

# CLINICAL DOCUMENTATION SPECIALIST



THE COMPREHENSIVE GUIDE  
VIRUTI SHIVAN

# Clinical Documentation Specialist

**Rn Phn Nkwuaku, Msn Cphq**



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Cphq, 2015-12-17 *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. *Clinical Documentation Specialist - The Comprehensive Guide* Viruti Shivan, 2024-03-28 *Mastering the Art of Medical Record Accuracy and Compliance for Enhanced Patient Care*. Dive into the essential world of clinical documentation with *Clinical Documentation Specialist: The Comprehensive Guide*, a pivotal resource designed for healthcare professionals committed to excellence in patient care through meticulous record keeping. This guide offers a deep dive into the principles of accurate and compliant medical documentation, highlighting its critical role in ensuring optimal patient outcomes and the seamless operation of healthcare systems. With an emphasis on practical strategies, real-world applications and the latest compliance standards, this book serves as an invaluable tool for both aspiring and experienced clinical documentation specialists. By focusing on enhancing communication between healthcare providers and supporting the delivery of high-quality care, it addresses the challenges and complexities of modern medical documentation practices. Without relying on images or illustrations for clarity, the guide stands out for its comprehensive coverage and insightful analysis, making it a unique addition to the professional library of healthcare providers. It transcends basic instructional material by weaving in theoretical knowledge with actionable advice, empowering readers to navigate the nuanced landscape of healthcare documentation with confidence. The absence of visual elements is more than compensated for by the depth of knowledge and the engaging writing style, ensuring that readers are equipped

with the knowledge and skills necessary to make a significant impact in their roles as guardians of patient information and care continuity

**Successful Collaboration in Healthcare** Colleen Stukenberg, 2010-01-27 This critically acclaimed work makes the case for collaboration and shows that it can be greatly enhanced with conscious understanding and systematic effort As a healthcare specialist who has worn many hats from direct care giver to case manager to documentation specialist Colleen Stukenberg is able to Show how to build trust and communicate

**The Clinical Documentation Improvement Specialist's Guide to ICD-10, Second Edition** Jennifer Avery, Cheryl Ericson, 2013-05-07 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

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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 The CCDS Exam Study Guide, 2010 *First Steps in Outpatient CDI* Anny Pang Yuen, Page Knauss, 2017-06-22 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 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 The CCDS Exam Study Guide (Certified Clinical Documentation Specialist Exam Study Guide). Fran Jurcak, CDI Specialist's Guide to ICD-10 Jennifer Avery, 2014-05-14 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



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**Documentation Fails** Darlene Maslek Colaianne,2020-09-13 As a Clinical Documentation Specialist CDS I reviewed documentation dictated and manually entered into the Electronic Medical Record EMR by Physicians So many fails My job was to bring these fails to the attention of the doctors and help them ensure accuracy and compliance Over several years I collected these memorable fails and wanted to share the most hilarious and puzzling ones with you I hope you enjoy them as much as I did when I came across them in a chart *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 why this resource 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 **Lined Notebook Journal**

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