Clinical Documentation Specialist Certification Ahima

Health law is a rapidly changing field, and students entering the HIM fields require the most recent knowledge to move the profession forward and achieve legal compliance. This revised reprint of Fundamentals of Law for Health Informatics and Information Management contains updates to the second edition. New features and major updates in to this edition include: Medical Identity Theft and Red Flags Rule Contracts, Antitrust, and Corporate Healthcare Liability 2013 HIPAA Privacy and Security updates under ARRA and HITECH updates, including Breach Notification Requirements Meaningful Use E-Discovery Security Safeguard Mechanisms Key Features Online resources include a linked reference list Addresses topics critical to effective HIM practice Instructor manual available online

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

Management of a Strategic Resources Package

CCS Exam Preparation, 8E

Coding and Reimbursement for Hospital Inpatient Services

2021 CDI Pocket Guide

Acdis Answers

Documentation Guidelines for Evaluation and Management Services

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

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.

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

CDI Workbook

Principles of Healthcare Reimbursement, Seventh Edition

ICD-9-CM Official Guidelines for Coding and Reporting

An Applied Approach

Outpatient CDI Pocket Guide

Clinical Documentation Improvement for Outpatient Care: Design and Implementation is an all-inclusive guide to establishing and enhancing CDI programs for the outpatient amd professional fee setting.
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 hte 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.
2021 ICD-10-CM Expert
Principles and Practice
The Complete Guide to CDI Management
Design and Implenation
Health Information Management
CPT Professional 2022
"This book helps readers understand the principles of medical record documentation and chart auditing. It introduces readers to principles of medical record documentation and how to conduct a medical record chart review in the physcian's or outpatient office"--Provided by publisher.
Medical Coding For Non-Coders delivers a valuable introduction to medical coding for those in healthcare who need to understand the process of coding, but do not need the level of specificity required to become a coding professional. In today's ever-growing, complex healthcare system, it is imperative that all healthcare professionals have a basic understanding of the coding process. This book explains how the documentation they supply impacts the coding process, healthcare data, and reimbursement as a whole. New to This Edition Provides information on the transition to ICD-10-CM and ICD-10 -PCS Updated for the most recent coding rules and regulations Updated appendices include the AHIMA code of ethics, and the process for querying physicians Key Features Presents a coding overview in an easy-to-understand format, detailing the impact of coding on reimbursement, compliance, and fraud and abuse. Provides a short overview of the coding systems, including information on the transition to ICD-10-CM and ICD-10-PCS. Provides an overview of the process of coding including what causes delays from patient admission to final billing of the visit. Addresses basic, yet critical questions such as: What does a coder require to provide accurate coded data? How is a medical record converted to coded data? How are codes assigned? How is coded data used?
A Practical Approach to Analyzing Healthcare Data 4e
Health Information Management Technology
The Clinical Documentation Improvement Specialist's Complete Training Guide
ICD-10-CM Code Book, 2021 Spiral Edition
Made Easy: a Professional Guide
Focusing on HCCs
This workbook/textbook package accompanies the main text Health Information: Management of a Strategic Resource (ISBN 0-7216-5132-1).
"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 the field, this book guides students through two-year academic programs in preparation for the Registered Health Information Technician (RHIT) certification exam and beyond"--
Foundations of Health Information Management - E-Book
Fundamentals of Law for Health Informatics and Information Management
2022 CDI Pocket Guide
A Professional Guide for Acute Inpatient Care and Inpatient Rehabilitation
Certified Documentation Improvement Practitioner (CDIP) Exam Preparation
Clinical Documentation Improvement Desk Reference for ICD-10-CM & Procedural Coding
Use this book and the Interactive CD-ROM to help prepare for the AHIMA Clinical Coding Specialist - Physician-based (CCS-P) certification examination. Practice interpreting documentation and applying clinical knowledge in assigning codes to diagnoses and procedures for a variety of patient settings.
Now in its second edition, The Clinical Documentation Improvement Specialist's Guide to ICD-10 is the only guide to address ICD-10 from the CDI point of view. Written by CDI experts and ICD-10 Boot Camp instructors, it explains the ICD-10 documentation requirements and clinical indicators of commonly reported diagnoses and the codes associated with those conditions. You'll find the specific documentation requirements to appropriately code a variety of conditions. The CDI Specialist's Guide to ICD-10, 2nd edition, not only outlines

the changes coming in October 2014, it provides detailed information on how to assess staffing needs, training requirements, and implementation strategies. The authors-an ICD-10 certified coder and CDI specialist-collaborated to create a comprehensive selection of ICD-10 sample queries facilities can download and use to jumpstart ICD-10 documentation improvement efforts. Develop the expertise and comfort level you'll need to manage this important industry change and help your organization make a smooth transition. The Clinical Documentation Improvement Specialist's Guide to ICD- 10, 2nd ed. is part of the library of products and services from the Association of Clinical Documentation Improvement Specialists (ACDIS). ACDIS members are CDI professionals who share the latest tested tips, tools, and strategies to implement successful CDI programs and achieve professional growth. Member benefits include a quarterly journal, members-only Web site, quarterly networking conference calls, discounts on conferences, and more. WHAT'S NEW? Completely revised to accommodate changes in ICD-10 implementation dates Dozens of targeted ICD-10 physician queries Updated ICD-10 benchmarking reports BENEFITS Sample ICD-10 queries Specificity requirements and clinical indicators by disease type and body system Staff training and assessment tools

Clinical Documentation Improvement (CDI) Made Easy, 2nd Edition

Medical Coding for Non-Coders

Professional Review Guide for the CCS-P Examination

Clinical Documentation Improvement

Documentation Rules and Rationales, with Exercises

Exam Preparation

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

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

Clinical Documentation Improvement for Outpatient Care

The CCDS Exam Study Guide

Sixth Edition: Concepts, Principles, and Practice
Clinical Documentation Improvement Faqs
First Steps in Outpatient CDI
The Physician Advisor's Guide to Clinical Documentation Improvement

First Steps in Outpatient CDI: Tips and Tools for Building a Program Anny P. Yuen, RHIA, CCS, CCDS, CDIP Page Knauss, BSN, RN, LNC, ACM, CPC, CDEO Find best practices and helpful advice for getting started in outpatient CDI with First Steps in Outpatient CDI: Tips and Tools for Building a Program. This first-of-its-kind book provides an overview of what outpatient CDI entails, covers industry guidance and standards for outpatient documentation, reviews the duties of outpatient CDI specialists, and examines how to obtain backing from leadership. Accurate documentation is important not just for code assignment, but also for a variety of quality and reimbursement concerns. In the past decade, outpatient visits increased by 44% while hospital visits decreased by nearly 20%, according to the Medicare Payment Advisory Commission. However, just because physicians are outside the hospital walls doesn't mean they're free from documentation challenges. For these reasons, CDI programs are offering their assistance to physician practices, ambulatory surgical centers, and even emergency rooms. This book will explore those opportunities and take a look at how others are expanding their record review efforts in the outpatient world. This book will help you: Target the outpatient settings that offer the greatest CDI opportunities Understand the quality and payment initiatives affecting outpatient services Understand the coding differences between inpatient and outpatient settings Identify data targets Incorporate physician needs to ensure support for program expansion Assess needs by program type

CPT® 2021 Professional Edition is the definitive AMA-authored resource to help health care professionals correctly report and bill medical procedures and services. Providers want accurate reimbursement. Payers want efficient claims processing. Since the CPT® code set is a dynamic, everchanging standard, an outdated codebook does not suffice. Correct reporting and billing of medical procedures and services begins with CPT® 2021 Professional Edition. Only the AMA, with the help of physicians and other experts in the health care community, creates and maintains the CPT code set. No other publisher can claim that. No other codebook can provide the official guidelines to code medical services and procedures properly. FEATURES AND BENEFITS The CPT® 2021 Professional Edition codebook covers hundreds of code, guideline and text changes and features: CPT® Changes, CPT® Assistant, and Clinical Examples in Radiology citations -- provides cross-referenced information in popular AMA resources that can enhance your understanding of the CPT code set E/M 2021 code changes - gives guidelines on the updated codes for office or other outpatient and prolonged services section incorporated A comprehensive index -- aids you in locating codes related to a specific procedure, service, anatomic site, condition, synonym, eponym or abbreviation to allow for a clearer, quicker search Anatomical and procedural illustrations -- help improve coding accuracy and understanding of the anatomy and procedures being discussed Coding tips throughout each section -- improve your understanding of the nuances of the code set Enhanced codebook table of contents -- allows users to perform a quick search of the codebook's entire content without being in a specific section Section-specific table of contents -- provides users with a tool to navigate more effectively through each section's codes Summary of additions, deletions and revisions -- provides a quick reference to 2020 changes without having to refer to previous editions Multiple appendices -- offer quick reference to additional information and resources that cover such topics as modifiers, clinical examples, add-on codes, vascular families, multianalyte assays and telemedicine services Comprehensive E/M code selection tables -- aid physicians and coders in assigning the most appropriate evaluation and management codes Adhesive section tabs -- allow you to flag those sections and pages most relevant to your work More full color procedural illustrations Notes pages at the end of every code set section and subsection

Pocket Glossary of Health Information Management and Technology
Health Information
Diagnosis Codes for Providers & Facilities
Concepts, Principles, and Practice
Clinical Coding Workout 2022
Registered Health Information Administrator (RHIA)

The book provides clear guides on how to perform the vital duties required in obtaining accurate, quality, complete, and specific documentation from the providers so as to reflect the quality of care, severity of illness and risk of mortality of admitted patients during their encounter to the hospital or inpatient rehab. The book is a "must have" for every CDIS or anyone involved in clinical documentation. The book has current ICD-10-CM/PCS update with pertinent information on the 2018 Official Coding Guidelines for Coding and Reporting, Coding Clinic advice, Pay for Performance, sample queries, various disease processes by MDCs, CDI strategy for success in inpatient rehab, rehab impairment group codes and categories, list of all the surgical and MS-DRGs, and much more. Remember, if it was not documented and documented accurately, it never happened.

Foundations of Health Information Management, 4th Edition is an absolute must for any student beginning a career in HIM. Balancing comprehensive coverage with an engaging, easy-to-understand tone, this text focuses on healthcare delivery systems, electronic health records, and the processing, maintenance, and analysis of health information to present a realistic and practical view of technology and trends in healthcare. It prepares you for the role of a Registered Health Information Technician who not only files and keeps accurate records, but serves as a healthcare analyst who translates data into useful, quality information that can control costs and further research. With new SimChart and SimChart for the Medical Office samples, the new 2014 AHIMA outcome-based competencies, and more exercises, this fourth edition puts you in a position to succeed on the

RHIT certification exam. Clear writing style and easy reading level makes reading and studying more time-efficient, and is ideal for two-year associate degree HIM programs and career schools. Chapter learning objectives are tied to the American Health Information Management Association's (AHIMA) HIM domains and subdomains to allow instructors to teach to the credentialing exam — and prepare you for the exam. Separate legal chapter covers HIPAA privacy regulations and emphasizes the importance of HIPAA compliance in today's healthcare system. Statistics chapter gives new students a foundation for learning. Four-color design and illustrations make content more appealing and easier to learn. Exercises at the end of every main section in each chapter encourage you to review and apply key concepts. Career Tip and Professional Profile boxes give you a broader view of the field and show you the many career options you have upon graduation and certification. Chapter summaries and reviews allow for easy review of each chapter's main concepts. Robust appendices, including sample paper records, electronic documentation, and demonstration of Microsoft Excel, equip you with all the extras you need to enter the HIM world. NEW! Content mapped to 2014 AHIMA CEE competencies and domains so you can prepare for the current health information environment and the RHIT exam. NEW! SimChart and SimChart for the Medical Office samples feature screenshots from EHRs to demonstrate electronic medical records in use. NEW! More exercises give you additional opportunities to practice your knowledge of material. NEW! AHIMA competency mapping included in the front of book to provide instructors and students with instant access to the AHIMA domains and competencies needed to prepare for the RHIT exam. NEW! Classroom handouts can be used in the classroom or as homework, and include a variety of exercises.

CPT 2021 Professional Edition

Investigating Complex Cases and Formulating Queries

Tips and Tools for Building a Program

Medical Record Auditor

CPT(R) 2022 Professional Edition is 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 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.