

NAIHS GENERIC STANDARD POSITION DESCRIPTION

Medical Records Technician GS-675-04

INTRODUCTION:

This position is located in the Medical Records department of a medical center, hospital, or health center/station. The facility provides a wide variety of health care services in these areas, but not limited to: General Surgery, Orthopedic, Pediatrics, OB/GYN, Intensive Care, Newborn Nursery, Emergency Medicine, Internal Medicine, Family Medicine, Ears, Nose and Throat (ENT), Optometry, Dentistry, Walk-In/Urgent Care, Public Health Nurse (PHN), Podiatry, Rehabilitative Services: (Physical/Speech/Occupational Therapy), Audiology, Behavioral Health/Social Services, Nursing Home, Community Based School Health Clinics, and a variety of specialty clinics, such as Plastic Surgery, Genetics, Cardiology, Dermatology, Nephrology, and Neurology.

The purpose of the position is to perform medical records technical duties which include the complete and accurate process and maintenance of records by analyzing, filing, compiling, scanning, releasing information, retrieving and dispatching charts/documents within a hybrid (paper/electronic) environment. The work performed directly impacts the timeliness, and scope of health care services and treatment provided to patients.

MAJOR DUTIES:

Ambulatory Services 75%:

Retrieves, processes, ensures the chart is complete with proper identification and dispatches records to the designated clinic. Pulls scheduled appointment charts and chart reviews. Health summaries are printed as needed.

Performs comprehensive quantitative and qualitative analysis of patient medical record daily to assure the presence of all components of the medical record are complete, valid and meets all accrediting and regulatory agencies and Medico-Legal requirements, in accordance with the Federal, State, and Indian Health Service (IHS) policies and procedures. Identifies discrepancies in medical documentation and routes the medical record back to the provider/department for completion immediately.

Files internal and external loose documents received daily to ensure continuity of patient care.

Re-file patient medical records daily into the main file after chart analysis is performed.

Maintains an assigned section of records by performing monthly chart audits for misfiled records, establish volumes for bulky charts, replaces torn or old record covers, and converts the number labels, ensures that all records are in approved chart sequence order, with new dividers in place for easy access to health information.

Maintains the Master Control log by adding newly assigned health record numbers and missing data to the log.

Conducts archiving processes i.e. purges, prepares and ships inactive records to the Federal Record Center (FRC) for storage. Prints all documents and images stored in the electronic health record system and filed in the paper record. Searches and re-establishes inactive patient charts. Updates Master Control Log and requests original chart referencing the FRC logs. Retrieves records for permanent or temporary withdrawal.

Provides a productivity report to the Supervisor.

Works with the healthcare team to accomplish goals and objectives, as it directly impacts the timeliness of patient care services.

Technical Services: (25%)

Performs a variety of technical medical record functions after-hours, weekends and holidays, when needed. These duties include, but not limited to:

Processes release of information to provide continuity of care.

Interviews patients for vital records (birth, death, paternity); thoroughly explains the birth certificate, paternity and Social Security process.

Scans health and/or administrative documents into the electronic health record (EHR) system on a timely basis and makes the proper disposition according to established guidelines.

Conducts random quality audits to ensure integrity of scanned images. Maintains a daily scanning and indexing log. Tracks and reports images scanned in error to the supervisor or designee for correction.

Other duties as assigned:

Some duties not specifically described or included in the Position Description (PD) may be assigned from time to time to meet the department's or facility's objectives and obligations.

Factor 1 - Knowledge Required by the Position:

Knowledge of basic medical terminology, accepted medical abbreviations, pharmaceutical terms, and medical abstracts. Basic knowledge of anatomy and physiology.

Knowledge in medical record forms and formats, and correlation of laboratory tests, surgical procedures, consents, and treatments with diagnoses, in order to assemble and scan medical records in the appropriate sequence and analyzing records to ensure all necessary forms and documents are present, accurate and complete.

Knowledge in the Resource and Patient Management System (RPMS) computer application software (or similar electronic record system).

Knowledge of computer applications, to generate reports and obtain information.

Knowledge of the imaging and scanning computer software and hardware application.

Knowledge of the Privacy Act of 1974 and Health Insurance Portability Accountability Act (HIPAA) of 1996, in regards to the patient's right to privacy and confidentiality, along with rules and regulations dealing with securing Federal records.

Basic knowledge of medico-legal and regulatory requirements of medical record and electronic health record systems.

Ability to communicate with internal and external customers to promote work efforts.

Factor 2 - Supervisory Controls:

The employee works under the general supervision of the Supervisor or designee. The supervisor defines overall program goals and priorities. The employee works independently in completing reoccurring assignments and refers questions to the supervisor when a source of information is not available or cannot be located. The supervisor reviews the work for results, accuracy, timeliness, and conformity to policy and procedural requirements.

Factor 3 - Guidelines:

The employee uses specific, detailed, written guidelines such as: medical facility manuals, circulars, technical manuals, policy and procedure manuals, other standard guidelines covering all aspects of the work. The employee works in strict adherence to guidelines and does not deviate from outlined steps unless the supervisor or designee authorizes it.

Factor 4 - Complexity:

The employee performs clear-cut, repetitive and interrelated tasks, with little modifications of how duties are performed. The employee assembles files and maintains hybrid patient records, which at times can be both general and complex. Determines the order in which information is assembled and filed. Performs chart analysis and determines whether or not it is legal to release certain protected health information.

Factor 5 - Scope and Effect:

The purpose of the position is to perform medical record keeping functions which is an integral part of the operation of a health care facility. The medical record is the key to all patient treatment; a legal and financial document of the facility; and is the primary means of communication between health care providers. The work has a direct impact on the accuracy, timeliness and reliability of medical records to render patient care, statistical retrieval, reimbursement and accreditation.

Factor 6 - Personal Contacts:

Daily contacts are with patients, physicians, nursing staff, and health care personnel within the immediate organization or work unit, and representatives of various outside State, Tribal and Federal agencies.

Factor 7 - Purpose of Contacts:

The purpose of the contacts are primarily to exchange factual information, establishing and completing medical records, and disclosing medical information from patient health records.

Factor 8 - Physical Demands:

Physical effort is expended through continuous standing, walking, stooping, bending, kneeling, lifting, reaching, pushing carts, climbing stairs and step stools/ladders. Frequently carries files to various areas throughout the facility.

Factor 9 - Work Environment:

The work environment involves risks and discomforts of a patient care setting including exposure to communicable diseases, working with office machines and computers. There is adequate light, heat, and ventilation in the work area.

OTHER SIGNIFICANT FACTORS:

The employee is required to work on a rotational basis for shift, evening, weekend and holidays for those health care facilities providing after-hour services and/or extended clinic hours to support patient care services.

Patient privacy and confidentiality is required. The Privacy Act of 1974 and Health Insurance Portability and Accountability Act (HIPAA) of 1996, mandates that the employee shall maintain complete confidentiality of all administrative, medical and personnel records and all other pertinent information that comes to his/her attention or knowledge. The Privacy Act HIPAA Privacy carry both civil and criminal penalties for unlawful disclosure of records. Violations of such confidentiality shall be cause for adverse action.