

COURSE OUTLINE**Health Information Technology 194  
International Classification of Diseases (ICD)  
Clinical Modifications (CM) Version 10****I. Catalog Statement**

Health Information Technology 194 provides the student with an overview of nomenclature and classification systems, with a focus on coding inpatient clinical information from medical records. Instruction includes coding diagnoses, utilizing the International Classification of Diseases (ICD), clinical Modifications (CM) Version 10 sequencing, and coding conventions.

This course is aligned with accreditation standards for the Commission on Accreditation for Health Informatics and Information Management (CAHIIM), an independent accrediting organization whose mission is to serve the public interest by establishing and enforcing quality standards for Health Informatics and Health Information Management (HIM) educational programs.

Total Lecture Units: 3.0

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Total Lecture Hours: 48.0

**Total Faculty Contact Hours: 48.0**

Prerequisite: Medical Office Administration 180 and

Recommended Preparation: Medical Office Administration 185, and eligibility for English 120, ESL 151, Business Administration 106, or equivalent.

**II. Course Entry Expectations**

Skills Level Ranges: Reading 5; Writing 5; Listening/Speaking 5; Math 3

Prior to enrolling in the course, the student should be able to:

1. explain health data and clinical documentation principles, standards, and guidelines.
2. describe regulatory, accreditation, licensure and certification standards related to health information in medical records in the acute-care hospital setting;
3. understand national and state regulatory and accreditation requirements for confidentiality, privacy, and security of health information to protect the patient and the acute-care hospital;
4. demonstrate a basic vocabulary of medical terms for each body system;
5. explain terms for common diagnostic and therapeutic interventions for each body system;
6. develop proficiency in the use of medical charting using current technology;
7. demonstrate ability to read health record reports with an understanding of medical terminology;
8. describe common disorders of selected body systems in terms of pathogenesis, etiology, clinical manifestations, common diagnostic tests, complications, and treatment modalities.

### III. Course Exit Standards

Upon successful completion of the required coursework, the student will be able to:

1. define ICD-10 coding and explain its use;
2. explain the need for clear and precise coding policies and procedures;
3. describe how coding policies and procedures are developed and what areas should be addressed;
4. apply knowledge of anatomy, clinical disease processes, treatment protocols, diagnostic and procedural terminology, and pharmacology to assign codes to diagnoses and procedures;
5. examine impact of abnormal diagnostic findings, including laboratory and radiological findings on coding;
6. define and understand the basic principles, conventions, and guidelines for ICD-10 diagnosis and procedure classifications.

### IV. Course Content

**Total Contact Hours = 48 hours**

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|--|---------|
| A. Background of the ICD-10 CM Classification                  | 8 hours |
| 1. Introduction to the ICD-10 CM classification                |         |
| 2. Conversion of ICD-version 9 to ICD-version 10               |         |
| 3. Principles of ICD-version 10                                |         |
| 4. ICD-version 10 steps and guidelines                         |         |
| B. System Definitions and Guidelines                           | 8 hours |
| 1. ICD Clinical Modification (CM) systems                      |         |
| 2. Official coding and reporting guidelines                    |         |
| 3. ICD-10-CM conventions                                       |         |
| 4. General Equivalence Mappings (GEMs)                         |         |
| C. Coding Signs and Symptoms of Conditions                     | 8 hours |
| 1. Differences between signs and symptoms                      |         |
| 2. Principal diagnose versus secondary diagnose                |         |
| 3. Subjective observations                                     |         |
| 4. Objective observations                                      |         |
| D. Diseases and Mental and Behavioral Disorders                | 8 hours |
| 1. Infections and parasite diseases                            |         |
| 2. Endocrine, nutritional, and metabolic diseases              |         |
| 3. Metabolic disorders   |         |
| 4. Mental and behavior disorders                               |         |
| E. Coding of Diseases  | 8 hours |
| 1. Diseases of the blood and blood-producing organs            |         |
| 2. Diseases of respiratory, digestive and genitourinary system |         |
| 3. Diseases of the skin and subcutaneous tissue                |         |
| 4. Diseases of female and reproductive system                  |         |
| F. Coding of Conditions and Complications                      | 8 hours |
| 1. Injuries and infections                                     |         |

2. Burns
3. Poisoning
4. Surgery and medical care

**V. Methods of Instruction**

The following methods of instruction may be used in the course:

1. lecture;
2. discussions;
3. hands-on activities, assignments, and case management;
4. online.

**VI. Out of Class Assignments**

The following out of class assignments may be used in this course:

Computer and written assignments, including the following examples:

1. assign ICD-10-CM code(s) for inpatient mock electronic medical record;
2. apply ICD-10-CM guidelines and identify one principal procedure and all applicable secondary procedures per physician chart documentation.

**VII. Methods of Evaluation**

The following methods of evaluation may be used in this course:

1. quizzes;
2. midterm examination;
3. presentations;
4. final examination.

**VIII. Textbook**

Leon-Chisen, Nelly. *ICD-10-CM and AICD-10-PCS Coding Hand Book*. Jackson: American Hospital Association Publishing, 2013. Print.

12<sup>th</sup> Grade Textbook Reading Level - ISBN-13: 9781556483844.

**IX. Student Learning Outcomes**

Upon successful completion of the required coursework the student will be able to:

1. apply ICD-10-CM coding guidelines and conventions to health record documentation with accuracy;
2. utilize ICD-10-CM coding classification system references correctly;
3. demonstrate ability to abstract clinical information from health record documentation;
4. discuss the impact of reimbursement, physician query process, and ICD-10-CM;
5. explain how diseases and procedures are classified and named with past, present, and future ICD-10-CM related classification systems;
6. apply clinical knowledge to code diagnoses for all body systems for inpatient/outpatient records;
7. interpret official ICD-10-CM guidelines for coding and reporting to assign ICD-10-CM codes for diagnoses.

**Justification for Need**

This course is a required course for the completion of the Associate of Science Degree program in Health Information Technology (HIT), which is currently being developed.