Common Course Outline
HIIT 201
ICD-9 Medical Coding
3 Credits

The Community College of Baltimore County

Description

HIIT 201 – 3 credits –ICD-9 Medical Coding teaches students how to code medical records using the ICD-9 classification system. Students learn ICD-9 coding guidelines as they relate to body systems and practice coding a variety of records, including records for inpatient, outpatient, same-day surgery, emergency room, clinic, and physicians' office settings. 3 credits; 3 lecture hours, 1 lab hour per week. *Prerequisites: HIIT 101 and HIIT 110; Corequisite: BIOL 109*

Overall Course Objectives

Upon successful completion of this course, students will be able to:

1. explain the ICD-9 coding guidelines as they relate to all body systems;
2. discuss coding guidelines and defend the logic of choosing a code utilizing correct terminology;
3. differentiate between coding guidelines for various types of medical records;
4. organize medical record for coding;
5. analyze and code medical records using the ICD-9 classification system;
6. analyze the correlation between ICD-9 diagnoses codes and case mix index;
7. identify discrepancies between coded data and supporting documentation;
8. explain proper procedures for making corrections to a medical record;
9. describe regulations, guidelines, and procedures for medical record retention;
10. apply codes following proper coding conventions;
11. analyze a physician's statement;
12. compare and contrast the ICD-9 coding system and the ICD-10-CM and ICD-10-PCS coding systems;
13. identify discrepancies between coded data and supporting documentation;
14. evaluate health care websites;
15. demonstrate increased productivity when coding medical records;
16. utilize computerized Encoder program and compliance software; and
17. audit medical records coded by others.

Major Topics

I. ICD-9 guidelines for disease and injury of each body system
II. Case Mix Analysis

III. Diagnostic and Procedural Groupings, such as:
    a. DRG
    b. APC
    c. APR-DRG

IV. Supplemental codes for external causes and factors influencing major events

V. Data differentiation in the medical record

VI. Locating data in the medical record

VII. EG Tumor and Trauma Registries

VIII. Legal issues related to coding medical records

IX. Federal regulations and compliance

X. HIPAA compliance

XI. Introduction to ICD-10-CM and ICD-10-PCS coding systems

XII. Electronic coding and auditing of medical records using encoder and other HIM software programs

<u>Course Requirements</u>

Grading: Grading procedures will be determined by the individual faculty member but will include the following:

1. At least five quizzes
2. Coding portfolio
3. Group discussions
4. Written research paper, minimum 500 words
5. Annotated website portfolio
6. Final medical record auditing project with oral presentation