Miami Dade College

Course Description

HIM2234 | Advanced Coding & Reimbursement Systems | 2.00 credits

This course is designed to apply the fundamentals of the Prospective Payment Systems as it applies to coding and reimbursement. The student will learn documentation criteria, examine validation reports of coded data, examine health record for compliance, and optimum reimbursement under current payment methodologies. Prerequisite: HIM 2222, 2222L; corequisite: HIM2234L.

Course Competencies

Competency 1: The student will demonstrate competency in applying the Official Guidelines for Coding and Reporting and ICD- 10 CM/PCS coding placing emphasis on UHDDS definitions, proper sequencing of principal diagnosis code, and verifying through clinical documentation by:

1. Adhering clinical vocabularies and recognizing its impact on the coding process
2. Researching the Unified Medical Language System as it applies to the health record
3. Applying the Official Guidelines for Coding and Reporting of ICD inpatient/outpatient coding
4. Applying the principles of classification and Uniform Hospital Discharge Data Set (UHDDS) and Uniform Ambulatory Core Data Set (UACDS) definitions as they apply to coding using ICD-10 and CPT/HCPCS
5. Defending the importance of hospital coding and the regulatory environment for HIM professionals
6. Distinguishing differences in use and structure of clinical vocabularies and classification systems
7. Defining DRG and list basic components
8. Relating classification system and PPS to healthcare delivery settings
9. Explaining the difference between encoder and grouper
10. Recognizing OIG role in compliance programs
11. Defining and identifying comorbidities and complications and determine their significance
12. Synthesizing Official Guidelines for Coding and Reporting and medical record documentation to justify selected codes
13. Reporting Coding Clinic criteria in ICD decisions/guidelines for medical record coding
14. Describing the relationship between the admissions process and billing for patient services
15. Reviewing health data for medical necessity
16. Stating rationale for Local and National Coverage Determination under the evidence-based process

Competency 2: The student will demonstrate the basic knowledge of PPS and MS-DRG/APCs components by:

1. Reviewing the history and purpose of the PPS
2. Identifying data elements to comprise a MS-DRG/APCs
3. Reviewing how MS-DRG/APC system is constructed
4. Identifying information on specific coding sequencing and requirements of the Medicare PPS
5. Defining relative weighting factor
6. Defining and determining the appropriate Major Diagnostic Category
7. Explaining the surgical hierarchy of MS-DRGs
8. Identifying appropriate Present on Admission (POA) indicator to diagnoses
9. Discussing outliers and its impact on the PPS
10. Analyzing Medicare Code Editor response
11. Stating current CMS changes regarding MS-DRGS, APR/DRG, MDC, and SOI
12. Describing the purpose and structure of Case-Mix classifications
13. Explaining the function of National Coverage Determination (NCD) and National Correct Coding Initiative (NCCI)
14. Correlating the various departments that impact the revenue cycle
15. Relating coding, charge capture, chargemaster, and itemized bill
16. Examining and determining appropriate steps in receipt of a remittance advice report
17. Stating common denial reasons

Competency 3: The student will demonstrate knowledge and apply skills as a health information technician in

monitoring coding data quality by:

1. Reviewing claim forms for accuracy
2. Describing data sets needed for claims processing
3. Demonstrating basic knowledge of confidentiality and HIPAA regulations
4. Showing correct selections to chargemaster, claims, and bill reconciliation
5. Demonstrating understanding of risk management procedures
6. Navigating, interpreting, retrieve information from EHR repository data systems
7. Creating analysis (patient ledger, practice, overdue balance, aging) reports
8. Describing the infrastructure databases of Data Quality Improvement Program and Coding Compliance Plan
9. Recognizing procedures for monitoring and evaluating the quality of health data collection
10. Assessing the adequacy of medical record documentation to ensure that it supports all diagnoses and procedures assigned codes
11. Stating purpose of HIPAA Electronic Health Care Transactions and Code Set standards
12. Describing the structure of Quality Improvement Organizations (QIOs)
13. Validating code assignment using encoder/grouper software in inter-rater reliability roleplay
14. Stating the role of the Medicare Administrative Contractor with respect to monitoring the Medicare System
15. Conducting data collection and analyzing code assignment
16. Collecting and reporting risk-adjustment statistics
17. Adhering to compliance standards for external reporting
18. Correlating the function of the Healthcare Cost and Utilization Project in data quality
19. Illustrating the impact of Recovery Audit Contractors (RAC)
20. Identifying the goal of quality improvement projects
21. Examining the role of the HIM professional in Data Quality Improvement Program

Learning Outcomes

- Use quantitative analytical skills to evaluate and process numerical data
- Formulate strategies to locate, evaluate, and apply information
- Use computer and emerging technologies effectively