



# ICD-10-CM Clinical Documentation Improvement Desk Reference 2014

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## **ICD-10-CM Clinical Documentation Improvement Desk Reference 2014 Optum360**

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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