Class Code: 2779
Occupational Area: Managerial
Work Area: Subsidiary
Effective Date: 6/1/2023
Last Action: Revised

Health Care Compliance Officer

Function of Job

Under administrative review from a designated administrator, to promote health care compliance related to clinical/business activities of a health care facility and to provide technical expertise in support of coding, billing, and medical records documentation.

Characteristic Duties and Responsibilities

A(n) Health Care Compliance Officer typically -

1. audits and verifies charge documents for physician and ancillary services using standardized coding systems, such as ICD-10-CM and CPT, for compliance with external and internal guidelines, laws, and regulations;
2. performs charge ticket and medical record chart reviews to confirm compliance with the adequacy of the documentation relative to Medicare and Medicaid guidelines;
3. assists in the development, implementation, and monitoring of compliance policies and operating procedures;
4. interacts with physicians and ancillary personnel to resolve problems with specific charges as needed;
5. performs prospective periodic charge and chart reviews of medical providers on an annual basis. Meet with medical providers when results of review warrant change in coding and/or documentation;
6. provides periodic reports, of findings and status of compliance programs and issues, to the institutional Compliance Officer;
7. assists in developing and delivering staff training and education for faculty physicians, medical residents, and staff members related to coding, billing, medical records documentation, and other issues related to compliance as necessary;
8. assists with the investigation of hotline fraud and abuse complaints;
9. functions as the primary person of record who maintains all laws, rules, and regulations concerning professional fee billing;
10. represents the compliance office as a member of institutional committees;
11. performs other related duties as assigned.

Minimum Acceptable Qualifications

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. Any one or combination totaling **four (4) years (48 months)** of the following types of preparation:

   A. College coursework in health care administration, health care compliance, business administration, or a closely related field as measured by the following conversion table or its proportional equivalent:

      - 30 semester hours equals one (1) year (12 months)
      - Associate's Degree (60 semester hours) equals eighteen months (18 months)
      - 90 semester hours equals two (2) years (24 months)
      - Bachelor's degree (120 semester hours) equals three (3) years (36 months)

   B. work experience coding complex charge documents for ancillary and physician services using standardized coding systems such as ICD-10-CM and CPT.

2. Any one of the following certifications: Certified Coding Specialist (CCS) or Certified Coding Specialist-Physician Based (CCS-P), **Registered Health Information Technician (RHIT), or Registered Health Information Administrator (RHIA)** by the American Health Information Management Association or certification as a Certified Procedural Coder (CPC) by the American Academy of Professional Coders.

Knowledge, Skills, and Abilities (KSAs)

1. Knowledge of medical technology
2. Knowledge of industry standards such as Medicare/Medicaid and/or Managed Care regulations
3. Knowledge of complex ICD-10 and CPT coding systems
4. Knowledge of third-party reimbursement billing requirements
5. Knowledge of auditing techniques
6. Knowledge of legal and ethical standards of the industry
7. Skill in verbal and written communication
8. Proficiency in ICD-10 and CPT coding
9. Ability to effectively develop and present training programs
10. Ability to effectively communicate with individuals at all levels in the institution
11. Ability to interpret State and Federal rules and regulations
12. Ability to work independently
13. Mathematical ability.