CONTENTS

AHA Central Office ......................52

¬ American Society of Anesthesiologists .......................54

¬ Aviacode .....................................55

Coding Concepts .................................55

First Class Solutions .........................56

Healthcare Cost Solutions ...............59

¬ Indiana University School of Informatics and Computing at IUPUI ................56

Labouré College ............................57

SourceHOV Healthcare, Inc. ........58

¬ Stat Solutions, Inc. ........................59

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Become a Code Cracker and Documentation Detective

LIKE THE HEALTHCARE profession itself, healthcare coding and clinical documentation improvement (CDI) are dynamic, ever-changing industries that require professionals to stay vigilant with their training. Hoping to help coding and CDI professionals with this task, the Journal of AHIMA’s Code Cracker and Documentation Detective web-exclusive columns feature industry experts diving into the details and offering readers best practices that ensure quality clinical information and properly coded and billed cases.

Specifically, Documentation Detective discusses how to achieve quality clinical documentation with a comprehensive approach aimed at covering all realms of the healthcare industry—inpatient, outpatient, physician office, and beyond. Code Cracker acts as both a job aid (How do I code diabetes mellitus with associated conditions again?) as well as a forum to vet big picture questions about the industry at large (Just how effective is computer-assisted coding?).

The vendors in this Resource Guide aim to offer services that help healthcare organizations get their coding and CDI work done right. This is also the objective of the Documentation Detective and Code Cracker blogs—illustrated below with a selection of popular recent posts that show a coding professional or CDI specialist’s work and training is never finished.

Code Cracker Highlights
Code Cracker is updated monthly and available at https://journal.ahima.org/category/blogs/code-cracker/.

Computer-Assisted Coding: Helpful or Hurtful?
Computer-assisted coding (CAC) has become a commonly recognized presence on the health information management scene, so much so that we now have coders in the workforce that have likely only ever briefly trained on coding without CAC—or potentially have never worked without CAC at all. But what impact does that have on the profession?

Will Coders Ever Return to the Office?
It feels like it has been much longer since the days when many coding professionals were working in the basement of a hospital, still coding from paper charts, the idea of being able to work from home much more dream than reality. Now that the telecommuting coder is indeed reality, some wonder what impact—postive or negative—this is having on work dynamics and quality.

Coding Diabetes Mellitus with Associated Conditions
One of the most popular Code Cracker articles, this post reviews the confusion among coding professionals regarding interpretation of the coding guideline “with.” An area that contains many instances of using this guideline in ICD-10-CM is coding Diabetes Mellitus with associated conditions. There are 53 instances of “with” subterm conditions listed under the main term Diabetes.

Documentation Detective Highlights
Documentation Detective is updated monthly and available at https://journal.ahima.org/category/blogs/documentation-detective/.

The Impact of Neonatal Abstinence Syndrome on Clinical Documentation
While neonatal abstinence syndrome is a serious condition, the lack of a standard clinical definition makes it difficult for providers to recognize the symptoms and accurately diagnose and treat newborns. If the syndrome is not recognized, and thus not documented, then the correct diagnosis code will not be assigned—which in turn impacts the state and national statistics regarding this syndrome.

Temporary Newborn Name Compliance: A Focus on Patient Safety
Assigning newborns temporary names at birth is a common practice for hospitals. As a result, a large volume of patients with similar identifiers could potentially result in duplicate records and increase the risk for sentinel events.

It’s Complicated: Post-Operative Complications
The challenge for CDI specialists is in determining if the condition is an expected outcome of the procedure or patient’s disease process, or if it is an actual post-operative complication. O
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Labouré’s Program v. Boot Camp Webinars:
Labouré’s program is different from webinar programs and boot camps because it is a college credit-bearing program.

Labouré College’s CDI program stands alone in its structured, group approach to learning a new healthcare discipline in an online format.

All courses are online and taught by nurses and doctors credentialed in CDI. The program includes weekly assignments, recorded lectures, hands-on practice activities, and discussion groups. **Most importantly, the program provides students with an experienced instructor who is available to answer their questions.** Students also have the opportunity to learn from fellow classmates with diverse professional backgrounds.

Each of the four courses covers one or more of the six CDI core competency groups. The eight credits of academic coursework represent 120 hours of instruction and approximately 250 hours of reading or written assignments. In total, this program represents approximately 10 weeks of training. This is a significant bonus to healthcare organizations hiring Labouré CDI graduates - they can start immediately on the clinical practice component of their education and training.

Courses:
- Record Review and Document Clarification
- Clinical Coding Practice
- Metrics and Education
- Compliance and Leadership

Quick Facts:
- Start in September, January, or May
- Can be completed in two semesters
- Earn eight college credits
- College accredited by NECHE
- Taught by CDI credentialed nurses and doctors
- Graduates are fully prepared to begin clinical practice in CDI departments
- Tuition: $2,920 - payment plans are available **(because this program qualifies for college credit it is commonly approved for tuition reimbursement by hospitals and healthcare organizations)**

For more information:
Please visit laboure.edu or contact the Admissions team at (617) 322-3575 or admissions@laboure.edu.
Program Chair, Elise Belanger, RHIA is also available at elise_belanger@laboure.edu.
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