

Medical Record Technician (Inpatient Analyst)
Statement of Difference
GS-0675-05

The duty of this position are essentially the same as those on the attached position description, but is established at one grade lower to accommodate recruitment, career develop or other purposes. Under this state of differences, the incumbent receives closer supervision, along with more detail instructions. Work is routinely checked for accuracy and overall quality.

When the incumbent of this position meets or exceeds work performance requirements as defined in reference position and otherwise satisfies the qualifications, time-in-grade requirements and restrictions, and other administrative requirements, a career-ladder promotion action on a non-competitive basis may be initiated by management.

Medical Records Technician (Inpatient Analyst)
GS-675-06
PX 1537

INTRODUCTION

This position is located in the Health Information Management Department of the Phoenix Indian Medical Center located in Phoenix, Arizona. The purpose of this position is to perform a variety of specialized and technical medical record functions, such as in depth record analysis, transcription, retrieving, compiling medical record data, specialized scanning process, and maintaining medical records in the form of Electronic Health Records (E.H.R.) for compliance with regulatory requirements.

MAJOR DUTIES AND RESPONSIBILITIES:

60% Incumbent performs comprehensive quantitative and qualitative analysis of all discharged patient records using both hard copy medical records and electronic health records, including day surgery records to assure the presence of all component parts of the medical record are complete, valid and meets all The Joint Commission (JTC) Standards, and in accordance with the State, and IHS policies and procedures. Responsible for assuring that compliance issues in relation to abstracting and analyzing are adhered to.

Responsible for completing deficiency cards for all identified deficiencies and key enters this information into the RPMS, utilizing the ADT Incomplete Chart menu.

Reviews the day surgery and inpatient discharge lists daily to assure all patient records are received from the inpatient wards. Reviews all paper records, assembles all records following the hospital chart sequencing policy and procedure. If the records are in the format of electronic, assures the forms are present in the electronic health records system, i.e. such as discharge summaries, operative reports, etc. If required forms are missing in the E.H.R., incumbent will search for the appropriate medical reports and scan a copy into the electronic health records into the appropriate E.H.R. tab, according to established guidelines.

Updates the medical records charge out guides on all records received and analyzed by placing cards in the proper out-guide in the main file room to identify the location of the charts of patients that have been discharged.

Conducts on a daily basis, quality controls by running, reviewing, and monitoring unsigned documents in the electronic health records system for compliance purposes, and notifying the appropriate providers of their unsigned documents hanging in the electronic health records.

15% Utilizing the Electronic Health Record, the technician checks for incoming transcribed reports, i.e., narrative summaries, operative reports, consultations, history and physicals and various other reports from the transcription service via EHR unsigned reports. Adjusts reports to facility format and makes necessary corrections as required by physicians. Assures that all reports are dictated according to the TJC regulations and IHS policies and procedures. Tracks all dictated reports by maintaining extensive logs and assures reports are received timely into the Electronic Health Records. Maintains a close working relationship with the medical staff and the contracted transcription service.

10% Responsible for establishing the physician incomplete/delinquent listing weekly by printing the previously key entered data into the RPMS ADT Incomplete Chart menu. Distributes copies to all physicians, Health Information Management Director and Director of Patient Financial Services.

A monthly incomplete/delinquent report is compiled by utilizing the incomplete records data plus the total number of monthly discharges to establish TJC threshold percentage statistics that identify records that are more than 30 days delinquent. This information is reported to the Medical Executive Committee on a monthly basis.

Confirms information is interchanged after the scanning and indexing process is completed. Ensures all files are stored by date scanned and reference logs are properly maintained. Maintains a daily productivity log of scanning and indexing activities for compliance and quality control purposes. Provides reports to the Supervisor.

Orients and trains new employees, practitioners, and other hospital personnel to their specific responsibilities in the maintenance of medical records/E.H.R. and especially to the incumbent's area of specialization such as issuing identification number to new providers for access to the Dictation System, and monitoring the electronic health dictation and transcription system.

Communicates effectively with the providers on a daily basis to ensure that the patient health information documents are complete, accurate, and relevant according to regulatory, policies and procedures.

15% OTHER MEDICAL RECORDS DUTIES:

Maintains Inpatient census - completes the daily and monthly Inpatient Census (M202 Report) with nursing to ensure accuracy at all times. Forwards copies of the census report to QI/RM, Director of Patient Financial Services, and other various departments.

Assists in the collection of data for medical records, research projects, chart reviews, etc., and as required performs technical medical records functions for outpatient and inpatient services such as releasing health information, etc.

Participates in continuous quality improvement monitoring on a routine basis relating to job function.

Insures routine telephone calls, visitors, and questions for information relating to services, directions, instructional and coordination of activities are answered correctly and in a positive timely manner.

Reviews, purge, and prepare the hard medical records for shipment to Federal Archive Record Center.

Prepares medical records for new patients, issues chart number and maintains the number control log on all numbers issued, and the master patient index cards.

Maintains confidentiality of medical records in accordance with the rules and regulations for the Privacy Act, Health Insurance Portability and Accountability Act (HIPAA), The Joint Commission, IHS, and Hospital Manuals.

FACTORS

Factor 1- Knowledge Required by the Position:

Extensive knowledge and understanding of the operations of the RPMS, Electronic Health Records (EHR), VistA Imaging and the Dictation/Transcription Electronic systems. In addition, a general understanding of computer systems and their relation to data quality management.

Knowledge in planning and managing a variety of tasks independently in accordance with priorities, needs and goals of the organization.

Extensive knowledge of medical terminology and anatomy to analyze and correct medical reports accurately with minimal supervision.

Knowledge of the Joint Commission standards, CMS Conditions of Participation, and IHS policy, procedures and regulations governing medical records in order to maintain accurate data for deficiency reporting.

Knowledge of medical record report formats to accurately process all transcription documents.

General knowledge in using a computer terminal for entering, finding, abstracting and searching for data.

Applies extensive knowledge of medical practice, terminology and judgment based on a substantial experience in medical record work. Work requires a high degree of technical knowledge and skill, as the incumbent will process medical records and data that involve non-routine problems.

Incumbent must have knowledge and be familiar with rules and regulations pertaining to a Compliance Program and various aspects of compliance issues, specifically coding and billing issues and its relation to Indian Health Service

Knowledge of the Privacy Act of 1974 and HIPAA, IHS related regulations in regards to confidentiality of patient records.

Factor 2- Supervisory Controls:

General supervision is provided by the Medical Record Administrative Specialist of the Coding section. The designee is expected to function with little guidance in all duties and be able to exercise careful judgment when needed and be responsible for carrying out duties. The supervisor provides advice and assistance on unusual situations or problems that are not covered by current regulations and procedures. The work is reviewed for accuracy, completeness and timeliness to ensure work quality.

Factor 3- Guidelines:

Guidelines - Work is performed using the RPMS User Guide, the Electronic Health Records Manual, the Privacy Act and HIPAA Privacy Rule, Medical Dictionaries, IHS and Service Unit Manuals, written and oral policies and procedures and technical dictionaries from the Medical Record Administrative Specialist of the Coding section. The incumbent uses judgment in applying and deviating from guidelines according to situations. The results of which substantially affect continuity of care and reimbursement collections to the center.

Factor 4- Complexity:

The work requires a high level of interrelated knowledge, skills and understanding of the Transcription dictating system, record analysis and medical record procedures in which an understanding of the overall system is necessary for effective performance of duties. The work encompasses detailed record analysis, identifying the different types of medical reports ordered and required to be filed within the record, entering the deficiency information in the RPMS incomplete chart menu to generate the weekly/monthly reports required. Medical terminology to make appropriate report corrections in various medical reports as required by physicians.

Factor 5- Scope and Effect:

The position reviews the inpatient/outpatient medical records either in the format of regular hard copy or in the electronic health records system in detail for deficiencies, i.e., signatures, missing reports and reports that are to be dictated by the physicians. Compiles statistical information and weekly/monthly reports generated and distributed to the medical staff, clinical director, and medical records committees. The work has direct effect on medical recordkeeping, risk management, resource allocation, third party reimbursements and direct impact on the accuracy, timeliness, and reliability of some medical record services.

Factor 6- Personal Contacts:

Personal contacts are with the Health Care Providers, Nursing Staff, Coding Staff, Patient Admission and Patient Accounts staff.

Factor 7- Purpose of Contacts:

Contacts with:

Health Care Providers and Nurses: are to assure all deficiencies and dictated reports are completed in a timely manner. Coding Staff: to assure that all discharged inpatient records are

received at the completion of analysis. Patient Admission Staff: to accurately identify patient admission and discharge services. Patient Accounts: to accurately identify all patients with third party coverage.

Factor 8- Physical Demands:

The work is primarily sedentary. There is some walking, standing, stooping, and carrying of light items such as manuals and files.

Factor 9- Work Environment:

The majority of the duties will be performed in an office setting under non-stressful environmental conditions and with some walking within the hospital and under similar conditions. Incumbent may be required to work on a rotational basis for shift, weekend and holiday duties.

OTHER SIGNIFICANT FACTORS:

Incumbent may be required to work on a rotational basis for shift, weekend and holiday duty as needed and assigned.

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