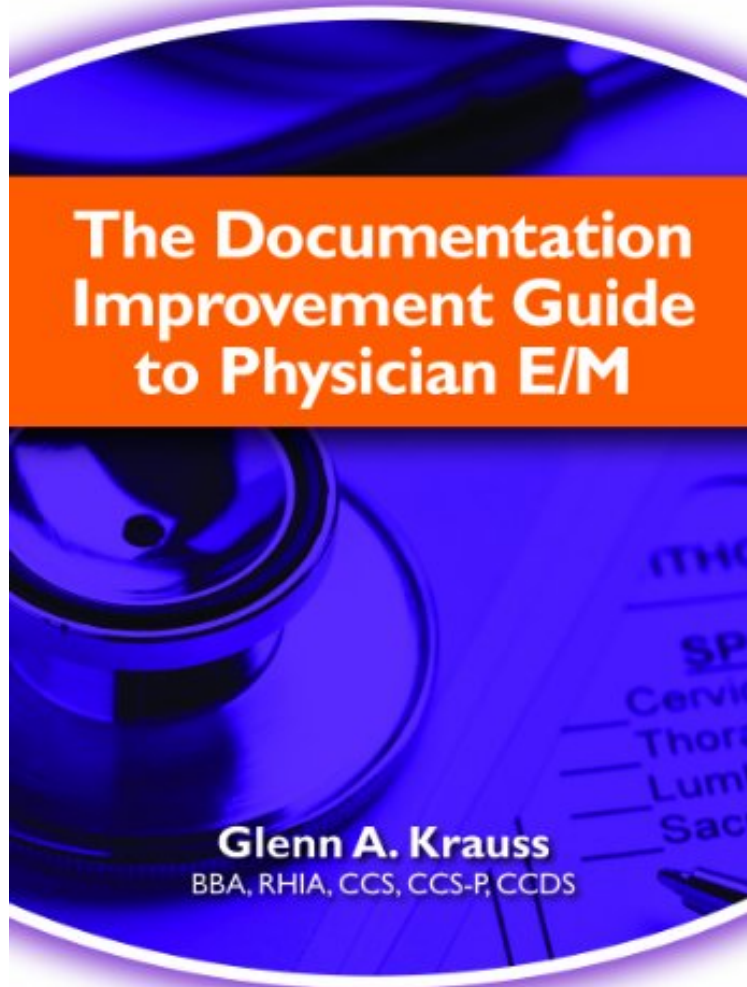


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## The Documentation Improvement Guide to Physician E/M

*HPro, Inc., Glenn A Krauss BBA RHIA CCS CCS-P CCDS*

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**HPro, Inc., Glenn A Krauss BBA RHIA CCS CCS-P CCDS : The Documentation Improvement Guide to Physician E/M** before purchasing it in order to gage whether or not it would be worth my time, and all praised The Documentation Improvement Guide to Physician E/M:

Give physicians a crash course in the documentation of E/M services Physicians who provide E/M services must document the necessary clinical information to support their medical decision-making. This is where CDI specialists play an important role, and The Documentation Improvement Guide to Physician E/M can help. This reference guide

helps CDI specialists explain to physicians how complete and accurate documentation benefits their E/M payments, prevents medical necessity denials, and provides the information they need to document correctly. This handbook offers the perfect portable reference guide for CDI specialists to educate physicians about E/M documentation. This handbook is provided in packs of 10 so CDI specialists can distribute copies to physicians during documentation improvement education sessions or in response to physician questions and requests for additional information. This reference guide will help CDI specialists:

- Better understand the complex guidelines that affect physician payment for E/M services
- Explain the importance of documentation to physicians beyond hospital reimbursement
- Clarify the purpose of queries and how responding to them benefits physicians' payments and public profiles
- Encourage physicians to provide adequate documentation that will reduce the number of denials for lack of documented medical necessity

Access a comprehensive list of additional online resources to further aid them in their important role

Take a look at the table of contents:

- Chapter 1: E/M Documentation
- Chapter 2: Components of E/M
- Chapter 3: Chief Complaint
- Chapter 4: History of Present Illness
- Chapter 5: Review of Systems
- Chapter 6: Past, Family, and Social History
- Chapter 7: Physical Examination
- Chapter 8: Medical Decision-Making
- Chapter 9: Amount and Complexity of Data
- Chapter 10: Critical Care
- Chapter 11: Medical Necessity and Clinical Documentation

Appendix

About the Author Meet the Author: Glenn Krauss, RHIA, CCS, CCS-P, CPUR, FCS, PCS, CCDS, C-CDI is a health information management (HIM) professional with extensive experience in Current Procedural Terminology (CPTreg;) and International Classification of Diseases, 9th Revision (ICD-9). He focuses on the role of medical record clinical documentation in charge capture, reimbursement, quality and outcomes studies, and establishing medical necessity. Krauss has served as a revenue cycle consultant, senior coding/reimbursement consultant and recovery audit contract project leader, manager of revenue systems and coding, revenue cycle coordinator and HIM director, vice president of coding and documentation compliance, coding instructor, coding technical advisor, data quality manager, HIM manager and health system analyst, clinical coding specialist, and medical records technician. He is also a member of the advisory board of the Association of Clinical Documentation Improvement Specialists.