Course/Program Title: MAP-108-01
Course/Program Team: Medical Record Analysis and Coding
Andrea Bower

Expected Learning Outcomes:
1. Utilize current ICD-10-CM, CPT and HCPCS code books to accurately convert medical record source document information into codes for purposes of billing and reimbursement.
2. Utilize concepts of medical necessity, correct coding initiative guidelines, and documentation requirements to develop accurate and appropriate coding for a variety of clinical situations.
3. Apply knowledge of CMS reimbursement methodologies and documentation regulations to develop accurate and appropriate coding for a variety of clinical situations.

Assessment
Course completion: Number passing at 75% or greater

Course Outcomes:
Common final exam for item analysis:
CO 1 Utilize ICD-10-CM, CPT and HCPCS code books properly for reimbursement.
CO 2 Utilize various concepts to appropriately code a variety of clinical situations.
CO 3 Apply CMS knowledge of reimbursement methodology in a variety of clinical situations.

Validation:
Completion of course with an average grade of 75% or greater
Common exam question accuracy rate of 75% or greater

Results
Course Completion:
82% (9/11) completed the course with a grade of 75% or greater
18% (2/11) completed the course with a grade less than 75%

Course Outcomes:

CO 1 Utilize ICD-10-CM, CPT and HCPCS code books properly for reimbursement. 96%
CO 2 Utilize various concepts to appropriately code a variety of clinical situations. 96%
CO 3 Apply CMS knowledge of reimbursement methodology in a variety of clinical situations. 69%
Follow-up
The Program Coordinator and the instructor will again focus on the CMS documentation regulations in order to improve the CO3 outcome. CO 1 and CO 2 did improve slightly from FA 17. Documentation regulations are constantly changing and more is required related to this.
Researching the newest regulations and incorporating them into the class for the students will be implemented.

Number of students assessed: 11

Budget justification: NA