REIMBURSEMENT CODING SERIES

Code No.	Class Title	Occ. Area	Work Area	Prob. Period	Effective Date	Last Action
4839	Reimbursement Coder	02	445	6 mo.	00/00/00	Rev.
4840	Reimbursement Coding Specialist	02	445	6 mo.	00/00/00	Rev.
4841	Reimbursement Coding Supervisor	03	445	6 mo.	00/00/00	Rev.

Promotional Line: 166 yellow, red – incumbents, turquoise – supervisors, green less than 70%

Series Narrative

Positions assigned to these classifications are professional coders responsible for coding of patient services provided in health care setting. Reimbursement Coders are entry level coders that code standard diagnosis and procedures. Reimbursement Coding Specialists performs complex coding in addition to auditing and analysis of coding related activities. The Reimbursement Coding Supervisor level is responsible for the overall coding operations of a large unit. The Reimbursement Coding Supervisors are responsible for overseeing the daily operations of coding and working closely with patient accounts, and other regulatory agencies to resolve issues pertaining to coding and for monitoring changes in coding procedures as dictated by third-party payers and governmental reform. Also employees at this level recommends processing standards and assists with training and teaching continuous education to coding staff as well as clinical staff while adhering to ethical practices and third party payer guidelines. 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.

DESCRIPTIONS OF LEVELS OF WORK

Level I: Reimbursement Coder 4839

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

A Reimbursement Coder 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; uses codes in referral processing for outpatient visits and procedures to ensure approval.

2. assists physicians, clinic and billing staff with coding, billing, and documentation issues.

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

4. prepares simple reports to illustrate reimbursement rates; maintains simple reports tracking unbillable charges awaiting correct of documentation by providers.

5. registers patients.

6. communicates with medical providers regarding documentation requirements.

7. attends coding and diagnosis seminars.

8. may update fee schedules and inform clinical staff of all changes and fee increases under the direction of supervisor; updates insurance matrix for billing staff.

9. composes simple correspondence to third party payers to resolve billing/charge problems; works ETM denials weekly for resubmission.

10. works with billing department to resolve and authorize adjustments to be made on patient's accounts; assists with daily deposits by verifying accuracy of payments; reviews outsourced billing practices for accuracy in billing.

11. performs other related duties as assigned.

Level II: Reimbursement Coding Specialist – ORIGINAL with CJASI 4840

Employees at this level code physician and ancillary medical services for the purposes of receiving maximum allowable reimbursement from payers and are able to code more complex cases accurately for reimbursement purposes. 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 Supervisor or related personnel.

A Reimbursement Coding Specialist typically –

1. conducts daily review and analysis of coding related rejections received from third party payers and of coding edits before submission to third party payers; corrects the coding denials for all specialties and coding edits assigned.

2. reviews coding and reimbursement rules using appropriate sources to keep updated on policy changes. communicates changes to PBS management and staff.

3. identifies and makes recommendations to director and Coding Coordinator for opportunities to create Claims Manager edits.

4. submits all appropriate/pertinent documentation with charge tickets to obtain best reimbursement and/or to explain unusual charges.

5. assists in development of policies and procedures related to coding of physician and ancillary provider services using ICD9-CM and CPT.

6. tracks appeals to ensure appropriate strategies are employed and to adjust accordingly; tracks consent forms for Medicaid ensuring pertinent offices have copies.

7. assists in resolving day-to-day coding related concerns communicated from patient/guarantor.

8. reviews random charge tickets to determine accuracy of CPT codes and appropriateness of modifiers. Refers to operative reports and medical records for completeness in relation to procedures and services performed.

9. provides analysis and reports on appeals outcomes on a quarterly basis.

10. serves a resource person for billing/coding issues for physicians, faculty, nurses, and support staff; provides expert advice and guidance on all coding related questions for PBS director, managers and staff.

11. collaborates with coding staff, Coding Coordinator and departmental staff including physicians with respect to additional documentation that may need to be prepared.

12. conducts research on complex coding problems using appropriate resources.

13. trains lower level staff, residents, fellows, etc.; may participate in the interviewing and hiring process.

14. reviews inpatient documentation at a high level of specificity and applies ICD-9-CM diagnosis and procedures codes while adhering to inpatient guidelines.

15. provides guidance to other departmental staff in identifying and resolving coding issues or errors.

16. utilizes coding skills as an outpatient coder.

17. serves as a resource person with regards to the rules for utilization of ICD-9-CM and CPT-4 diagnosis codes for services rendered and for coding related inquiries.

18. Is responsible for abstracting codes and other information from the hospital system for billing and reporting purposes.

19. analyzes and resolves claim denials that are rejected by editors from the Patient Accounts department.

20. may perform periodic audit reviews i.e. physician documentation, summary list, per hospital compliance department.

21. keeps abreast of bulletins, newsletters, and periodicals; attends workshops to stay current on coding issues, trends, and changes in regulations governing medical record coding documentation.

22. maintains national standards for coding accuracy and internal standards for productivity.

23. maintains CEU as dictated by AHIMA certification standards.

24. maintains confidentiality of patient health information at all times.

Level III: Reimbursement Coding Supervisor 4841

Employees at this level work under administrative direction from a designated supervisor. They manage, direct, and monitor all coding activities for physician, inpatient, and/or 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 or coordinate daily activities in the coding area and direct personnel responsible for the coding of charge documents.

A Reimbursement Coding Supervisor typically –

1. coordinates workflow; maintains productivity reports and assesses workload periodically to assess appropriate staffing levels. 66 %

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

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

4. may prepare complex reports detailing third party reimbursement rates. 66 %

5. 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.

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

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

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

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

10. reviews newsletters and the *Federal Register* on a routine basis; issues notifications to physicians and appropriate personnel regarding changes in reimbursement; keeps abreast by reading newsletters and/or attending seminars to stay current with coding issues and regulations governing medical records coding and documentation. 66%

11. 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. 33%

12. may represent department and unit in the development of institutional coding policies and procedures. 66%

13. 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. 66%

14. supervises lower level staff including hiring, evaluating, disciplining and interviewing. 66 %

15. maintains the Experian Claims scrubber program; reviews and corrects edits from program; enters charges in the WWT Epic billing system; creates, updates, and maintains information in the electronic charge capture system and runs reports as requested.

16. reviews clinic tickets and assigns ICD-9, CPT codes modifiers; reviews operative reports and assigns ICD-9 and CPT codes and modifiers.

17. resolves billing questions from patients, faculty, and staff.

18. performs duties listed in lower level of this classification series.

19. performs other related duties as assigned.

MINIMUM ACCEPTABLE QUALIFICATIONS REQUIRED FOR ENTRY INTO:

Level I: Reimbursement Coder 4839

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. High school graduation or GED.

2. Any one or any combination totaling **18 months** from the following categories:

   A. 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.

   B. 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 4840

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. High School graduation or GED.

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

KNOWLEDGE, SKILLS, AND ABILITIES (KSAs)

1. Possession of personal attributes listed for Reimbursement Coder.

2. Skill in researching complex coding questions.

3. Ability to supervise others.

4. Ability to compose reports.

5. Mathematical ability.

Level III: Reimbursement Coding Supervisor 4841

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. High school graduation or GED.

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. Three) (3) years//36 months of work experience, two (2 years)/ 24 months that are comparable to that performed at the Reimbursement Coding Specialist 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.

2. Proficiency in researching complex coding questions.

3. Supervisory ability.

4. Ability to compose complex reports.

5. Ability to develop training programs and seminars.

6. Mathematical ability.