Guide to Clinical Validation, Documentation and Coding -- 2015

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For decades, coders have sought a concise, reliable and easy-to-follow tool for those problematic diagnoses and inpatient procedures that are most often questioned by payers. Now there is a unique new resource that provides the clinical criteria necessary for code assignment. This new tool also describes the clinical documentation needed for determining if the condition is a complication, or when a medical condition should be coded as an additional diagnosis. Now coders, utilization review staff and HIM managers can systematically evaluate the clinical criteria that influence code assignments and patient care.

Key Features and Benefits

Covers 50 of the most challenging inpatient medical diagnoses and procedures.

Provides detailed clinical criteria and physician documentation requirements needed to justify code assignments.

Helps craft physician queries that address fine distinctions in a patient's medical condition and ensure appropriate reimbursement.

Provides a detailed clinical description of problematic diagnoses or procedures --from a coder's perspective--plus the clinical criteria that support code assignment.

Assists coders in determining what clinical elements are necessary for initial diagnosis code assignment, when it should be coded as a complication and when the condition should be coded as an additional diagnosis.

Identifies other terminology that would qualify for the ICD-10-PCS specific root operation term.

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