Coding in the Long Term Acute Care Setting

Audio Seminar/ Webinar

October 18, 2007

Practical Tools for Seminar Learning

© Copyright 2007 American Health Information Management Association. All rights reserved.
Disclaimer

The American Health Information Management Association makes no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. AHIMA has no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this audio seminar, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this program. AHIMA makes no guarantee that the use of this program will prevent differences of opinion or disputes with Medicare or other third party payers as to the amount that will be paid to providers of service.

As a provider of continuing education, the American Health Information Management Association (AHIMA) must assure balance, independence, objectivity and scientific rigor in all of its endeavors. AHIMA is solely responsible for control of program objectives and content and the selection of presenters. All speakers and planning committee members are expected to disclose to the audience: (1) any significant financial interest or other relationships with the manufacturer(s) or provider(s) of any commercial product(s) or services(s) discussed in an educational presentation; (2) any significant financial interest or other relationship with any companies providing commercial support for the activity; and (3) if the presentation will include discussion of investigational or unlabeled uses of a product. The intent of this requirement is not to prevent a speaker with commercial affiliations from presenting, but rather to provide the participants with information from which they may make their own judgments.
Faculty

**Ella James, MS, RHIT, CPHQ**

Ms. James is director of corporate health information management and the health information security and the privacy officer at Hospital for Special Care in New Britain, Connecticut. The corporation, Center of Special Care, includes a 228-bed long-term acute hospital, a 280-bed skilled nursing facility, and specialty clinics in the community.

Ella is past president of the Connecticut Health Information Management Association and an American Health Information Management Association (AHIMA) Community of Practice (CoP) facilitator for long-term care. She also chairs the coding committee for the National Association of Long Term Hospitals (NALTH), and is actively involved in coding audits and education of coding and documentation practices in the long-term acute care hospital environment across the nation.

Ella is contributing author for two other AHIMA publications, *Health Information Management Compliance: Guidelines for Preventing Fraud and Abuse, Forth Edition* and *Documentation for Medical Records*.

Ella received her Master of Science degree in healthcare administration at Saint Joseph’s College in Maine.

Ella has presented programs on the Health Insurance Portability and Accountability Act (HIPAA) at the state, regional, and national levels, and has presented several programs on long-term acute care coding for NALTH.

**Susan M. Marre, RHIA**

Ms. Marre is director of medical records at New England Sinai Hospital in Stoughton, MA. Susan is currently president-elect of the Massachusetts HIMA and previously served as the director of Advocacy and Legislation and chairperson of the Awards Task Force 2005-2007. She was the lead delegate for Massachusetts 2006. In addition, Susan serves as president of the Silver Lake Boys High School Basketball Boosters.

Susan is a coding consultant for the National Association of Long Term Hospitals (NALTH) and a faculty member for NALTH Coding Boot Camp. She is a frequent lecturer on long-term acute care coding and PPS at NALTH meetings and served as secretary on the NALTH Coding Committee.
Table of Contents

Disclaimer .................................................................................................................... i
Faculty ....................................................................................................................... ii
Goals .......................................................................................................................... 1
Documentation and Coding Principles ........................................................................ 1
  CMS Advice ............................................................................................................. 2
  Coding and Reporting for LTCH ............................................................................ 3
  COPD and Asthma .................................................................................................. 4
  Polling Question ..................................................................................................... 4
  Respiratory Failure ............................................................................................... 5
  Polling Question ..................................................................................................... 5
  Vent Weaning ......................................................................................................... 6
  Septicemia, SIRS, Sepsis, Severe Sepsis, and Septic Shock ..................................... 6
  Urosepsis ............................................................................................................... 7
  Pneumonia ............................................................................................................. 7
  Continued Antibiotics ............................................................................................ 8
  CHF ........................................................................................................................ 8
  Combination Code .................................................................................................. 9
  Diabetes .................................................................................................................. 10
  Osteomyelitis ....................................................................................................... 10
  Decubital Ulcers ................................................................................................... 11
  Cellulitis ............................................................................................................... 11
  Debridement ......................................................................................................... 12
  Hypertension ....................................................................................................... 12
  Hypertension with Heart Disease ......................................................................... 13
  Hypertensive Renal Disease .................................................................................. 13
  Elevated Blood Pressure ...................................................................................... 14
  HIV ...................................................................................................................... 14
  Neoplasms ........................................................................................................... 15
  Late Effect ............................................................................................................. 15
  Fractures ............................................................................................................... 16
  Burns ..................................................................................................................... 16
  V Codes ............................................................................................................... 17
  Aftercare .............................................................................................................. 17
  Acquired Brain Injury ........................................................................................... 18
  Chronic Kidney Disease ....................................................................................... 18
  Previous Conditions ............................................................................................ 19
  References .......................................................................................................... 19

MS-DRG System
  Severity-Adjusted DRGs ....................................................................................... 20
  Final DRGs ............................................................................................................ 21
  CC List .................................................................................................................. 22
    Criteria ............................................................................................................... 24
  Heart Failure ....................................................................................................... 26
  Kidney Disease .................................................................................................... 27
  Bronchitis ............................................................................................................ 27
  Decubitus Ulcers ................................................................................................ 28
  Diabetes ............................................................................................................... 29
  Heart Disease ..................................................................................................... 29
  Others .................................................................................................................. 30
  Resources .......................................................................................................... 31

Audience Questions

Appendix ................................................................................................................... 34
  CE Certificate Instructions .................................................................................... 35
Goals

- Review coding resources that apply to the LTCH setting
- Highlight October 1, 2007 changes
- Give examples of coding challenges and best practices for coding professionals

Documentation and Coding Principles 2007
Coding and Reporting for LTCH

- The Medicare program defines Long Term Care Hospitals (LTCHs) as hospitals that have a provider agreement with Medicare and have an average Medicare inpatient length of stay of greater than 25 days. Medicare covers LTCHs under the Long Term Care Hospital Prospective Payment System (LTCH PPS) rules with cost reporting periods beginning on or after October 1, 2002.

CMS Advice

- Depending on the documentation in the medical record, unresolved acute conditions and/or the codes for late effects or rehabilitation may be used in the LTCH setting.
Coding and Reporting for LTCH

- LTCHs should be aware that if the patient is being admitted for continuation of treatment of an acute or chronic condition, guidelines at Section (I)(B)(10) of the Official Coding Guidelines are applicable concerning the selection of principal diagnosis.

Documentation and Coding

- The importance of consistent, complete documentation in the medical record cannot be overemphasized.
- Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.
- The physician is the most important link to accurate, detailed diagnosis coding assignment.
COPD and Asthma

- The conditions that comprise COPD are obstructive chronic bronchitis, subcategory 491.2X, and emphysema, category 492. X
- All asthma codes are under category 493, Asthma. Code 496, Chronic airway obstruction, not elsewhere classified, is a nonspecific code that should only be used when the documentation in a medical record does not specify the type of COPD being treated.

COPD “Coding Clinic”

Polling Question:
What is the appropriate code assignment for acute bronchitis and acute exacerbation of asthma?

*1 496
*2 491.22
*3 493.22
*4 491.22 & 493.22
Respiratory Failure

- Code 518.81, Acute respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter-specific coding guidelines (obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence. Respiratory failure may be listed as a secondary diagnosis if it occurs after admission.

Polling Question

A patient with chronic myasthenia gravis goes into acute exacerbation and develops acute respiratory failure. The patient is admitted due to the respiratory failure. What is the Principal diagnosis?

1  358.01 Myasthenia gravis
2  518.81 Acute respiratory failure
**Vent Weaning**

- The weaning of an intubated patient is included in counting the length of time that a patient is on mechanical ventilation. There may be several attempts to wean the patient off of the ventilator prior to extubation.
- The purpose of weaning is to allow the patient to gradually assume the work of breathing, while being carefully monitored for any evidence of cardiopulmonary instability. Not all patients require a period of weaning.

*Coding Clinic*, Fourth Quarter 1991

**Septicemia, SIRS, Sepsis, Severe Sepsis, and Septic Shock**

Continuum of Illness Due to Infection

Bacteremia → Septicemia → Sepsis

Severe Sepsis ← Septic Shock

MODS → Death

*(Multiple Organ Dysfunction Syndrome)*
Urosepsis - Old Guidance

- The term *urosepsis* refers to pyuria or bacteria in the urine (not the blood) and is coded to 599.0, Urinary tract infection, site not specified.

Pneumonia

- A diagnosis of pneumonia must be determined by a physician. A coder can not determine the type of pneumonia based on laboratory findings and other information in the medical record without seeking clarification from the physician.
Continued Antibiotics

- A patient is admitted to the LCTH for continuation of antibiotics. The physician's orders state, "continue IV antibiotics for 14 days for infection".
- According to Coding Clinic, Fourth Quarter 1999 the infection should be coded.

CHF

- CHF unspecified 428.0
- Left sided 428.1
- Right sided 428.0
- Diastolic
  - diastolic 428.30
  - acute 428.31
  - acute on chronic 428.33
  - chronic 428.32
CHF

- Systolic 428.20
  - acute 428.21
  - acute on chronic 428.23
  - chronic 428.22
- Acute 428.41
- Acute on chronic 428.43
- Chronic 428.42

Combination Code

- Combination codes are used in the LCTH setting
  - A combination code is a single code used to classify:
    - Two diagnoses, or
    - A diagnosis with an associated secondary process (manifestation)
    - A diagnosis with an associated complication
Diabetes

- Codes under category 250, Diabetes mellitus, identify complications/manifestations associated with diabetes mellitus. A fifth-digit is required for all category 250 codes to identify the type of diabetes mellitus and whether the diabetes is controlled or uncontrolled.
  - 0 type II or unspecified type, not stated as uncontrolled.
  - 1 type I, [juvenile type], not stated as uncontrolled.
  - 2 type II or unspecified type, uncontrolled.
  - 3 type I, [juvenile type], uncontrolled.

Osteomyelitis

Question:
- A patient was admitted with complaints of continuous bleeding from a chronic ulcer of the left heel. The patient has non-insulin dependent diabetes, peripheral vascular disease due to the diabetes, end-stage renal disease, hypertension, and status post right above-the-knee amputation. Because of gangrene and acute Osteomyelitis from the heel ulcer, the patient underwent a left below the knee amputation.
Decubital Ulcers

- Decubital ulcers are described in several stages, is it appropriate to assign a code for a stage one ulcer?
- Assign code 707.0x Decubitus ulcer, for any decubitus ulcer. *ICD-9-CM* does not classify ulcers by severity or stage.

Cellulitis

- In coding cellulitis associated with open wound or with ulcer of the skin, the usual guidelines for designating the principal diagnosis apply.
- If the patient is seen primarily for treatment of the open wound, then the appropriate code for open wound, complicated, is assigned, with an additional code for the cellulitis to indicate the specific complication.
- If the wound is trivial and in itself does not require treatment or if it was treated earlier and the patient is now seen because of the cellulitis, the code for the cellulitis may be sequenced first with an additional code for open wound, complicated.
**Debridement**

- Excisional debridement is the surgical removal or cutting away of devitalized tissue, necrosis, or slough. Depending on circumstances such as the patient's condition, availability of a surgical suite, or extent of area to be debrided, excisional debridement can be performed in the operating room, emergency room, or at the patient's bedside.

*Coding Clinic, Fourth Quarter 1988*

---

**Hypertension**

- Hypertension, Essential, or NOS is assigned to category code 401 with the appropriate fourth digit to indicate malignant (.0), benign (.1), or unspecified (.9).

- Do not use either .0 malignant or .1 benign unless medical record documentation supports such a designation.
Hypertension with Heart Disease

- Heart conditions (425.8, 429.0-429.3, 429.8, 429.9) are assigned to a code from category 402 when a causal relationship is stated (due to hypertension) or implied (hypertensive).

Hypertensive Renal Disease with Chronic Renal Failure

- Assign codes from category 403, hypertensive renal disease, when conditions classified to categories 585-587 are present. Unlike hypertension with heart disease, ICD-9-CM presumes a cause-and-effect relationship and classifies renal failure with hypertension as hypertensive renal disease.
Elevated Blood Pressure

- For a statement of elevated blood pressure without further specificity, assign code 796.2, elevated blood pressure reading without diagnosis of hypertension, rather than a code from category 401.

HIV

- Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.
- In this context, “confirmation” does not require documentation of positive serology or culture for HIV; the physician’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.
**Neoplasms**

- If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.
- When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

**Late Effect**

- A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury. Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.


**Coding of Fractures**

- The principles of multiple coding of injuries should be followed in coding fractures.
  - The acute care code for the fracture is only coded in a LTCH if the fracture occurred in the facility. Patients admitted with fractures are coded to aftercare of healing fractures or late effects of fractures.

**Burns**

- Current burns (940-948) are classified by depth, extent and by agent (E code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement).
**V Codes**

- Four uses of V codes:
- When a person who is not currently sick encounters the health services for some specific reason, such as to act as an organ donor, to receive prophylactic care, such as inoculations or health screenings, or to receive counseling on health related issue.

**Aftercare**

- Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare V code should not be used if treatment is directed at a current, acute disease or injury, the diagnosis code is to be used in these cases.
Acquired Brain Injury

- A diffuse axonal injury (DAI) is also referred to as a shear injury and is frequently observed in patients with severe head trauma. This type of injury normally occurs from traumatic deceleration/acceleration such as in a car accident. There is extensive damage to the nerve tissue and the brain’s normal chemical processes are disrupted. Patients may present with a variety of temporary or permanent functional impairments, depending on the severity of the injury. DAI is a major cause of persistent vegetative state and morbidity and is a significant medical problem because of the patient’s high level of debilitation.

Chronic Kidney Disease

- Effective October 1, 2005, changes were made to the ICD-9-CM classification to recognize more current terminology related to chronic kidney disease (CKD) rather than imprecise terms like chronic renal failure and chronic renal insufficiency. The descriptor for code 585, Chronic renal failure, has been changed to Chronic Kidney Disease. Code 585 has been expanded to recognize current staging of chronic kidney disease developed by the National Kidney Foundation (NKF).

*Coding Clinic, Fourth Quarter 2005*
Previous Conditions

- If the physician has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some physicians include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy. History codes may be used as secondary codes if they have an impact on current care or influence treatment.

References:

- Official Guidelines for Coding and Reporting, October 1, 2007
- AHA Coding Clinic for ICD-9-CM
- ICD-9-CM Diagnosis Tabular
- http://projects.ipro.org/index/hpmp-news
- LTCH PPS Training Manual from CMS
MS-DRG System
2007

Severity-Adjusted DRG System

- Creation in FY08 of 745 new Medicare Severity DRGs (MS-DRGs) replace 538 FY07 DRGs and reviewed and revised the complication and comorbidity list
- Significant revision to the complication and comorbidity (CC) list that will impact DRG assignment, coding and physician documentation
- Present on admission does not affect LTCHs in FY08
Severity-Adjusted DRG System

The final MS-DRGs:
- Represent the first major review and revision of the DRG system since its inception (24 years ago)
- Represent comprehensive approach to applying severity of illness stratification for Medicare patients throughout the DRGs
- Greatly improve CMS’ ability to identify groups of patients with varying levels of severity using secondary diagnoses
- Improve CMS’ ability to assign patients to different DRG severity levels based on resource use that is independent of the patient’s secondary diagnosis

Severity-Adjusted DRG System

- Adoption of MS-DRGs in FY2008 is expected to be permanent for the IPPS
- Transition to cost based weighting
- Blend of relative weights: 50% CMS-DRG/ 50% MS-DRG weight
Severity-Adjusted DRG System

- Most comprehensive review of the CC list since the creation of the DRGs
- As a result of changes that have occurred during the 22 years since the implementation of the IPPS, the CC list as previously defined had lost much of its power to discriminate hospital resource use.
- Net effect of better coding of secondary diagnoses, reductions in hospital length of stay, increased availability of post-acute care services, and shift to outpatient care is that nearly 80 percent of patients now have a CC.
- Previously, 115 DRGs are split based on the presence or absence of a CC.

Severity-Adjusted DRG System

- Major complication or comorbidity (MCC),
- A complication or comorbidity (CC), or
- Non-complication or comorbidity (non-CC).
Severity-Adjusted DRG System

- MCC: Any diagnosis that was a CC in the revised CC list and was an APDRG major CC and was an APR-DRG default severity level 3 (major) or 4 (extensive).
- Non-CC: Any diagnosis that was a non-CC in the revised CC list and was an AP-DRG non-CC and was an APR-DRG default severity level of 1 (minor).
- CC: Any diagnoses that did not meet either of the above criteria were designated as a CC.
- CMS’ medical consultants identified specific clinical situations in which the diagnosis should not be considered a CC (added to CC exclusion list).

Severity-Adjusted DRG System

- 13,549 secondary diagnosis codes reviewed
- CMS has modified the previous CC list from 3,326 diagnosis codes to a revised list of 1,584 major complications/comorbidities (MCC) and 3,343 CCs.
Severity-Adjusted DRG System

- Criteria for inclusion in revised CC list:
  - Substantially increased hospital resource use
  - Intensive monitoring,
  - Expensive and technically complex services, or
  - Extensive care requiring a greater number of caregivers.
    - Requires consistently greater impact on hospital resources
  - Significant acute disease,
  - Acute exacerbation of significant chronic diseases,
  - Advanced or end stage chronic diseases and
  - Chronic diseases associated with extensive debility.

Severity-Adjusted DRG System

- Each diagnosis for which Medicare data were available was evaluated to determine its impact on resource use and to determine the most appropriate CC subclass (non-CC, CC, or MCC) assignment.
- CMS’ medical consultants identified specific clinical situations in which the diagnosis should not be considered a CC (added to CC exclusion list).
- Diagnoses that were closely associated with patient mortality were assigned different CC subclasses, depending on whether the patient lived or died.
- Excluded E codes and congenital abnormalities.
Severity-Adjusted DRG System

- Most chronic diseases not assigned to revised CC list.
- Acute manifestation of the chronic disease must be present and coded.
- Exceptions for advanced stage or associated with systemic physiologic decompensation and debility.
- Medicare data does not show chronic or “unspecified” codes are more resource intensive.

Severity-Adjusted DRG System

- Examples included are:
  - Acute myocardial infarction
  - Cerebrovascular accident (CVA)
  - Acute respiratory failure
  - Acute renal failure
  - Pneumonia
  - Septicemia

- Other acute diseases included if their impact on hospital resource use would be expected to be comparable to these
Severity-Adjusted DRG System

• Final MCCs
  • 428.21, Acute systolic heart failure
  • 428.41, Acute systolic and diastolic heart failure
  • 428.43, Acute on chronic systolic heart failure
  • 428.31, Acute diastolic heart failure
  • 428.33, Acute on chronic diastolic heart failure

• Final CCs:
  • 428.1, Left heart failure
  • 428.20, Systolic heart failure NOS
  • 428.22, Chronic systolic heart failure
  • 428.32, Chronic diastolic heart failure
  • 428.40, Systolic and diastolic heart failure

Severity-Adjusted DRG System

• Removal from the revised CC list:
  • 428.0, Congestive heart failure NOS
  • 428.9, Heart failure NOS

• The precise type of heart failure must be specified in order for an MCC or CC to be assigned.
Severity-Adjusted DRG System

- **Current CCs:**
  - 585.1 - 585.9 Chronic kidney disease, stage I through V, end stage renal disease, unspecified

- **Final MCC:**
  - 585.6, End stage renal disease

- **Final CC:**
  - 585.4, Chronic kidney disease, stage IV (severe)
    - 585.5, Chronic kidney disease, stage V
  - **Final removal from the revised CC list:**
    - 585.1, Chronic kidney disease, stage I
    - 585.2, Chronic kidney disease, stage II (mild)
    - 585.3, Chronic kidney disease, stage III (moderate)
    - 585.9, Chronic kidney disease, unspecified

Severity-Adjusted DRG System

- **Current CCs removed from final list:**
  - 491.20 Obstructive chronic bronchitis without exacerbation
  - 491.8/491.9 Other chronic bronchitis/Unspecified
  - 492.8 Other emphysema
  - 493.20 Chronic obstructive asthma unspecified
  - 496 Chronic airway obstruction NEC

- **Final CC:**
  - Specified forms of COPD remain CCs e.g.:
    - 491.21, 491.22, 493.01, 493.02, 493.11, 493.12, 493.21, 493.22, 493.91, 493.92
Severity-Adjusted DRG System

- Current CCs:
  - 428.0 - 428.9

- Changed:
  - Remove chronic diseases without a significant acute manifestation.
  - Chronic diagnoses having a broad range of manifestations are not assigned to the CC list as long as there are codes available that allow the acute manifestations to be coded separately.
  - Non-specific codes should not be included on the CC list.

Severity-Adjusted DRG System

- Current CC: 707.0x decubitus ulcer

- Final CCs, decubitus ulcers:
  - Unspecified site (707.00)
  - Elbow (707.01)
  - Other site (707.09)

- Final MCCs, decubitus ulcers:
  - Upper back (707.02)
  - Lower back (707.03)
  - Hip (707.04)
  - Buttock (707.05)
  - Ankle (707.06)
  - Heel (707.07)
Severity-Adjusted DRG System

- Current CC: Diabetes mellitus (except 5th digit of “0”)
- Final MCC:
  - Diabetes with ketoacidosis 250.10-250.13
  - Diabetes with hyperosmolarity 250.20-250.23
  - Diabetes with coma 250.30-250.33
- Current CC’s removed from CC List:
  - Diabetes with renal manifestations (250.4x)
  - Diabetes with ophthalmic manifestations (250.5x)
  - Diabetes with neurological manifestations (250.6x)
  - Diabetes with peripheral circulatory disorders (250.7x)
  - Diabetes with other specified manifestations (250.8x)
  - Diabetes with unspecified complications (250.9x)

Severity-Adjusted DRG System

- Other conditions that would no longer be considered CCs include
  - Atrial fibrillation (427.31)
  - Mitral valve disease codes (396.0- 396.9)
  - Dehydration (276.51)
  - Hyperkalemia (276.7)
  - Angina pectoris (413.9)
  - Renal dialysis status (V45.1)
Severity-Adjusted DRG System

• Former non-CCs designated as CCs or MCCs
  • Transient ischemic attack (435.0-435.9) - CC
  • Jaundice (782.4) - CC
  • Aphasia (784.3) - CC
  • Viral pneumonia (480.0-480.9) - MCC

Severity-Adjusted DRG System

• Some additions to the CC list include:
  • V55.1 Attention to gastrostomy
  • V85.0 Body Mass Index (BMI) less than 19, adult
  • V85.4 Body Mass Index (BMI) greater than or equal to 40, adult
MS-DRG Resources

AHIMA Resources:
- http://www.ahima.org/reimbursement
  This site provides a summary of available resources for MS-DRGs.
- Coding Community CoP (Community of Practice)
- Long Term Acute Care CoP
- State CoP (found under Geographic, [state name])

Audience Questions
Audio Seminar Discussion

Following today’s live seminar
Available to AHIMA members at
www.AHIMA.org

Click on Communities of Practice (CoP) - icon on top right
or sign on to MyAHIMA
AHIMA Member ID number and password required - for members only

Join the Long Term Acute Care Community from your
Personal Page then under Community Discussions,
choose the Audio Seminar Forum
You will be able to:
• Discuss seminar topics
• Network with other AHIMA members
• Enhance your learning experience

AHIMA Audio Seminars/ Webinars

Visit our Web site
http://campus.AHIMA.org
for information on the seminar schedule.
While online, you can also register
for seminars or order CDs and
pre-recorded Webcasts of past seminars.

The 2008 seminar/webinar schedule is now posted
Upcoming Seminars/ Webinars

Diagnostic Coding for Blood Diseases
November 8, 2007

Coding Clinic Update
November 13, 2007

Thank you for joining us today!

Remember – sign on to the AHIMA Audio Seminars Web site to complete your evaluation form and receive your CE Certificate online at:


Each person seeking CE credit must complete the sign-in form and evaluation in order to view and print their CE certificate

Certificates will be awarded for AHIMA and ANCC Continuing Education Credit
Appendix

CE Certificate Instructions ..................................................................................................................35
To receive your

**CE Certificate**

Please go to the Distance Education Web site


click on

“Complete Online Evaluation”

You will be automatically linked to the CE certificate for this seminar after completing the evaluation.

*Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.*