

WHY CONTINUED CODING & CLINICAL DOCUMENTATION IMPROVEMENT EDUCATION IS NECESSARY.



Keep up-to-date with the latest code changes.



Appropriately identify all unique procedure elements that must be separately coded.



Reduce drops in the Case Mix Index (CMI) due to the lack of coded MCCs and CCs.



Reduce A/R days.



Decrease denied claims and pre/post payment reviews.



Reduce improper payment rates for home health claims.



Tell the patient's story more accurately, helping hospitals and clinicians get credit for good outcomes.



Improve and sustain the quality of data used for clinical and operational decision-making.

HOW CAN ELSEVIER HELP?

Our education provides expert-authored, referenced education to the level of granularity necessary to function within the parameters of multiple initiatives. Our solutions provide assessment, education, practice, and remedial training for the novice and experienced, and cover coding, documentation, compliance, and revenue cycle knowledge and skills. Improving the performance of staff arguably improves the quality of data and the ability for organizations to have accurate and complete data as well as the expectation to receive appropriate reimbursement. Elsevier's solutions include:

CDI – improve documentation accuracy and comprehensiveness for quality programs and payment.

Coding – train staff on how to evaluate and abstract information from the health record documentation and assign ICD-10-CM, ICD-10-PCS, and/or CPT codes for the inpatient and outpatient settings, leading to better quality scores and appropriate reimbursement.

Home Health Coding – help bring down the 50%+ error rate with clinical and administration education that reduces risk, promotes quality documentation, and supports optimal care.

Reimbursement Essentials – quality programs including POA, HAC, quality measures.

Regulatory Essentials – compliance education reinforces medical necessity, HIPAA privacy and security, and regulatory requirements.

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