

Bookmark File PDF Certified Clinical  
Documentation Specialist Exam Study Guide

**Certified Clinical  
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Exam Study Guide**

*Intro / prep handbook on basics of the  
quality field / its philosophies for  
ASQE's CQIA (Certified Quality  
Improvement Associate) certification  
exam.*

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clinicians...always dependable, always*

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*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*

*Risk-adjustment practices consider chronic diseases as predictors of future health care needs and expenses. Correct and detailed documentation and*

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*compliant diagnosis coding are critical for proper risk adjustment. Risk Adjustment Documentation & Coding, 2nd Edition provides: Risk-adjustment parameters to improve documentation related to severity of illness and chronic diseases. Code abstraction guidelines and recommendations to improve diagnostic coding accuracy without causing financial harm to the practice or health facility. Chronic disease ICD-10-CM coding summaries for*

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*quick reference and study. The impact of risk-adjustment coding (hierarchical condition category (HCC) coding) on a practice should not be underestimated: More than 75 million Americans are enrolled in risk-adjusted insurance plans. This population represents more than 20% of those insured in the United States. Insurance risk pools under the Affordable Care Act include risk adjustment. CMS has proposed expanding audits on risk-adjustment coding.*

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*FEATURES AND BENEFITS* Five chapters delivering an overview of risk adjustment, common administrative errors, best practices, and guidance for development of internal risk-adjustment coding policies. Ten chronic disease ICD-10-CM coding summaries for quick reference and study. Two appendices offering mappings and tabular information of ICD-10-CM codes that risk-adjust to HCCs and RxHCCs. Learning and design features:

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*Vocabulary terms highlighted within the text and defined at the bottom of the page. "Advice/Alert Notes" that highlight important coding and documentation advice from federal regulatory sources. "Sidebars" that provide derivative story and additional information, such as "Coding Tips" that guide coders with practical advice from sources like AHA's Coding Clinic and cautionary notes about conflicts and exceptions "Clinical Examples" that*

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*underscore key documentation issues for risk adjustment "Clinical Coding Examples" that provide snippets or full encounter notes and codes to illustrate risk-adjustment coding and documentation concepts "Documentation tips" that highlight recommendations to physicians regarding what should be included in the medical record or how ICD-10-CM may classify specific terms "Examples" that explain difficult concepts and promote understanding of*



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*those concepts as they relate to a section "FYI" call outs that provide quick facts "Abstract & Code It!" exercises that test diagnosis abstraction and coding skills (exclusive to Chapter 4) Extensive end-of-chapter "Evaluate Your Understanding" sections that include multiple-choice questions, true-or-false questions, audit and Internet-based exercises. Two downloadable course tests and slide presentations*

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*for each chapter. Exclusive content for academic educators: A test bank containing 100 questions and a mock risk-adjustment certification exam with 150 questions.*

*This book presents an overview of the key debates that took place during the Economic and Social Council meetings at the 2007 High-level Segment, at which ECOSOC organized its first biennial Development Cooperation Forum. The discussions also revolved around the*

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*theme of the second Annual Ministerial Review, "Implementing the internationally agreed goals and commitments in regard to sustainable development."--P. 4 of cover.*

*Dialogues at the Economic and Social Council*

*The Clinical Documentation Improvement Specialist's Complete Training Guide*

*The ASQ Certified Quality Improvement Associate Handbook*

*PDR Nurse's Drug Handbook*

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*Ncct Test Review for the National Center for Competency Testing Exam The Cccls Exam Study Guide, Fourth Edition*

**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**

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**the exam or to apply, visit**

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- \* 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**

**The SAS® Certified Specialist Prep Guide: Base Programming Using SAS® 9.4 prepares you to take the new SAS 9.4 Base Programming -- Performance-Based Exam. This is the official guide by the SAS Global Certification Program. This prep guide is for**

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**both new and experienced SAS users, and it covers all the objectives that are tested on the exam. New in this edition is a workbook whose sample scenarios require you to write code to solve problems and answer questions. Answers for the chapter quizzes and solutions for the sample scenarios in the workbook are included. You will also find links to exam objectives, practice exams, and other resources such as the Base SAS® glossary and a list of practice data sets. Major topics include importing data, creating and modifying SAS data sets, and identifying and correcting both data syntax and programming logic errors. All exam**

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**topics are covered in these chapters: Setting Up  
Practice Data Basic Concepts Accessing Your Data  
Creating SAS Data Sets Identifying and Correcting  
SAS Language Errors Creating Reports  
Understanding DATA Step Processing BY-Group  
Processing Creating and Managing Variables  
Combining SAS Data Sets Processing Data with DO  
Loops SAS Formats and Informats SAS Date, Time,  
and Datetime Values Using Functions to Manipulate  
Data Producing Descriptive Statistics Creating Output  
Practice Programming Scenarios (Workbook)  
CDI Companion for Physician Advisors: Notes From**

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**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**



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**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**

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**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.**

**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**

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**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**

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**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.**

**The Book of Style for Medical Transcription  
CPT Professional 2022**

**Tips and Tools for Building a Program**

**Risk Adjustment Documentation and Coding**

**First Steps in Outpatient CDI**

**Healthcare Documentation**

*Lists over 1,500 of the latest and most common FDA-*

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*approved drugs, including information on drug action, dosage, interactions, contraindications, and guidelines for administration.*

*The Institute of Medicine study Crossing the Quality Chasm (2001) recommended that an interdisciplinary summit be held to further reform of health professions education in order to enhance quality and patient safety. Health Professions Education: A Bridge to Quality is the follow up to that summit, held in June 2002, where 150 participants across disciplines and occupations developed ideas about how to integrate a core set of competencies into health professions education. These core competencies include patient-centered care, interdisciplinary teams, evidence-*

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*based practice, quality improvement, and informatics. This book recommends a mix of approaches to health education improvement, including those related to oversight processes, the training environment, research, public reporting, and leadership. Educators, administrators, and health professionals can use this book to help achieve an approach to education that better prepares clinicians to meet both the needs of patients and the requirements of a changing health care system.*

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*Official 2022 ICD-10-CM Expert Code Book Do you ever struggle with the level of ICD-10-CM code*

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*The Model Rules of Professional Conduct provides an up-*

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to-date resource for information on legal ethics. Federal, state and local courts in all jurisdictions look to the Rules for guidance in solving lawyer malpractice cases, disciplinary actions, disqualification issues, sanctions questions and much more. In this volume, black-letter Rules of Professional Conduct are followed by numbered Comments that explain each Rule's purpose and provide suggestions for its practical application. The Rules will help you identify proper conduct in a variety of given situations, review those instances where discretionary action is possible, and define the nature of the relationship between you and your clients, colleagues and the courts.

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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

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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

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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

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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

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

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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.

The Physician Advisor's Guide to Clinical Documentation Improvement Physician advisors are not just needed for



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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

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areas by Major Diagnostic Category \* Review government initiatives and claims denial patterns, providing physician advisors concrete tools to sway physician documentation

Occupational Outlook Handbook

Certified Coding Associate Exam Secrets Study Guide

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Where Success Takes Root

The CCDS Exam Study Guide

**It's not the quantity of clinical documentation that matters—it's the quality. Is your clinical**

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**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**

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**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**

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**proactive measures to eliminate documentation problems Work the coding mantra—specificity, specificity, specificity Avoid common documentation errors identified by CERT and RACs Know the facts about EMR templates—and the pitfalls of auto-populate features Master documentation in the EMR with guidelines and tips Conquer CDI time-based coding for E/M The Clinical Documentation Reference Guide is approved for use during the CDEO® certification exam.**

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**General Strategy review including: Make Predictions, Answer the Question, Benchmark, Valid Information, Avoid Fact Traps, Milk the Question, The Trap of Familiarity, Eliminate Answers, Tough Questions, Brainstorm, Read Carefully, Face Value, Prefixes, Hedge Phrases, Switchback Words, New Information, Time Management, Contextual Clues, Don't Panic, Pace Yourself, Answer Selection, Check Your Work, Beware of Directly Quoted Answers, Slang, Extreme Statements, Answer Choice Families; A comprehensive review including: Nervous System, Signs and Symptoms, Major Hormones, Respiratory System, Cardiac Review, Grief Process,**

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Organ Functions, Pathological Conditions, Basic  
Tissues, Normal Lab Values, Testing Tips,  
Communications, Key Acronyms, Definitions,  
Business and Its Environment, Professional  
Education, Skills Demonstrated, Office Procedures,  
Telephone Protocol, Management, Employability  
Skills, Accounting, Computer Management,  
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The Ccde Exam Study Guide, Third Edition**

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

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

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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

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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

Clinical Documentation Improvement (CDI) Made Easy is a great resource and reference that every Clinical Documentation Improvement

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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

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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

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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. 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



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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.

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2022 CDI Pocket Guide

The Physician Advisor's Guide to Clinical  
Documentation Improvement

Coding and Reimbursement for Hospital Inpatient  
Services

Health Professions Education

2021 CDI Pocket Guide

***Ideal for learners with no prior experience  
and those seeking refresher training,  
Healthcare Documentation: Fundamentals***

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***and Practice, 4/e is the most comprehensive healthcare documentation learning system available. It begins with a thorough overview of the medicolegal and technology aspects of healthcare documentation, including key trends such as electronic health records, security, privacy, and speech recognition. Next, it provides integrated content linked to 10 hours of exceptionally authentic medical dictation practice. Extensive exercises in the text combine with online audio exercises to systematically reinforce core knowledge and***

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***build critical thinking, editing, and research skills. The final chapter focuses on finding employment and preparing students for the workplace, professional development, and continuing education. This edition has been extensively revised for the latest industry trends and techniques, contains many new learning features, and offers a compelling new full-color design with many new illustrations.***

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

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***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***

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***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.***

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***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***

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***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***



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***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***

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***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***

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**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**

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**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.**

**Official 2022 HCPCS Level II Expert Code Book**

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