Medical Coding Programs

Outcomes and External Standards

Description

A program of study that prepares individuals to perform specialized data entry, classification, and record-keeping procedures related to medical diagnostic, treatment, billing, and insurance documentation. Includes instruction in medical records and insurance software applications, basic anatomy and physiology, medical terminology, fundamentals of medical science and treatment procedures, data classification and coding, data entry skills, and regulations relating to Medicare and insurance documentation.

Program Outcomes

A. Accurately code diagnoses and procedures in a variety of healthcare settings using currently accepted coding systems

B. Differentiate among the different reimbursement methodologies

C. Interpret health data content to support the assignment of correct medical codes and for reimbursement

D. Follow health information requirements and standards

E. Apply computer technology in the completion of health information processes

F. Comply with established legal and ethical standards of health information practice (domain 6)

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External Standards

CERTIFIED CODING ASSOCIATE (CCA) EXAMINATION CONTENT OUTLINE

DOMAIN I: Health Records and Data Content (20%)

1. Collecting and maintaining health data.

2. Analyzing health records to ensure that documentation supports the patient s diagnosis and procedures, and reflects progress, clinical findings, and discharge status.

3. Requesting patient-specific documentation from other sources (for example, ancillary departments, physician’s office, and so on).

4. Applying clinical vocabularies and terminologies used in the organization s health information systems.

DOMAIN II: Health Information Requirements and Standards (14%)

5. Evaluating the accuracy and completeness of the patient record as defined by organizational policy and external regulations and standards.

6. Monitoring compliance with organization-wide health record documentation guidelines.

7. Reporting compliance finding according to organization policy.

8. Assisting in preparing the organization for accreditation, licensing and/or certification surveys.

DOMAIN III: Clinical Classification Systems (36%)

9. Using electronic applications to support clinical classification and coding (for example, encoders).

10. Assign secondary diagnosis procedures codes using ICD-9-CM official coding guidelines.

a. Assigning principal diagnosis (Inpatient) or first listed diagnosis (Outpatient).

b. Assigning secondary diagnosis(es), including complications and comorbidities (CC).

c. Assigning principal and secondary procedure(s).

11. Assigning procedure codes using CPT coding guidelines.

12. Assigning appropriate HCPCS codes.

13. Identifying discrepancies between coded data and supporting documentation.

14. Consulting reference materials to facilitate code assignment.

DOMAIN IV: Reimbursement Methodologies (10%)

15. Validating the data collected for appropriate reimbursement.

a. Validating Diagnosis Related Groups (DRGs).

b. Validating Ambulatory Payment Classifications (APCs).

16. Complying with the National Correct Coding Initiative.

17. Verifying the National and Local Coverage Determinations (NDC/LDC) for medical necessity.

DOMAIN V: Information and Communication Technologies (6%)

18. Use of a computer to ensure data collection, storage, analysis and reporting of information.

19. Use of a common software applications (for example, word processing; spreadsheets; e-mail) in the execution of work processes.

20. Use of specialized software in the completion of HIM processes.

DOMAIN VI: Privacy, Confidentiality, Legal, and Ethical Issues (14%)

21. Applying policies and procedures for access and disclosure of personal health information.

22. Releasing patient-specific data to authorized individuals.

23. Applying ethical standards of practice.

24. Recognizing and report privacy issues and problems.

25. Protecting data integrity and validity using software or hardware technology.

AAPC - CERTIFIED PROFESSIONAL CODER (CPC)

CPC 1: Proficiency in adjudicating claims for accurate medical coding for diagnoses, procedures and services performed by physicians and recognized licensed non-physician providers in physician-based settings.

CPC 2: Proficiency across a wide range of services, which include: evaluation and management, anesthesia, surgical services, radiology, pathology, medicine

CPC 3: Sound knowledge of medical coding rules and regulations alone with keeping current on issues regarding medical coding, compliance, and reimbursement. A trained medical coding professional can best handle issues such as medical necessity, claims denials, bundling issues and charge capture.

CPC 4: Ability to integrate medical coding and reimbursement rule changes into practice culture in a timely manner to include updating fee schedules and super-bills.

CPC 5: Knowledge of anatomy, physiology, and medical terminology commensurate with ability to correctly code provider services and diagnoses.