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Documentation Guidelines

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Commissioned by the Department of
Health and Human Services, Key
Capabilities of an Electronic Health
Record System provides guidance on

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the most significant care delivery-related capabilities of electronic health record (EHR) 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

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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

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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 Capabilities of an Electronic Health Record System provides a set of basic functionalities that an EHR system

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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,

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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.

Managers of health information have a professional stake in understanding the

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legal 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

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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

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information on patient record requirements, access to health information, confidentiality, computerized records, and other areas. CPT(R) 2022 Professional Edition is the definitive AMA-authored resource to help healthcare professionals

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correctly report and bill medical
procedures and services.

Journal of AHIMA

The Clinical Documentation

Improvement Specialist's Complete

Training Guide

A Guide to Hospital Outpatient Issues

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Clinical Documentation Improvement
Faqs

Clinical Documentation Improvement
for Outpatient Care

**"Creates a blueprint for
success in the health
information management (HIM)**

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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

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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

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**Health Information Technician
(RHIT) certification exam and
beyond"--**

**CPT® 2021 Professional
Edition is the definitive AMA-
authored resource to help
health care professionals**

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**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,**

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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

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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

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**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:**

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**CPT® Changes, CPT®
Assistant, and Clinical
Examples in Radiology
citations -- provides cross-
referenced information in
popular AMA resources that
can enhance your**

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**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**

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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

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**procedural illustrations -- help
improve coding accuracy and
understanding of the anatomy
and procedures being
discussed Coding tips
throughout each section --
improve your understanding of**

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**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**

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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

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**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,**

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add-on codes, vascular families, multianalyte assays and telemedicine services Comprehensive E/M code selection tables -- aid physicians and coders in assigning the most

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**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**

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Documentation Guidelines

**the end of every code set
section and subsection
Documentation for Health
RecordsClinical
Documentation Improvement
Specialist's HandbookHC Pro,
Inc.**

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**The Physician Advisor's Guide
to Clinical Documentation
Improvement
Documentation Guidelines for
Evaluation and Management
Services
Acdis Answers**

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Exam Preparation
Registered Health Information
Administrator (RHIA)
Clinical Documentation
Improvement for Outpatient
Care: Design and
Implementation is an all-inclusive

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guide to establishing and enhancing CDI programs for the outpatient and professional fee setting.

Take charge of ICD-10 documentation requirements The implementation of ICD-10 brings

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with its 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

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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.

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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

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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

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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

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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

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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

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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

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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

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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

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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

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electronic records, changing regulatory landscapes, and resource limitations. The Complete Guide to CDI Management incorporates the deep expertise of multiple authors with varied backgrounds

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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

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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

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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

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Population Principal Diagnosis
Assignment Types of DRG
Reviews Quality Focus Summary
Chapter 3: Developing
Relationships Sharing the
Mission Physician Engagement
Obstacles to Developing a

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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

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Chapter 4: Department
Structures and Staffing
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Physician Advisor Creating a
Career Ladder Continuing
Education CDI Department

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Meetings Evaluations
Credentialing Initialing vs.
Revitalizing Summary Chapter 5:
Demonstrating the Return on
Investment Measuring Success
Productivity and Sample Metrics
Summary Chapter 6: Challenges

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and How to Overcome Them
Organization Issues Resource
Issues Summary Appendixes
Appendix A: Resources
First Steps in Outpatient CDI
Release and Disclosure
Long Term Care Health

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Information Practice and
Documentation Guidelines
Pocket Glossary of Health
Information Management and
Technology
Basic ICD-10-CM and
ICD-10-PCS Coding 2020

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ICD-10-CM 2018: The Complete Official Codebook provides the entire updated code set for diagnostic coding. This codebook is the cornerstone for

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establishing medical
necessity, determining
coverage and ensuring
appropriate
reimbursement.

Your new CDI specialist
starts in a few weeks.

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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

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spend time creating
training materials from
scratch. ACDIS'
acclaimed CDI Boot Camp
instructors have created
The Clinical
Documentation

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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

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reviewing records. The Clinical Documentation Improvement Specialist's Complete Training Guide is the perfect resource for CDI program managers to help new CDI

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professionals understand their roles and responsibilities. It will get your staff trained faster and working quicker. This training guide provides:

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An introduction for
managers, with
suggestions for training
staff and guidance for
manual use Sample
training timelines Test-
your-knowledge questions

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to reinforce key
concepts Case study
examples to illustrate
essential CDI elements
Documentation challenges
associated with common
diagnoses such as

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sepsis, pneumonia, and
COPD Sample policies and
procedures

Now in its second
edition, The Clinical
Documentation
Improvement Specialist's

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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

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the ICD-10 documentation requirements and clinical indicators of commonly reported diagnoses and the codes associated with those conditions. You'll find

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the specific
documentation
requirements to
appropriately code a
variety of conditions.
The CDI Specialist's
Guide to ICD-10, 2nd

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edition, not only outlines the changes coming in October 2014, it provides detailed information on how to assess staffing needs, training requirements,

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and implementation strategies. The authors— an ICD-10 certified coder and CDI specialist— collaborated to create a comprehensive selection of ICD-10 sample queries

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facilities can download and use to jumpstart ICD-10 documentation improvement efforts. Develop the expertise and comfort level you'll need to manage this

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important industry change and help your organization make a smooth transition. The Clinical Documentation Improvement Specialist's Guide to ICD- 10, 2nd

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are CDI professionals who share the latest tested tips, tools, and strategies to implement successful CDI programs and achieve professional growth. Member benefits

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include a quarterly journal, members-only Web site, quarterly networking conference calls, discounts on conferences, and more.

WHAT'S NEW? Completely

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revised to accommodate
changes in ICD-10
implementation dates
Dozens of targeted
ICD-10 physician queries
Updated ICD-10
benchmarking reports

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BENEFITS Sample ICD-10
queries Specificity
requirements and
clinical indicators by
disease type and body
system Staff training
and assessment tools

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Made Easy: a
Professional Guide
Health Information
Management
Guidelines Regarding
Maintenance and
Disclosure of Health

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Information

Clinical Documentation

Improvement

Key Capabilities of an
Electronic Health Record
System

First Steps in Outpatient CDI: Tips and

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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

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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

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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

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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

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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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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

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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

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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),

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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

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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

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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

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Improvement Specialist's Handbook includes a CD-ROM loaded with all of the working tools you'll find in the book.

Among them

This book covers documentation procedures in acute care settings specific topics include health record law and Hipaa regulations, nursing documentation, and

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documentation for specialty care. This book replaces Ahima's documentation requirements for the acute care patient record.

Health Information Management
Technology
ICD-10-CM 2018 the Complete Official
Codebook

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Ethical Health Informatics

Medical Records and the Law

Management of a Strategic Resources
Package

*ACDIS Answers: Clinical
Documentation Improvement
FAQs ACDIS Answers:*

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*Clinical Documentation
Improvement FAQs is a
quick reference guide for
the most common questions
faced by CDI specialists.
Organized by Major
Diagnostic Categories and*

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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

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*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*

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concurrent medical record review. Whether you're wondering about sequencing guidelines, staff productivity, escalation policies, diabetes coding, or documentation

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*requirements for acute
kidney injury, ACDIS
Answers provides quick,
easily understandable
information from respected
experts in CDI, including
ACDIS' own Boot Camp*

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*instructors and Advisory
Board members.*

*This workbook/textbook
package accompanies the
main text Health
Information: Management of
a Strategic Resource (ISBN*

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0-7216-5132-1).

ICD-10-CM 2022: The Complete Official Codebook provides the entire updated code set for diagnostic coding, organized to make the

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challenge of accurate coding easier. This codebook is the cornerstone for establishing medical necessity, correct documentation, determining

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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

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facilitate accurate coding. The book also contains supplementary appendixes including a coding tutorial, pharmacology listings, a list of valid three-

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*character codes and
additional information on
Z-codes for long-term drug
use and Z-codes that can
only be used as a
principal diagnosis.
Official 2022 coding*

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*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*

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codes, including a conversion table and code changes by specialty. QPP symbol in the tabular section. The symbol identifies diagnosis codes associated with Quality

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*Payment Program (QPP)
measures under MACRA. New
and updated coding tips.
Obtain insight into coding
for physician and
outpatient settings.
Chapter 22 features U-*

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*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*

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*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*

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identify coding notes and instructions, additional character requirements, codes associated with CMS hierarchical condition categories (HCC), Medicare Code Edits (MCEs),

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manifestation codes, other specified codes, and unspecified codes.

Placeholder X. This icon alerts the coder to an important ICD-10-CM convention--the use of a

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*"placeholder X" for
three-, four- and five-
character codes requiring
a seventh character
extension. Coding
guideline explanations and
examples. Detailed*

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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

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translation table. This table is used to determine muscle/tendon action (flexor, extensor, other), which is a component of codes for acquired conditions and injuries

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*affecting the muscles and
tendons Index to Diseases
and Injuries. Shaded
guides to show indent
levels for subentries.
Appendices. Supplement
your coding knowledge with*

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information on proper coding practices, risk-adjustment coding, pharmacology, and Z-codes. Tips and Tools for Building a Program CPT Professional 2022

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*The Modifier Clinic
Concepts, Principles, and
Practice
CPT 2021 Professional
Edition*

**Stepped-up efforts to ferret
out health care fraud have**

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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

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under federal fraud and abuse prohibitions as defined in the Medicaid statute and Stark legislation. And you'll discover what goes into an effective corporate compliance program. With a growing number of

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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.
***Health Administration
The Physician Advisor's Guide***

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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

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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

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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

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***needs and expectations of
physicians * Highlight
documentation improvement
focus areas by Major
Diagnostic Category * Review
government initiatives and
claims denial patterns,
providing physician advisors***

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***concrete tools to sway
physician documentation
Letter Report
Certified Documentation
Improvement Practitioner
(CDIP) Exam Preparation
Health Information
2022 CDI Pocket Guide***

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Documentation for Acute Care

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

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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 would not be considered ethical. Clinical Documentation Improvement

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(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

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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

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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

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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

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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

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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

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Specialist.

2021 CDI Pocket Guide

The CCDS Exam Study Guide

ICD-10-CM 2022 the Complete
Official Codebook with Guidelines
Health Care Fraud and Abuse