COMMON COURSE OUTLINE: Course discipline/number/title: HIMC 1830: Advanced Coding and Reimbursement

A. CATALOG DESCRIPTION

1. Credits: 3
2. Hours/Week: 5 (1 lecture/2 lab)
3. Prerequisites (Course discipline/number): BTEC 1001, on-line tutorial, or the instructor’s permission is required when the course is offered online. BTEC 1600, HIMC 2620, HIMC 2630, HIMC 1840, HIMC 1810, and HIMC 1820. College-level reading skills: Appropriate score on RCTC placement test or completion of appropriate developmental course with grade of C or better.
4. Co-requisites (Course discipline/number): None
5. MnTC Goals (if any): NA

This course provides a study of numerous health insurance plans, reimbursement methodologies, and compliance strategies. Students will continue using the principles of ICD-9-CM and CPT coding to ensure proficiency in coding with ICD-9-CM and CPT using patient records and advanced concepts of coding. Students will adhere to current regulations and established guidelines in code assignment. Students will use electronic applications and work processes to support clinical classification and coding.

B. DATE LAST REVISED (Month, year): January, 2011

C. OUTLINE OF MAJOR CONTENT AREAS:
Analysis of the United States healthcare insurance industry and its reimbursement methodologies

D. LEARNING OUTCOMES (GENERAL): The student will be able to:
1. Explain classifications, taxonomies, nomenclatures, terminologies, and clinical vocabularies.
2. Apply principles and applications of ICD-9-CM, ICD-10, and CPT/HCPCS coding systems.
3. Compare diagnostic and procedural reimbursement groupings.
4. Explain casemix analysis and indexes.
5. Explain Medicare Severity Diagnosis Related Groups (MS-DRGs).
6. Compare coding compliance strategies, auditing, and reporting.
7. Identify coding quality monitors and reporting.
8. Use and maintain electronic applications and work processes to support clinical classification and coding.
9. Apply diagnosis procedures codes using ICD-9-CM.
10. Apply procedure codes using CPT/HCPCS.
11. Ensure accuracy of diagnostic/procedural groupings (DRG, APC, etc.).
12. Adhere to current regulations and established guidelines in code assignment.
13. Validate coding accuracy using clinical information found in the health record.
14. Us and maintain applications and processes to support other clinical classification and nomenclature systems (ICD-10 CM, SNOMED, DSM-IV, etc.).
15. Resolve discrepancies between coded data and supporting documentation.
16. Apply correct coding initiative.
17. Apply policies and procedures for the use of clinical data required in reimbursement and prospective payment systems in healthcare delivery.
18. Support accurate billing through coding, chargemaster, claims management, and bill reconciliation process.
19. Use established guidelines to comply with reimbursement and reporting requirements such as NCCI.
20. Compile patient data and perform data quality reviews to validate code assignment and compliance with reporting requirements such as OPPS.
21. Explain commercial, managed care, and federal insurance plans.
22. Explain billing processes and procedures (such as claims, EOB, ABN, EDI).
23. Devise a plan for chargemaster maintenance.
24. Utilize regulatory guidelines (LMRP, PRO).

E. LEARNING OUTCOMES (MNTC): NA
F. METHODS FOR EVALUATION OF STUDENT LEARNING:
1. Online discussions
2. Textbook assignments
3. Papers
4. Tests

G. RCTC CORE OUTCOME(S) ADDRESSED:
- Communication
- Critical Thinking
- Global Awareness/Diversity
- Civic Responsibility
- Personal/Professional Accountability
- Aesthetic Response

H. SPECIAL INFORMATION (if any): None