



COURSE OUTLINE : MOA 194
D Credit – Degree Applicable
COURSE ID 010451
Cyclical Review: November 2021

COURSE DISCIPLINE : MOA
COURSE NUMBER : 194
COURSE TITLE (FULL) : International Classification of Diseases (ICD) Clinical Modifications (CM)
Version 10
COURSE TITLE (SHORT) : Interntl Classifictn Diseases
ACADEMIC SENATE DISCIPLINE: Office Technology

CATALOG DESCRIPTION

MOA 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.

Total Lecture Units:3.00

Total Laboratory Units: 0.00

Total Course Units: 3.00

Total Lecture Hours:54.00

Total Laboratory Hours: 0.00

Total Laboratory Hours To Be Arranged: 0.00

Total Contact Hours: 54.00

Total Out-of-Class Hours: 108.00

Prerequisite: MOA 180.



ENTRY STANDARDS

	Subject	Number	Title	Description	Include
1	MOA	180	Electronic Health/Medical Records	Explain health data and clinical documentation principles, standards and guidelines to ensure the quality of the health record in a medical clinic or an acute-care hospital setting;	Yes
2	MOA	180	Electronic Health/Medical Records	describe regulatory, accreditation, licensure and certification standards related to health information to medical records in the acute-care hospital setting;	Yes
3	MOA	180	Electronic Health/Medical Records	demonstrate understanding of national and state regulatory and accreditation requirements for confidentiality, privacy, and security of health information to protect the patient and the acute-care hospital;	Yes
4	MOA	180	Electronic Health/Medical Records	use current technology and systems to ensure the quality of the medical record and to ensure the optimum collection, analysis, storage, release, retrieval, and reporting of health information to appropriate users and requestors;	Yes
5	MOA	180	Electronic Health/Medical Records	describe a Health Information Management (HIM) Department in an acute-care hospital, medical clinic or any other health care establishment;	Yes

EXIT STANDARDS

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

STUDENT LEARNING OUTCOMES

- 1 Apply International Classification of Diseases Version 10 (ICD-10) Clinical Modification (CM) coding guidelines and conventions to health record documentation with accuracy.
- 2 Explain how diseases and procedures are classified and named with past, present, and future International Classification of Diseases Version 10 (ICD-10) Clinical Modification (CM) related classification systems.



- 3 Apply clinical knowledge to code diagnoses for all body systems for inpatient/outpatient records.

COURSE CONTENT WITH INSTRUCTIONAL HOURS

	Description	Lecture	Lab	Total Hours
1	Background of the International Classification of Diseases Version 10 (ICD-10) Clinical Modification (CM) Classification <ul style="list-style-type: none"> • Introduction to the ICD-10 CM classification • Conversion of ICD-version 9 to ICD-version 10 • Principles of ICD-version 10 • ICD-version 10 steps and guidelines 	9	0	9
2	System Definitions and Guidelines <ul style="list-style-type: none"> • ICD Clinical Modification (CM) systems • Official coding and reporting guidelines • ICD-10-CM conventions • General Equivalence Mappings (GEMs) 	9	0	9
3	Coding Signs and Symptoms of Conditions <ul style="list-style-type: none"> • Differences between signs and symptoms • Principal diagnose versus secondary diagnose • Subjective observations • Objective observations 	9	0	9
4	Diseases and Mental and Behavioral Disorders <ul style="list-style-type: none"> • Infections and parasite diseases • Endocrine, nutritional, and metabolic diseases • Metabolic disorders • Mental and behavior disorders 	9	0	9



5	Coding of Diseases <ul style="list-style-type: none"> • Diseases of the blood and blood-producing organs • Diseases of respiratory, digestive and genitourinary system • Diseases of the skin and subcutaneous tissue • Diseases of female and reproductive system 	9	0	9
6	Coding of Conditions and Complications <ul style="list-style-type: none"> • Injuries and infections • Burns • Poisoning • Surgery and medical care 	9	0	9
				54

OUT OF CLASS ASSIGNMENTS

- 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.

METHODS OF EVALUATION

- 1 quizzes
- 2 midterm examination
- 3 presentations
- 4 final examination

METHODS OF INSTRUCTION

- Lecture
- Laboratory
- Studio
- Discussion
- Multimedia
- Tutorial
- Independent Study
- Collaboratory Learning
- Demonstration



Field Activities (Trips)

Guest Speakers

Presentations

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TEXTBOOKS

Title	Type	Publisher	Edition	Medium	Author	IBSN	Date
ICD-10-CM and AICD-10-PCS Coding Hand Book	Required	American Hospital Association Publishing		print	Leon-Chisen, Nelly	9781556484377	2018