CONCEPT

# Clinical Coding Course: ICD-10-AM/ACHI, AR-DRG Grouping and Coding Audit

8 – 12 August 2027
Riyadh - KAFD district five-star



# Clinical Coding Course: ICD-10-AM/ACHI, AR-DRG Grouping and Coding Audit

**Ref:** 1565_25211 **Date:** 8 – 12 August 2027 **Location:** Riyadh - KAFD district five-star **Fees:** 20000 SAR

## Introduction:

Clinical coding with ICD-10-AM/ACHI, AR-DRG grouping and coding audit is the subject of this 1-week course for health information management, clinical coding and revenue cycle teams, who produce a coding quality and HIM improvement plan for a case hospital. Hospitals moving to DRG-based payment lose income and casemix credibility when coding conventions are applied unevenly, grouping errors go undetected and coding backlogs delay claims. Nominees already abstract, code or supervise inpatient episodes, and teaching is by case study on coded episodes, grouper outputs and audit samples. CoreConcept Training Center delivers this clinical coding course.

## Course Objectives:

- Apply ICD-10-AM and ACHI conventions and the associated coding standards to inpatient episodes
- Trace how principal diagnosis, additional diagnoses and interventions drive AR-DRG assignment and episode complexity
- Plan and run coding quality audits with defined sampling, error categories and re-grouping of changed episodes
- Set coder productivity, turnaround and backlog targets and monitor them with unit-level KPIs
- Govern medical records through chart completion, retention, release of information and access controls
- Build a coding quality and HIM improvement plan with priorities, owners and review points

## Target Audience:

- Health information management staff responsible for medical records completeness, retention and release
- Clinical coders who assign diagnosis and intervention codes to inpatient and day-case episodes
- Coding team supervisors who allocate work, review output and manage backlogs
- Revenue cycle staff who depend on grouped episodes for claims and casemix reporting
- Coding auditors who sample episodes and report error rates to management

## Course Outline:

### Day 1: Coding Function Foundations and Casemix Context

- ICD-10-AM Structure Tabular List and Alphabetic Index Navigation
- ACHI Intervention Blocks and Procedure Code Construction
- DRG Payment Models and Casemix Funding Principles Compared
- Coding Unit Roles From Abstraction to Grouped Episode
- Coding Function Current-State Baseline Using a Maturity Checklist

### Day 2: Coding Conventions, Standards and AR-DRG Grouping Logic

- Principal Diagnosis Selection Under the Coding Standards
- Additional Diagnosis Criteria and Condition Onset Flags
- Combination Codes, Multiple Coding and Sequencing Conventions
- AR-DRG Major Diagnostic Category and Adjacent DRG Assignment
- Episode Clinical Complexity Score and DRG Split Interpretation

### Day 3: Coding Practice on Inpatient Episodes and Grouper Edits

- Discharge Summary Abstraction Worksheet for Inpatient Episodes
- Surgical Episode Coding With ACHI Procedure Sequencing
- Medical Episode Coding for Chronic and Acute Comorbidities
- Grouper Edit Reports and Ungroupable Episode Resolution
- Same-Day and Maternity Episode Coding Conventions Applied

### Day 4: Coding Audit, Productivity Control and Records Governance

- Coding Audit Sampling Plans by DRG Risk and Volume
- Coding Error Taxonomy and DRG Change Rate Calculation
- Coder Productivity Benchmarks Turnaround Time and Backlog Ageing
- Chart Completion Tracking and Deficient Record Escalation
- Medical Records Retention Schedule and Release of Information Workflow

### Day 5: Case Study and Coding Quality Improvement Plan

- Case Hospital Audit Sample Recoded and Regrouped
- Case Audit Findings Analysed by Error Category
- Case Coding Unit KPI Dashboard and Staffing Model
- Coder Feedback and Education Cycle Design
- Coding Quality and HIM Improvement Plan Completion

## Skills You Will Gain:

- Clinical Classification Navigation
- Principal Diagnosis Sequencing
- AR-DRG Grouping Analysis
- Coding Audit Design
- Coding Error Root Cause Classification
- Coding Workload Management
- Health Record Lifecycle Control
- Casemix Data Quality Assurance

## Why Attend This Course:

- Deliver a coding quality and HIM improvement plan to the HIM manager and revenue cycle lead
- Decide which DRGs, coders and episode types to audit first based on risk and volume
- Avoid lost casemix income, claim delays and audit findings caused by inconsistent coding and backlogs
- Coach fellow coders on sequencing conventions and recurring error patterns found in audit

## Conclusion:

Back at work, the participant presents the coding quality and HIM improvement plan to the HIM manager, coding supervisors and revenue cycle lead, who use it to set audit priorities, coder targets and records governance actions ahead of DRG-based claims. Finance uses the audit error and DRG change figures to judge casemix reliability. After the first quarterly audit cycle, the unit should review error rates, backlog ageing and the coder feedback outcomes, then adjust sampling and staffing.

## Frequently Asked Questions FAQ:

### What should participants know before a clinical coding course on ICD-10-AM/ACHI and AR-DRG?

Participants should already work with inpatient records, coding or claims and know basic medical terminology. Prior use of a coding classification helps but deep grouper knowledge is not needed. Anonymised coded episodes or audit reports from their own unit are useful during the case study.

### How does this clinical coding and AR-DRG course differ from a clinical documentation improvement course?

It concentrates on the coding unit itself: applying conventions, reading grouper output, auditing coded episodes, managing coder productivity and governing records. A documentation improvement course focuses on reviewing clinician notes and writing queries to physicians before coding.

## Why does clinical coding accuracy matter so much once a hospital moves to AR-DRG grouping?

Under DRG-based payment each coded episode determines the group and its weight, so a wrong principal diagnosis or a missed complication can move an episode to a different DRG. Coding accuracy therefore affects funding, casemix reporting and audit exposure together.

## What do participants take back from the clinical coding, AR-DRG and coding audit course?

Participants take back a coding quality and HIM improvement plan, an audit sampling method, an error taxonomy with DRG change calculation, a coding unit KPI dashboard and a records governance checklist for chart completion, retention and release of information.