MEDICAL RECORDS CODER III

DISTINGUISHING FEATURES OF THE CLASS: Under general supervision, an incumbent of this class is responsible for addressing appeals to insurance companies, and coding highly complex medical records, including all diagnoses, operative and diagnostic procedures in patient medical records, using the current International Classification of Diseases (ICD), Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedures Coding System (HCPCS) and entering coded information into an automated grouper system. This class differs from the Medical Records Coder II in that addressing appeals is distinctive to this class and the level of knowledge required is greater. Supervision is not a responsibility of this class, however, technical guidance and acting in a lead role is expected. Does related work as required.

EXAMPLES OF WORK: (Illustrative Only)

Addresses appeals to insurance denials to facilitate expedient resolution and reimbursement;

Interprets and applies American Hospital Association (AHA) Official Coding guidelines to articulate and support principle and secondary diagnoses and selected procedures;

Identifies and analyzes patterns in possible coding errors or other trends and reports to the Supervising Medical Records Coder;

Participates in mandated Medical Record Review processes;

Using the current HCPCS and ICD-9-CM and CPT coding systems, assigns and records an accurate code to all diagnoses, procedures, and operations as documented by the attending physician in the indicated patient's medical record;

Insures that all factors necessary for assigning an accurate DRG (Diagnostic Related Group) are present, and that all diagnoses are ranked properly;

Makes appropriate contacts in order to acquire or clarify necessary information;

Enters final diagnostic code numbers and narrative descriptions of diagnoses and procedures into an automated grouper system;

Compiles and updates the appeal log detailing denials, hospital's reply and follow-up responses;

Provides information and responds to inquiries regarding medical documentation and DRG'S to hospital staff including Utilization and Quality Assurance staff, Patient Accounts staff and the Risk Manager;

Abstracts information from medical records to compile reports and statistical information;

May perform other incidental tasks, as needed.

EXAMPLES OF WORK: (Cont'd)

Enters data such as diagnosis, treatment, admission and discharge dates, length of stay, etc. on hospital-wide or regional automated database;

May train lower level coders and provide technical guidance and expertise;

Uses computer applications or other automated systems such as spreadsheets, word processing, calendar, e-mail and database software in performing work assignments;

Accesses protected health information (PHI) in accordance with departmental assignments and guidelines defining levels of access (i.e. incidental vs. extensive).

REQUIRED KNOWLEDGE, SKILLS, ABILITIES AND ATTRIBUTES: Comprehensive knowledge of the American Hospital Association (AHA) Official Coding Guidelines; comprehensive knowledge of the current HCPCS, CPT and ICD codes; thorough knowledge of DRG and APC classification systems; thorough knowledge of medical terminology; thorough knowledge of the principles of the unit medical record system and its operation; ability to understand and code medical records; ability to communicate effectively both orally and in writing; ability to effectively use computer applications or other automated systems such as spreadsheets, word processing, calendar, e-mail and database software in performing work assignments; ability to read, write, speak, understand, and communicate in English sufficiently to perform the essential duties of the position; assertiveness; thoroughness; sound judgment; tact; discretion; initiative; accuracy; physical condition commensurate with the demands of the position.

MINIMUM ACCEPTABLE TRAINING AND EXPERIENCE: High School or equivalency diploma and six years of experience where the primary function of the position must have been medical records coding, four of which must have been within the last five years, two of which must have involved coding emergency room or trauma cases.

SUBSTITUTION: Satisfactory completion of 30 credits towards an Associate's or Bachelor's Degree* in Health Information Management may be substituted on a year for year basis for up to four years of the general coding experience. There is no substitution for the two years of specialized experience.

SPECIAL REQUIREMENT: Either (a) possession of the Certified Coding Specialist (CCS) or CCS-P certification or (b) eligibility for certification as Registered Health Information Administrator (RHIA) (formerly Registered Records Administrator (RRA)) or as a Registered Health Information Technologist (RHIT) (formerly Accredited Records Technician (ART)) by the American Health Information Management Association at time of temporary appointment and must be certified at time of permanent appointment.

*NOTE: The only acceptable evidence of eligibility for certificaton as RHIA or RHIT will be a letter from the American Health Information Management Association stating that the candidate has been admitted to the proximate examination.

NOTE: Unless otherwise noted, only experience gained after attaining the minimum education level indicated in the minimum qualifications will be considered in evaluating experience.

*SPECIAL NOTE: Education beyond the secondary level must be from an institution recognized or accredited by the Board of Regents of the New York State Education Department as a post-secondary, degree-granting institution.