HIM-2401: INTERMEDIATE CODING

Cuyahoga Community College

Viewing: HIM-2401 : Intermediate Coding

Board of Trustees:
January 2024

Academic Term:
Fall 2024

Subject Code
HIM - Health Information Management

Course Number:
2401

Title:
Intermediate Coding

Catalog Description:
Continuation in the study of coding and classifications systems in a variety of healthcare settings. Upon completion students should be able to apply coding principles to correctly assign codes using the International Classification of Diseases, Tenth Revision, Clinical Modification and Procedural Coding System (ICD-10-CM and PCS) and Current Procedural Terminology (CPT) and apply systems to optimize reimbursement.

Credit Hour(s):
2

Lecture Hour(s):
1
Lab Hour(s):
3

Requisites

Prerequisite and Corequisite
Departmental approval: Program Director approval.

Outcomes

Course Outcome(s):
Apply coding principles to correctly assign codes using the International Classification of Diseases, Tenth Revision, Clinical Modification and Procedural Coding System (ICD-10-CM and PCS) and Current Procedural Coding (CPT) conventions.

Essential Learning Outcome Mapping:
Not Applicable: No Essential Learning Outcomes mapped. This course does not require application-level assignments that demonstrate mastery in any of the Essential Learning Outcomes.

Objective(s):
1. Determine the guidelines for sequencing and designating principal diagnosis and procedures codes
2. Determine the correct codes and sequence diagnoses and procedures using the encoder for assigned exercises and for inpatient and outpatient health records
3. Determine the presence of a complication, a major complication and/or a co-morbidity in the inpatient health record
4. Determine physician documentation that supports the accurate diagnostic and procedural coding
5. Apply the ICD-10-CM and PCS Official Coding Guidelines for Coding and Reporting using the encoder system to determine the correct coding for inpatient health records
6. Apply the ICD-10-CM Official Outpatient Coding Guidelines for Coding and Reporting using the encoding system to determine the correct coding for outpatient services
7. Compute the Medicare Severity Diagnostic Related Group (MS-DRG) with or without a complication or Major Complication and Co-Morbidity (MCC)

Course Outcome(s):

Analyze current regulations and established guidelines in clinical classification systems.

Essential Learning Outcome Mapping:

Not Applicable: No Essential Learning Outcomes mapped. This course does not require application-level assignments that demonstrate mastery in any of the Essential Learning Outcomes.

Objective(s):

1. Determine Severity of Illness utilizing the clinical classification system guidelines and current regulations
2. Resolve Coding Edits by utilizing the tools the correct coding initiatives, outpatient code editor, National Coverage Determination (NCDs) regulations, and Local Coverage Determinations regulations (LCDs), etc. to determine correct procedural coding
3. Discuss legal and ethical implications for health information professionals in assuring accuracy in coding to determine the Medicare Severity-Diagnostic Related Group (MS-DRG)

Course Outcome(s):

Evaluate computer assisted coding for compliance

Essential Learning Outcome Mapping:

Not Applicable: No Essential Learning Outcomes mapped. This course does not require application-level assignments that demonstrate mastery in any of the Essential Learning Outcomes.

Objective(s):

1. Identify the strengths and weaknesses of computer assisted coding (CAC) in order to assist with fraud detection and prevention.
2. Verify coding accuracy and appropriateness in coding exercises depicting coding in the Computer Assisted Coding (CAC) software.

Course Outcome(s):

Determine Hospital-Acquired Conditions (CAC) and Present on Admission (POA) indicators

Essential Learning Outcome Mapping:

Not Applicable: No Essential Learning Outcomes mapped. This course does not require application-level assignments that demonstrate mastery in any of the Essential Learning Outcomes.

Objective(s):

1. Determine the "Present on Admission" (POA) indicators for each diagnosis code for inpatient health care records
2. Evaluate and sequence diagnostic and procedure codes using the encoder for coding exercises and health records
3. Determine the presence of Hospital Acquired conditions (HACs)

Methods of Evaluation:

1. Class participation
2. Quizzes
3. Attendance
4. Homework assignments
5. Midterm examination
6. Final examination

Course Content Outline:

1. Ethical implications of Diagnostic Related Groups
    a. DRG "creep"
    b. maximization and/or up-coding
    c. changing code sequence
    d. omitting codes
    e. coders" liability

   f. Impact on healthcare facilities
   g. Impact on HIM departments
2. Coding for Inpatient Prospective Payment System
   a. Prospective payment system coding instructions
   b. Guidelines for sequencing and designating principal diagnosis and procedure
      i. definitions
         1. principal diagnosis
         2. principal procedure
      ii. general guidelines
      iii. chapter specific guidelines
   c. Using the health record to code
      i. discharge summary
      ii. progress notes
      iii. admission note/data base/history and physical
      iv. operative notes
      v. pathology report
      vi. anesthesia record
      vii. consultation report
      viii. nurses notes
      ix. medication record
      x. cardiac catheterization report
      xi. computerized axial tomography (CAT) report
      xii. electrocardiogram (ECG/EKG) report
      xiii. electroencephalogram
      xiv. laboratory test report
      xv. radiology (x-ray) report
      xvi. nuclear medicine reports
      xvii. ultrasonography
   d. Documentation to look for in the health record that might indicate the presence of a complication
      i. readmission within 48 hours of discharge
      ii. return to the operating room within 48 hours of surgery
      iii. transfer to special care unit during hospitalization
      iv. transfer from one hospital service to another
      v. cancellation of a planned discharge
      vi. mechanical ventilation/placement of endotrachial tube/oxygen therapy
      vii. acute change in mental status
      viii. blood transfusion other than in the operating room
      ix. isolation
   e. Encoder usage
   f. Use of the coding clinic
   g. Official coding guidelines
   h. Coding practice
   i. Given exercises, the student will identify
      i. principal diagnosis
      ii. principal procedure
      iii. other diagnosis and procedures to be included on the uniform Bill
      iv. any other diagnoses or procedures which require coding for the healthcare facility to have appropriate data
   j. Given exercises and health records the student will correctly code and sequence diagnoses and procedures using the encoder and assign the Present On Admission (POA) indicator
   k. Compute the Medicare Severity Diagnostic Related Group (MS-DRG) with or without a complication or Major Complication and Co-Morbidity (MCC).

Resources

Bronnert, June, et al. (2023) *Clinical Coding Workout: Practical Exercises Without Answers*, Chicago: American Health Information Management Association.

Sayles, Nanette. (2020) *Health Information Management Technology : An applied Approach*, Chicago : AHIMA.

Schraffenberger, Lou Ann. (2018) *Basic ICD-10-CM/PCS Coding Exercises*, CHICAGO:AHIMA.

American Medical Association. (2023) *Current Procedural Terminology (CPT) manual*, Chicago: American Medical Association.

Resources Other

Enrollment in American Health Information Management Association Virtual Lab (AHIMA vLAB)
3M Encoder online resources

Top of page
Key: 2171