



The 2016 CDI Pocket Guide

Richard D. Pinson MD FACP CCS, Cynthia L. Tang RHIA CCS, HCPro a division of BLR

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The 2016 edition of the best-selling *CDI Pocket Guide* by authors **Dr. Richard Pinson and Cynthia Tang** has been comprehensively updated for ICD-10.

This authoritative CDI reference guide focuses on the most common opportunities to improve clinical documentation, coding, and DRG assignment impacting reimbursement, severity of illness, quality reporting, and pay-for-performance.

The five sections Guidelines, Key References, Comorbid Conditions, DRG Tips, and the MS-DRG Table are designed for quick and easy reference.

This compact reference guide is essential for any new or experienced CDS, coder, physician advisor, and any others involved in CDI.

What's NEW in 2016?

ICD-10! You'll find all sections of the guide updated with the ICD-10-CM Official Coding Guidelines, Coding Clinic, ICD-10 codes, tips, and strategies to ease the transition from ICD-9.

In addition to ICD-10, we have added new **clinical references**, including accidental puncture and laceration, injuries and fractures, peritonitis, and more. Our expanded **comorbid conditions** section includes secondary diagnoses with high impact on MS-DRGs and APR-DRGs, as well as quality and **CMS pay-for-performance** outcome metrics.

You'll find updated citations of medical literature and other authoritative sources to support diagnostic definitions, criteria, and guidelines, in addition to strategies for integrating CMS pay-for-performance initiatives into your CDI program.

Testimonials

My CDI Pocket Guide is an invaluable tool! I reference it daily in my reviews, writing queries and educating physicians regarding documentation opportunities. I would be lost without it!

Norma B., clinical documentation specialist, Bay Medical Center

The CDI Pocket Guide is a practical, portable reference that the CDS can carry in his/her pocket and easily reference while reviewing the record on the patient care unit versus having to carry cumbersome ICD coding books to the units with stickies and notes throughout the coding books.

Cindy Z., HIM director, Milford Hospital

An essential tool for our documentation specialists and coders each section provides the clinical criteria needed to recognize documentation improvement opportunities in the medical record!

Karen S., HIM director, Nanticoke Hospital

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