NORTHWESTERN CONNECTICUT COMMUNITY COLLEGE

COURSE SYLLABUS

Course Title: Medical Coding /Coding 1 **Course #: HIM * 210**

HIM* 205

Course Description: MEDICAL CODING (3 credits)

This course introduces students to nomenclatures and classification systems used in healthcare. The course provides in-depth coverage of the ICD-10-CM and ICD-10-PCS coding systems. Students will begin with simple coding cases and advance to more complex coding and auditing. Healthcare reimbursement issues will be explored with emphasis on the need for documentation to support accurate code assignment and billing for healthcare services. Students will apply the Uniform Hospital Discharge Data Set (UHDDS). The ICD-10-CM will be compared to the DSM-5 codes for behavioral health. An overview of HCPCS, DRG's, ICD-9 and ICD-11, medical coding and the regulatory environment will also be included. Coding applications are considered by specialty and body system, incorporating medical terminology, anatomy and physiology. Students will gain hands on coding skills through data abstracting, chart note auditing, and medical record coding exercises. This course covers common coding terminologies, and a review of Insurance and Reimbursement topics used in healthcare delivery, electronic health records, reporting and management.

Prerequisites: MED 125 or HIM 101 and BIO* 110 or higher both with a grade of "C" or better.

Goals:

- To develop the coding competencies necessary to be a competent medical coder.
- To examine the roles and responsibilities of a medical coder in the healthcare environment.
- To apply logical, critical and analytical processes in identifying problems, alternative solutions and making informed decisions related to the billing and coding in the healthcare environment

Importance of Course in Program/Discipline

American Health Information Management Association (AHIMA) Curriculum Competencies:

The AHIMA Council for Excellence in Education developed competencies for associate degree students with the most recent update in the 2014 Curricula requirements. This program covers the AHIMA recommended competencies in six domains including (I) Data Content, Structure, and Standards, (II) Information Protection: Access, Disclosure, Archival, Privacy & Security, (III)

Informatics, Analytics, and Data Use, (IV) Revenue Management, (V) Compliance, and (VI) Leadership. This course addresses the following AHIMA competencies (learning level this course/program goal):

Domain I: Data Content Structure and Standards

Subdomain I.A Classification Systems

I.A.1. Apply diagnosis/procedure codes according to current guidelines (3/3)

I.A.2. Evaluate the accuracy of diagnostic and procedural coding (3/5)

I.A.3. Apply diagnostic/procedural groupings (3/3)

I.A.4. Evaluate the accuracy of diagnostic and procedural groupings (3/5)

Subdomain I.B. Health Record Content and Documentation

I.B.1. Analyze the documentation in the health record to ensure it supports the diagnosis and reflects the patient's progress, clinical findings, and discharge status (4/4).

Domain IV: Revenue Management

Subdomain IV.A. Revenue Cycle and Reimbursement

IV.A.2. Evaluate the revenue cycle management process (3/5)

Domain V: Compliance

Subdomain V.B. Coding

V.B.1 Analyze current regulations and established guidelines in clinical classification systems (2/4)

V.B.2. Determine accuracy of computer assisted coding assignment and recommend corrective action (2/5)

Subdomain V.D. Clinical Documentation Improvement

V.D.2. Develop appropriate physician queries to resolve data and coding discrepancies (3/6).

Domain VI: Leadership

Subdomain VI.H. Ethics

VI.H.1. Comply with ethical standards of practice (3/5)

Learning Outcomes:

At the conclusion of this course, the Health Information Management Student will be able to:

- Use the ICD-10-CM code set to assign correct codes for diagnoses.
- Use the ICD-10-PCS code set to assign correct codes for procedures.
- Demonstrate the different function and use of the DSM-5 vs ICD-10-CM.
- Demonstrate the use of the Uniform Hospital Discharge Data Set (UHDDS) in coding, billing, and reporting.
- Employ auditing techniques to identify incorrect diagnostic or procedural code assignment.
- Employ auditing techniques to identify incorrect diagnostic/procedural groupings.
- Analyze the documentation in the health record to ensure it supports the diagnosis and reflects the patient's progress, clinical findings, and discharge status.

- Interpret the role of the coder and the coding process in the revenue cycle of a healthcare organization.
- Explain current regulations and established guidelines in clinical classification systems.
- Describe computer assisted coding and potential problems with computer-assisted coding accuracy.
- Write appropriate physician queries to resolve data and coding discrepancies.
- Apply the Standards of Ethical Coding