

Clinical Documentation Resources

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 through 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

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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-

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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

Provides documentation procedures designed to meet or exceed standards by accrediting agencies, 3rd party payors, and HIPAA compliance Covers training and examples of empirical evidence of client progress from the intake to termination Revised to cover DSM-5 revisions Includes training in documenting treatment outcomes Everything you need to know to record client intake, treatment, and progress—incorporating the latest managed care, accrediting agency, and government regulations Paperwork and record keeping are day-to-day realities in your mental health practice. Records must be kept for managed care reimbursement; for accreditation agencies; for protection in the event of lawsuits; to meet federal HIPAA regulations; and to help streamline patient care in larger group practices, inpatient facilities, and hospitals. The standard professionals and students have turned to for quick and easy, yet comprehensive, guidance to writing a wide range of mental health documents, the Fourth Edition of *The Psychotherapy Documentation Primer* continues to reflect HIPAA and accreditation agency requirements as well as offer an abundance of examples. Fully updated to include diagnostic criteria of the DSM-5, *The Psychotherapy Documentation Primer, 4th Edition* is designed to teach documental skills for the course

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of psychotherapy from the initial interview to the discharge. The documentation principles discussed in the text satisfy the often-rigid requirements of third-party insurance companies, regulating agencies, mental health licensing boards, and federal HIPAA regulations. More importantly, it provides students and professionals with the empirical and succinct documentation techniques and skills that will allow them to provide clear evidence of the effects of mental health treatment while also reducing the amount of their time spent on paperwork.

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and

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reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The premier resource for professional nursing practice, *Nursing: Scope & Standards of Practice, 3rd Edition*, is informed by the advances in health care and professional nursing today. This keystone standard contains 17 national standards of practice and performance that define the who, what, where, when, why and how of nursing practice. The scope and standards of practice inform and guide nursing practice and are often used as a reference for: Quality improvement initiatives Certification and credentialing Position descriptions and performance appraisals Classroom teaching and in-service education programs Boards of nursing members' orientation programs and regulatory decision-making activities It also outlines key aspects of nursings' professional role and practice for any level, setting, population focus, or specialty and more! In sum, *Nursing Scope and Standards of Practice* is a detailed and practical discussion of the competent level of nursing practice and professional performance. It is a must-have for every registered nurse. - Publisher.

Product Description The *Ophthalmic Scribe Manual* is the ultimate how-to manual for

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learning to scribe in ophthalmology. If you're interested in learning more about scribing in retina, cornea, comprehensive, glaucoma, or oculoplastics, this manual has you covered. Inside, you will find over 100 full-color figures and tables illustrating the most important concepts, Anatomy & Physiology, organized high-yield abbreviations, must know medications, must know imaging modalities, and high-yield specialty-specific pathology. About the Author After graduating with a Bachelor of Science in Biology from the University of North Carolina at Chapel Hill and prior to enrolling in medical school, my job search brought me back home to Atlanta where I accepted a position as an Ophthalmic Medical Scribe. I had no prior experience as a scribe or in the healthcare field, but I knew that quickly improving my understanding of ophthalmology would be essential for my success. I searched the web to obtain every piece of relevant ophthalmology information that I could find, and I spent hours experimenting with the functionalities of the eye clinic's electronic medical record to better prepare myself for my new role. However, I found that it took a significant amount of time and effort to sift through the excessive online information before I was able to hone in on the relevant material. Due to the lack of designated ophthalmic medical scribe training resources and the vast amount of irrelevant information online, I decided that the creation of The Ophthalmic Scribe Manual was warranted. With over 3 years of scribing experience and over 20,000 patient encounters, as well as having published a variety of first author case reports and review articles in prominent ophthalmic medical journals, I am

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confident that my experiences will offer an immediate benefit to those seeking to excel in this rewarding profession. Review "Very well-written! This looks terrific and will be great for widespread use particularly in training programs, especially with the growing need for trained ophthalmic personnel."

Publisher's Note: Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality, authenticity, or access to any online entitlements included with the product. Today's health care is much more than Medicine. Health care professionals and administrators must be familiar with the non-medical aspects of health care if they are to be successful. From the basics of government and private insurance, to reimbursement methods, payment models, practice paradigms and new industry trends this indispensable guide provides much-needed information for medical students and residents, emerging health care professionals, and anyone who wants a clear perspective on the requisites, protocols, and regulations of today's health care system. The greater number of ICD-10-CM diagnostic codes means an even bigger need for detailed clinical documentation. Making the right codes selection requires having adequate clinical detail, and under ICD-10, clinician's documentation will-- more than ever--translate into reimbursement gained or lost. The quality of clinical documentation is a longstanding challenge. This manual provides the resources you need to gain physician cooperation and to enhance coding through clinical documentation improvement for ICD-10-CM. Important Note: Clinical documentation improvement

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(CDI) is not about how to code in ICD-10. 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.

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 book pinpoints current and impending threats to the healthcare industry's data security.

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

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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.

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

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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

This pocket-size guide saves nurses precious time while ensuring that a complete patient record is created and that legal, quality assurance, and reimbursement requirements are met. This handbook provides specific verbiage for charting patient progress, change or tasks accomplished for approximately 50 common problems. The new third edition has been completely updated to include Critical Assessment Findings, Subjective Findings for Documentation, Resources for Care and Practice, Legal Considerations, Time Saving Tips, and new Managed Care information. Plus, roughly 15 additional common problems and diagnoses have been added making this practical resource more valuable than ever. Diagnoses are in alphabetical order allowing for fast and easy access. Each patient problem or diagnosis found in this handbook includes specific documentation guidelines for the following aspects of nursing care:

*Assessment of patient problem *Associated nursing diagnosis *Examples of objective findings for documentation *Examples of subjective findings for documentation
*Examples of assessment of the data *Examples of potential medical problems for this

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patient *Examples of the documentation of potential nursing interventions/actions
*Examples of the evaluations of the interventions/actions *Other services that may be indicated and their associated interventions and goals/outcomes *Nursing goals and outcomes *Potential discharge plans for this patient *Patient, family, caregiver educational needs *Resources for care and practice *Legal considerations for documentation, as appropriate

Introductory chapters describe documentation, the medical record systems of nursing documentation, and current JCAHO and ANA standards related to documentation. Specialty sections provide important and specific guidelines for hospice care and maternal-child care. Appendices provide the latest NANDA-approved nursing diagnoses, descriptions of services provided by other disciplines, abbreviations, and a listing of resources (i.e., directory of resources, clinical newsletters and journals, Internet resources, further reading). Includes Time Saving Tips boxes to help minimize the time needed for documentation responsibilities. Each diagnosis includes a Critical Assessment Components/Findings section to help nurses with their critical decision making and determine whether an assessment finding indicates immediate attention or patient follow up. The Goals/Outcomes section of each diagnosis now appears at the beginning so that nurses know the intended goals and outcomes up front before beginning the assessment. All documentation guidelines now include sections on Examples of Subjective Findings for Documentation and Resources for Care and Practice. Includes Legal Considerations for Documentation as appropriate

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to highlight important legal issues. Part One has been updated to reflect the current managed care environment, including new information required by the National Community of Quality Assurance [NCQA], so that nurses can incorporate and focus on these changes as they document

CPT® 2021 Professional Edition is the definitive AMA-authored resource to help health care professionals correctly report and bill medical procedures and services. Providers want accurate reimbursement. Payers want efficient claims processing. Since the CPT® code set is a dynamic, everchanging standard, an outdated codebook does not suffice. Correct reporting and billing of medical procedures and services begins with CPT® 2021 Professional Edition. Only the AMA, with the help of physicians and other experts in the health care community, creates and maintains the CPT code set. No other publisher can claim that. No other codebook can provide the official guidelines to code medical services and procedures properly. **FEATURES AND BENEFITS** The CPT® 2021 Professional Edition codebook covers hundreds of code, guideline and text changes and features: CPT® Changes, CPT® Assistant, and Clinical Examples in Radiology citations -- provides cross-referenced information in popular AMA resources that can enhance your understanding of the CPT code set E/M 2021 code changes - gives guidelines on the updated codes for office or other outpatient and prolonged services section incorporated A comprehensive index -- aids you in locating codes related to a specific procedure, service, anatomic site, condition, synonym, eponym or

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abbreviation to allow for a clearer, quicker search Anatomical and procedural illustrations -- help improve coding accuracy and understanding of the anatomy and procedures being discussed Coding tips throughout each section -- improve your understanding of the nuances of the code set Enhanced codebook table of contents -- allows users to perform a quick search of the codebook's entire content without being in a specific section Section-specific table of contents -- provides users with a tool to navigate more effectively through each section's codes Summary of additions, deletions and revisions -- provides a quick reference to 2020 changes without having to refer to previous editions Multiple appendices -- offer quick reference to additional information and resources that cover such topics as modifiers, clinical examples, add-on codes, vascular families, multianalyte assays and telemedicine services Comprehensive E/M code selection tables -- aid physicians and coders in assigning the most appropriate evaluation and management codes Adhesive section tabs -- allow you to flag those sections and pages most relevant to your work More full color procedural illustrations Notes pages at the end of every code set section and subsection

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

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benefits their E/M payments, prevents medical necessity denials, and provides the information they need to document correctly. This handbook offers the perfect portable reference guide for CDI specialists to educate physicians about E/M documentation. This handbook is provided in packs of 10 so CDI specialists can distribute copies to physicians during documentation improvement education sessions or in response to physician questions and requests for additional information. This reference guide will help CDI specialists:

- Better understand the complex guidelines that affect physician payment for E/M services
- Explain the importance of documentation to physicians beyond hospital reimbursement
- Clarify the purpose of queries and how responding to them benefits physicians' payments and public profiles
- Encourage physicians to provide adequate documentation that will reduce the number of denials for lack of documented medical necessity
- Access a comprehensive list of additional online resources to further aid them in their important role

Take a look at the table of contents:

- Chapter 1: E/M Documentation
- Chapter 2: Components of E/M
- Chapter 3: Chief Complaint
- Chapter 4: History of Present Illness
- Chapter 5: Review of Systems
- Chapter 6: Past, Family, and Social History
- Chapter 7: Physical Examination
- Chapter 8: Medical Decision-Making
- Chapter 9: Amount and Complexity of Data
- Chapter 10: Critical Care
- Chapter 11: Medical Necessity and Clinical Documentation
- Appendix

The Internship, Practicum, and Field Placement Handbook is a practical guide for interns in the helping professions, with real-world knowledge of the skills students need

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through every phase of their practicum, field placement, or internship. This text expertly guides students through the essential skills needed for beginning work in the field of mental health and outlines skills that will serve students throughout their academic and professional careers. Skills discussed include how to make a great first impression, understanding the process and content of clinical writing, recordkeeping, working with peers and supervisors, understanding diversity, cultivating self-care, and promoting safety. Every phase of the internship is discussed chronologically: from finding and preparing for placements to concluding relationships with clients and supervisors. Following an evidence and competency-based approach, the latest research findings are reviewed from the fields of psychology, social work, and counseling. The Internship, Practicum, and Field Placement Handbook is an invaluable resource for students, faculty, and supervisors engaged in the exciting, challenging experience of transitioning from academia into clinical training in the field. Free online resources available at www.routledge.com/9781138478701 support the text.

Including all of the information necessary for safe, competent practice, this is a practical, hands-on educational and training resource for nurses working in telephonic health care settings. It delivers the requisite tools and instruction for optimizing patient communication, performing assessments, and providing effective care of chronic conditions. Moving step-by-step from simple to complex information, the resource demystifies the process of telephonic nursing care and describes numerous tools such as

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learning outcomes, algorithms, exercises to reinforce learning, case studies, and critical thinking questions that help readers develop and hone telehealth nursing skills. The text instructs nurses on how to actively listen to the patient "between the lines" in the absence of an in-person examination and discern the right questions to ask and tone to adopt. Chapters provide enhanced communication techniques to perform comprehensive health assessments with only the sense of hearing and resources available through the telephone. Clinical pearls are scattered throughout the text from those who have been "in the trenches" and cared for a wide variety of patients using the telehealth nursing techniques illustrated in this book. Key Features: Helps nurses understand the keys to successful telehealth nursing Teaches enhanced, specialized communication techniques including "active listening" Guides nurses in assessing patients using only sense of hearing/active listening Includes case studies, algorithms, patient teaching resources and more Reviews body systems and disease processes with application exercises

This is the eBook of the printed book and may not include any media, website access codes, or print supplements that may come packaged with the bound book. A comprehensive guide to creating effective documentation in occupational therapy. Documenting Occupational Therapy Practice, 3/e is the most comprehensive text on occupational therapy documentation currently on the market, covering general documentation principles, clinical documentation, electronic documentation, school

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system documentation, and documentation of administrative tasks. More than just a how-to manual, the text explores important ethical, legal, and language issues related to documentation in addition to presenting step-by-step strategies for creating successful SOAP notes, communications, and documentation. The Third Edition has been fully updated to reflect current AOTA official documents and new electronic documentation tools, and has been reorganized to improve readability. Effective review tools help readers truly master documentation techniques and strategies, while the text's accompanying website provides additional learning resources that can be accessed on the go. Teaching and Learning Experience This text offers a comprehensive guide to creating effective documentation for occupational therapy. It provides:

- Comprehensive coverage of all areas of practice: Chapters examine the underlying concepts of good documentation in clinical, school, and administrative settings.
- Practical techniques and strategies that prepare students for the workplace: Chapters present clear, effective strategies for drafting documentation and communication that can be directly applied in professional settings.
- Exploration of ethical and legal issues: Discussions help students understand how documentation affects others and provide problem-solving strategies for addressing legal and ethical issues.
- Coverage of electronic documentation: Screenshots and discussion of electronic health record (EHR) systems familiarize students with current documentation technologies.
- Effective learning tools: Review exercises and numerous reference tools

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help students truly master text material.

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.

THE #1 Drug Guide for nurses & other clinicians...always dependable, always up to date! Look for these outstanding features: Completely updated nursing-focused drug monographs featuring 3,500 generic, brand-name, and combination drugs in an easy A-to-Z format NEW 32 brand-new FDA-approved drugs in this edition, including the

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COVID-19 drug remdesivir—tabbed and conveniently grouped in a handy “NEW DRUGS” section for easy retrieval NEW Thousands of clinical updates—new dosages and indications, Black Box warnings, genetic-related information, adverse reactions, nursing considerations, clinical alerts, and patient teaching information Special focus on U.S. and Canadian drug safety issues and concerns Photoguide insert with images of 439 commonly prescribed tablets and capsules

The text has a variety of user friendly lists, tables, charts, summaries, articles, practice tests, clinical documentation sample forms, resources and contact information about case management in healthcare and human services. There are more than 100 pages of material in addition to the handouts made available in the seminar. The contents of this case management handbook include the following: the differences between case management and social work; case management history; governmental responses in the past; other titles used for case managers; admission summaries; case management service and treatment plans; multi-cultural recommendations for case managers; case management confidentiality; continuity of care; philosophy of case management; case manager status; supervision of case managers; preventing unnecessary prescription problems; depression screenings; case manager attitudes with the chronically mentally ill; counseling and case management professional ethics; establishing rapport with providers; customer service and case management; avoiding case management burnout; hepatitis A/B/C screenings; HIV/AIDS screening; TB screening; release of

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information; screening for substance use disorders; progress notes; discharge summaries; social history/assessment; psychological history/assessment; medical/dental history/assessment; educational/vocational history/assessment; legal history/assessment; top work settings; top job titles; HMO models; insurance; legal/medical/insurance terms; and case management organizations.

Efficient and accurate data management processes are essential for the successful conduction of clinical trials. The clinical research industry is unique among biomedical fields in that much of the reporting is still conducted using paper-based systems.

Recent trends towards exchanging paper-based documentation methods for electronic documentation methods have shown that implementation of digital resources have the potential to expedite clinical development. This practicum sought to evaluate paper-based and electronic documentation processes in a cancer clinic in regards to efficiency and user satisfaction, and determine which documentation form was superior in these areas. Retrospective analyses and a survey were used as the sources of data to assess for these differences. It was determined that the replacement of paper-based methods with electronic methods of documentation at this particular clinic resulted in both greater timeliness and higher user satisfaction.

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

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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.

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,

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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:

An AHA Press/Jossey-Bass Publication. Written by Jill Callahan Dennis, an expert in health information management and health care risk management, *Privacy and Confidentiality of Health Information* offers a step-by-step approach to understanding and providing the necessary protections to patient data. This essential guide presents proven solutions to the most common risks to health privacy and summarizes the resources that can be used to avoid breaches in confidentiality no matter what the health care setting--acute care, long-term care,

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ambulatory care, or home care.

Accompanying floppy disk contains ... "24 ready-to-use sample forms that meet the documentation requirements of virtually every managed care organization."--Page 4 of cover. 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!

Documentation for Physical Therapist Practice: A Clinical Decision Making Approach provides the framework for successful documentation. It is synchronous with Medicare standards as

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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 skillfully explains how to document the interpretation of examination findings so that the medical record accurately reflects the evidence. In addition, the results of consultation with legal experts who specialize in physical therapy claims denials will be shared to provide current, meaningful documentation instruction.

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

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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.

Dr. Rhonda Sutton's second edition of the straightforward guide to progress notes includes additional examples, information, documentation, and clinical language that expands on the utility and readability of the first book. Additional case studies provide examples of how to use the STEPs to format notes. New chapters include information on clinical language and documentation. This book covers everything about progress notes, from how to write them, to how to store them, and even what to do when someone requests to them. In addition, clinical terms and abbreviations are included as well as suggestions for other clinical documentation such as termination letters, privacy statements, and professional disclosure statements. Suited for all types of mental health clinicians, this book will help therapists improve upon their progress notes and other forms of clinical documentation.

Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources. This book clearly and concisely provides guidelines for appropriate and careful documentation of care. This new edition includes the latest changes and trends in

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nursing documentation as they relate to the newly restructured healthcare environment. Revised by the American Medical Association (AMA), Graduate Medical Education Directory, 2012-2013 (Green Book) contains comprehensive information on 9,000 Accreditation Council for Graduate Medical Education-accredited programs (GME) in the United States, including Residency, Fellowship, and Combined programs, plus residency application and career-planning resources. Revisions and updates: specialty/subspecialty information, Match data, 215 new programs, and 3,000 teaching institutions.

Clearly and concisely provides guidelines for appropriate and careful documentation of care. Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources. In addition, it plays a large role in how third party payors make payment or denial decisions. This new edition includes the latest changes and trends in nursing documentation as related to the newly restructured healthcare environment. Special attention focuses on the latest documentation issues specific to specialty settings, such as acute care, home care, and long-term care, and a variety of clinical specialties, such as obstetrics, pediatrics, and critical care.--Amazon.com.

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