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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.

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Table of Contents And Clinical Documentation Improvement Desk Reference

1. Understanding the eBook And Clinical Documentation Improvement Desk Reference
 - The Rise of Digital Reading And Clinical Documentation Improvement Desk Reference
 - Advantages of eBooks Over Traditional Books
2. Identifying And Clinical Documentation Improvement Desk Reference
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an And Clinical Documentation Improvement Desk Reference
 - User-Friendly Interface
4. Exploring eBook Recommendations from And Clinical Documentation Improvement Desk Reference
 - Personalized Recommendations
 - And Clinical Documentation Improvement Desk Reference User Reviews and Ratings
 - And Clinical Documentation Improvement Desk Reference and Bestseller Lists

5. Accessing And Clinical Documentation Improvement Desk Reference Free and Paid eBooks
 - And Clinical Documentation Improvement Desk Reference Public Domain eBooks
 - And Clinical Documentation Improvement Desk Reference eBook Subscription Services
 - And Clinical Documentation Improvement Desk Reference Budget-Friendly Options
6. Navigating And Clinical Documentation Improvement Desk Reference eBook Formats
 - ePub, PDF, MOBI, and More
 - And Clinical Documentation Improvement Desk Reference Compatibility with Devices
 - And Clinical Documentation Improvement Desk Reference Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of And Clinical Documentation Improvement Desk Reference
 - Highlighting and Note-Taking And Clinical Documentation Improvement Desk Reference
 - Interactive Elements And Clinical Documentation Improvement Desk Reference
8. Staying Engaged with And Clinical Documentation Improvement Desk Reference
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers And Clinical Documentation Improvement Desk Reference
9. Balancing eBooks and Physical Books And Clinical Documentation Improvement Desk Reference
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection And Clinical Documentation Improvement Desk Reference
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine And Clinical Documentation Improvement Desk Reference
 - Setting Reading Goals And Clinical Documentation Improvement Desk Reference
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of And Clinical Documentation Improvement Desk Reference
 - Fact-Checking eBook Content of And Clinical Documentation Improvement Desk Reference
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning

- Utilizing eBooks for Skill Development
- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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