ICD-10-CM Clinical Documentation Improvement Desk Reference - 2015

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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 (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.

Key Features and Benefits:

Includes the unique "ICD-10 Translator" that maps clinical terms. An exclusive documentation resource that maps ICD-9-CM clinical terminology to the associated ICD-10-CM terms to speed finding the correct code.

See key terms. Confirm accurate code selection for every chapter of ICD-10-CM.

Know when ICD-10-CM differs dramatically from ICD-9-CM. Alerts and warnings in the text of this book call your attention to situations where ICD-10-CM coding protocols are different from ICD-9-CM and significantly affect code choices.

Streamline the query process. Show physicians which medical terms are essential to assigning codes in ICD-10-CM. Includes best practice query forms that get results without unduly influencing clinicians.

Know when the coding system rules affect how documentation is interpreted.

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