

**NOVA COLLEGE-WIDE COURSE CONTENT SUMMARY
HIM 215 - HEALTH DATA CLASSIFICATION SYSTEMS (5 CR.)**

Course Description

This course focuses on disease and procedure classification systems currently utilized for collecting health data for the purpose of statistical research and financial reporting. Lecture 4 hours. Laboratory 2 hours. Total 6 hours per week.

General Course Purpose

This course is designed to give the student an introduction to the specialized classification schemes and nomenclatures used in the health care data collection with emphasis placed on ICD-9-CM classification. In addition, the student will gain exposure in abstracting and indexing diagnostic and procedural codes as well as retrieving medical information for research purposes. Considerable time will be spent coding diagnoses and procedures.

Course Prerequisites/Co-requisites

Prerequisites are HIM 110 and BIO 141 or NAS 150 or permission of instructor.

Course Objectives

- Apply and follow policies and procedures for coding health care data from primary health records, e.g. diagnoses, procedures, and exclusion of nonessential diagnoses and procedures.
- Follow federal regulations and AHIMA guidelines for sequencing diagnoses and procedures as applicable to the appropriate patient care setting.
- Apply the Uniform Hospital Discharge Data Set definitions and guidelines for determining principle diagnoses and procedures as applicable to the appropriate patient care setting.
- Conduct quality assessment to ensure continuous improvement in ICD-9-CM and CPT/HCPCS Level I coding and collection of quality health data.
- Assess the adequacy of health record documentation to ensure that it supports all diagnoses and procedure assigned codes for inpatient/ambulatory records.
- Read and interpret clinical information from primary health records to identify all diagnoses and procedures which affect the current episode of care.
- Clarify conflicting/ambiguous clinical information with the responsible health care provider.
- Apply knowledge of anatomy, clinical disease procedures, diagnostic and procedural terminology, and pharmacology to assign accurate codes to diagnoses and procedures.
- Apply policies and procedures for abstracting and collecting health care data, computing health care descriptive statistics, and retaining health care information.
- Utilize current references in health information management to complete both oral and written assignments.
- Refuse to fraudulently maximize reimbursement by assigning codes that do not conform to approved coding principles/guidelines.
- Apply knowledge of the prospective payment system to confirm DRG assignment which assures optimal reimbursement.
- Apply the "Basic Coding Guidelines for Outpatient Services" and "Diagnostic Coding and Reporting Requirements for Physician Billing" to select and sequence diagnoses, conditions, problems or other reasons which require coding in an ambulatory care encounter/visit.
- Sequence the ICD-9-CM codes for diagnosis, condition, problem or other reason for

encounter/visit shown in the health record to be chiefly responsible for the services provided during the encounter/visit.

- Apply knowledge of CPT-4 format, guidelines and definitions and items of commonality to locate the correct procedural codes and sequence them correctly.
- Refuse to unfairly maximize reimbursement by unbundling services and codes that do not conform to CPT-4 basic coding principles and reimbursement guidelines.

Major Topics to be Included

- a. ICD-9-CM
- a. DRG's
- b. Current Procedural Terminology (CPT-4) and HCPCS
- c. SNOMED
- d. DSM-IV
- e. Data Retrieval