



# Coding Education Program Approval Manual



## Table of Contents

<b><i>Coding Education Program Approval Manual</i></b>	<b>Page #</b>
<b>Introduction</b>	4
<b>The Approval Process Flowchart</b>	6
<b>Step 1: Letter of Intent</b>	6
<b>Step 2: Report for Approval</b> <ul style="list-style-type: none"> <li>• <i>Approval Criteria for Coding Certificate Programs</i></li> <li>• <i>Report Format</i></li> </ul>	6-9
<b>Step 3: Review Process</b>	9
<b>Coding Approval Decisions</b>	10
<b>Fees for Approval</b>	11
<b><i>Coding Program Curriculum Guide</i></b>	
<b>What is a Coding Specialist?</b>	13
<b>What is Coding Certification?</b>	13
<b>An Overview of AHIMA</b>	14
<b>Coding Systems</b>	14-15
<b>Official Coding Guidelines</b>	16
<b>Physical Resources</b>	17-18
<b>Overview of Curriculum Content</b>	18-22

<b>Instructional References</b>	22
<b><i>Appendix A: Standards of Ethical Coding</i></b>	23-24
<b><i>Appendix B: Content of the CCA Exam</i></b>	25-26
<b><i>Appendix C: Related Organizational Sources</i></b>	27
<b><i>Appendix D: Coding Program Sponsor Fact Sheet</i></b>	28

# **CODING EDUCATION PROGRAM APPROVAL MANUAL**

The purpose of this manual is to present guidelines for coding education programs wishing to seek AHIMA Approval. The guidelines are designed to facilitate an effective and efficient process of decision-making with regard to the approval of a coding program. A step-by-step process is presented.

## **INTRODUCTION**

Health information coding is the process of assigning alphanumeric representations to clinical documentation. Originally, coding was performed to classify mortality (cause of death) information on death certificates. However, clinical coding was expanded to classify morbidity (disease) and procedural data as the health care industry matured. The coding of health-related information facilitates data management of diagnoses and procedures and other types of health-related goods and services for use in clinical care, research, and education. Codes are an abbreviated representation of the clinical concepts they represent.

Since the implementation of the Centers for Medicare and Medicaid Services' (CMS) prospective payment system (PPS) for hospital inpatient acute care in 1983, there has been a great deal of emphasis placed on coding as a reimbursement tool. As CMS has added PPS systems to other settings such as hospital outpatient, long term care, and home health, the requirements for accurate coded data for reimbursement of services have exponentially increased. Currently, reimbursement of hospital, ambulatory, and physician claims for Medicare patients depends entirely on the assignment of codes to describe diagnoses, services, and procedures provided. Additionally, other third party payers have followed Medicare's lead and are using coded data for claims processing. In the 1990s, the federal government scrutinized the problem of healthcare fraud and abuse by increasing compliance reviews, and assessment of fines and penalties for inappropriate payment. As the basis for reimbursement, correct clinical coding on claims for payment has become crucial as healthcare providers seek to maintain compliance by the use of official coding guidelines and reporting requirements that ensure data integrity.

Today, there are many demands for complete and accurate coded clinical data in all types of healthcare settings, public health and medical research. Coded data serves as the primary information source for many health information assessment tools, as well as data required for an electronic health record. Clinical documentation is transformed to an electronic resource through clinical code assignment as an input into an information or billing system.

In addition to use on claims for reimbursement, clinical codes are included within data sets used to evaluate the processes and outcomes of healthcare. Coded data are also used internally by institutions for decision support, quality management activities, case-mix management, planning, marketing and other administrative and research activities.

## **APPROVAL**

**Approval** is a process of external peer review in which an agency grants public recognition to a program of study that meets established qualifications and educational standards. Approval of a specialized academic course of study is known as program approval. Participation in an approval process is voluntary since there is no legal requirement for specialized programs to participate. The Approval Process under AHIMA is a paper peer review process. Coding certificate programs seek program approval through AHIMA, while degree-granting institutions with academic programs in Health Information Management at the associate or baccalaureate degree level, seek *accreditation* through the Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM). (See [www.cahiim.org](http://www.cahiim.org))

### **What is Coding Program Approval?**

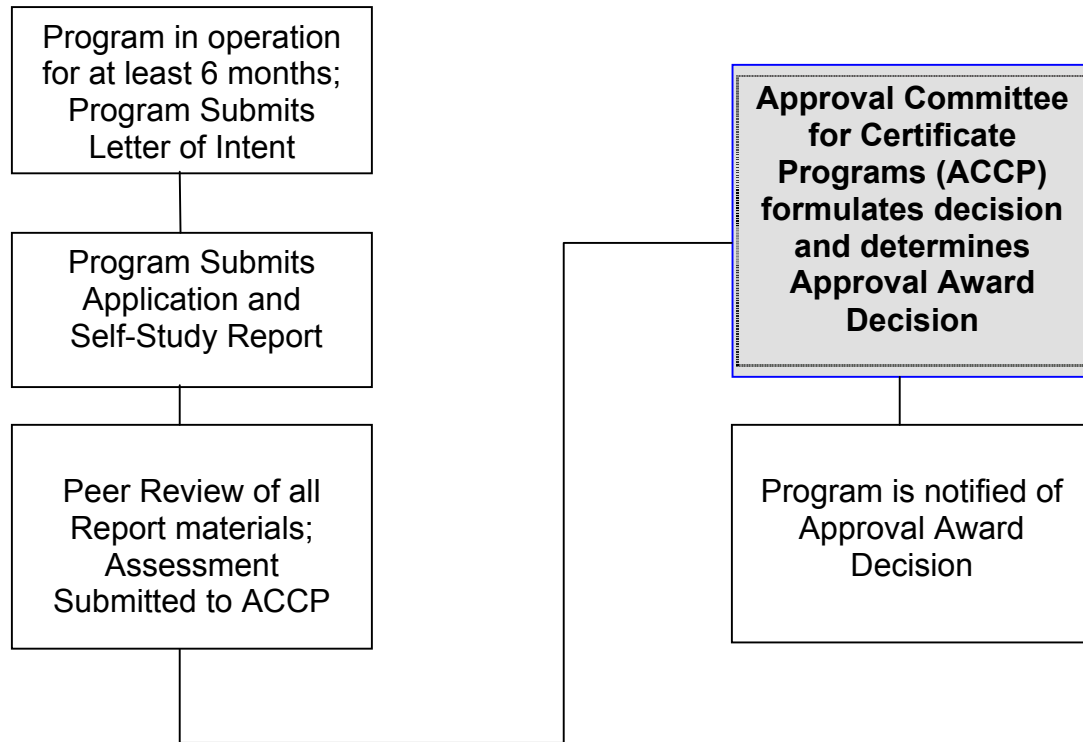
The AHIMA, in recognizing a quality coding education program, has developed a process by which organizations providing coding education can be peer reviewed against a minimum set of standards for entry-level coding professionals. This process allows academic institutions, healthcare organizations, and private companies to be acknowledged as offering an **AHIMA Approved Coding Certificate Program**.

These programs must also meet additional educational and organizational 'best practice' criteria as established by the AHIMA. The *Approval Program* is specific to Coding Programs that are non-degree granting but conclude with a certificate of completion. Approval of a Coding Program is not required for application to sit for any of the AHIMA Coding certifications, including the CCA, CCS and CCS-P certification examinations. There is no formal *accreditation* process for coding programs.

Several factors make *Approval* valuable including but not limited to the following:

1. Identifies for the public specialized programs that meet established standards of educational quality.
2. Stimulates improvement of educational standards by involving faculty and staff in self-evaluation and planning.
3. Promotes a better understanding of the goals of professional coding education.
4. Provides reasonable assurance that practitioners possess the necessary job skills upon entry into the profession.
5. Assists specialized programs in achieving their objectives.

## THE APPROVAL REVIEW PROCESS



The Coding Program applying for Approval must complete the following steps:

### STEP I: LETTER OF INTENT

A letter of intent to apply for Approval should be sent to the Education Department of AHIMA. A general listing or synopsis of the coding curriculum with contact hours or credit hours for each course must be submitted with the Letter of Intent.

### STEP 2: REPORT FOR APPROVAL *(See page 9, Instructions for Preparing the Report)*

The Coding Program sponsor will be notified by AHIMA upon review of the synopsis of curriculum, as to suitability and timetable to proceed to Step 2. Comments regarding the curriculum will be provided to the sponsor at that time. A formal written report for a coding education program must be submitted to the Education Department of AHIMA.

Programs must review and incorporate the minimum curriculum requirements for the development and evaluation of the program. *(See page 12, Coding Program Curriculum Guide)*. Programs seeking AHIMA approval are classified into two categories:

- I. Comprehensive Coding Certificate Program
- II. Coding Program for Physician Practices

Programs must demonstrate and document compliance with the following **Approval Criteria for Coding Certificate Programs**:

- A. The organization offering coding instruction (academic institution, healthcare organizations, private companies, etc.) must ensure that:
  - 1. The program has been in existence a minimum of six months;
  - 2. Instruction follows established coding guidelines and practices;
  - 3. Financial resources are adequate to fulfill obligations to currently enrolled students;
  - 4. Non-discriminatory practices with respect to race, color, creed, sex, age, disabling conditions (handicaps), and national origin are practiced; and
  - 5. Evidence of annual program assessment and incorporation of community of Interest needs.
  
- B. The organization must provide evidence that appropriate systems/policies are in place and, when appropriate, published for determining how:
  - 1. Students are admitted to the program;
  - 2. Records are maintained for student enrollment and evaluation in sufficient detail to document learning progress and achievement;
  - 3. Student/faculty/instructor grievances are handled by a clearly written and consistent process according to an established protocol, communicated to affected parties;
  - 4. There is a defined process for student withdrawal and refunds of tuition/fees.
  
- C. Announcements and promotions must accurately reflect the program being offered. The organization must clearly indicate the intended competencies and outcome of the coding program: (I.) comprehensive coding certificate program, or (II.) coding program for physician practices.
  
- D. The instructors/faculty and content developers must demonstrate current knowledge in course content through appropriate professional development activities. Coding course instructors and content developers for the professional course content, must possess an AHIMA recognized credential: RHIA, RHIT, CCS, or CCS-P.

- E. Sufficient instructional staff must be provided to assure that students receive adequate attention, instruction and feedback to acquire the knowledge and competence needed for entry level coding practice.
  
- F. The Curriculum Plan must include:
  - 1. The curriculum must include the AHIMA coding curriculum knowledge clusters and show how the appropriate knowledge base is obtained.
  - 2. Appropriate course content must be reinforced by structured practice experiences to apply learned principles.
  - 3. Course content and curriculum sequencing must be established in accordance with recognized educational principles, to develop the competencies necessary for entry-level coding practice.
  
- G. Clearly written course material (syllabi) must be provided to the student, which clearly describes course learning objectives and supervised professional practice assignments to be achieved, the frequency of testing and other documented student evaluation and the competencies required for completion.
  
- H. Testing methods (evaluation systems) must include content related to the objectives and competencies described in the curriculum for both didactic and supervised professional practice education components. They must be employed frequently enough to provide timely feedback of the students' progress and to serve as a reliable indicator of the effectiveness of course design and instruction.
  
- I. Programs must periodically evaluate their effectiveness in achieving the instructional goals and AHIMA's coding competencies. Such evaluation of outcomes should include job placement rates, and student and employer satisfaction with the program. The results of this process must be reflected in the curriculum and other dimensions of the program.

## **REPORT FORMAT**

*The report and any supportive information should be securely bound when sent in a **three-ring** notebook binder.*

### **Instructions for Preparing the Report**

Use 8-1/2 X 11 inch paper, single sided and single-spaced. If excerpts from sources are pertinent to the Report, duplicate the information and cite the sources from which they were taken. Number each page in sequence. Use index dividers to separate the report.

**Do not use paper clips or staples, do not spiral bind the report, and only use white paper.**



The program director should organize the Report in the following manner:

1. Cover sheet or title page.
2. Table of contents.
3. Coding Program Sponsor Fact Sheet (*See Appendix D*)
4. Brief description of the program and how it is organized.
5. Curriculum vitae of instructional faculty and content developer(s).
6. Narrative materials and/or documentation addressing how the program meets each item listed in the criteria.
6. Complete course syllabi for each course in the Coding Certificate Curriculum, describing the contact hours or credit hours, course objectives, assignments, and methods of evaluation.
7. Two (2) samples of testing instruments.

**All submitted program information must be in English.**

**Please send three (3) copies of your Report and Correspondence by U.S. Mail or Express Mail to:**

**Tamara Dailey, Education Department  
AHIMA  
233 N. Michigan Avenue, Suite 2150  
Chicago, Illinois 60601-5519  
312.233.1100  
[tamara.dailey@ahima.org](mailto:tamara.dailey@ahima.org)**

### **STEP 3. REVIEW PROCESS**

On receipt of the **application fee and the program Self-Study Report**, an assessment of the information provided in the report will be conducted by peer review. The peer reviewers will determine whether:

- All required information has been submitted;
- The narrative and documentary materials clearly describe the program; and
- The program is in compliance with the criteria.

The program will be contacted for any needed information. The final assessment report is placed on the agenda of the next meeting of the Approval Committee for Certificate Programs (ACCP).

The ACCP reviews the assessment report and determines an Approval Award decision. *All granted ACCP Approval Awards are final.*

## Continuing Program Assessment

For continuing programs - AHIMA will send Notifications of Renewal of Approval with applications, preparation materials and dates for submission.

**Programs that do not re-apply for Approval will be removed from the Directory of Approved Coding Programs.**

## CODING APPROVAL DECISIONS

When determining Approval decisions, the ACCP will state that a program's compliance is "met" or "not met" based on the *Approval Criteria for Coding Certificate Programs*. The assessment report will be provided to the program after completion of the process.

Following are the Approval categories. ***A program's Approval period is time limited and will expire unless the program re-applies for Approval.***

**Approval for Five years:** For programs with no criteria deficiencies.

**\*Withholding of Approval:** For applicant programs that do not meet the approval criteria.

If the ACCP determines that one or more deficiencies are correctable within a reasonable response time of no more than six (6) months, the program will be notified and given guidance on meeting the criteria requirements. The program may submit the specific information required to meet the criteria stated; the ACCP will reassess and confirm a final Approval decision. If the timeline is not met and/or the criteria are deemed to not be met, the ACCP will Withhold Approval for the program.

If the ACCP Withholds Approval for a program, it identifies all aspects of the program that are not in compliance and sends guidance to the program regarding all possible means of meeting the requirements.

*\*Programs must wait (1) one year before re-applying for Approval.*

**Withdrawal of Approval:** *The ACCP may at anytime withdraw the Approval status of the program due to non-compliance with the required Approval criteria.*

**Voluntary Withdrawal of Approval:** The ACCP recognizes and accepts this action at the sponsoring organization's request. The program's name is removed from the list of approved programs.

(Students enrolled in Approved Coding Certificate Programs are eligible for AHIMA Student Membership, only after Approval has been conferred.)

## FEES FOR APPROVAL

Make checks payable to AHIMA. Payments must be in U.S. dollars.

**\*Application for Program Approval Fee – \$1800.00.** This fee must be submitted with the program's Self-Study Report. The application fee is non-refundable and non-transferable.

***\*If the program is affiliated with an existing CAHIIM accredited program the application fee is \$1200.00.***

If Approval is awarded, there is no annual maintenance fee during the years of Approval.

# Coding Program Curriculum Guide

## **CODING PROGRAM CURRICULUM GUIDE**

This Coding Program Curriculum Guide was initially developed by the AHIMA Council on Education to assist educational institutions in the development of a coding curriculum. The Professional Practice staff of AHIMA and volunteer coding professionals periodically revises the curriculum guide. The materials are intended solely as a guide and carry no explicit or implicit assurances of approval.

### **What is a Coding Specialist?**

**A clinical coding specialist** is a knowledge worker in health care organizations who reviews and analyzes health data. The coding specialist is responsible for translating diagnostic and procedural terms and services utilized by healthcare providers into coded form. The translation process may require interaction with the healthcare provider to ensure that the terms have been used and translated correctly according to the convention of the coding system used and the use of the information in coded form. The resulting code set is then utilized for a variety of purposes including billing, submission of claims to health plans for payment, clinical research, public health reporting and statistical reporting for decision support. Clinical coding specialists are employed by all types of health care organizations including acute and long term care hospitals, physician offices and clinics, Nursing homes, Home Health Agencies, Community Mental Health Clinics, health plans, government agencies, and other organizations involved with the provision or funding of health services.

### **What is Coding Certification?**

The American Health Information Management Association's Council on Certification (COC) administers an entry-level coding certification examination, the CCA (Certified Coding Associate). Programs that meet the criteria for coding approval have been determined by AHIMA to contain the necessary components that would prepare a student to be a competent, entry-level clinical coding professional. . Students who complete an approved coding certificate program should be ready to sit for the CCA exam.

It should be noted that AHIMA also offers two additional coding certification examinations - the CCS (Certified Coding Specialist) and CCS-P (Certified Coding Specialist – Physicians' Office). These mastery-level certification examinations have been established to recognize individuals with specialized, advanced coding competencies. Individuals interested in either of these two mastery-level certifications should gain substantial coding experience before taking either of these examinations. They are not recommended for students who have recently completed a coding certificate program and have no other coding experience.

## **An Overview of AHIMA**

The American Health Information Management Association (AHIMA) is the professional organization of over 50,000 professionals in the health information management field. It is the association where members and affiliates with an interest in HIM interact and share their experiences and professional insight. AHIMA fosters the professional development of its members through education, certification, and lifelong learning. These commitments promote quality health information for the benefit of the public, healthcare consumers and providers, and other users of clinical data. Visit [www.ahima.org](http://www.ahima.org) for more information about AHIMA initiatives, programs, resources and membership.

AHIMA is also committed to ensuring standards and information integrity in health data and health information management. As such, AHIMA is one of the four Cooperating Parties -- with the American Hospital Association, National Center for Health Statistics, and The Centers for Medicare and Medicaid Services -- who work together to clarify the International Classification of Disease coding guidelines used in the United States. The work of the Cooperating Parties is officially published in *Coding Clinic for ICS-9-CM*, through the American Hospital Association.

AHIMA also has representation on the Editorial Advisory Board for *Coding Clinic for ICD-9-CM*, is actively involved with the CPT Editorial Panel, and works with other agencies charged with oversight and maintenance of clinical coding systems.

## **CODING SYSTEMS**

There are two coding schemes most commonly used in the United States today: ICD-9-CM (Diagnosis reporting for all settings and Procedure Coding for Inpatients) and HCPCS/CPT used in ambulatory and hospital outpatient settings. With the advancement of electronic health records, additional data sets and coding systems will be added for specific reporting needs in the industry. Other classification and vocabulary systems such as DSM-IV, ICD-O and SNOMED-CT are already in use today within the United States, with ICD-10 used internationally.

### **ICD-9-CM - International Classification of Diseases - 9th Revision - Clinical Modification.**

ICD-9-CM is a medical classification system used to describe diagnoses and) procedures. In hospitals the ICD-9-CM system is used as a basis for DRGs (Diagnosis Related Groups) for Medicare and other selected health plan inpatient stays. ICD-9-CM code selections a critical factor in the resulting DRG, and thus determines the hospital's reimbursement for each case.

The US Department of Health and Human Services, the Public Health Service, and National Center publish the official version of ICD-9-CM for Health Statistics and The Centers for Medicare and Medicaid Services. ICD-9-CM is a modification of the

International Classification of Diseases (ICD) published by the World Health Organization (WHO). The ICD-9-CM classification system is comprised of three volumes:

- Volume 1: Diseases Tabular List
- Volume 2: Diseases Alphabetic Index
- Volume 3: Procedures Tabular List and Alphabetic Index

It is anticipated that a clinical modification of ICD-10 will be implemented in the United States in the near future. Revisions in the ICD code systems are implemented in accordance with the HIPAA (Health Insurance Portability and Accountability Act of 1996) as a mandated process for updating standard medical code sets.

The ICD-9-CM Volume III procedure classification currently used for hospital inpatient procedure reporting has been recommended by the National Center for Vital and Health Committee to be replaced with the ICD-10-PCS system in the future. This also will be implemented in accordance with HIPAA requirements.

### **CPT - Current Procedural Terminology / HCPCS – Healthcare Common Procedure Coding System.**

CPT is the coding system used to describe services provided by physicians and other healthcare providers and/or facilities. In addition to its use by physicians, CPT is used to report services provided by hospital outpatient and ancillary departments, hospital emergency departments and other outpatient facilities. CPT includes three categories of codes Category 1 codes are the general code set, Category II codes are tracking codes used for performance measurement by health care providers and Category III codes are temporary codes used for reporting emerging technology, services and/or procedures before they meet the qualifications required for the general CPT code set (Category I).

The Centers for Medicare and Medicaid Services (CMS), US Department of Health and Human Services, initially created a three-level system known as HCPCS (Healthcare Common Procedure Coding System) to meet reporting and reimbursement requirements for claims processing. The levels are as follows:

Level I      Physicians' Current Procedural Terminology (CPT), Fourth Edition, developed by the American Medical Association; numeric codes

Level II      National Codes developed by CMS describing physician and non-physician services; alphanumeric codes.

*Level III      Local Codes were developed by the local Medicare carrier but HIPAA called for the elimination of local codes effective December 31, 2003.*

At a minimum, all coding programs should provide instruction in the current HIPAA mandated standard transactions and code sets. As of 2004 that includes the application of ICD-9-CM, Volumes 1-3 and Level I and II HCPCS codes.

## OFFICIAL CODING GUIDELINES

Regarding ICD-9-CM coding guidelines, the September 3, 1986, *Federal Register*, stated, "Coding guidelines are clarified through unanimous agreement by the Cooperating Parties of the ICD-9-CM Coding Clinic." The official guidelines are published in the *Coding Clinic for ICD-9-CM*, available from the American Hospital Association. *Coding Clinic* is an essential companion to the coding system books and may be obtained from:

American Hospital Association  
Publications  
1 North Franklin Street  
Chicago, IL 60606  
Phone No. (800) 261-6246  
[www.aha.org](http://www.aha.org)

Web sites for the other Cooperating Parties are as follows:

- National Center for Health Statistics – [www.cdc.gov/nchs](http://www.cdc.gov/nchs)
- American Health Information Management Association – [www.ahima.org](http://www.ahima.org)
- The Centers for Medicare and Medicaid Services [cms.hhs.gov/](http://cms.hhs.gov/)

The *CPT Assistant* newsletter, published by the American Medical Association, contains authoritative advice from the publishers of *Current Procedural Terminology*.

*CPT Assistant*  
Subscription Department  
515 North State Street  
Chicago, IL 60610  
AMA Web site address: [www.ama-assn.org](http://www.ama-assn.org)  
Phone No. (800) 621-8335  
Fax No. (312) 464-5600

Encoding systems used in instructional laboratories may include these references and tools within the program for student reference. Additional clinical references should be available in a library or via Internet links in a distance education program for reference when completing code assignment exercises.



## PHYSICAL RESOURCES:

Coding programs should have a space where students can practice coding skills in addition to time spent in the classroom. Several items should be considered for inclusion in a coding laboratory such as the references discussed as official guidelines and clinical reference works to expand the clinical knowledge base of the students for interpretation of clinical reports. Copies of clinical documentation and reports will be needed to provide case scenarios for analysis and selection of codes.

**Sample Health Records:** Students need to code sample health records in addition to workbook exercises. Sample records should be of sufficient quantity and quality so as to provide the students with experience in a variety of clinical cases and record types (e.g., hospital inpatient, outpatient, long term care, and physician office.)

The following statements outline AHIMA's position on the use of health records in educational programs and are to insure that those who use hospital and health records stored by the educational program preserve the confidentiality of patient information.

- Hospitals and other healthcare facilities are encouraged to release health records to health information management programs for use in their educational programs. When medical records are no longer needed by the healthcare facility, which normally occurs after paper records have been microfilmed and prior to shredding, the original records can be donated to an educational institution. Facilities with electronic systems may generate temporary paper copies that could be provided as samples as long as steps are taken for de-identification of protected health information to protect the privacy of the patient. It is possible that through an arrangement with a facility using electronic health record systems, students could access a demonstration or test system for experience with health service documentation and standard transactions and code set generation.
- Health records in any available form are essential for the education of coding students. In the educational program health records are used by the students for coding sequencing, and resulting DRG, APC and other reimbursement grouping of diagnoses and procedures.
- Information received from a patient and documented in health records as a result of treatment, examination, observation or conversation is privileged and faculty/students realize that this information should be kept confidential. Patient identification must be removed from records prior to student use.
- Educational programs understand that if they maintain the actual hard copy records, the records should be stored in a locked room to assure access only to authorized users.
- The same principle holds for electronic information generated from actual patient data. The database/files should be appropriately protected to assure access only to

authorized users. This may include password protection, encryption, or other technological means available.

**References.** Reference materials to be used in solving coding problems should be made available in a practice laboratory or through online applications and web-based links. Examples of useful reference materials that the institution could make available in the laboratory are medical textbooks, dictionaries, and handbooks. There are also numerous publications that have been developed specifically for coders that could be useful in helping the students interpret information from the patient record. Finally, authoritative or official coding guidelines (e.g., from *Coding Clinic* and *CPT Assistant*) must be available for student reference. Maintaining adequate reference materials helps to enhance student learning in the laboratory setting.

**Computers and Encoder Software.** Computer software tools that incorporate the text and logic of the coding systems in an automated form are also available from several vendors. Some vendors have Internet-based systems available for distance education programs. Some products also contain coding references, guidelines, payer edits and other tools that help with code selection. Access to commercial encoder applications should be made available to students either through a practice laboratory or in practice experiences. Clinical coding professionals will need to be familiar with such systems since use of a computer and specialized software is integral to employability and job performance.

## OVERVIEW OF CURRICULUM CONTENT

### Biomedical Sciences

*Intent: To develop an understanding of the clinical knowledge base through study of the structure and function of the healthy human body, pathophysiology, diagnostic and treatment modalities, and pharmacotherapy for clinical management of patient care and to enhance professional communication in healthcare environments. Whenever possible linking the biomedical science knowledge base to the process of code assignment is useful and enhances learning.*

The biomedical sciences may be taught as pre-requisites or co-requisites to the professional coding curriculum.

- **Anatomy and Physiology** – A study of the structure and function of the human body utilizing a system approach. Emphasis placed on the gross and microscopic anatomy as well as the physiology of the cell, skeletal system, muscular system, nervous system, cardiovascular, respiratory, urinary, reproductive, endocrine, and digestive systems. (Recommend 45 contact hours)
- **Medical Terminology** – Designed to teach students to accurately spell, pronounce and define common medical terms related to major disease

processes, diagnostic procedures, laboratory tests, abbreviations, drugs, and treatment modalities. (Recommend 45 contact hours)

- Pathophysiology - Emphasis placed on the disease processes affecting the human body via an integrated approach to specific disease entities, including the study of causes, diagnosis and treatment of disease. (Recommend 45 contact hours)
- Pharmacotherapy - Emphasis is placed on the understanding of the action of drugs, including the absorption, distribution, metabolism and excretion of drugs by the body. (Recommend 20 contact hours)

## **Information Technology**

*Intent: To introduce the concepts of computer technology related to healthcare and the tools and techniques for collecting, storing and retrieving healthcare data.*

- Introduction to Computers -- Concepts related to hardware and software, the impact of computers on society and computer systems/data communications networks.
- Computer Software Applications in Healthcare - Overview of commonly available software tools used in health care, including introduction to encoding tools and computer assisted coding software used in health care data processing today. Introduction to the electronic health record. (Recommend 45 contact hours)

## **Healthcare Data Content and Structure**

*Intent: To introduce the generic components of the content, use and structure of healthcare data and data sets and how these components relate to primary and secondary record systems and to introduce legal, ethical, privacy, security and confidentiality issues and practices applicable to health information. (Recommend 45 contact hours)*

- Healthcare Data/Content
  - Content of health record
  - Documentation requirements
  - Healthcare data sets
  - Primary versus secondary records
  - Legal/Ethical issues
    - Privacy, Confidentiality
    - Security
    - HIPAA requirements

- Release of information
- Professional Ethics

## **Healthcare Delivery Systems**

*Intent: To describe the organization, financing, regulatory and delivery of different healthcare services, and the 'continuum of care' concept. (Recommend 45 contact hours)*

- Healthcare Delivery Systems
  - Organization of healthcare delivery
  - Healthcare organization
  - Accreditation standards
  - Licensure/regulatory agencies
  - Payment and reimbursement systems

## **Clinical Coding and Classification Systems**

*Intent: To develop an understanding of coding and classification systems in order to assign valid diagnostic and/or procedure codes. It will include the validation of coded clinical information, and case mix/severity of illness data.*

### **Basic Diagnosis Coding Systems** (Recommend 45 contact hours)

- International Classification of Diseases ICD-9-CM
- International Classification of Diseases ICD-10-CM
- Other diagnosis coding systems or code sets (DSM-IV, ICD-0, etc.)
- Use of official coding guidelines and reporting requirements.

### **Basic Procedure Coding Systems** (Recommend 45 contact hours)

- ICD-9-CM Volume III
- Current Procedural Terminology – CPT-4
- HCPCS Level II codes
- Other procedure coding systems
  - ICD-10-PCS

**Intermediate Diagnosis Coding\*** (Recommend 45 contact hours; optional for physician practice coding)

- Case studies using more complex code assignments with ICD-9-CM. Include PPS application examples for ICD coding (DRG, RUGS, HHRG, etc.)
- Compare contrast ICD-9-CM and ICD-10-CM code assignments and conventions.
- Introduction to Systematized Nomenclature of Medicine - Clinical Terms; a very high level overview of its role in the health care delivery system as the basis for an electronic health record - outlining its relationship to the administrative code sets currently used for billing and statistical reporting. Include definitions for crosswalks and maps used in the clinical coding process

**Intermediate Procedure Coding\*** (Recommend 45 contact hours)

- RBRVS, APCs, ASC examples used including professional fee billing examples in coding (Evaluation and Management services, surgical services, etc.)
- Case studies and more complex code assignments using CPT and HCPCS Level II codes
- Procedure coding for inpatients (ICD-9-CM Volume III or ICD-10-PCS - compare and contrast the two systems at an introductory level)

*\*These courses must include hands-on exposure to computerized encoding systems*

- *Logic based encoding software*
- *Automated code book software systems*
- *Natural Language processing coding systems*

**Reimbursement Methodologies**

*Intent: To study the uses of coded data and health information in reimbursement and payment systems appropriate to all healthcare settings and managed care. Includes contemporary prospective payment systems and key health plans, charge master maintenance, identify fraudulent billing practices.* (Recommend 45 contact hours)

- Prospective payment system
- Diagnosis Related Groups
- Ambulatory Payment Classifications
- ASC Groups
- Resource Based Relative Value Scale
- Third party payers
- Billing and insurance procedures
- Explanation of benefits

- Quality Improvement Organizations (QIO) and their role in the payment process
- Charge master description and maintenance
- Managed care/capitation
- Compliance issues
- Health plan claims processing and coding
- Billing for healthcare services using codes
- Auditing and monitoring the coding process for regulatory compliance

## Medical Office Procedures

*Intent: Provide a working knowledge of concepts, processes and procedures in the billing cycle from point of service to receipt of payment; recognize components of a compliance plan for physician office billing, filing of appeals, etc.*

(Recommend 45 contact hours; optional for Comprehensive Coding; required for Physician Practice Coding)

## Professional Practice Experience/Practicum/Internship

*Intent: To provide the student with coding practices in a hospital, physician's office, clinic or other healthcare setting with directed projects common to a clinical coding specialist on the job.* (Recommend 60 contact hours)

- At a minimum, students should have practice with clinical code assignment and billing methodologies. Programs should include projects and cases that replicate typical coding tasks in a physician's office, hospital outpatient clinic, ambulatory surgery, and hospital acute care settings that employ coding professionals.

## Instructional References

Many excellent coding-related publications are available from the American Health Information Management Association. Consult the online AHIMA bookstore for the newest textbooks, references, workbooks and other media: [www.ahima.org/store](http://www.ahima.org/store)

Additional resources are available on the Assembly on Education Community of Practice. The AOE CoP is open only to AHIMA members who are involved in education. To be added to the AOE CoP, please contact the AHIMA Education Department for access:

[Tamara.dailey@ahima.org](mailto:Tamara.dailey@ahima.org)

Many fine publications for coding education are also available through various publishers. Coding programs are not restricted to AHIMA publications.

## **APPENDIX A: Standards of Ethical Coding**

In this era of payment based on diagnostic and procedural coding, the professional ethics of health information coding professionals continue to be challenged. A conscientious goal for coding and maintaining a quality database is accurate clinical and statistical data. The following standards of ethical coding, developed by AHIMA's Coding Policy and Strategy Committee and approved by AHIMA's Board of Directors, are offered to guide coding professionals in this process.

1. Coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data.
2. Coding professionals in all healthcare settings should adhere to the ICD-9-CM (International Classification of Diseases, 9th revision, Clinical Modification) coding conventions, official coding guidelines approved by the Cooperating Parties,\* the CPT (Current Procedural Terminology) rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets. Selection and sequencing of diagnoses and procedures must meet the definitions of required data sets for applicable healthcare settings.
3. Coding professionals should use their skills, their knowledge of currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes.
4. Coding professionals should only assign and report codes that are clearly and consistently supported by physician documentation in the health record.
5. Coding professionals should consult physicians for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record.
6. Coding professionals should not change codes or the narratives of codes on the billing abstract so that meanings are misrepresented. Diagnoses or procedures should not be inappropriately included or excluded because payment or insurance policy coverage requirements will be affected. When individual payer policies conflict with official coding rules and guidelines, these policies should be obtained in writing whenever possible. Reasonable efforts should be made to educate the payer on proper coding practices in order to influence a change in the payer's policy.


7. Coding professionals, as members of the healthcare team, should assist and educate physicians and other clinicians by advocating proper documentation practices, further specificity, and re-sequencing or inclusion of diagnoses or procedures when needed to more accurately reflect the acuity, severity, and the occurrence of events.
8. Coding professionals should participate in the development of institutional coding policies and should ensure that coding policies complement, not conflict with, official coding rules and guidelines.
9. Coding professionals should maintain and continually enhance their coding skills, as they have a professional responsibility to stay abreast of changes in codes, coding guidelines, and regulations.
10. Coding professionals should strive for optimal payment to which the facility is legally entitled, remembering that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines.

Revised 12/99


*The Cooperating Parties are the American Health Information Management Association, American Hospital Association, The Centers for Medicare and Medicaid Services and the National Center for Health Statistics. All rights reserved. Reprint and quote only with proper reference to AHIMA's authorship.*



## APPENDIX B: Content of the CCA EXAM

 <b>Certified Coding Associate Detailed Content Outline<sup>1</sup></b>	Recall	Application	Analysis	Total
<b>I. Health Data Content, Requirements, and Standards</b> This content area addresses competencies related to the content and use of healthcare data. The content area will also address competencies related to regulations and standards associated with health information management, which are distributed by private and governmental agencies (e.g., CMS, JCAHO, NCQA)	4	12	4	20
1. Conduct qualitative analysis to assure that documentation in the health record supports the diagnosis and reflects the progress, clinical findings and discharge status of the patient				
2. Assist in developing health record documentation guidelines			X	
3. Verify timeliness, completeness, accuracy, and appropriateness of data and data sources (e.g., patient care, management, billing reports and/or data bases)			X	
4. Abstract records for department indices/data bases/registries		X	X	
5. Request patient-specific information from other sources			X	
6. Perform quantitative analysis of health records to evaluate compliance with regulations and standards				
7. Perform qualitative analysis of health records to evaluate compliance with regulations and standards				
8. Ensure facility-wide adherence to health information services' regulatory requirements (e.g., OIG Compliance Plan, Correct Coding Initiative)				
<b>II. Clinical Classification Reimbursement Methodologies</b> This content area addresses competencies related to the uses of coded data and reimbursement.	12	36	12	60
1. Assign diagnosis/procedure codes using				
a. ICD-9-CM			X	
b. CPT/HCPCS				
2. Validate coding accuracy using clinical information found in the				

<sup>1</sup> Shaded "X" indicates that no items are written at that cognitive level.

 <b>Certified Coding Associate Detailed Content Outline<sup>1</sup></b>	Recall	Application	Analysis	Total
health record				
3. Validate reimbursement classification system assignments				
4. Collect the data necessary to assign patients to severity of illness categories		X	X	
5. Analyze the facility's patient case-mix and payment rates to assure accurate/appropriate reimbursement				
6. Maintain departmental and facility-wide coding guidelines			X	
7. Assist in the facility's billing process			X	
8. Investigate health plan payment denials				
9. Assist in using coded data for strategic planning/reporting			X	
<b>III. Information Technology and Healthcare Delivery</b> This content area addresses competencies related to global issues in healthcare and information technology.	<b>4</b>	<b>6</b>	<b>0</b>	<b>10</b>
1. Protect data integrity and validity using software or hardware technology			X	
2. Query facility-wide databases to retrieve information			X	
3. Use common software packages (e.g., spreadsheets, databases, word processing, graphics, presentation, statistical, e-mail)			X	
4. Understand the role of various providers and disciplines throughout the continuum of healthcare services		X	X	
<b>TOTALS</b>	<b>20</b>	<b>54</b>	<b>16</b>	<b>90*</b>

\* Candidates will sit for 100 items. Ninety items are scored. Ten items are pretest.

To read more about the CCA exam, please access the link below or contact the **Certification Dept** by calling 312.233.1100 or by e-mail at [info@ahima.org](mailto:info@ahima.org).

<http://www.ahima.org/certification/cca.app.pdf>

<sup>1</sup> Shaded "X" indicates that no items are written at that cognitive level.

## APPENDIX C: Related Organizational Resources

<p>AHIMA Phone: 312 233 1100 Fax: 312-233 1090 <a href="http://www.ahima.org">http://www.ahima.org</a></p> <p>American Hospital Association Phone: 312 422 300 Orders: 800-242-2626 <a href="http://www.aha.org">http://www.aha.org</a></p> <p>American Medical Association 312-464-5000 Fax Orders: 312-464-5600w <a href="http://www.ama-assn.org">http://www.ama-assn.org</a></p> <p>The Centers for Medicare and Medicaid Services <a href="http://cms.hhs.gov/">http://cms.hhs.gov/</a></p> <p>Elsevier Health Science Info Source (former W.B. Saunders) <a href="http://www.us.elsevierhealth.com/">www.us.elsevierhealth.com/</a></p> <p>Glencoe/McGraw-Hill Phone: 800-334-7344 Fax: 614-860-1877 <a href="http://www.glencoe.com/">http://www.glencoe.com/</a></p> <p>Ingenix (Formerly St. Anthony and MediCode publishing) 1.800.INGENIX (464.3649) <a href="http://www.ingenix.com/">http://www.ingenix.com/</a></p>	<p>Jones and Bartlett (Formerly Aspen Publishers) 800-832-0034 <a href="http://www.jbpub.com">http://www.jbpub.com</a></p> <p>MC Strategies Phone: 800-999-6274 <a href="http://www.mcstrategies.com/">http://www.mcstrategies.com/</a></p> <p>MedBooks Phone: 800-443-7397 <a href="http://www.medbooks.com/">http://www.medbooks.com/</a></p> <p>National Center for Health Statistics <a href="http://www.cdc.gov/nchs/">http://www.cdc.gov/nchs/</a></p>
---	--

**APPENDIX D:****Coding Program Sponsor - Fact Sheet**

Sponsoring Organization:	
Mailing Address:	
City:	
State:	
Zip Code:	
Phone: FAX: Email Address:	
Web site URL:	

**Administrative officers of the organizational unit in which the program is located:**

Dean/comparable officer: (if applicable):	
Title:	
Address if different than program:	
Program Director/Content Developer:	
Credentials:	
Phone: FAX: Email Address:	

**Students:**

Number of Students currently enrolled	
---------------------------------------	--