Ahima Documentation Guidelines

First Steps in Outpatient CDIThe Physician Advisor's Guide to Clinical Documentation ImprovementThe Clinical Documentation Improvement Specialist's Guide to ICD-10Health Information Management TechnologyHealth Information ManagementCopy Functionality ToolkitRegistries for Evaluating Patient OutcomesICD-9-CM Official Guidelines for Coding and ReportingLegal and Ethical Aspects of Health Information ManagementDocumentation for Health RecordsICD-10-CM Official Guidelines for Coding and Reporting - FY 2020 (October 1, 2019 - September 30, 2020)Fundamentals of Law for Health Informatics and Information ManagementCPT Professional 2020ICD-10-CM and ICD-10-PCS Preview ExercisesToday's Health Information ManagementThe Computer-Based Patient RecordData Analytics in Healthcare Research, Tools and Strategies, 2eClinical Documentation Improvement for Outpatient CareCertified Documentation Improvement Practitioner (CDIP) Exam PreparationMedical Transcription For DummiesJournal of AHIMAHealth Information - E-BookRHIT Exam Flashcard Study SystemThe Clinical Documentation Improvement Specialist's Complete Training GuideKey Capabilities of an Electronic Health Record SystemRisk Adjustment Documentation and CodingThe Complete Guide to CDI ManagementEthical Health InformaticsIndependent Medical CodingBasic ICD-10-CM and ICD-10-PCS Coding 2019Ethical Challenges in the Management of Health InformationThe Essential CDI Guide to Provider QueriesClinical Documentation ImprovementRelease and DisclosureThe CCDS Exam Study GuideRegistered Health Information Administrator (RHIA)Clinical Documentation ImprovementHealth Information ManagementBasic CPT and HCPCS Coding 2020The Complete Diagnosis Coding Book

First Steps in Outpatient CDI

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

The Physician Advisor's Guide to Clinical Documentation Improvement

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

Health Information Management Technology

Clinical Documentation Improvement for Outpatient Care: Design and Implementation is an all-inclusive guide to establishing and enhancing CDI programs for the outpatient amd professional fee setting.

Health Information Management

This User’s Guide is intended to support the design, implementation, analysis, interpretation, and quality evaluation of registries created to increase understanding of patient outcomes. For the purposes of this guide, a patient registry is an organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes. A registry database is a file (or files) derived from the registry. Although registries can serve many purposes, this guide focuses on registries created for one or more of the following purposes: to describe the natural history of disease, to determine clinical effectiveness or cost-effectiveness of health care products and services, to measure or monitor safety and harm, and/or to measure quality of care. Registries are classified according to how their populations are defined. For example, product registries include patients who have been exposed to biopharmaceutical products or medical devices. Health services registries consist of patients who have had a common procedure, clinical encounter, or hospitalization. Disease or condition registries are defined by patients having the same diagnosis, such as cystic fibrosis or heart failure. The User’s Guide was created by researchers affiliated with AHRQ’s Effective Health Care Program, particularly those who participated in AHRQ’s DEcIDE (Developing Evidence to Inform Decisions About Effectiveness) program. Chapters were subject to multiple internal and external independent reviews.

Copy Functionality Toolkit

Registries for Evaluating Patient Outcomes

This second edition prepares current coding professionals with knowledge required by the implementation of ICD-10-CM and ICD-10-PCS, and readies coding students for a smooth transition into the workplace. The exercises here give early adopters, consultants, and trainers a practical opportunity to familiarize themselves with the basic structure of ICD-10, and to understand its similarities and differences from ICD-9.

ICD-9-CM Official Guidelines for Coding and Reporting

Legal and Ethical Aspects of Health Information Management

CPT(R) 2020 Professional Edition is the definitive AMA-authored resource to help health care professionals correctly report and bill medical procedures and services.

Documentation for Health Records

ICD-10-CM Official Guidelines for Coding and Reporting - FY 2020 (October 1, 2019 - September 30, 2020)

Fundamentals of Law for Health Informatics and Information Management

Clinical Documentation Improvement (CDI) Made Easy is a great resource and reference that every Clinical Documentation Improvement Specialist/Professional (CDIS/CDIP), coder, physician champion/advisor, and others involved in the CDI must have. The book is a compendium of sound clinical knowledge and experience, clinical documentation expertise, and quality, which will help the CDIS/CDIP and others maximize their potentials in performing their core duties. Whether you are a new CDIS trying to learn CDI or an experienced CDIS hoping to stay current with CDI world, or involved in the CDI, this book will be very valuable to you. Remember, accurate and quality documentation is a reflection of great patient care. "If it wasn't documented, and documented accurately, it never happened." This book clearly explained various query opportunities by Major Disease Classifications (MDCs) with some sample queries. It defines and analyses different disease processes, creates CDIS awareness and what to look for under various MDCs, ICD-10-CM/PCS, explained current CMS Pay for Performance (P4P), and the CDI responsibility under P4P, explained some pertinent coding guidelines, 2016 Official Coding Guidelines for Coding and Reporting, AHIMA/ACDIS practice brief for queries and compliance, and much more. I have no doubt in my mind that this book is a concise but a comprehensive tool and reference that anyone involved in CDI should always have at his/her side. The Author Anthony O Nkwuaku, RN, PHN, MSN, CPHQ, CCDS is very knowledgeable and experienced as a clinician, clinical instructor, and Clinical Documentation Improvement Specialist.

CPT Professional 2020

The fast and easy way to explore a medical transcriptioncareer Flexibility is one of the most enticing aspects of a career inmedical transcription. Perfect for in the office, at home, or onvacation, medical transcriptionists can often createlifestyle-appropriate schedules. The transcription field alsoappeals as a part-time, post-retirement income source forex-healthcare-industry workers. If you're interested in a career inthis growing field, Medical Transcription For Dummies servesas an accessible entry point. With guidance on getting through training and certification

andexploring opportunities within the myriad different kinds ofemployment arrangements, Medical Transcription For Dummiesgives you everything you need to get started in medicaltranscription. Guides you on getting though medical transcription training andcertification Includes expert advice and tips on how to approach complexmedical jargon and understand procedures Plain-English explanations of medical terminology, anatomy andphysiology, diagnostic procedures, pharmacology, and treatmentassessments Whether used as a classroom supplement or a desk reference,students and professionals alike can benefit from MedicalTranscription For Dummies.

ICD-10-CM and ICD-10-PCS Preview Exercises

Today's Health Information Management

The Computer-Based Patient Record

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

Data Analytics in Healthcare Research, Tools and Strategies, 2e

Clinical Documentation Improvement for Outpatient Care

Today's Health Information Management reflects the recent trends and developments in technology, law, and organizational management that have changed the HIM profession. This book guides the health information professional

in performing a more central role in the delivery of health care than ever before, addressing both the principles and practices of health information management. The integrated approach highlights the interplay of informatics, e-HIM, and HIPAA contextually as each topic relates to each chapter.

Certified Documentation Improvement Practitioner (CDIP) Exam Preparation

This is the fifth edition of the definitive reference source on the management of health records. Health Information Management provides the basic guidelines on content and structure, analysis, assessment, and improvement of information critical to every health care organization. This thoroughly revised and updated edition reflects the significant changes in the field and the most current and successful practices most notably, the computerization of record operations and systems, and of the record itself.

Medical Transcription For Dummies

Journal of AHIMA

Health Information - E-Book

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.

RHIT Exam Flashcard Study System

The Essential CDI Guide to Provider Queries Marion Kruse, BSN, RN, MBA Jennifer Cavagnac, CCDS The Essential CDI Guide to Provider Queries is the authoritative source for defining policies, procedures, and best practices for provider queries. Thanks to ICD-10-CM/PCS implementation, as well as the advancement of electronic health records and electronic query systems, CDI programs are being pushed in challenging new directions--requiring CDI specialists to redefine where and how they generate queries. Meanwhile, CDI program managers need innovative solutions to improve their query process, target high-risk diagnoses, and educate delinquent providers, coders, or CDI professionals. The Essential CDI Guide to Provider Queries is the only resource that provides a comprehensive analysis of query guidelines and easy-to-follow strategies to improve your processes. Using the tools provided in this vital guide, you can update your practices to meet the challenges of ICD-10-CM/PCS, government payer initiatives, auditor denials, and electronic initiatives. With sample queries, policies, procedures, and national benchmarking data included, The Essential CDI Guide to Provider Queries is a valuable addition to your CDI library. You'll also find information on: ICD-10 implementation Recovery Auditors process Electronic health records Electronic query efforts Compliance risks and OIG scrutiny TABLE OF CONTENTS Chapter 1: Healthcare Reimbursement Initiatives Chapter 2: Regulatory Environment Chapter 3: Coding Advancements Chapter 4: Query Guidance Progression Chapter 5: The Query Process Chapter 6: Electronic Health Records and the Advancement of eQueries Chapter 7: Query Assessments, Program Auditing, and Education Opportunities BONUS TOOLS Sample query policies and procedures, sample processes for eQuery review, sample DRG reconciliation process, sample queries for common ICD-10-CM/PCS difficulties, sample queries related to recent query practice recommendations in Guidelines for Achieving a Compliant Query Practice. WHO SHOULD READ THIS? Clinical documentation Improvement manager/director Clinical documentation integrity manager/director HIM manager/director Case management manager/director Director of revenue Cycle CDI specialist Quality manager

The Clinical Documentation Improvement Specialist's Complete Training Guide

Key Capabilities of an Electronic Health Record System

Health law is a rapidly changing field, and students entering the HIM fields require the most recent knowledge to move the profession forward and achieve legal compliance. This revised reprint of Fundamentals of Law for Health Informatics and

Information Management contains updates to the second edition. New features and major updates in to this edition include: Medical Identity Theft and Red Flags Rule Contracts, Antitrust, and Corporate Healthcare Liability 2013 HIPAA Privacy and Security updates under ARRA and HITECH updates, including Breach Notification Requirements Meaningful Use E-Discovery Security Safeguard Mechanisms Key Features Online resources include a linked reference list Addresses topics critical to effective HIM practice Instructor manual available online

Risk Adjustment Documentation and Coding

The Complete Guide to CDI Management

Most industries have plunged into data automation, but health care organizations have lagged in moving patients' medical records from paper to computers. In its first edition, this book presented a blueprint for introducing the computer-based patient record (CPR). The revised edition adds new information to the original book. One section describes recent developments, including the creation of a computer-based patient record institute. An international chapter highlights what is new in this still-emerging technology. An expert committee explores the potential of machine-readable CPRs to improve diagnostic and care decisions, provide a database for policymaking, and much more, addressing these key questions: Who uses patient records? What technology is available and what further research is necessary to meet users' needs? What should government, medical organizations, and others do to make the transition to CPRs? The volume also explores such issues as privacy and confidentiality, costs, the need for training, legal barriers to CPRs, and other key topics.

Ethical Health Informatics

Resource added for the Health Information Technology program 105301.

Independent Medical Coding

Risk-adjustment practices consider chronic diseases as predictors of future healthcare needs and expenses. Detailed documentation and compliant diagnosis coding are critical for proper risk adjustment. Risk Adjustment Documentation & Coding provides: * Risk adjustment parameters to improve documentation related to severity of illness and chronic diseases. * Code abstraction designed to improve diagnostic coding accuracy without causing financial harm to the practice or health facility. The impact of risk adjustment coding--also called 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. Meticulous diagnostic documentation and coding is key to accurate risk-adjustment reporting. This book will help align the industry though an objective compilation and presentation of risk adjustment documentation and coding issues, guidance, and federal resources. Features and

Benefits * Five chapters delivering an overview of risk adjustment, common administrative errors, best practices, topical review of clinical documentation improvement and coding for risk adjustment alphabetized by HCC group, and guidance for development of internal risk adjustment coding policies. * Six appendices offering mappings, tabular information, and training tools for coders and physicians that include an alphanumeric mapping of ICD-10-CM codes to HCCs and RxHCCs and information about Health and Human Services HCCs versus Medicare Advantage HCCs. * Learning and design features: - Vocabulary terms highlighted within the text and conveniently defined at the bottom of the page. - "Advice/Alert Notes" that highlight important advice from the ICD-10-CM Guidelines for Coding and Reporting. - "Key Coding Concepts" that offer the advice published in ICD-10-CM Coding Clinic for ICD-10-CM and ICD-10-PCS. - "Sidebars" that detail measurements pertinent to risk adjustment seen in physician documentation, eg., cancer staging, disability status, or GFRs. - "Coding Tips" that guide coders to the right answers (using terminology and ICD-10-CM Index and Tabular entries) or provide cautionary notes about conflicts in the official ICD-10-CM guidance. - "Clinical Examples" that underscore key documentation issues for risk adjustment. - Clinical coding examples that provide snippets or full encounter notes and codes to illustrate key issues for the HCC or RxHCC. - "Documentation tips" 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. * Extensive end-of-chapter "Evaluate Your Understanding" sections that include multiple-choice questions, true-or-false questions, and Internet-based exercises. * Downloadable slide presentations for each chapter that cover key content and concepts. * Exclusive content for academic educators: A test bank containing 100 questions and a mock risk-adjustment certification exam with 150 questions

Basic ICD-10-CM and ICD-10-PCS Coding 2019

Ethical Challenges in the Management of Health Information

Now in its second edition, The Clinical Documentation Improvement Specialist's Guide to ICD-10 is the only guide to address ICD-10 from the CDI point of view. Written by CDI experts and ICD-10 Boot Camp instructors, it explains the ICD-10 documentation requirements and clinical indicators of commonly reported diagnoses and the codes associated with those conditions. You'll find the specific documentation requirements to appropriately code a variety of conditions. The CDI Specialist's Guide to ICD-10, 2nd edition, not only outlines the changes coming in October 2014, it provides detailed information on how to assess staffing needs, training requirements, and implementation strategies. The authors-an ICD-10 certified coder and CDI specialist-collaborated to create a comprehensive selection of ICD-10 sample queries facilities can download and use to jumpstart ICD-10 documentation improvement efforts. Develop the expertise and comfort level you'll need to manage this important industry change and help your organization make a smooth transition. The Clinical Documentation Improvement Specialist's Guide to ICD- 10, 2nd ed. is part of the library of products and services from the Association of Clinical Documentation Improvement Specialists (ACDIS). ACDIS members are

CDI professionals who share the latest tested tips, tools, and strategies to implement successful CDI programs and achieve professional growth. Member benefits include a quarterly journal, members-only Web site, quarterly networking conference calls, discounts on conferences, and more. WHAT'S NEW? Completely revised to accommodate changes in ICD-10 implementation dates Dozens of targeted ICD-10 physician queries Updated ICD-10 benchmarking reports BENEFITS Sample ICD-10 queries Specificity requirements and clinical indicators by disease type and body system Staff training and assessment tools

The Essential CDI Guide to Provider Queries

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 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

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

Release and Disclosure

The CCDS Exam Study Guide

Understanding the complex legal and ethical principles that govern health information management is more important than ever. To help you successfully navigate these legal issues, LEGAL AND ETHICAL ASPECTS OF HEALTH INFORMATION MANAGEMENT is revised, updated, and expanded, providing the opportunity to focus on law and ethics as they relate to HIM. Key topics include the role of social media in health care, expansion of existing materials on e-discovery, compliance, completeness of the health record, breaches of confidentiality, and much more. Features include enrichment activities, mapping to CAHIIM standards,

and interactive quizzing and case studies to help develop practical application and high-level problem solving skills. Written by a seasoned HIM professional and lawyer, LEGAL AND ETHICAL ASPECTS OF HEALTH INFORMATION MANAGEMENT, 4th Edition provides a complete solution for understanding the legal and ethical concerns that safeguard health care information today. Important Notice: Media content referenced within the product description or the product text may not be available in the ebook version.

Registered Health Information Administrator (RHIA)

Clinical Documentation Improvement

Health Information Management

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

Basic CPT and HCPCS Coding 2020

There is an enormous and growing demand for skilled medical coders, creating a

severe shortage in a large variety of coding situations. Demand greater than supply can result in excellent compensation for those on the supply side. So, how do you determine if medical coding is the profession for you? If you are already a medical coder, how do you identify and evaluate the rapidly expanding variety of opportunities open to you? INDEPENDENT MEDICAL CODING, 2nd edition: The Comprehensive Guidebook for Career Success as a Medical Coder (just published by Rayve Productions) provides answers to these questions and many more, such as What is Coding?; Are You Ready to Go Solo?; What is the Future of Coding in Health Care? The 448-page book also gives extensive information regarding Medical Coding Education and Experience; Continuing Professional Education; Becoming Credentialed; Medical Transcriptionists as Coding Specialists; Salary Projections Based on Survey Data; Types of Coding Systems; Establishing Your Independent Coding Business; Alternative Careers for the Health Care Coding Specialist; Establishing Fees; Marketing Tips; Contracts and Independent Contractors; Building a Successful Coding/Consulting Business; Professional Ethics; Finances; and much more, including descriptions of the authors' favorite references and resources and the appendix's twenty-three exhibits of helpful forms and documents.

The Complete Diagnosis Coding Book

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

ROMANCE ACTION & ADVENTURE MYSTERY & THRILLER BIOGRAPHIES & HISTORY CHILDREN'S YOUNG ADULT FANTASY HISTORICAL FICTION HORROR LITERARY FICTION NON-FICTION SCIENCE FICTION