Clinical documentation improvement

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Clinical Documentation Improvement (CDI) is the recognized process of improving healthcare records to ensure improved patient outcomes, data quality and accurate reimbursement. The profession was developed in response to the Centers for Medicare and Medicaid Services (CMS) Diagnostic-Related Group (DRG) system, and gained greater notice around 2007.[1]

CDI professionals act as intermediaries between Inpatient coders who translate diagnoses into data and healthcare providers and nurses. As many clinical coders don't have patient care backgrounds, and healthcare providers might not realize the importance of accurate documentation, the CDI professional serves to make the connection between these two groups.[1] CDI professionals should be familiar with Medicare Severity DRGs (MS-DRG) ICD-9 to ICD-10 coding.

The Association of Clinical Documentation Improvement Specialists (ACDIS), part of HCPro, Inc., is a provider of integrated information, education, training, and consulting products and services in healthcare regulation and compliance. ACDIS provides Certified Clinical Documentation Specialist (CCDS) certification, and a CDI boot camp.[2] The Association for Integrity in Health Care Documentation (AIHCD) offers a C-CDI certification. The American Health Information Management Association (AHIMA), which also offers the certified documentation improvement professional (CDIP) credential.[1]

Healthcare documentation serves as a legal document, validates the patient care provided, facilitates claims processing, coding, billing and reimbursement, and facilitates quality reviews.[3]

See also

- Clinical coder
- Electronic health record
- Health care
- Health informatics
- Health information management
- Health information technology
- Hospital information system

References

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2. "About ACDIS". Retrieved 17 Apr 2014.
3. Hailes, John (2012). "Truly Understanding Clinical Documentation Improvement for ICD-10" (PDF). *U.S. Indian Health Service*. Retrieved 17 Apr 2014.

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