

Clinical Documentation Specialist Certification

2021 Procedural Coding Expert This procedural coding book is designed for a clinical coder's daily work—not the classroom or AAPC's credentialing exams. It contains AMA's CPT® codes paired with Medicare fee schedule rules and payment guidelines. For years, physician practices, outpatient hospitals, and ASCs have benefited from this easy-to-navigate resource that arranges codes in a design known to simplify and speed up the process of coding, billing, and reimbursement. You'll find a comprehensive listing of annual code additions, changes, deletions, and reinstatements in the appendix as well as new code icons and notes, reimbursement information, mid-year changes, and whole lot more. Key Features and Benefits Adhesive tabs- Tab the sections you use most for easy reference Official 2021 AMA CPT® Codes and Nomenclature - Find all current CPT® codes and their descriptions in one place Official Medicare Information- Medicare national rules conveniently included for accurate coding Notes to Determine Which Codes Should Be Reported in Conjunction - Find the codes associated with the one you're reporting Modifiers at Code Level and Modifier Icons – Quickly identify the right modifier for the right code Facility and Non-facility RVUs and Global Follow-up Days- Accurately report to Medicare with guidance from the Medicare Fee Schedule Helpful Illustrations- View color plates at the beginning of the book for anatomical references, plus view detailed illustrations and photographs throughout to help you understand the procedures and body parts in each section Code-specific Definitions, Rules, and References- Review comprehensive information to assist with accurate coding and speedy reimbursement CPT® Assistant Citations- Locate AMA guidance as published in the CPT® Assistant using citations with each referenced code Extensive User-friendly Index - Find codes in a flash with the most accurate and expansive index of any CPT® coding resource, with terms listed in a variety of ways MACRA Icons and Appendix – Apply the new MACRA rules properly Medicare Coverage Rules with Icons and Pub. 100 References - Understand which policies apply to CPT® codes prior to claim submission with icons and references for each rule, plus a copy of the applicable policy in the appendix Spiral Binding - Lays flat for easy-to-use coding and durability

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

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

The Future of Nursing explores how nurses' roles, responsibilities, and education should change significantly to meet the increased demand for care that will be created by health care reform and to advance improvements in America's increasingly complex health system. At more than 3 million in number, nurses make up the single largest segment of the health care work force. They also spend the greatest amount of time in delivering patient care as a profession. Nurses therefore have valuable insights and unique abilities to contribute as partners with other health care professionals in improving the quality and safety of care as envisioned in the Affordable Care Act (ACA) enacted this year. Nurses should be fully engaged with other health professionals and assume leadership roles in redesigning care in the United States. To ensure its members are well-prepared, the profession should institute residency training for nurses, increase the percentage of nurses who attain a bachelor's degree to 80 percent by 2020, and double the number who pursue doctorates. Furthermore, regulatory and institutional obstacles -- including limits on nurses' scope of practice -- should be removed so that the health system can reap the full benefit of nurses' training, skills, and knowledge in patient care. In this book, the Institute of Medicine makes recommendations for an action-oriented blueprint for the future of nursing.

Compliance pocket guide of inpatient, outpatient observation (including the two midnight rule) clinical diagnostic, medical necessity, and quality of care documentation for ICD-10.

Lists over 1,500 of the latest and most common FDA-approved drugs, including information on drug action, dosage, interactions, contraindications, and guidelines for administration.

Compliance pocket guide for inpatient clinical diagnostic, medical necessity, and quality of care documentation.

AAPC's CDEO® Certification Study guide is specifically designed to help individuals prepare for the CDEO® exam. Ten chapters will guide you through provider communication and compliance, clinical conditions and diagnosis coding, documentation requirements associated with E/M services and CPT coding. This study guide covers each section found on the exam, plus it will provide you with testing tips for taking AAPC's CDEO® exam. If you have coding or auditing experience or have successfully completed documentation training, this study guide will optimize your exam preparation. This study guide is not an introduction to clinical documentation, but a review of documentation concepts. Key Features:

Practical Examples Testing Techniques for CDEO® exam Questions designed to mimic the CDEO® certification exam Each chapter includes ten review questions geared to test important coding concepts Study guide written by same task force who wrote the CDEO® exam Practice exam with 50 multiple choice questions with answers and rationales AAPC's CDEO® Online Practice Exams highly recommended to supplement this study guide. These online practice exams will add an additional 60 multiple choice questions and 10 fill-in-the-blank coding cases to your preparation.

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

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.cdiassociation.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

The official guide by the SAS Global Certification Program, SAS Certified Professional Prep Guide: Advanced Programming Using SAS 9.4 prepares you to take the new SAS 9.4 Advanced Programming Performance-Based Exam. New in this edition is a workbook whose sample scenarios require you to write code to solve problems and answer questions. Answers to the chapter quizzes and solutions to 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 SQL processing, SAS macro language processing, and advanced SAS programming techniques. All exam topics are covered in the following chapters: SQL Processing with SAS PROC SQL Fundamentals Creating and Managing Tables Joining Tables Using PROC SQL Joining Tables Using Set Operators Using Subqueries Advanced SQL Techniques SAS Macro Language Processing Creating and Using Macro Variables Storing and Processing Text Working with Macro Programs Advanced Macro Techniques Advanced SAS Programming Techniques Defining and Processing Arrays Processing Data Using Hash Objects Using SAS Utility Procedures Using Advanced Functions Practice Programming Scenarios (Workbook)

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

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 AHDl'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.

The ultimate guide for anyone wondering how President Joe Biden will respond to the COVID-19 pandemic—all his plans, goals, and executive orders in response to the coronavirus crisis. Shortly after being inaugurated as the 46th President of the United States, Joe Biden and his administration released this 200 page guide detailing his plans to respond to the coronavirus pandemic. The National Strategy for the COVID-19 Response and Pandemic Preparedness breaks down seven crucial goals of President Joe Biden's administration with regards to the coronavirus pandemic: 1. Restore trust with the American people. 2. Mount a safe, effective, and comprehensive vaccination campaign. 3. Mitigate spread through expanding masking, testing, data, treatments, health care workforce, and clear public health standards. 4. Immediately expand emergency relief and exercise the Defense Production Act. 5. Safely reopen schools, businesses, and travel while protecting workers. 6. Protect those most at risk and advance equity, including across racial, ethnic and rural/urban lines. 7. Restore U.S. leadership globally and build better preparedness for future threats. Each of these goals are explained and detailed in the book, with evidence about the current circumstances and how we got here, as well as plans and concrete steps to achieve each goal. Also included is the full text of the many Executive Orders that will be issued by President Biden to achieve each of these goals. The National Strategy for the COVID-19 Response and Pandemic Preparedness is required reading for anyone interested in or concerned about the COVID-19 pandemic and its effects on American society.

Samour & King's Pediatric Nutrition in Clinical Care, Fifth Edition provides comprehensive coverage of the nutritional aspects of pediatric clinical care. A widely trusted resource for more than twenty years, this text combines coverage of nutrition assessment and care with detailed coverage of normal growth, relevant disease states, and medical nutrition therapy.

AAPC's CPMA® Certification Study guide is specifically designed to help individuals prepare for the CPMA® exam. Five chapters will guide you through a review of medical record standards and documentation guidelines, coding and documentation compliance, coding and reimbursement concepts, audit scope and statistical sampling methods, medical record audit abstraction, and category risk analysis and communication. The study guide covers all the content sections found on the exam and will also provide you with testing tips for taking the AAPC's CPMA® exam. The study guide is not an introduction to coding but a review of coding concepts. Key Features: - Practical Examples - Testing Techniques for CPMA® exam - Questions designed to mimic the CPMA® certification exam - Each chapter includes ten review questions geared to test important concepts - Study guide written by same task force who wrote the CPMA® exam - 50 Test your Knowledge questions with answers and rationales - 50 question practice test with answers and rationales AAPC's CPMA® Online Practice Exams are highly recommended to supplement this study guide. These online practice exams will add an additional 150 questions to your preparation. 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-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.

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.

All the forms, handouts, and records mental health professionals need to meet documentation requirements—fully revised and updated The paperwork required when providing mental health services continues to mount. Keeping records for managed care reimbursement, accreditation agencies, protection in the event of lawsuits, and to help streamline patient care in solo and group practices, inpatient facilities, and hospitals has become increasingly important. Now fully updated and revised, the Fourth Edition of The Clinical Documentation Sourcebook provides you with a full range of forms, checklists, and clinical records essential for effectively and efficiently managing and protecting your practice. The Fourth Edition offers: Seventy-two ready-to-copy forms appropriate for use with a broad range of clients including children, couples, and families Updated coverage for HIPAA compliance, reflecting the latest The Joint Commission (TJC) and CARF regulations A new chapter covering the most current format on screening information for referral sources Increased coverage of clinical outcomes to support the latest advancements in evidence-based treatment A CD-ROM with all the ready-to-copy forms in Microsoft® Word format, allowing for customization to suit a variety of practices From intake to diagnosis and treatment through discharge and outcome assessment, The Clinical Documentation Sourcebook, Fourth Edition offers sample forms for every stage of the treatment process. Greatly expanded from the Third Edition, the book now includes twenty-six fully completed forms illustrating the proper way to fill them out. Note: CD-ROM/DVD and other supplementary materials are not included as part of eBook file.

This indispensable guide focuses on validating programs written to support the clinical trial process from after the data collection stage to generating reports and submitting data and output to the Food and Drug Administration.

2021 Official HCPCS Level II Expert Code Book An essential key to quality measures, durable medical goods, injectable drugs, outpatient surgery, Medicaid, Blue Cross/Blue Shield, and many other codes. Complete with supplementary information for each code, it's designed for

clinical coders as both an easy-to-use office guide and the preferred choice to prepare for all AAPC certification exams. AAPC's difference means these features: HCC Reporting Guide Receive expert advice regarding HCC reporting in 2021 Tabs - Simply flip to the chapter you need, saving you time during your exam or in the office Comprehensive 2021 Code Updates – Stay up to date. AAPC code books will notify you about new, deleted, and changed codes modifiers. More Brand Name Drugs in Table of Drugs - Pairing drugs with codes can be difficult. Simplify the process with easy to understand tables and tips. Modifiers Easier to Find and Use - Modifiers are easy to use and handy to find with a front cover fold-out flap that contain the modifier information you need to code accurately Additional Information for Each Chapter - Included information will help you meet your quota or pass your exam APC Status Indicators and ASC Designation Symbols - Find the codes payable through OPPS, and we'll help you do it accurately DMEPOS Icon - AAPC books make billing DME easier with supplemental information. In-depth Illustrations - View the various items associated with codes, along with anatomical illustrations. AHA Coding Clinic for HCPCS References - AHA Coding Clinic® not only helps you report supplies and services accurately; it helps you stand up to challenges User-friendly Appendixes - Appendixes have the extra information you want, including the relevant parts of Medicare's Pub 100 Color-coded Bars and Icons - Ask around, no HCPCS Level II books are as color-coded and easy to use as this. With Pub. 100 references, age and sex edits, quantity alerts, new/deleted/revised code changes, and government coverage and rules for each code, the 2021 Official HCPCS Level II Expert Code Book is an essential key.

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

Compliance pocket guide of inpatient, outpatient observation (including the 2 midnight rule) clinical diagnostic, medical necessity and quality of care documentation for ICD-10.

AAPC's CPCO™ certification study guide is specifically designed to help individuals prepare for the CPCO™ exam. Twelve chapters will cover all the exam sections: a history of compliance, OIG compliance program guidance, HIPAA, EMTALA, CLIA, OSHA, and other key enforcement laws. Test taking techniques are also included to optimize exam preparation. Key Features: - History of compliance in the United States - OIG Compliance Program Guidance - Key enforcement laws including human resources - Practical examples - Testing techniques for CPCO™ exam - Questions designed to mimic the CPCO™ certification exam - Review questions geared to test important concepts for each chapter - 90+ questions with answers and rationales AAPC's CPCO™ Online Practice Exam is highly recommended to supplement this study guide. This online practice exam will add 50 questions to your preparation.

Risk-adjustment practices consider chronic diseases as predictors of future health care needs and expenses. Correct and detailed documentation and 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 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. 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: 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 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 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 for each chapter. Exclusive content for academic educators: A test bank containing 100 questions and a mock risk-adjustment certification exam with 150 questions.

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 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

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 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 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)

"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 physician's or outpatient office"--Provided by publisher.

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

2021 Official ICD-10-CM Expert for Providers and Facilities ESSENTIAL! For new, 2021 codes and guidelines, AAPC's Official ICD-10-CM Expert for Providers and Facilities is a must-have resource for clinical coders. When it comes to ease-of-use, usable content and accuracy, there is no substitute. AAPC's ICD-10-CM was written by medical coding experts and custom-tailored as an easy, essential reference for use in the office, medical facilities, classrooms, and for exams. New 2021 codes and guidelines are supported by helpful information for every coder, biller, and other professional dealing in healthcare revenue. Color coding and illustrations make the material easy to navigate, digest and remember. AAPC's difference includes these features: New for 2021! 2021 new, changed, and deleted codes updates assure you will have the codes you need at work and during your examination 2021 Official Guidelines in the front of the book build the foundation for your documentation of medical necessity and accuracy Additional character icons help make your book a one-stop, easy-to-use resource Expanded online updates and tips to help you succeed at work or in your exam Yellow-highlighted orientation lines - Index to Diseases and Injuries include highlights that are like maps to the correct indentation, meaning you can easily find the right code categories Highlighted codes - Easily find MACRA quality measure-related diagnosis codes Adhesive tabs - Save time by adding custom tabs Symbols/alerts with Z codes - Conveniently Identify primary Dx for this code chapter Age and Gender icons - Save yourself from embarrassing mistakes Primary Diagnosis indicators - Take any guesswork out of which code to report Manifestation codes - Add the information needed to make codes more payable Detailed illustrations - Understand the geography and pathology in the codes Extension symbols - Identify encounter, recovery stage, or laterality Spiral binding - Lay your book open and flat for an easy-to-use coding reference

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.

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