
CDIP Toolkit (Clinical Documentation Improvement Toolkit AHIMA) with Complete Solutions

recent drivers of CDI (p2) - ANSWER-- MS-DRGs 2007 to reflect SOI/ROM

- POA indicators 2008
- Medicare Advantage/Part C (capitated, HCC)
- some payers moving to APR DRGs
- compliance reviews: RAC, Zone Program Integrity Contractors, Medicaid Integ Contractors

purpose of CDI program (p2) - ANSWER-to initiate concurrent and, as appropriate, retrospective reviews of health records for conflicting, incomplete, or nonspecific provider documentation.

goal of CDI reviews (p2) - ANSWER-to identify clinical indicators to ensure that all diagnoses and procedures are supported by ICD-9-CM codes.

key CDI stakeholders (p3) - ANSWER-- HIM and coding departments

- Case management and utilization review
- Medical staff and physician leadership
- Executive leadership
- Patient financial services or billing
- Finance and revenue cycle
- Quality and risk management
- Nursing
- Compliance and ethics

some examples of CDI goals (p4) - ANSWER-- Obtain clinical documentation that captures the patient severity of illness and risk of mortality

- Identify and clarify missing, conflicting, or nonspecific physician documentation related to diagnoses and procedures
- Support accurate diagnostic and procedural coding, MS-DRG assignment, leading to appropriate reimbursement
- Promote health record completion during the patient's course of care, which promotes patient safety
- Improve communication between physicians and other members of the healthcare team

Ahima Clinical Documentation Improvement Toolkit

Pamela Carroll Hess



Ahima Clinical Documentation Improvement Toolkit:

The Clinical Documentation Improvement Specialist's Handbook, Second Edition Heather Taillon, 2011-01-21

The Clinical Documentation Improvement Specialist's Handbook Second Edition Marion Kruse MBA RN Heather Taillon RHIA CCDS Get the guidance you need to make your CDI program the best there is The Clinical Documentation Improvement Specialist's Handbook Second Edition is an all inclusive reference to help readers implement a comprehensive clinical documentation improvement CDI program with in depth information on all the essential responsibilities of the CDI specialist This edition helps CDI professionals incorporate the latest industry guidance and professional best practices to enhance their programs Co authors Heather Taillon RHIA and Marion Kruse MBA RN combine their CDI and coding expertise to explain the intricacies of CDI program development and outline the structure of a comprehensive multi disciplinary program In this edition you will learn how to Adhere to the latest government and regulatory initiatives as they relate to documentation integrity Prepare for successful ICD 10 transition by analyzing your CDI program Step up physician buy in with the improved education techniques Incorporate the latest physician query guidance from the American Health Information Management Association AHIMA Table of Contents Chapter 1 Building the CDI Program Chapter 2 CDI and the healthcare system Chapter 3 Application of coding guidelines Chapter 4 Compliant physician queries Chapter 5 Providing physician education Chapter 6 Monitoring the CDI program What's new in the Second Edition Analysis of new industry guidance including AHIMA's Managing an Effective Query Process and Guidance for Clinical Documentation Improvement Programs CMS guidance from new IPPS regulations MLN Matters articles Quality Improvement Organizations and the Recovery Audit Contractor RAC program among others Strategies to help you incorporate the guidance into your CDI program Tools to help you interpret MAC initiatives and RAC focus areas to enhance your CDI program and help prevent audit takebacks New sample queries forms tools and industry survey data BONUS TOOLS This book also includes bonus online tools you can put to use immediately Sample query forms Sample job descriptions for CDI managers and CDI specialists Sample evaluation form for CDI staff Sample pocket guide of common documentation standards

Health Care Finance and the Mechanics of Insurance and Reimbursement Michael K. Harrington, 2019-10-01 Health Care Finance and the Mechanics of Insurance and Reimbursement stands apart from other texts on health care finance or health insurance in that it combines financial principles unique to the health care setting with the methods and process for reimbursement including coding reimbursement strategies compliance financial reporting case mix index and external auditing It explains the revenue cycle in detail correlating it with regular management functions and covers reimbursement from the initial point of care through claim submission and reconciliation Thoroughly updated for its second edition this text reflects changes to the Affordable Care Act Managed Care Organizations new coding initiatives new components of the revenue cycle from reimbursement to compliance updates to regulations surrounding health care fraud and abuse changes to the Recovery Audit Contractors RAC

program and more

Legal and Ethical Standards for Nurses, 4th Edition Sheryl Feutz-Harter, 2012-05 To practice nursing effectively today requires a sound understanding of the legal system and the laws specifically affecting nurses *Legal and Ethical Standards for Nurses* is filled with practical information covering topics such as delegation documentation professional liability insurance regulatory issues advance directives and many others While these are exciting and challenging times for nurses clinically they are equally challenging legally It is therefore increasingly important that each nurse learn how to protect herself and her nursing license The 4th Edition includes an expanded discussion of healthcare fraud and the False Claims Act information about the HITECH Act has been added and there is a section about the impact of HIPAA on the use and disclosure of protected health information Issues with new technologies such as electronic communications and medical records are also addressed And there is a new chapter on staffing issues including handling questionable assignments and mandatory overtime as well as a discussion of Allow natural death orders All chapters include the update on applicable laws and case law

Health Information - E-Book Mervat Abdelhak, Mary Alice Hanken, 2014-12-24 Uncover the latest information you need to know when entering the growing health information management job market with *Health Information Management of a Strategic Resource* 5th Edition Following the AHIMA standards for education for both two year HIT programs and four year HIA programs this new edition boasts dynamic state of the art coverage of health information management the deployment of information technology and the role of the HIM professional in the development of the electronic health record An easy to understand approach and expanded content on data analytics meaningful use and public health informatics content plus a handy companion website make it even easier for you to learn to manage and use healthcare data Did You Know boxes highlight interesting facts to enhance learning Self assessment quizzes test your learning and retention with answers available on the companion Evolve website Learning features include a chapter outline key words common abbreviations and learning objectives at the beginning of each chapter and references at the end Diverse examples of healthcare deliveries like long term care public health home health care and

ambulatory care prepare you to work in a variety of settings Interactive student exercises on Evolve including a study guide and flash cards that can be used on smart phones Coverage of health information infrastructure and systems provides the foundational knowledge needed to effectively manage healthcare information Applied approach to Health Information Management and Health Informatics gives you problem solving opportunities to develop proficiency EXPANDED Data analytics meaningful use and public health informatics content prepares HIM professionals for new job responsibilities in order to meet today s and tomorrow s workforce needs EXPANDED Emphasis on the electronic health care record educates you in methods of data collection governance and use NEW Chapter on data access and retention provides examples of the paper health record and its transition to the EHR NEW Focus on future trends including specialty certifications offered by the AHIMA the American Medical Informatics Associations AMIA and the Health Information Management Systems Society HIMSS explains the vast number of job opportunities and expanded career path awaiting you **Clinical Documentation**

Improvement Pamela Carroll Hess,2015 Health Care Information Systems Karen A. Wager,Frances Wickham Lee,John P. Glaser,2009-06-02 This book is a primary text on the effective use of data and information technology to improve organizational performance in health care settings This book provides the fundamental knowledge and tools that students need to manage information and information resources effectively within a variety of health care organizations Back cover

Clinical Documentation Improvement Ruthann Russo,2009-08-01 Cover title includes subtitle Achieving excellence

Certified Documentation Improvement Practitioner (CDIP) Exam Preparation Sharon Easterling,2016 The Clinical Documentation Improvement Specialist's Complete Training Guide Laurie L. Prescott,2014-10-23 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 **The Physician Documentation Improvement Pocket Guide, Third Edition** Cheryl Ericson,2014-10-22 Physician Documentation Improvement Pocket Card Third Edition Packs of 25 Cheryl Ericson MS RN CCDS CDIP AHIMA Approved ICD 10 CM PCS Trainer Sold in packages of 25 Use the Physician Documentation Improvement Pocket Card Third Edition to help your physicians remember key documentation points The six

panel card includes everything from documentation basics to severity of illness clinical indicators Updated for 2014 this third edition simplifies tips to common documentation improvement opportunities And it fits easily in the physician s pocket Start your CDI physician education efforts with the accompanying online instruction manual and help physicians understand common documentation gaps This product Provides documentation basics for the short term acute care inpatient setting Includes tips for discharge summary documentation Details documentation needed to establish a condition as a reportable diagnosis Presents key reminders for documentation to reflect patient acuity Offers advice for how to differentiate among acute chronic and resolved conditions Helps providers translate commonly vague documentation of a patient s chief complaint into a more precisely associated diagnosis Includes both printed pocket card and online PDF formats Folds for physicians to carry in their pockets and is laminated for durability and easy cleaning The latest edition of the Physician Documentation Improvement Pocket Card helps you improve patient acuity and severity by focusing on common areas of vague and nonspecific physician documentation ACDIS Education Director and lead CDI Boot Camp instructor Cheryl Ericson brings her vast experience to bear in creating a simple to follow easy to use tip sheet and accompanying user s guide to help improve your physicians documentation Online user manual will explain how to use the pocket cards and explain some CDI basics *The Physician Advisor's Guide to Clinical Documentation Improvement* Trey La Charité,James S. Kennedy,2014

Bridging the Gap Between Coding and Clinical Documentation Improvement (CDI) Anneleah Williams

Bridges,2020-02-14 Physicians play vital roles in the overall quality of patient care However HIM professionals and clinical documentation improvement specialists also share essential roles in the healthcare system as guardians of PHI and advocates for continuity of care through consistent documentation and accurate code assignment Clinical documentation improvement specialists CDIS are responsible for the communicative aspects of the process often serving as a liaison between the provider and the coder The CDIS ensures that the medical record is complete there is clinical validation to support diagnoses and that the medical record is consistent without conflicting or obscure documentation HIM professionals share some of the responsibility of CDIS in addition to abstracting data from the medical record and assigning the appropriate codes to accurately report the patient s clinical picture Without the two teams working hand in hand to improve the medical record s documentation billing errors could ensue and the quality of patient care is at risk The process is very detailed and requires a clinical and coding mind to work efficiently More organizations are calling for their CDIS to learn the fundamentals of coding and for their coders to review the medical record with clinical eyes Which is whythisresource proves invaluable Whether you re already skilled in HIM but want to add CDI expertise to your resume or an existing CDIS looking to update your coding skillset this publication will be of good use to you **Clinical Documentation Reference Guide - First Edition**

AAPC,2020-03-12 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

The Clinical Documentation Sourcebook Donald E. Wiger,2005-03-04 All the forms handouts and records mental health professionals need to meet documentation requirements 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 This updated and revised Third Edition provides you with a full range of forms checklists and clinical records essential for effectively and efficiently managing your practice From intake to diagnosis and treatment through discharge and outcome assessment The Clinical Documentation Sourcebook Third Edition offers sample forms for every stage of the treatment process Greatly expanded from the second edition the book now includes twenty six fully completed forms illustrating the proper way to fill them out as well as fifty two ready to copy blank forms The included CD ROM also provides these forms in Word format so you can easily customize them to suit your practice With The Clinical Documentation Sourcebook Third Edition you ll spend less time on paperwork and more time with clients Includes documentation for child family and couples counseling Updated for HIPAA compliance as well as to reflect the latest JCAHO and CARF regulations New focus on clinical outcomes supports the latest innovations in evidence based practice

Clinical Documentation Improvement Specialist's Handbook Colleen Garry,2014-05-14 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 CDI Companion for Physician Advisors Trey La Charité,La Charité, MD CcDs,2016-11 When it comes to clinical documentation physician advisors have a range of important responsibilities from query escalation to denials management and everything in between With all these tasks on their plate physician advisors are constantly pulled in different directions making it hard to make the best use of their time CDI Companion for Physician Advisors Notes From the Field is designed to help physician advisors structure their time properly and carry out their CDI duties effectively and efficiently This book will help physician advisors Find their feet in the CDI role Identify tools to provide effective documentation education for physicians and CDI staff Engage medical staff in documentation improvement efforts Understand common documentation deficiencies for difficult diagnoses such as sepsis heart failure and kidney disease Work with their CDI team to tackle advanced record reviews in areas such as quality audit defense and outpatient HCCs Figure out how to best structure their time to carry out CDI duties

Document Management and Imaging Toolkit AHIMA Staff,2012-10-08

Clinical Documentation Improvement Specialists Complete Training Guide Laurie L. Prescott (R. N.),2014 *The Documentation Improvement Guide to Physician E/M* Glenn A. Krauss,2012-02-27 Give physicians a crash course in the documentation of E M services Physicians who provide E M services must document the necessary clinical information to support their medical decision making This is where CDI specialists play an important role and The Documentation Improvement Guide to Physician E M can help This reference guide helps CDI specialists explain to physicians how complete and accurate documentation benefits their E M payments prevents medical necessity denials and provides the information they need to document correctly This handbook offers the perfect portable reference guide for CDI specialists to educate physicians about E M documentation This

handbook is provided in packs of 10 so CDI specialists can distribute copies to physicians during documentation improvement education sessions or in response to physician questions and requests for additional information This reference guide will help CDI specialists Better understand the complex guidelines that affect physician payment for E M services Explain the importance of documentation to physicians beyond hospital reimbursement Clarify the purpose of queries and how responding to them benefits physicians payments and public profiles Encourage physicians to provide adequate documentation that will reduce the number of denials for lack of documented medical necessity Access a comprehensive list of additional online resources to further aid them in their important role Take a look at the table of contents Chapter 1 E M Documentation Chapter 2 Components of E M Chapter 3 Chief Complaint Chapter 4 History of Present Illness Chapter 5 Review of Systems Chapter 6 Past Family and Social History Chapter 7 Physical Examination Chapter 8 Medical Decision Making Chapter 9 Amount and Complexity of Data Chapter 10 Critical Care Chapter 11 Medical Necessity and Clinical Documentation Appendix

The Essential Guide to Supporting Quality Care Measures Through Documentation Improvement LAURIE L. PRESCOTT, Sharme Brodie, 2017-06 Resource added for the Health Information Technology program 105301

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