REIMBURSEMENT CODING SERIES

Code No.	Class Title	Occ. Area	Work Area	Prob. Period	Effective Date	Last Action
4839	Reimbursement Codering ~~Specialist I~~	02	445	6 mo.	00/00/00	Rev.
4840	Reimbursement Coding Specialist ~~II~~	02	445	6 mo.	00/00/00	Rev.
4841	Reimbursement Coding Supervisor (Level III)	03	445	6 mo.	00/00/00	Rev.

Promotional Line: 166

Series Narrative

Positions assigned to these classifications are professional coders responsible for coding of patient services provided in health care units. Lower level ~~specialists~~coders are training level ~~specialists~~coders involved in the routine day-to-day coding. Intermediate level coders ~~specialists~~ perform complex coding in addition to auditing and analysis of coding related activities. The Supervisor ~~Manager~~ level is responsible for the overall coding operations of a large unit. All levels must demonstrate proficiency in coding and must be knowledgeable of the requirements of industry standards such as Medicare and/or Managed Care regulations and the International Classification of Disease (ICD-9) and the Current Procedural Terminology (CPT) systems of coding. Coding ~~Managers~~ Supervisors are responsible for monitoring changes in coding procedures as dictated by third-party payers and governmental reform. The higher level also recommends processing standards and teaching coding of diagnoses and procedures to the lower levels of this series as well as clinical staff to maximize reimbursement while adhering to ethical practices and third party payer guidelines.

DESCRIPTIONS OF LEVELS OF WORK

Level I: Reimbursement Codering ~~Specialist I~~ **4839**

Employees at this level are entry-level coders functioning under the direct supervision of a Reimbursement Coding Specialist ~~II~~ or ~~Manager~~ Supervisor. Level I employees are training positions and are involved in the routine day-to-day coding and associated work.

A Reimbursement Codering ~~Specialist I~~ typically –

1. assigns codes for ancillary and physician services using standardized coding systems such as ICD-9-CM and CPT, or verifies coding performed by clinical staff for accuracy

2. performs simple analysis of payment patterns in a smaller department having fewer clinical specialties

3. prepares simple reports to illustrate reimbursement rates

4. attends coding and diagnosis seminars

5. may update fee schedules and inform clinical staff of all changes and fee increases under the direction of supervisor

6. composes simple correspondence to third party payers to resolve billing/charge problems

7. may perform periodic audit reviews, researches needed changes and recommends needed changes to the Department Administrator; researches and reports policy changes mandated by federal and state reimbursement programs under the direction of supervisor

8. works with billing department to resolve and authorize outpatient adjustments to be made on patient's accounts

9. may assist in training and supervising lower level employees

10. performs other related duties as assigned

Level II: Reimbursement Coding Specialist ~~II~~ 4840

Employees at this level code physician and ancillary medical services for the purposes of receiving maximum allowable reimbursement from payers. They also perform other coding related functions such as training, research of coding issues, and auditing coding transactions. They function under the general supervision of a Reimbursement Coding ~~Manager~~ Supervisor or related personnel.

A Reimbursement Coding Specialist ~~II~~ typically –

1. codes complex charge documents for ancillary and physician services using standardized coding systems such as ICD-9-CM and CPT, or verifies coding performed by clinical staff and lower level coders for accuracy

2. determines actions such as submissions of additional documentation on individual claims to increase reimbursement levels and provide additional/supplementary documentation needed for payer consideration of non-routine charges

3. interacts with physicians, ancillary personnel and third-party payers to resolve problems with specific charges

4. maintains and updates fee schedules

5. conducts audits of documentation in order to verify accuracy of codes, dates of service, and assure documentation support codes; processes physician's services as needed

6. recommends changes in coding procedures and routinely monitors and investigates the impact of coding on insurance reimbursement

7. composes complex or sensitive correspondence to third-party payers to resolve charge/billing problems

8. may analyze payment patterns

9. prepares complex reports illustrating reimbursement rates

10. as directed by supervisor, researches and assists in the development of policies and procedures related to the coding of physician services using the ICD-9-CM and CPT

11. performs periodic reviews of department charge tickets and researches needed changes; recommends needed changes to appropriate supervisor; researches and reports policy changes mandated by federal and state reimbursement programs

12. may train lower level employees in this series

13. may supervise lower level staff members of small units including interviewing, hiring, evaluating and disciplining; in large units, may assist the Reimbursement Coding ~~Manager~~ Supervisor in these duties

14. may attend faculty/division meetings to inform physicians and staff of new coding issues specific to that division and also of recurring problems with functions such as completing the charge ticket

15. performs other related duties as assigned

Level III: Reimbursement Coding ~~———~~ Supervisor ~~III~~ 4841

Employees at this level work under administrative direction from a designated supervisor and manage, direct and monitor all coding activities for physician and ancillary services in a unit. They are responsible for performing studies and recommending both unit and institutional standards of reimbursement, fee structure, billing and other medical receivable issues to appropriate personnel. They supervise activities and direct personnel responsible for the coding of charge documents.

A Reimbursement Coding Supervisor~~Manager~~ typically –

1. develops policies and procedures related to coding of services incorporating applicable legal/ethical/institutional standards

2. performs complex studies of third-party reimbursement patterns involving multiple physicians and fee structures and provides recommendations to physicians or administrators based on findings

3. may prepare complex reports detailing third party reimbursement rates

4. conducts seminars for physicians, residents, administrators and staff on ICD-9-CM and CPT coding, third-party payer submission and billing as it affects timely and effective reimbursement

5. provides expert advice and guidance to administrators, faculty and staff regarding coding, documentation and other third party payer regulations

6. researches and keeps abreast of policy changes mandated by state and federal reimbursement programs; notifies affected personnel on a routine basis

7. researches reimbursement issues related to new services and complete feasibility studies; writes correspondence to third-party payers

8. develops fee schedules for new and existing services provided by the department for approval by physicians and administrators

9. reviews newsletters and the *Federal Register* on a routine basis; issues notifications to physicians and appropriate personnel regarding changes in reimbursement

10. investigates low reimbursement of patient services by third-party payers such as managed care contract reimbursement analysis; performs complex analysis of findings and recommends changes to administrators and physicians

11. may represent department and unit in the development of institutional coding policies and procedures

12. supervises lower level staff including hiring, evaluating, disciplining and interviewing; collects time cards and submits to appropriate staff

13. coordinates workflow; maintains productivity reports and assesses workload periodically to assess appropriate staffing levels.

14. performs other related duties as assigned

MINIMUM ACCEPTABLE QUALIFICATIONS REQUIRED FOR ENTRY INTO:

Level I: Reimbursement Cod~~ering Specialist I~~ 4839

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. Any one or any combination totaling **one (1) year, six (6) months (or 18 months),** from the following categories:

   Work experience in a healthcare setting (i.e. hospital, physician's office, nursing home, billing agency) utilizing ICD-9 and CPT coding systems to assign codes for services provided to patients

   College course work relating to healthcare operations that includes the following specific topics: Medical Terminology, Human Anatomy and Physiology, ICD-9 Coding and CPT Coding

   - 6 semester hour equals 6 months
   - 12 semester hours equals 12 months
   - 18 semester hours equals 18 months

NOTE: Designation as CPC Apprentice, CPC, CPC-H Apprentice or Certification as an RHIT, RHIA, CCS CCS-P by the American Health Information Management Association satisfies all the requirements for this class.

KNOWLEDGE, SKILLS, AND ABILITIES (KSAs)

1. Knowledge of medical terminology
2. Knowledge of ICD-9 and CPT coding systems
3. Analytical ability
4. Mathematical ability
5. Organizational ability
6. Ability to interact with a variety of persons, including physicians and ancillary staff

Level II: Reimbursement Coding Specialist ~~II~~ 4840

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. One (1) year/twelve (12) months of work experience comparable to that performed at Reimbursement Coder~~ing Specialist I~~ level of this series or in other positions of comparable responsibility
2. Certification as a Certified Coding Specialist (CCS) or Certified Coding Specialist—Physician based (CCS-P) or Registered Health Information Technologists (RHIT) or Registered Health Information Administrator (RHIA) by the American Health Information Management Association, or certification as a Certified Procedural Coder (CPC) or a Certified Procedural Coder-Hospital (CPC-H) by the American Academy of Professional Coders

KNOWLEDGE, SKILLS, AND ABILITIES (KSAs)

1. Possession of personal attributes listed for Reimbursement Coding Specialist I
2. Skill in researching complex coding questions
3. Ability to supervise others
4. Ability to compose reports

Level III: Reimbursement Coding Supervisor ~~III~~ 4841

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. One (1) year/twelve (12) months of work experience comparable to that performed at Reimbursement Coder~~ing Specialist I~~ level of this series or in other positions of comparable responsibility

2. Certification as a Certified Coding Specialist (CCS) or Certified Coding Specialist—Physician based (CCS-P) or Registered Health Information Technologists (RHIT) or Registered Health Information Administrator (RHIA) by the American Health Information Management Association, or certification as a Certified Procedural Coder (CPC) or a Certified Procedural Coder-Hospital (CPC-H) by the American Academy of Professional Coders

3. Two (2) years/twenty four (24) months of work experience comparable to that performed at the Reimbursement Coding Specialist ~~I~~II level of this series or in other positions of comparable responsibility

KNOWLEDGE, SKILLS, AND ABILITIES (KSAs)

1. Possession of personal attributes listed for Reimbursement Coding Specialist ~~I~~II

2. Proficiency in researching complex coding questions

3. Supervisory ability

4. Ability to compose complex reports

5. Ability to develop training programs and seminars