Clinical documentation is a great opportunity for HIM processionals. It holds much promise for our profession. CDI has been around for years but lately many organizations are reinventing their programs and refocusing them to support population health, federal audits, meaningful use, ICD-10 and information governance initiatives. Whether you are currently working in CDI or you are just curious about how to move in this direction this bundle is a great opportunity!

Writing Effective and Compliant Physician Queries

Product #: AUDA013014 | CEUS: 2
Recorded live on: January 30, 2014
Faculty: Garry L. Huff, MD, CCS, CCDS

Physician queries by coders and concurrent documentation specialists are an essential part of accurate coding and billing. If done properly queries can provide enormous benefits for the physicians and the facility. If done incorrectly, queries can have a negative impact on physician response rates and compliance.

This presentation will offer advice regarding how to construct queries that will provide more effective communication with the physician and how to avoid denials and potential coding abuse allegations by external reviewers.

Objectives

- Understand why we need to query physicians
- Understand how to perform a compliant physician query
- Review case examples

CMS Pay for Performance Methodology

Product #: AUDA051314 | CEUS: 2
Recorded live on: August 19, 2014
Faculty: Kristen Geissler, MS, MBA, PT, CPHQ

CMS made several material changes to their pay-for-performance programs in the FY2014 Final Rule for the Inpatient Prospective Payment System (IPPS). The Hospital Readmissions Reduction Program (HRRP) has added conditions, and the Value-Based Purchasing (VBP) program has new and removed measures. There are also new measures for the FY2015 Hospital-Acquired Conditions Reduction Program with new financial impact. Each of these programs is highly dependent on accurate and complete provider documentation. The audience will learn at a high level the elements and methodology for each of these pay-for-performance quality components, as well as key strategies to related to documentation and coding that will impact these measures.

Objectives

- Describe the new and existing national pay-for-performance metrics
- Explain the documentation and risk adjustment components of these metrics
- Outline strategies related to documentation that will contribute to quality metric performance
Establishing a Second Level Review Process

Product #: AUDA062614 | CEUS: 2
Recorded live on: June 26, 2014

Faculty: Cheryll Rogers, RHIA, CDIP, CCS, CTR

This course will provide a basic introduction to the establishment of a second level review process, and how a documentation improvement program supports the success of this initiative.

Compliance initiatives, RAC prepayment DRG program, OIG audits, and denials related to patient status billing errors are some of the challenges hospitals face in trying to receive accurate and fair reimbursement for services provided to Medicare inpatients. The establishment of a proactive second level review process by a multidisciplinary team, prior to submission of the bill to third party payers, can help to ensure:

Objectives

• Accurate coding and DRG assignments
• Appropriate level of care to avoid patient status billing errors
• Physicians, coders, and case managers focus on accurate and complete medical record documentation to support the medical necessity of the hospital admission as well as accurate and complete coding of diagnosis and procedures resulting in the correct DRG assignment.

Optimizing Compliance in the Emergency Department

Product #: AUDA111314 | CEUS: 2
Recorded live on: November 13, 2014

Faculty: Robin Shannon, BSN, MN, MBA

As the contributor to more than 50 percent of the average hospital’s inpatient admissions, the emergency department (ED) treats large and growing patient volumes and can have a tremendous impact on regulatory compliance for a hospital. This webinar will outline several areas impacted by clinical information captured in the ED that every HIM director and compliance officer should be aware of. It will then define strategies for ensuring compliance attainment, enhancing current IT investments, and improving outcomes with current initiatives such as ICD-10-CM compliance. Because the ED is the primary patient entry point and arguably the most expensive place for patients to receive care, optimizing EHR investments in this setting is critical to achieve enterprise-wide success.

Objectives

• Evaluate the impact of emergency department (ED) clinical documentation on regulatory compliance.
• Explain the importance of ED documentation in the determination of accurate and specific ICD-10 codes.
• Describe how Clinical Documentation Improvement (CDI) efforts in the ED can ensure compliance and reduce risk.
• Describe how to develop a team approach to support Clinical Documentation Improvement in the ED.
• List system attributes and compliance measures hospitals should look for and apply to mitigate risk.

Note: All webinars can be purchased individually, outside of the bundle listed here. Webinar pricing for members is $125 per webinar ($145 for nonmembers). Each webinar is 60 minutes in length. There are no refunds or credits for previously purchased programs. To purchase webinars individually visit ahima.org/education/webinars.