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(Clinical Documentation Specialist) Certification Exam ICD-10 and Clinical Documentation How to Write Clinical Patient Notes: The Basics Documentation Improvement for Quality and Value INTRODUCTION TO CLINICAL DOCUMENTATION IMPROVEMENT STORYTIME MEDICAL CODING 5-HIM HEALTHCARE PROFESSIONS THAT DOES NOT DEAL WITH DIRECT PATIENT CARE! Tips for Developing Physician Queries Clinical Documentation Improvement | OPERATOR INSIGHTS | Healthcare Revenue Cycle Future of Clinical Documentation: AI, Automation, Virtual Scribing... Clinical Documentation Improvement 2016 09 14 13 00 Clinical Documentation Integrity Clinical Indicators Hcpro Coders are constantly analyzing documentation for clues and details that may indicate the need for a physician query. For example, coders should watch for clinical evidence that points to a condition that the physician may not have explicitly documented. Coders also need to be wary of reporting conditions without accounting for context or other clinical indicators in the documentation.

~~Examine documentation for clinical indicators that ...~~ HcPro

Clinical Indicators Hcpro Be on the lookout for these specific clinical clues to provide clinical support for a CHF query, says Spryszak: An echocardiogram that shows an ejection fraction (EF) of less than 50%, which is indicative of systolic heart failure, or an EF of greater than 50%, which generally indicates diastolic heart failure.

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Congestive heart failure (CHF) is one example of a condition for which coders and CDI specialists should understand clinical indicators before querying physicians, says Lynne Spryszak, RN, CCDS, CPC-A, a CDI educator at HcPro, Inc., in Marblehead, MA. Be on the lookout for these specific clues to provide clinical

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support for a CHF query, says Spryszak:

~~Tip: Understand clinical indicators of CHF before ... — HCPro~~

Clinical Indicators Hcpro Be on the lookout for these specific clues to provide clinical support for a CHF query, says Spryszak: An echocardiogram that shows an ejection fraction (EF) of less than 40%, which is indicative of

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Clinical Indicators Hcpro Yet they typically identify multiple clinical criteria and provide appropriate management for respiratory failure, which creates query opportunities. In this article, we will discuss a variety of clinical indicators for respiratory failure and identify a number of common documentation improvement opportunities ...

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When a practitioner documents a diagnosis that does not appear to be supported by the clinical indicators in the health record, it is currently advised that a query be generated to address the conflict or that the conflict be addressed through the facility ' s escalation policy. ”

~~Q&A: Query options for lack of clinical indicators — HCPro~~

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E-mail; Print; RSS; Q&A: Capture clinical indicators in the medical record CDI Strategies, February 14, 2013. Want to receive articles like this one in your inbox? Subscribe to CDI Strategies!. Q: We recently had a case where the patient was admitted from the ED with pneumonia but the attending hospitalist diagnosed acute bronchitis because the chest x-ray did not show infiltrates or any of ...

~~Q&A: Capture clinical indicators in the ... hcpro.com~~

Association of Clinical Documentation Improvement Specialists, May 1, 2015. Historically, organizations—primarily hospitals—tended to focus on diagnosis-related group (DRG) validation and limit their clinical validation to utilization review efforts, says Cheryl Ericson, MS, RN, CCDS, CDIP, CDI education director at HCPro in Danvers, Massachusetts, who spoke during the “ Defining the Role of CDI Through Clinical Validation ” webinar earlier this year.

~~Clinical validation reviews defense against denials—HCPro~~

The provider uses clinical indicators as part of the process to determine if a patient has a specific condition. There are numerous “ medically accepted standards ” for clinical indicators for most diagnoses, however, a provider can determine the diagnosis by any clinical indication that he/she feels is present and represents a condition in the patient.

~~Q&A: Clinical indicator contradictions | ACDIS~~

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Consider what stage your CDI program is at. If it ' s a new program, KPIs may be limited to CC/MCC capture and query agreement rates. More advanced programs need to add in quality KPI measures, including clinical validation for denials prevention. Patient safety indicators and hospital-acquired conditions for quality measures would be another area.

~~CDI Week 2020 Q&A: CDI and key performance indicators | ACDIS~~

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I know all about pseudo-hyponatremia with hyperglycemia and would never query for hyponatremia with a

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markedly elevated glucose. My question is if I had a NA - 130 yesterday, & a NA - 128 today (both with glucose WNL), would these clinical findings in & of themselves qualify as valid clinical indicators to query for hyponatremia.

~~Hyponatremia Query Clinical Indicators — ACDIS Forums~~

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clinical indicators of a body mass index of 15, intake of 25% to 50%, skin breakdown, cachexia, weakness and a nutrition consult with Megace®, nutritional supplementation, may be all the patient can tolerate at that point in time. We strive to demonstrate the effects of the malnutrition on the patient ' s condition, again digging

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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

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

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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

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

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edition, not only outlines the changes coming in October 2014, it provides detailed information on how to assess staffing needs, training requirements, 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 2013 CDI Pocket Guide helps you take clinical findings and dig deeper, and look for additional details -- such as medications and other conditions -- to develop the most accurate picture of the patient's condition. Authors Dr. Richard Pinson and Cynthia Tang draw on more than fifty years' cumulative experience and provide the clinical coding authority to strengthen patient care quality and resource utilization, and improve compliance and reimbursement. What's Inside * A portable and easy reference to keep DRGs and diagnoses at your finger tips * The latest coding guidelines and relative weights so you don't report inaccurate codes * Clinical indicators to help identify documentation opportunities and formulate an appropriate query to the

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physician * 2013 DRG table with relative weights, GMLOS, and transfer DRG indicator Also included in this edition is an ICD-10 overview and a preview of the ICD-10 changes in each of the individual sections.

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

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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.

ACDIS Answers: Clinical Documentation Improvement FAQs ACDIS Answers: Clinical Documentation Improvement FAQs is a quick reference guide for the most common questions faced by CDI specialists. Organized by Major Diagnostic Categories and broken down into specific topics of concern, ACDIS Answers provides information not only on documentation needs but also on issues related to the CDI profession. This compendium of commonly asked CDI questions is an essential reference book and office companion, valuable for new CDI specialists as well as those experienced in concurrent medical record review. Whether you're wondering about sequencing guidelines, staff productivity, escalation policies, diabetes coding, or documentation requirements for acute kidney injury, ACDIS Answers provides quick, easily understandable information from respected experts in CDI, including ACDIS' own Boot Camp instructors and Advisory Board members.

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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

Clinical Validation Reviews for CDI Professionals tackles the nuances of a critical concern for CDI professionals and provides expert guidance for meeting challenging chart reviews head-on. With government auditors frequently denying claims due to lack of clinical indicators for documented diagnoses, CDI professionals are left asking whether they should simply code a clinically unsupported diagnosis or query the physician. While the answer may seem clear, querying can lead to productivity reductions, additional education outreach, and a call for broader policies governing query escalation and reconciliation. This brand-new book leverages its authors' expertise to help CDI professionals effectively and efficiently navigate these issues during a necessary query process. By understanding clinical validation concerns, CDI staff can become

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better translators and storytellers--clarifying the medical record without appearing to question the physician's medical judgment.

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