MEDICAL RECORDS CODER

NATURE OF WORK IN THIS CLASS

This is technical work involved in coding and abstracting of in-patient, ambulatory surgery, emergency and out-patient services health records.

Employees in this class are responsible for coordinating the data abstracted.

ILLUSTRATIVE EXAMPLES OF WORK

(Any one position may not include all the duties listed, nor do the examples cover all the duties which may be performed.)

Codes all diagnoses and procedures on in-patient, ambulatory, emergency, and out-patient charts using the International Classification of Diseases, 9th Revision: Clinical Modification (ICD-9-CM), Current Procedural Terminology (CPT), Health Care Financing Administration's Common Procedural Coding System (HCPCS), Uniform Hospital Discharge Data Set (UHDDS) definitions and established sequencing guidelines.

Ensures that all data in patients' charts are complete and accurate for assigning of ICD-9-CM, CPT and HCPCS codes by working closely with the medical staff to clarify entries in the patients' charts, add diagnoses as necessary, and/or change an incorrectly described diagnosis.

Enters abstracted data and assigned diagnostic and procedural codes into the computer.

Generates timely reports on the abstracted data and makes recommendations for improvement to the Medical Health Records Administrator.

Applies quality improvement and volume indicators to the coding, abstracting, and reports generated.

Reads materials, views educational films, and attends meetings and workshops pertinent to coding of patient health records.

Applies computer knowledge and experience to strengthen and continue to build a strong automated management information system.

Reads materials, views educational films, and attends meetings and workshops pertinent to coding of patient health records.

Applies computer knowledge and experience to strengthen and continue to build a strong automated management information system.

Respects each patient's right to privacy, particularly the privacy of the medical record and safeguards the confidential information of each patient record.

Performs related duties as required.

MINIMUM KNOWLEDGE, ABILITIES AND SKILLS

Working knowledge of the principles and practices of ICD-9-CM, CPT-4, and HCPCS coding.

Working knowledge of anatomy, physiology, and their application to medical science.

Knowledge of hospital rules governing medial record practices.

Ability to interpret and apply pertinent Federal, State and Local laws and regulatory agencies guidelines, relative to coding and abstracting of patient information.

Ability to operate manual and automated systems and to recommend modifications to enhance their effectiveness.

Ability to participate in on-going coding training and advancement.

Ability to work effectively with employees and the public.

Ability to communicate effectively, orally and in writing.

Ability to maintain records and prepare reports.

MINIMUM EXPERIENCE AND TRAINING

A) One (1) year of experience in acute care hospital coding, abstracting and automated health records; and graduation from a two-year Medical Records Technician program or satisfactory completion of the American Health Information Management Association's (AHIMA) correspondence course for Medical Record Technicians; or

B) One (1) year of experience in acute care hospital coding, abstracting and automated health records and certification as a Certified Coding Specialist (CCS) from the American Health Information Management Association; or

C) Any equivalent combination of experience and training which provides the minimum knowledge, abilities and skills.

Established: November 1993
Pay Grade: I

ELOY P. HARA
Executive Director,
Civil Service Commission