

NOVA COLLEGE-WIDE COURSE CONTENT SUMMARY

HIM 254 – ADVANCED CODING AND REIMBURSEMENT (3 CR.)

Course Description

Focuses on the applications and evaluation of advanced coding skills through practical exercises using actual healthcare data; while examining the components of DRGs, APCs and APGs and other prospective payment in the healthcare environment. Utilizes current coding standards in identifying payment methodologies, revenue cycle management and reimbursement. Lecture 3 hours.

General Course Purpose

The purpose of the course is to introduce new concepts and assist students in applying sound coding principles to the following topics:

- Quality of coded data
- Healthcare fraud and abuse
- Prospective payment systems
- Classification/language systems: ICD, ICD-10-CM/PCS, ICD-O, ICIDH, DSM, SNOMEDCT, Reed, UMLS and others.
- Current USA insurance/reimbursement systems

This course is a requirement of the Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM) which is the accrediting organization for degree-granting programs in health informatics and information management. The course will be offered to any student that meet the prerequisites and/or are enrolled in the Health Information Management (HIM) or Clinical Data Coding (CDC) programs.

Course Prerequisites/Corequisites

Prerequisites: HIM 250 and HIM 255

Course Objectives

Upon completing the course, the student will be able to:

Quality of coded data

- a) Identify the steps necessary for thorough record review for complete and correct coding; with key coding principles and official guidelines in building a quality assessment/performance improvement system
- b) Illustrate the importance of timeliness processes on economic well-being of healthcare facility (the effects of accounts receivables and importance of remittance advice)
- c) Apply the encoder (i.e. 3M, Quantim) for correct coding assignment, ethical optimization the impact of concurrent versus retrospective coding
- d) Outline the steps in coder recruitment, training, monitoring and retention
- e) Assess the importance of the federal initiative in coding quality and fraud investigation (Inspector General's work plan; demonstrate knowledge in developing an organizational compliance plan)

Prospective payment systems

- a) Examine the components of DRGs, APCs and APGs and prospective payment in the acute care hospital environment (historical development, structure, correct determination, monitoring, professional and ethical issues facing HIM professionals)
- b) Evaluate the major prospective payment systems used in other healthcare settings (IPPS, HHRGs, RUGs, RICs) (historical development, structure, correct determination, monitoring, professional education)
- c) Differentiate between capitation and risk adjusted methodologies of payment systems

Other classification/language systems

- a) Analyze the development and implementation strategy of ICD-10-CM and ICD-10-PCS and other classification systems in IC family, specifically ICD-O and ICIDH

- b) Determine the core structure of DSM, SNOMED/CT and Reed classifications and the importance of language development in UMLS

Current USA insurance and reimbursement systems

- a) Differentiate the key concepts of the types of insurance and third party payer reimbursement in US marketplace.

Major Topics to be Included

- a) Healthcare fraud/Inspector General work plan
- b) Quality of coded data
- c) Prospective payment: acute care hospital system
- d) Prospective payment: ambulatory and other healthcare settings
- e) Ethical issues in prospective payment
- f) Key concepts in insurance and reimbursement
- g) Types of third party payers and insurance processing
- h) Physician service reimbursement
- i) Claims and Accounts receivable management
- j) Reimbursements impact on managed care