

Position Title: HIM Coder II
Department: Health Information Management
Pay rate: \$14.65 min doe

Job Summary: Responsible for coding all patient types including: service sheets, emergency room records, inpatient records, outpatient surgery, observation, ambulatory unit, and pain clinic

Job Relationships: Responsible to: HIM Manager
Positions directly supervised: None

Essential Job Functions:

The following is a summary of the essential functions of this job. The incumbent may perform other duties, both major and minor, that are not mentioned below; and specific functions may change from time to time. Demonstrates general office/filing skills. Participates in continuing education activities as deemed necessary by the director/supervisor. Performs yearly update review. Participates in training on new equipment/software as necessary. Maintains continuing education hours for certification if applicable. Remains current on HCPCS level II and III, CPT-4, ICD-9-CM coding principals; National Correct Coding Initiative; APC assignment; and LMRP (Local Medical Review Policy) through formal and informal programs, activities, articles, etc. Reviews assigned periodicals within a month of receipt. Obtains additional knowledge of DRG changes and updates. Demonstrates ability to work regularly scheduled hours unless otherwise authorized or requested. Meets coding quality standards of 95% accuracy. Meets abstract standards of 99% accuracy. Reviews charts thoroughly for diagnoses and procedures. Assigns codes following coding rules and regulations established by coding authorities including the federal and state regulations. Codes charts with a minimum standard of 2 minutes per service sheet; 8 minutes per ER record; 20 minutes for inpatient charts, outpatient surgery, observation, AMU, and pain clinic charts while maintaining quality standards above. Refer charts to coding supervisor for questions regarding diagnoses and codes. Ability to code records utilizing 3-M encoder/SMS-MIRA coding/abstracting system. Perform preliminary transfusion reviews on coded records. Performs APC assignment and review. Performs DRG assignment and review. Acts as a resource for hospital staff, level I coders, and other level II coders. Performs audits as requested by supervisor/director. Performs anesthesia coding with accuracy levels as noted above. Understands and demonstrates the concept of optimizing versus maximizing for DRG assignment. Understanding of chargemaster driven code assignments versus medical records code assignments. Demonstrates personal attitudes and behavior that contributes to the growth of the hospital. Demonstrates ability to maintain equipment. Demonstrates ability to serve as preceptor in assigned job status.

Education and formal training:

Completion of high school plus coding certification. Ten (10) years of on the job work in this field will provide the equivalent of coding certification.

Work Experience:

Two years with coding certification. Otherwise, ten (10) years minimum experience.

Knowledge, skills, and abilities required:

Must have an understanding of medical terminology. Must have computer skills. Must have problem-solving abilities.

Physical Requirements:

Must be able to see computer screen, read records, speak, and communicate with other personnel in a professional manner. Must be able to organize materials effectively. Must be able to lift at least 10 pounds. Must be able to remain seated for extended periods with intense concentration.