



About **Dr. Remer's Learning Modules for Clinical Documentation Integrity for Providers**

Do your providers understand the linkage between their documentation and the determination of quality and reimbursement? Is your case mix index commensurate with the complexity and severity of your patient population? Are you leaving money on the table because your quality metrics aren't reflecting the quality of care your providers deliver?

Now, introducing the first learning modules explaining clinical documentation that have been created by a physician for physicians and other providers. Dr. Erica Remer, a nationally renowned clinical documentation expert, draws on her 25 years of clinical practice as an emergency physician to engage fellow clinicians and inspire them to improve their documentation. Since she can't be everywhere educating everyone, she designed these modules to spread the good word.

Take-aways include:

- Understanding why documentation isn't a burden but is an integral component of providing excellent care to our patients
- Learning the importance of using specific verbiage to convey severity of illness and complexity of the patient's condition
- Recognizing that the CDI professional wants to help the provider get credit for taking excellent care of complicated patients

Modules available:

Particularly aimed at the hospitalist, resident, intensivist. Best viewed as a set, with special pricing for the purchase of the complete set of 3:

- **Best Documentation Practices: The Good, The Bad, and The Risky**
 - Why do we document? What are the challenges of documentation in the electronic environment? How do we document optimally? Where are the pitfalls associated with risky documentation practices?
- **Documentation to Demonstrate Quality of Care** (and for Optimal Reimbursement)
 - How is quality in medicine judged? What is the relationship between documentation, the determination of quality metrics, and reimbursement? Why is clinical documentation integrity important?
- **Clinical Documentation: How CDI Can Help**
 - What is the role of the CDI specialist? What evokes queries and how should you respond? What conditions make a difference? How can you document in a codable format to demonstrate the quality of care? Understanding that the CDIS is your ally, not your enemy.

Specialty and topic-specific modules:

- **Sepsis: Aligning practice with principle**
 - Making sense of the evolution of the sepsis definition. What is the current definition of sepsis and how do you diagnose and document it and attend to core measures? What is the contribution of organ dysfunction? How can you help coders to pick up the appropriate codes?
- **Clinical Documentation in the ED: Helping your hospital, helping your group**
 - Understanding why excellent documentation supports medical necessity and quality metrics. Recognizing that helping the hospital achieve their quality and reimbursement targets benefits your ED group. Increasing number and specificity of diagnoses to improve risk-adjustment. Introducing the CDI team and concept to emergency providers.
- **Clinical Documentation: CDI and Quality for Surgeons**
 - Educating the surgeon as to the relationship between documentation, quality determination, and reimbursement. Understanding the CDI professional’s role and how to collaborate with the CDI team. Introduction to specific surgical clinical conditions and how to best document procedures.
- **Clinical Documentation: CDI and Quality for Neurosurgeons**
 - Educating the neurosurgeon as to the relationship between documentation, quality determination, and reimbursement. Understanding the CDI professional’s role and how to collaborate with the CDI team. Introduction to specific neurosurgical clinical conditions and how to best document procedures.

Why should you purchase these for your providers?

- Compelling education effortlessly obtained on their electronic device at the clinician’s convenience
- **Continuing medical education** included (depending on the module: 0.75 – 1.0 credit hour category AMA PRA Category 1 Credit™)
- Excellent for **resident** training (improve their documentation you, enhance their value to future employers)
- Excellent for **onboarding** new providers to level-set expectations
- Can be incorporated in your organizational **compliance** program
- Establish a relationship between your CDI professionals and the provider, paving the way for the CDI team and physician advisors to expand, cultivate, and maintain that relationship

* **ROI:** If a provider successfully documents a **single** major comorbid condition or complication (MCC) **once** where the patient would have been in the lowest DRG tier, the module/s more than pays for itself

DRG number	DRG name	CC/MCC designation	Relative weight	\$ w/base rate \$6000	Difference between highest and lowest tier
025	Craniotomy & Endovasc Procedures	w/ MCC	4.3945	\$26,367	\$11,987
027		No CC/MCC	2.3967	\$14,380	
871	Sepsis	w/MCC	1.8663	\$11,198	\$3,197
193	Simple Pneumonia	w/MCC	1.3335	\$ 8,001	

For more information or to purchase modules, go to icd10md.com or contact Dr. Remer at 216-514-1643.