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Take charge of ICD-10 documentation requirements The implementation of ICD-10 brings with it new documentation requirements that will have a significant impact on the work of your CDI team. The higher degree of specificity of information needed to code accurately will have a direct correlation to reimbursement and compliance. CDI specialists need a firm understanding of the new code set, and the rules that govern it, to obtain the appropriate level of documentation from physicians. The Clinical Documentation Improvement Specialist's Guide to ICD-10 is the only book that addresses ICD-10 from the CDI point of view. Written by CDI experts, it explains the new documentation requirements and clinical indicators of commonly reported diagnoses and the codes associated with those conditions. You'll find the specific documentation requirements to appropriately code conditions such as heart failure, sepsis, and COPD. Learn from your peers The Clinical Documentation Improvement Specialist's Guide to ICD-10 includes case studies from two hospitals that have already begun ICD-10 training so you can use their timelines as a blue print to begin your organization's training and implementation. ICD-10 implementation happens in 2013. It's not too soon to start developing the expertise and comfort level you'll need to manage this important industry change and help your organization make a smooth transition. Benefits: * Tailored exclusively for CDI specialists * Side-by-side comparison of what documentation is necessary now v. what will be required starting October 1, 2013 * Timelines to train physicians in new documentation requirements to ensure readiness by implementation date * Strategies and best practices to ensure physician buy-in CCDS Notebook A simple gift idea; 120 pages ruled notebook with a glossy finish custom cover. An a4 size general purpose notebook. Publisher's Note: Products purchased from Third Party sellers are not guaranteed by the publisher for quality, authenticity, or access to any online entitlements included with the product. Clear, concise, and simple to follow—everything you need to master the documentation process quickly and easily Communicating Clinical Decision Making Through Documentation is the top choice for professionals and students seeking complete coverage of the documentation process including billing and coding. It shows how to ensure every service rendered and billed is supported by showing what to document, how to do it, and why it is so important. This text includes a refreshing student-friendly approach to the topic. You will find an abundance of cases portraying real-life case scenarios and it delivers must-know information on writing patient/client care notes, incorporating document guidelines, documenting clinical decision making (includes evidence-based practice), and performing billing and coding tasks. With Communicating Clinical Decision Making Through Documentation, you'll effectively maintain and organize records, record appropriate information, and receive proper payment based on the documentation content. A to Z coverage of physical therapy documentation, including: Documentation Standards and Guidelines Medicare Home Health Electronic Medical Records (EMR) International Classification of Functioning (ICF) Model and Application Pediatrics Legal Issue Utilization Review & Management Skilled Nursing Facilities Sample Documentation Content Initial Examination and Evaluation Criteria Continuum of Care Content and Goal Writing Exercises Documentation Aspects of Supervising PTAs Abbreviations Payment ICD-10 and CPT Codes and Application Chapter Review Questions Content Principles 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. Clinical or translational science is the field of study devoted to investigating human health and disease, interventions and outcomes for the purposes of developing new treatment approaches, devices, and modalities to improve health. New molecular tools and diagnostic technologies based on clinical and translational research have lead to a better understanding of human disease and the application of new therapeutics for enhanced health. Clinical and Translational Science is designed as the most authoritative and modern resource for the broad range of investigators in various medical specialties taking on the challenge of clinical research. Prepared with an international perspective, this resource begins with experimental design and investigative tools to set the scene for readers. It then moves on to human genetics and pharmacology with a focus on statistics, epidemiology, genomic information, drug discovery and development, and clinical trials. Finally, it turns to legal, social, and ethical issues of clinical research concluding with a discussion of future prospects to provide readers with a comprehensive view of the this developing area of science. Clinical research is one of the fastest growing fields in private practice and academic medicine with practical biological, physiological, cellular, and therapeutic applications Contributions from international leaders provide insight into background and future understanding for clinical and translational science Provides the structure for complete instruction and guidance on the subject from fundamental principles, approaches and infrastructure to human genetics, human pharmacology, research in special populations, the societal context of human research, and the future of human research Clinical Documentation Quick Reference for Long-Term Care Barbara Acello, MS, RN Save time while achieving accurate, comprehensive documentation for every resident in your facility This resource, designed to be used at the resident's bedside, will help nurses improve their efficiency and quality of documentation by guiding them through 150 of the most common conditions, procedures, and situations encountered in a long-term care facility. With a detailed and comprehensive description of each symptom or condition, nurses will have a thorough

list of what to check for and what to document during every shift, based on the specific circumstances of a given resident. Guarantee your residents receive the best quality of care and ensure your facility maintains compliant documentation with the help of Clinical Documentation Quick Reference for Long-Term Care. Clinical Documentation Quick Reference for Long-Term Care will: Help nurses save time while achieving accurate, comprehensive documentation for every resident in their care Provide clinicians with documentation procedures for the 150 most common conditions, procedures, and situations encountered in long-term care Aid in identifying problems and related interventions through assessment guidelines by system Nursing This clinical manual is an ideal and standardized platform for preparing nursing students with the essential tools for documenting their nursing process. It teaches nursing students how to gather important data about each client in the clinical setting. Using this manual, the student nurse will be able to perform high quality documentation that is accurate and consistent in the client profile and laboratory and diagnostics, and their correlation and significance to the client's diagnosis or diagnoses. This manual also covers the medication administration record, nursing interventions and rationales, and intake and output forms. The Situation Background Assessment Recommendation (SBAR) form and the use of a concept map complete the list of resources provided. Using this standardized documentation, the student will be able to: • Identify the primary patient data (past and present), diagnosis, and treatment plan. • Analyze patient data correlating and drawing conclusions relevant to patient outcome. • Document finding in a systematic manner. • Interpret diagnostic findings as relate to patient diagnosis This manual is intended for use in medical, surgical, and critical care clinical nursing courses. Understand the when, why, and how! Here's your guide to developing the skills you need to master the increasing complex challenges of documenting patient care. Step by step, a straightforward 'how-to' approach teaches you how to write SOAP notes, document patient care in office and hospital settings, and write prescriptions. You'll find a wealth of examples, exercises, and instructions that make every point clear and easy to understand. 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 AHDI'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. All the forms, handouts, and records a mental health professional needs to meet the documentation requirements of the managed care era The paperwork required when providing mental health services in the current era of third-party accountability continues to mount. This updated and revised Second Edition keeps today's mental health professionals on top of all the latest developments by providing a full arsenal of forms, checklists, and clinical records essential to effectively manage a practice. From intake to diagnosis and treatment through discharge and outcomes assessment, The Clinical Documentation Sourcebook offers sample forms for every stage of the treatment process. Expanded by 30% from the first edition, the book now includes 30 fully completed forms as well as 36 ready-to-copy blank forms that are also provided on disk so they may be easily customized. With The Clinical Documentation Sourcebook you'll spend less time on paperwork and more time with clients. Ready-to-use blank forms, handouts, and records make it easy to satisfy the paperwork demands of HMOs, insurers, and regulatory agencies Completed copies of forms illustrate the exact type of information required Clear, concise explanations of the purpose of each form—including when it should be used, with whom, and at what point Forms may be copied from the book or customized on the included disk Clinical documentation improvement (CDI) is not about how to code in ICD-10-CM or CPT. CDI is knowing what to look for in medical records, as well as how to ask for clarification and get ongoing changes to the notes and comments provided by physicians. Important Note: The greater number of ICD-10-CM diagnostic codes means an even bigger need for detailed clinical documentation. Making the right code selection requires having adequate clinical detail, and under ICD-10-CM, clinician's documentation willmore than evertranslate into reimbursement gained or lost. This book has information regarding the new developments in clinical instrumentation, focusing on fluorometers and densitometers, explaining the principles, the use of high performance liquid chromatography in clinical laboratories. Automated Microbiology; dabbling into detection, light scanning and analysis of particles. Amore recent aspect of automation has been, made possible by the advent of the microprocessor orcomputer-on-a-chip. The development of miniature, inexpensive micro-computers has resulted in the automation for relatively sophisticated processes. The two aspects of automation are represented in this monograph. The automated control of physical processes, and automation of the information processing. There are elements of both aspects of automation in this book. The areas discussed do emphasize more or less strongly either tight automated control of physical processes or automation of information processing. They all represent the attempt of medical technology to yield more precise, accurate, less expensive and faster to acid in the clinical diagnosis. Develop the skills you need to effectively and efficiently document patient care for children and adults in clinical and hospital settings. This handy guide uses sample notes, writing exercises, and EMR activities to make each concept crystal clear, including how to document history and physical exams and write SOAP notes and prescriptions. Providing in-depth guidance for proper review of medical documentation in today's changing medical environment, this fourth edition of the Medical Record Auditor is full of new content. New topics include electronic health records (EHR), ICD-10 coding, Health Information Management and many other issues essential for maintaining compliance. Learn critical auditing fundamentals, read dozens of case studies, use the checkpoint exercises to test your knowledge, and download actual audit forms to help improve your process. Features and Benefits - New content addresses EHRs, ICD-10 coding and more - Downloadable forms. One copy of each audit form is included, but all forms are downloadable from website - Case studies. Ten different specialties are featured with more than 80 total case studies - Checkpoint exercises. Test your knowledge to confirm comprehension of new content This comprehensive handbook provides adaptable assessment and documentation processes for social skill development in music therapy group sessions for children with developmental disabilities. It also includes a CD-ROM of forms and tools, as well as songs that help to facilitate social interaction. In light of an increasing awareness of errors in medicine and of the importance of decision support in clinical systems, the study of medical decision-making has evolved into an increasingly influential area of research in medical informatics. Understanding decision processes and the source of cognitive errors can provide a meaningful framework for facilitating decision making in practice and support safe patient care through technology use. This research examines the skills related to clinical performance, the cognitive process involved in informing clinical decision-making and the impact of these competencies on the use of information systems in patient care settings by the physician assistant (PA) population. Understanding decision processes can provide a meaningful framework for facilitating decision making in practice and support technology mediated clinical decision support for PA providers. While information on clinical informatics research is available for physicians and nurses, none have been dedicated exclusively to PAs. Results of this study will be used to inform the development of health information technology which is used by this growing population of healthcare providers and can contribute to their professional development and patient safety. 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 Patient-centered, high-quality health care relies on the well-being, health, and safety of health care clinicians. However, alarmingly high rates of clinician burnout in the United States are detrimental to the quality of care being provided, harmful to individuals in the workforce, and costly. It is important to take a systemic approach to address burnout that focuses on the structure, organization, and culture of health care. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being builds upon two groundbreaking reports from the past twenty years, To Err Is Human: Building a Safer Health System and

Crossing the Quality Chasm: A New Health System for the 21st Century, which both called attention to the issues around patient safety and quality of care. This report explores the extent, consequences, and contributing factors of clinician burnout and provides a framework for a systems approach to clinician burnout and professional well-being, a research agenda to advance clinician well-being, and recommendations for the field. 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. Cover title includes subtitle: "Achieving excellence." Thoroughly updated for its Second Edition, this comprehensive reference provides clear, practical guidelines on documenting patient care in all nursing practice settings, the leading clinical specialties, and current documentation systems. This edition features greatly expanded coverage of computerized charting and electronic medical records (EMRs), complete guidelines for documenting JCAHO safety goals, and new information on charting pain management. Hundreds of filled-in sample forms show specific content and wording. Icons highlight tips and timesavers, critical case law and legal safeguards, and advice for special situations. Appendices include NANDA taxonomy, JCAHO documentation standards, and documenting outcomes and interventions for key nursing diagnoses. The perfect guide to charting! The popular Davis’s Notes format makes sure that you always have the information you need close at hand to ensure your documentation is not only complete and thorough, but also meets the highest ethical and legal standards. You’ll even find coverage of the nuances that are relevant to various specialties, including pediatric, OB/GYN, psychiatric, and outpatient nursing. 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 All the forms, handouts, and records you need to meet the paperwork requirements of the managed care era In an era of third-party accountability, your professional survival could hinge on your ability to comply with the documentation requirements of insurers and regulatory agencies. Written by an experienced clinician who has trained thousands of mental health professionals in effective clinical documentation, this sourcebook helps you minimize the potential for billing disputes–or worse–by arming you with the full retinue of required forms, checklists, and records. An indispensable resource for mental health professionals working in inpatient, partial hospitalization, day treatment, and/or residential treatment programs, The Continuum of Care Clinical Documentation Sourcebook is the only book that brings together sample documents covering all stages of treatment–from intake and admission to outcome assessment. Ready-to-use blank forms, handouts, and records make it easy to satisfy the paperwork demands of HMOs, insurers, and regulatory agencies Completed copies of forms illustrate the exact type of information required Clear, concise explanations of the purpose of each form–including when it should be used, with whom, and at what point Forms may be copied from the book or customized on the included disk Clinical Documentation Improvement for Outpatient Care: Design and Implementation is an all-inclusive guide to establishing and enhancing CDI programs for the outpatient amd professional fee setting. the author will provide once available There are many subfields within the medical fields like doctor, physician or MD, the allied health professions, 100+ nursing specialties, holistic medicine, drugs and biotechnology, medical technician jobs, medical devices and products, genetics, care worker, medical administration, etc. I cover medical jobs and schools for many fields in this book. There is more info in my other medical books. One is a basic framework of medicine in the United States. Another is the medical infrastructure of the world. I created a book for cancer and one for holistic medicine. The 149 volumes are as follows: Volume 1. A Medical Career Exploration Guide Volume 2. A Medical Career Exploration Website Guide Volume 3. A Medical Job Guide 1 Volume 4. A Medical Job Guide 2 Volume 5. A Medical Job Guide 3 Volume 6. A Medical Job Guide 4 Volume 7. A Medical Job Guide 5 Volume 8. A Medical Job Guide 6 Volume 9. A Medical Job Website Guide 1 Volume 10. A Medical Job Website Guide 2 Volume 11. A Medical Job Website Guide 3 Volume 12. Medical Job Websites for Canada, U.S. and the World Volume 13. A Medical Job Website Guide at dmoz-odp.org/Health/Medicine/Employment and dmoz-odp.org/Business/Healthcare/Employment Volume 14. A Health Profession Website Guide at Volume 15. A U.S. Job Website Guide by State at careerprofiles.info: General, Med, Ed and Govt Jobs Volume 16. Use this Find a Doctor-Hospital-Clinic-Healer Guide to Find Jobs Volume 17. A Medical Profession Job Guide 1 Volume 18. A Medical Profession Job Guide 2 Volume 19. A Medical Profession Job Guide 3 Volume 20. A Medical Profession Job Guide 4 Volume 21. A Medical Profession Guide at explorehealthcareers.org 1 Volume 22. A Medical Profession Guide at explorehealthcareers.org 2 Volume 23. A Pediatrics (Children’s Medicine) Career Guide Volume 24. A Doctor-Physician-MD Career-Job Guide Volume 25. A Doctor-Medical Job Website Guide from a Dead Website residentphysician.com Volume 26. An Obstetrics-Gynecology-Neonatal Nurse Career Guide Volume 27. A Nurse Career Guide Volume 28. A Nursing Blog Guide Volume 29. A Nursing Education-School Guide Volume 30 A Nurse Job Website Guide Volume 31. A Nurse Job Website Guide by U.S. State Volume 32. A World Nurse Job Guide Volume 33. A Canada Nurse Job Guide Volume 34. A Specific Nurse Category Job Guide 1 Volume 35. A Specific Nurse Category Job Guide 2 Volume 36. A Specific Nurse Category Job Guide 3 Volume 37. A Specific Nurse Category Job Guide 4 ... The 2014 Guide to Clinical Validation, Documentation and Coding provides the clinical criteria necessary for code assignment. This resource describes the clinical documentation needed for determining if the condition is a complication, or when a medical condition should be coded as an additional diagnosis. Now coders, utilization review staff, and HIM managers can systematically evaluate the clinical criteria that influence code assignments and patient care. Covers 50 of the most challenging inpatient medical diagnoses and procedures. Provides detailed clinical criteria and physician documentation requirements. Code assignment justifications are thoroughly outlined. Helps craft physician queries. Learn how to address fine distinctions in a patient's medical condition and ensure appropriate reimbursement. Provides a detailed clinical description of problematic diagnoses or procedures--from a coder's perspective--plus the clinical criteria that support code assignment. Assists coders in determining what clinical elements are necessary for initial diagnosis code assignment, when it should be coded as a complication, and when the condition should be coded as an additional diagnosis. Ties in to ICD-10-PCS. Identifies other terminology that would qualify for the ICD-10-PCS specific root operation term. Better patient management starts with better documentation! Documentation for Rehabilitation: A Guide to Clinical Decision Making in Physical Therapy, 3rd Edition shows how to

accurately document treatment progress and patient outcomes. Designed for use by rehabilitation professionals, documentation guidelines are easily adaptable to different practice settings and patient populations. Realistic examples and practice exercises reinforce concepts and encourage you to apply what you've learned. Written by expert physical therapy educators Lori Quinn and James Gordon, this book will improve your skills in both documentation and clinical reasoning. A practical framework shows how to organize and structure PT records, making it easier to document functional outcomes in many practice settings, and is based on the International Classification for Functioning, Disability, and Health (ICF) model - the one adopted by the APTA. Coverage of practice settings includes documentation examples in acute care, rehabilitation, outpatient, home care, and nursing homes, as well as a separate chapter on documentation in pediatric settings. Guidelines to systematic documentation describe how to identify, record, measure, and evaluate treatment and therapies - especially important when insurance companies require evidence of functional progress in order to provide reimbursement. Workbook/textbook format uses examples and exercises in each chapter to reinforce your understanding of concepts. NEW Standardized Outcome Measures chapter leads to better care and patient management by helping you select the right outcome measures for use in evaluations, re-evaluations, and discharge summaries. UPDATED content is based on data from current research, federal policies and APTA guidelines, including incorporation of new terminology from the Guide to Physical Therapist 3.0 and ICD-10 coding. EXPANDED number of case examples covers an even broader range of clinical practice areas. The Clinical Documentation Improvement Specialist's Guide to ICD-10, Second Edition 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. In it you'll find the specific documentation requirements to appropriately code a variety of conditions. The Clinical Documentation Improvement Specialist's Guide to ICD-10, Second 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 that facilities can download and use to jumpstart their ICD-10 documentation improvement efforts. Develop the expertise and comfort level you 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, Second Edition, 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 TABLE OF CONTENTS Chapter 1: ICD-10 primer Chapter 2: Conventions and Guidelines Chapter 3: Physician queries Chapter 4: CDI target areas Chapter 5: ICD-10-CM/PCS Provider Education Documentation for Physical Therapist Practice: A Clinical Decision Making Approach provides the framework for successful documentation. It is synchronous with Medicare standards as well as the American Physical Therapy Association's recommendations for defensible documentation. It identifies documentation basics which can be readily applied to a broad spectrum of documentation formats including paper-based and electronic systems. This key resource utilizes a practical clinical decision making approach and applies this framework to all aspects of documentation. This text emphasizes how the common and standard language of the Guide to Physical Therapist Practice and the International Classification of Functioning, Disability, and Health (ICF) model can be integrated with a physical therapist's clinical reasoning process and a physical therapist assistant's skill set to produce successful documentation. Includes content on documentation formations: Initial Evaluations, Re-examination Notes, Daily Notes, Conclusion of the Episode of Care Summaries, Home Exercise Program Reviews all the important issues related to style, types of documentation, and utilization of documentation Covers documentation relevant in different settings (inpatient, home health, skilled nursing facility, outpatient) Helps students learn how to report findings and demonstrate an appropriate interpretation of results Includes up-to-date information in line with APTA Guidelines for Defensible Documentation, World Health Organization, International Classification of Functioning Disability and Health Mode, and Medicare Reviews electronic documentation, ICD-9, ICD-10, and CPT codes Includes important chapters on Interprofessional Communication, Legal Aspects, Principles of Measurement 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 Intended as a primer for those just beginning to study nursing informatics, this text equally provides a thorough introduction to basic terms and concepts, as well as an in-depth exploration of the most popular applications in nursing practice, education, administration and research. The Third Edition is updated and expanded to reflect the vast technological advances achieved in health care in recent years. Readers will learn how to use computers and information management systems in their practices, make informed choices related to software/hardware selection, and implement computerized solutions for information management strategies.

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- Guide To Clinical Documentation
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- The Essentials Of Clinical Documentation
- New Developments In Clinical Instrumentation
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- Communicating Clinical Decision Making Through Documentation Coding Payment And Patient Categorization
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- Guide To Clinical Validation Documentation And Coding 2014
- Introduction To Nursing Informatics
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