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

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 recommend 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, Medicaid, and/or Managed Care regulations and the International Classification of Disease (ICD-9-CM and/or ICD-10), Healthcare Common Procedure Coding System (HCPCS) 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 involved in the routine day-to-day coding and associated work.

A Reimbursement Coder typically –

1. assigns codes for ancillary, hospital services and medical providers using standardized coding systems such as ICD-9-CM, ICD-10, HCPCS and/or CPT, or verifies coding performed by clinical staff for accuracy; uses codes in referral processing for outpatient visits and procedures.

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

3. maintains simple reports such as tracking unbillable charges.

4. communicates with medical providers.

5. attends coding seminars.

6. under the direction of the supervisor, updates and informs clinical staff of all changes in the fee schedules.

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

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

9. performs other related duties as assigned.

Level II: Reimbursement Coding Specialist – 4840

Employees at this level code for ancillary, hospital services and medical providers for the purposes of receiving maximum allowable reimbursement from payers and/or are able to code more complex cases accurately for reimbursement purposes. They also perform other coding related functions such as training, research, and auditing. They function under the general supervision of a Reimbursement Coding Supervisor or related personnel.

A Reimbursement Coding Specialist typically –

1. may review inpatient and/or outpatient documentation to assign the appropriate ICD-9-CM, ICD-10, CPT, and/or HCPCS diagnosis and procedures codes while adhering to coding guidelines.

2. 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.

3. is responsible for abstracting codes and other information from the hospital system for billing and reporting purposes. Identifies and makes recommendations for coding edits.

4. assists in development of policies and procedures related to coding of medical providers, ancillary, and/or hospital services using ICD9-CM, ICD-10, HCPCS, and/or CPT.

5. tracks appeals to ensure appropriate strategies are employed and to adjust accordingly; assists in resolving day-to-day coding related issues; serves as a resource person for billing/coding purposes

6. may review charge tickets and/or documentation to determine accuracy of CPT and diagnosis coding.

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

8. reviews, analyzes and corrects or resolves claim denials.

9. may perform periodic audit reviews.

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

11. performs other related duties as assigned.

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 medical providers, hospital services, and/or ancillary services in a unit. They may perform audits and make recommendations based on findings. They supervise or coordinate daily activities in the coding area and direct personnel responsible for the coding.

A Reimbursement Coding Supervisor typically –

1. coordinates and/or assigns workflow to assess appropriate staffing levels.

2. maintains productivity reports.

3. develops policies and procedures related to coding; may represent department and unit in the development of institutional coding policies and procedures.

4. may perform complex studies of third-party reimbursement patterns and provide recommendations to medical providers and/or administrators based on findings.

5. may prepare complex reports.

6. conducts educational coding seminars.

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

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

9. reviews newsletters and the *Federal Register* on a routine basis.

10. may investigate 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 perform audit reviews, researches and recommends needed changes to coding staff, medical providers, and/or administrators.

12. may supervise lower level staff including interviewing, hiring, evaluating, and/or disciplining.

13. may oversee and/or maintain the claims scrubber program; creates, updates, and maintains information in the electronic charge capture system and runs reports as requested.

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

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

16. 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 (AHIMA) 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. Maintains knowledge of national standards for coding accuracy and internal standards for productivity.

4. Maintains CEU (Continuing Education Units) as dictated by AHIMA certification standards.

5. Maintains confidentiality of patient health information at all times.

6. Analytical ability.

7. Mathematical ability.

8. Organizational ability.

10. Ability to interact with a variety of persons, including medical providers 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 (AHIMA), 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 (AHIMA), 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.