on information and tools, such as staff assessment worksheets, career ladder templates, sample audits, and models for data analytics.

The Clinical Documentation Improvement Specialist's Complete Training Guide

2021 CDI Pocket Guide

The Ccdis Exam Study Guide, Third Edition

Notes from the Field

The most comprehensive resource for hospital inpatient coding and reimbursement! Provides educators, students, and healthcare practitioners with the most authoritative guidance available for managing inpatient coding and reimbursement issues. This must-have resource was developed to give you easier access to the most up-to-date information you need for inpatient coding and reimbursement. You'll save time and make more effective decisions with this one-of-a-kind resource. Covers reimbursement methodologies for hospital inpatient services, the structure and organization of the Medicare Inpatient Acute Care Prospective Payment System, the relationship between coding and DRG assignment, and data quality and coding compliance processes related to coding and reimbursement for inpatient services. The Association of Clinical Documentation Integrity Specialists (ACDIS) developed the Certified Clinical Documentation Specialist-Outpatient (CCDS-O) credential to provide a trusted baseline of competency for CDI in the outpatient setting, which includes locations such as physician practices, hospital clinics, and the emergency department. For those planning to sit for the CCDS-O exam, The CCDS-O Exam Study Guide is their resource to help prepare. 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 Free CEU with Purchase: With every purchase of a 2022 AAPC code book, you can register for a free code book training worth 1 CEU. Each training course will provide an overview of the code book including the history of the coding system, a tour of each book, and tips for success! Training courses only available for ICD-10-PCS, ICD-10-CM, HCPCS Level II, and 2022 AMA CPT® code book

The Ccids-O Exam Study Guide

Homeschool, Task Manager, 6x9 Inch, Planner, Budget Tracker, Planning, Daily, Over 100 Pages

Clinical Documentation Improvement Specialist's Handbook

CPT Professional 2022

Occupational Outlook Handbook

CDI Companion for Physician Advisors: Notes From the Field Claude "Trey" La Charit♦, MD, CCDS When it comes to clinical documentation, physician advisors have a range of important responsibilities, from query escalation to denials management and everything in between. With all these tasks on their plate, physician advisors are constantly pulled in different directions, making it hard to make the best use of their time. CDI Companion for Physician Advisors: Notes From the Field is designed to help physician advisors structure their time properly and carry out their CDI duties effectively and efficiently. This book will help physician advisors: Find their feet in the CDI role Identify tools to provide effective documentation education for physicians and CDI staff Engage medical staff in documentation improvement efforts Understand common documentation deficiencies for difficult diagnoses such as sepsis, heart failure, and kidney disease Work with their CDI team to tackle advanced record reviews in areas such as quality, audit defense, and outpatient HCCs Figure out how to best structure their time to carry out CDI duties About the author: Claude "Trey" La Charit♦, MD, CCDS, is a hospitalist with the University of Tennessee Medical Center (UTMC) and a past ACDIS Advisory Board member. He serves as the physician advisor for UTMC's clinical documentation integrity program, coding, and Recovery Auditor response. La Charit♦ is a regular contributor to CDI Journal, co-author of the Physician Advisor's Guide to CDI, and a co-lead instructor for the popular Physician Advisor Boot Camp.

CCDS Notebook A simple gift idea; 120 pages ruled notebook with a glossy finish custom cover. An a4 size general purpose notebook.

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

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

Clinical Documentation Improvement

Nursing 2022 Drug Handbook

Successful Collaboration in Healthcare

The Ccids Exam Study Guide, Fourth Edition

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

Lined Notebook Journal Clinical Documentation Specialist Because Freakin' Awesome Is Not An Official Job Title. This Lined Notebook Journal Clinical Documentation Specialist Because Freakin' Awesome Is Not An Official Job Title will help you keep your day organized and keep up with your daily errands. This Lined Notebook Journal Clinical Documentation Specialist Because Freakin' Awesome Is Not An Official Job Title gift idea for librarians, students, any literature junkie you know, teachers, members of a book

club . If you are looking for book related gifts for thanksgiving, graduation, anniversary, birthday, christmas.

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.

**How a Clinical Documentation Specialist Found Humor While Reviewing Physician Documentation
Future Clinical Documentation Specialist**

True Medical Documentation Fails

Quality Medical Editing for the Healthcare Documentation Specialist

The CcDs Exam Study Guide, 2012 Update

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

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.cdiasociation.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

CCDS Exam Study Guide, Third Edition Fran Jurcak, RN, MSN, CCDS Laurie L. Prescott, MSN, RN, CCDS, CDIP In 2016, those sitting for the Certified Clinical Documentation Specialist (CCDS) exam face the biggest changes to the test yet. The updated exam has been expanded from 120 to 140 items and has a brand-new section on quality of care. In addition, it incorporates updates to the Official ICD-10-CM Guidelines for Coding and Reporting as well as critical Coding Clinic ICD-10 guidance related to documentation and querying. To help candidates prepare for this updated exam, the best-selling CCDS Exam Study Guide has been refreshed. The third edition of the guide targets the test objectives and content outline prepared by the CCDS Certification Board, letting candidates focus their time on areas of CDI practice with which they are least familiar. Also, this year the CCDS Exam Study Guide comes with an online practice exam, allowing prospective examinees to practice and get instant results--just like the certification exam offers. The CCDS Exam Study Guide, Third Edition will: Help candidates determine whether they are ready to take the CCDS exam Give qualified candidates the confidence they need to succeed Provide sample questions for self-assessment Deliver proven test-taking strategies and "day of the test" tips The CCDS Exam Study Guide reviews: The inpatient prospective payment system (IPPS) ICD-10-CM Official Guidelines for Coding and Reporting and selected entries from AHA Coding Clinic for ICD-10-CM Query processes and procedures Common clinical conditions and indicators for query opportunities CDI program metrics and data analytics RAC preparedness and CDI ethics The impact of reportable diagnoses on quality of care Each chapter reviews CDI program principles and contains sample questions for self-testing. Table of Contents Introduction Chapter 1: Healthcare Regulations, Reimbursement, and the Inpatient Prospective Payment System (IPPS) Chapter 2: Identification of Clinical Indicators Chapter 3: Medical Record Documentation Chapter 4: Healthcare Facility CDI Program Analysis Chapter 5: Utilizing Communication and Education Skills to Champion CDI Chapter 6: Official Guidelines for Coding and Reporting Chapter 7: Professionalism, Ethics, and Compliance Chapter 8: Impact of Reportable Diagnoses on Quality of Care Chapter 9: Tips to Prepare for the Exam This book also includes online practice questions.

Ten Vital Steps to Enhance Your Health Technology Career

The CCDS Exam Study Guide (Certified Clinical Documentation Specialist Exam Study Guide).

CDI Companion for Physician Advisors

The Book of Style for Medical Transcription

Hillcrest Medical Center: Healthcare Documentation and Medical Transcription

This notebook is the best choice for Future Clinical Documentation Specialist students to sketch, take notes..., and a good gift for Future Clinical Documentation Specialist students and even children with Future Clinical Documentation Specialist dreams. * 6x9 inches * 120 page * high quality

This critically acclaimed work makes the case for collaboration and shows that it can be greatly enhanced with consistent understanding and systematic effort. As a healthcare specialist who has worn many hats from direct care giver to case manager to documentation specialist, Colleen Stukenberg is able to – Show how to build trust and communication and demonstrates specific opportunities where collaboration can make all the difference Identify ways that quality of care and financial factors overlap and the advantages that can be garnered through an understanding of this Explain how the different roles view information through different types of knowledge and how an understanding of each perspective makes it easier to find the best source for important answers Discuss the education and ever-increasing role of the clinical documentation specialist who is often involved in all facets of a patient's progress, from intake and admission right up through discharge. As the author points out, good healthcare is dependent on the right person performing the right role, which promotes excellent collaboration. And when people are allowed to function in their proper roles, job satisfaction increases, which in itself leads to better attitudes, which then leads to even deeper levels of collaboration with it, the successful promotion of safe, quality care.

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 author, 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 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 Standardized training and assessment tools

CDI Specialist's Guide to ICD-10

Ccdis Notebook

Certified Clinical Documentation Specialist Notebook Gift 120 Pages Ruled with Stethoscope Cover

Guide to Clinical Documentation

The CDI Specialist's Complete Training Guide

Clinical Documentation Improvement Specialist's HandbookHC Pro, Inc.

Ideal for classroom use, individual study, or professional training, QUALITY MEDICAL EDITING FOR THE HEALTHCARE DOCUMENTATION SPECIALIST, First Edition, is a timely, unique text designed to teach and reinforce essential skills for medical editors. Comprehensive in scope, this practical guide explains the differences between medical editing and traditional transcription; how to use technology, word expander programs, and computer accessories effectively; and ways to improve accuracy--including developing excellent listening skills and the ability to correctly decipher accents, identify medications, and distinguish soundalikes. The authors have also provided a variety of sample reports--including more than 200 medical reports and their corresponding dictation audio files. Reports span numerous specialties and document types, creating extensive opportunities to learn the medical editing process, practice formatting and editing, and become familiar with common errors produced by speech recognition. The text also features extensive information on professional development, continuing education, and earning credentials, as well as useful tips on gaining experience, finding employment, and advancing one's career. Abundant teaching and learning features--such as material on grammar and punctuation, review activities, critical-thinking exercises, and several appendices with key references and resources--make this text even more valuable for current and aspiring medical editors seeking career success. Important Notice: Media content referenced within the product description or the product text may not be available in the ebook version. As a Clinical Documentation Specialist (CDS) I reviewed documentation dictated and manually entered into the Electronic Medical Record (EMR) by Physicians. So many fails. My job was to bring these fails to the attention of the doctors and help them ensure accuracy and compliance. Over several years I collected these memorable fails and wanted to share the most hilarious and puzzling ones with you. I hope you enjoy them as much as I did when I came across them in a chart.

The Physician Advisor's Guide to Clinical Documentation Improvement

The Clinical Documentation Improvement Specialist's Handbook

Coding and Reimbursement for Hospital Inpatient Services

ICD-10-CM Complete Code Set 2022

Certified Documentation Improvement Practitioner (CDIP) Exam Preparation

The first two years of a Clinical Documentation Improvement (CDI) specialist's career often feels like a whirlwind of learning. Many in the field call it the steepest learning curve of their professional lives. After their two-year anniversary, committed individuals can show their professional dedication by sitting for the Certified Clinical Documentation Specialist (CCDS) exam. The CCDS Exam Study Guide, Fourth Edition, helps

those ready to sit for the test ensure they're prepared to excel. The latest edition aligns the testing content domains in a chronological manner with how new CDI professionals obtain core skill sets. The Study Guide provides targeted information regarding test objectives prepared by the CCDS Certification Committee, letting candidates focus their time on areas of CDI practice with which they are least familiar.
2022 CDI Pocket Guide