

## NAIHS GENERIC STANDARD POSITION DESCRIPTION

Medical Records Technician (Coder)  
GS-675-8

### **I. INTRODUCTION**

This position is located in the Medical Records department for an inpatient unit in a medical center and hospital. The medical center and hospital provides a wide variety of health care services in the areas of; General Surgery, Orthopedic, Pediatrics, OB/GYN, Intensive Care, Newborn Nursery, Emergency Medicine, Internal Medicine, Family Medicine, EENT, Optometry, Dentistry, Walk-In/Urgent Care, Home Health Care, Community Based School Health Clinics, and a variety of specialty clinics, such as Plastic Surgery, Genetics, Cardiology, Dermatology, Nephrology, and Neurology.

This function assures that complete and accurate diagnostic and procedural coded data is present for research, epidemiology, outcomes and statistical analysis, financial and strategic planning, reimbursement, evaluation of quality of care, and communication to support the patient's treatment. The coding function provides the primary source for medical data and information used in health care and promotes the continuity of medical care and optimization of reimbursement.

The employee is responsible for ensuring that, in the assignments of diagnostic and procedural codes, to capture resources and services rendered to Indian beneficiaries and non-beneficiaries alike for claims to be billed to third party payers. Enhancing health care projects and planning purposes uses the resulting funds collected and posted. The successful efforts impacts the funds collected.

This position works in a hybrid (paper/electronic) medical record environment, alternating between abstracting and coding pertinent medical data from the medical record into the RPMS; and analyzing medical data entered by the clinician into the Electronic Health Record (EHR).

### **II. MAJOR DUTIES**

#### ***Medical Coding and Data Entry (75%):***

1. Quantitative Analysis - Performs comprehensive review of the record to assure the presence of all component parts, such as: correct name, health record number, signatures and dates where required, and all reports which appear to be indicated by the treatment rendered.

2. **Qualitative Analysis** - Evaluates the record for documentation, consistency, accuracy and correlation of recorded data, such as medical necessity and modifier usage. Ensures the final diagnosis as stated by the physician is valid, complete and accurately reflects the care and treatment rendered.
3. Analyzes provider documentation to assure the appropriate Evaluation & Management (E&M) levels are assigned using the correct CPT codes.
4. Assures diagnostic and procedural terminology used is consistent with currently acceptable medical nomenclature.
5. Assigns and sequences ICD/CPT/HCPCS/CDT/DSM codes to diagnosis and procedures from documented information.
6. Assures that the diagnosis responsible for length of stay is appropriately identified and that the secondary diagnoses are sequenced properly in order to assure maximum allocation under the Diagnostic Related Group (DRG) system. If there are any questions/problems with documentation the provider is notified immediately.
7. **Medico-legal Requirements** - Makes the final determination that the record is complete, accurate, and reflects data to justify the diagnosis and warrant treatment without infringing on decisions concerning a physician's clinical judgment.
8. Assigns the HCPCS level II code to facilitate the coding of supplies and services provided by physicians, therapist, home health, outpatient department, and other caregivers.
9. Enters all required data components identified and outlined by I.H.S. Patient Education protocols and standards, and all indicators for the Government Performance Reporting Act (GPRA). The results directly impacts the overall statistical data and funding source decision making for the facility.
10. Enters transaction codes and data from charge tickets or super bills, to optimize reimbursement collections for the facility.
11. Adheres to all official coding guidelines, conventions, standards of ethical coding and rules established by the American Health Information Management Association (AHIMA) American Medical Association (AMA), Centers for Medicare & Medicaid (CMS) and the Indian Health Service.

12. Generates daily RPMS/EHR reports to review, identifies errors, inconsistencies, discrepancies and/or trends and discusses with the appropriate medical, nursing, or health care providers, and recommends appropriate modifications to RPMS/EHR entry.

**Technical Duties (25%):**

1. Provides ongoing education, updates and briefs physicians, nursing staff, and health care personnel within the immediate organization or work unit, on coding updates, rules, regulations, and guidelines.
2. Assists with performing routine audits in accordance with the facility Compliance Plan and Performance Improvement, which may include findings from provider documentation trends, coding peer reviews, and reimbursement denials.
3. Assists in development and modification of facility coding policies and procedures.
4. Submits monthly Case Mix Index (CMI) reports as required.
5. The employee in conjunction with the Utilization Review Coordinator has responsibility for the coordination and management of the reimbursement system to ensure quality care in the most cost-efficient manner. Working with various departments identifying problems and suggesting methods to maximize reimbursements.

**III. FACTORS:**

**Factor 1 - KNOWLEDGE REQUIRED BY THE POSITION**

Extensive knowledge of medical terminology and abbreviations; anatomy and physiology; major disease processes; pharmacology; pathophysiology and the metric system to identify specific clinical findings, to support existing diagnoses, or substantiate listing additional diagnoses in the medical record.

Skilled in correlating pharmacy, laboratory, radiology, treatments and results with diagnoses.

Extensive knowledge of coding conventions and rules established by the American Health Information Management Association (AHIMA), American Medical Association (AMA), Center for Medicare & Medicaid (CMS), and the Indian Health Service Coding Guidelines for assignment of diagnostic and procedural codes.

Extensive knowledge of medical coding classification systems and references for both outpatient and inpatient such as the International Classification of Diseases (ICD), Diagnostic Related Groups (DRGs), Healthcare Common Procedure Coding (HCPC), and Current Procedural Technology (CPT), Current Dental Technology (CDT) and Diagnostic Systemic Medicine (DSM).

Thorough knowledge of Medical Records/Health Information Management theory, principles, practices, techniques, concepts and policies to analyze the medical record and participate in performance improvement activities.

Thorough knowledge of medico-legal aspects of medical records/health information management.

Thorough knowledge of the Privacy Act of 1974 regulations and requirements and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule of 1996 regarding responsibilities for patient confidentiality.

Thorough knowledge of Joint Commission, Center for Medicare & Medicaid Services (CMS), Office of Inspector General, IHS policies, and other regulatory agencies to ensure the record complies with requirements.

Thorough knowledge of quantitative and qualitative processes to analyze health information.

Extensive skills operating electronic medical records/health information management systems.

Skilled in data abstraction, collection and generate automated computerized reports to compile and organize information for reporting and presentations.

Thorough knowledge of Performance Improvement methodology to track, trend, recommend resolutions, and report on status of adverse or quality service.

Exceptional communication skills to conduct briefings and training classes, and to communicate at a professional level with all health care personnel.

Writing skills to prepare reports and other materials.

**Factor 2 - SUPERVISORY CONTROL:**

The employee works independently under general supervision of the Supervisor or designee. The supervisor defines overall program goals and priorities. Employee works on own initiative and independently, prioritizes work and resolves problems within the scope of Service Unit policies.

The employee coordinates unusual situations that do not have clear precedents with the supervisor. The Supervisor places considerable reliance upon the employee's knowledge of medical coding and medical record technology. The supervisor reviews the work for results achieved, technical soundness, and conformity to medical record policy and requirements.

**Factor 3 - GUIDELINES**

Guidelines include: Encoder, ICD, CPT, HCPCS, CDT, DSM and other coding classification systems, RPMS users guide, Physician's Desk Reference, the Privacy Act & HIPAA Privacy, medical dictionaries, IHS and Service Unit manuals, Joint Commission, Internal Control Policy, Medical Records/Health Information Management guidelines, regulatory Coding guidelines from AHIMA, CMS and AMA, written and oral policies and procedures. These guides are general in nature and do not cover all areas of the work performed by the employee, such as cases involving new diseases, treatments, or experimental drugs.

The employee uses judgment to adapt and interpret guidelines for application to specific cases or problems using discretion and initiative in deciding on the right course of action to correct deficiencies and improve reliability of information in the records. This may require developing approaches and work methods within the framework established by higher level authority, devising procedures to use when applying new regulatory requirements, or adapting to new computer technology

**Factor 4 - COMPLEXITY**

The work involves highly complex Medical Record processes and procedures. The Employee performs periodic reviews of other employees' work to confirm conformance to policies, regulations and Medical Records Standards. Furthermore, the employee carries out specialized assignments such as setting up special registries, assisting with a wide range of quality assurance/PI studies, providing problem-solving services in specific areas of medical records/research activities, coding complicated medical records, or making recommendations to improve procedures for compiling and retrieving medical record information. The decisions about what needs to be done requires the employee to determine the relevance of many facts and conditions which meet coding standards, CMS, Utilization Reviews, JCAHO, Compliance, legal and regulatory standards. Uses a complex body of specialized subject matter knowledge, interviewing, interpreting and

investigation techniques to assure that accurate information is abstracted in an effective and efficient manner.

The work involves analyzing and interpreting conditions and elements to correct complicated inconsistencies or discrepancies in the Medical Records.

**Factor 5 - SCOPE AND EFFECT**

The primary function of this position is an integral portion of the operation of the medical center/hospital/health center. Because information in the medical record is the basis for clinical decision-making as well as reimbursement, coding entries must be complete and accurate. Reimbursement depends on the coding accuracy, diagnoses, procedures and appropriate DRG assignment. The work typically has a direct effect on medical record keeping and a direct impact on the accuracy, documentation, timeliness, reliability and acceptability in the medical records/health information management services.

Work has considerable impact on the accreditation status of the medical center/hospital/health center, quality of patient care, reliability of research data and the maximization of third-party reimbursement.

The coding function is a primary source used in health care today, and promotes provider/patient continuity, accurate data, statistic information, such as GPRA, and the ability to optimize reimbursement.

**Factor 6 - PERSONAL CONTACTS and Factor 7: PURPOSE OF CONTACTS**

Daily contacts are with physicians, nursing staff, and health care personnel within the immediate organization or work unit, and representatives of various outside state, Tribal and federal agencies to obtain or exchange information to coordinate work efforts and resolve technical problems.

**Factor 8 - PHYSICAL DEMANDS**

The work is sedentary, however there may be some walking, standing, carrying of light items such as manuals or files within the work area with the majority of time spent at the computer terminal entering medical and coding data that require intense concentration. The visual demand is intensive and the usage of computer terminals have been known to have adverse health effects and discomforts such as eye strain, headaches, poor concentration and irritability. The extensive use of the keyboard for long periods can cause shoulder, arms and wrist strain and prevention should be taken with wrist supports and routine exercises.



**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. Work is performed in a tobacco-free office setting. 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. Patients' problems are to be discussed only in the context of assuring professional care. 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 and HIPAA Privacy carry both civil and criminal penalties for unlawful disclosure of records. Violations of such confidentiality shall be cause for adverse action.

This position is covered under the "Indian Child Protection Act" and is hereby designated an authorized child care position subject to P.L. 101-630 and P.L. 101-647.