STAFFING

1. **REASON FOR ISSUE:** To establish a Department of Veterans Affairs (VA) qualification standard for Medical Records Technician (Coder), General Schedule (GS)-0675, appointed under 38 U.S.C. § 7401(3) and 38 U.S.C. § 7405 (a)(1)(B).

2. **SUMMARY OF CONTENTS/MAJOR CHANGES:** This handbook contains mandatory procedures on staffing. This policy establishes qualification standards for the Medical Records Technician (Coder) occupation. This policy removes the Medical Records Technician (Coder) references and standards in Appendix II-G35, and moves the Medical Records Technician (Coder) Qualification Standard to Appendix II-G57. It expands the descriptions for assignments for inpatient, outpatient, or the combination of both, to allow for flexibility at facilities, and adds the assignment for Consolidated Coding Units. The policy is established under VA's title 38 hybrid excepted service employment system and the authority of Public Law 111-163, "Caregivers and Veterans Omnibus Health Services Act of 2010." Authority is given to the Secretary of VA under 38 U.S.C. § 7402, to prescribe qualifications for occupations identified in or established under 38 U.S.C. § 7401(3) and 38 U.S.C. § 7405(a)(1)(B). These changes will be incorporated into the electronic version of VA Handbook 5005 that is maintained on the Office of the Chief Human Capital Officer Website.

3. **RESPONSIBLE OFFICE:** Recruitment and Placement Policy Service (059), Office of the Chief Human Capital Officer.

4. **RELATED DIRECTIVE:** VA Directive 5005, Staffing.

5. **RESCISSIONS:** None.

CERTIFIED BY:

/s/
Melissa S. Glynn, Ph.D.
Assistant Secretary for
Enterprise Integration

BY DIRECTION OF THE SECRETARY OF VETERANS AFFAIRS:

/s/
Daniel R. Sitterly
Assistant Secretary for Human Resources and Administration/ Operations, Security, and Preparedness

DISTRIBUTION: Electronic Only

NOTE: This transmittal page accompanied the former VA Handbook 5005, Staffing publication. It is provided for reference to the establishment of this qualification standard.

MEDICAL RECORDS TECHNICIAN (CODER)
QUALIFICATION STANDARD
GS-0675
Veterans Health Administration

1. **COVERAGE.** Medical coding falls under the jurisdiction of health information management (HIM). The following are the requirements for appointment as a Medical Records Technician (MRT) (Coder) performing medical coding in the Veterans Health Administration (VHA). These requirements apply to all VHA MRT (Coder) positions in the GS-0675 series. MRTs (Coder) are skilled in classifying medical data from patient health records in the hospital setting, and/or physician-based settings, such as physician offices, group practices, multi-specialty clinics, and specialty centers. These coding practitioners analyze and abstract patients' health records, and assign alpha-numeric codes for each diagnosis and procedure. To perform this task, they must possess expertise in international classification of diseases (ICD), current procedural technology (CPT), and the healthcare common procedure coding system (HCPCS). MRT (Coder) professionals may be assigned to outpatient coding, inpatient coding, or a combination of outpatient/inpatient coding. Also, this work can be performed in a consolidated coding unit (CCU). MRT (Coder) may also provide education related to coding and documentation. MRT (Coder) assignments above the journey level include clinical documentation improvement specialist (CDIS) and auditor.

2. **AUTHORITIES.**

   a. [P.L. 111-163, Caregivers and Veterans Omnibus Health Services Act of 2010](#);

   b. [38 U.S.C. § 7401, Appointments in Veterans Health Administration](#);

   c. [38 U.S.C. § 7402, Qualifications of appointees](#);

   d. [38 U.S.C. § 7403, Period of appointments; promotions](#);

   e. [38 U.S.C. § 7405, Temporary full-time appointments, part-time appointments and without-compensation appointments](#);

   f. [38 U.S.C. § 7407, Administrative provisions for section 7405 and 7406 appointments](#).

3. **DEFINITIONS.**

   a. **Journey Level.** The full performance level for the MRT (Coder) assignment is GS-8.

b. **Creditable Experience.** Experience is only creditable if it is directly related to the position to be filled. To be creditable, the candidate's experience must have demonstrated the use of knowledge, skills, and abilities (KSAs) associated with current practice and must be paid or non-paid employment equivalent to a MRT (Coder).

c. **Quality of Experience.** To be creditable, experience must be documented on the application or resume and verified in an employment reference or through other independent means.

d. **Part-Time Experience.** Part-time experience as a professional MRT is creditable according to its relationship to the full-time work week. For example, an MRT would receive one week of full-time credit for each two weeks of half-time work.

e. **Predominant Specialty Area.** Lead/Supervisory MRT (Coder) whose assignments involve two or more MRT specialty areas will be assigned the parenthetical title for the predominant specialty area being led/supervised.

f. **Apprentice/Associate Level Certification.** This is considered an entry level coding certification and is limited to certification obtained through the American Health Information Management Association (AHIMA), or the American Academy of Professional Coders (AAPC).

    To be acceptable for qualifications, the specific certification must represent a comprehensive competency in coding across a wide range of services. Stand-alone specialty certifications do not meet the definition of apprentice/associate level certification and are not acceptable for qualifications. Certification titles may change and certifications that meet the definition of apprentice/associate level certification may be added/removed by the above certifying bodies. However, current apprentice/associate level certifications include: Certified Coding Associate (CCA), Certified Professional Coder-Apprentice (CPC-A) and Certified Outpatient Coding-Apprentice (COC-A).

g. **Mastery Level Certification.** This is considered a higher-level health information management or coding certification and is limited to certification obtained through AHIMA or AAPC. To be acceptable for qualifications, the specific certification must represent a comprehensive competency in the occupation. Stand-alone specialty certifications do not meet the definition of mastery level certification and are not acceptable for qualifications. Certification titles may change and certifications that meet the definition of mastery level certification may be added/removed by the above certifying bodies. However, current mastery level certifications include: Certified Coding Specialist (CCS), Certified Coding Specialist – Physician-based (CCS-P), Registered Health Information Technician (RHIT), Registered Health Information Administrator (RHIA), Certified Professional Coder (CPC), Certified Outpatient Coder (COC), Certified Inpatient Coder (CIC).

h. **Clinical Documentation Improvement Certification.** This is limited to certification obtained through AHIMA or the Association of Clinical Documentation Improvement

Specialists (ACDIS). To be acceptable for qualifications, the specific certification must certify mastery in clinical documentation. Certification titles may change, and certifications that meet the definition of clinical documentation improvement certification may be added/removed by the above certifying bodies. However, current Clinical Documentation Improvement Certifications include: Clinical Documentation Improvement Practitioner (CDIP) and Certified Clinical Documentation Specialist.

4. **BASIC REQUIREMENTS.**

a. **Citizenship.** Citizen of the United States. (Non-citizens may be appointed when it is not possible to recruit qualified citizens in accordance with chapter 3, section A, paragraph 3g, this part.)

b. **Experience and Education**

(1) **Experience.** One year of creditable experience that indicates knowledge of medical terminology, anatomy, physiology, pathophysiology, medical coding, and the structure and format of a health records.
OR,

(2) **Education.** An associate's degree from an accredited college or university recognized by the U.S. Department of Education with a major field of study in health information technology/health information management, or a related degree with a minimum of 12 semester hours in health information technology/health information management (e.g., courses in medical terminology, anatomy and physiology, medical coding, and introduction to health records);

OR,

(3) Completion of an AHIMA approved coding program, or other intense coding training program of approximately one year or more that included courses in anatomy and physiology, medical terminology, basic ICD diagnostic/procedural, and basic CPT coding. The training program must have led to eligibility for coding certification/certification examination, and the sponsoring academic institution must have been accredited by a national U.S. Department of Education accreditor, or comparable international accrediting authority at the time the program was completed;

OR,

(4) **Experience/Education Combination.** Equivalent combinations of creditable experience and education are qualifying for meeting the basic requirements. The following educational/training substitutions are appropriate for combining education and creditable experience:

(a) Six months of creditable experience that indicates knowledge of medical

terminology, general understanding of medical coding and the health record, and one year above high school, with a minimum of 6 semester hours of health information technology courses.

(b) Successful completion of a course for medical technicians, hospital corpsmen, medical service specialists, or hospital training obtained in a training program given by the Armed Forces or the U.S. Maritime Service, under close medical and professional supervision, may be substituted on a month-for-month basis for up to six months of experience provided the training program included courses in anatomy, physiology, and health record techniques and procedures. Also, requires six additional months of creditable experience that is paid or non-paid employment equivalent to a MRT (Coder).

c. **Certification.** Persons hired or reassigned to MRT (Coder) positions in the GS-0675 series in VHA must have either (1), (2), or (3) below:

(1) Apprentice/Associate Level Certification through AHIMA or AAPC.

(2) Mastery Level Certification through AHIMA or AAPC.

(3) Clinical Documentation Improvement Certification through AHIMA or ACDIS.

NOTE: Mastery level certification is required for all positions above the journey level; however, for clinical documentation improvement specialist assignments, a clinical documentation improvement certification may be substituted for a mastery level certification.

d. **Loss of Credential.** Following initial certification, credentials must be maintained through rigorous continuing education, ensuring the highest level of competency for employers and consumers. An employee in this occupation who fails to maintain the required certification must be removed from the occupation, which may result in termination of employment. At the discretion of the appointing official, an employee may be reassigned to another occupation for which he/she qualifies, if a placement opportunity exists.

e. **Grandfathering Provision.** All persons employed in VHA as a MRT (Coder) on the effective date of this qualification standard are considered to have met all qualification requirements for the title, series, and grade held, including positive education and certification that are part of the basic requirements of the occupation. For employees who do not meet all the basic requirements in this standard, but who met the qualifications applicable to the position at the time they were appointed to it, the following provisions apply:

(1) Such employees may be reassigned, promoted up to and including the journey level, or changed to lower grade within the occupation, but will not be promoted beyond the journey level or placed in supervisory or managerial positions.

(2) Such employees in an occupation that requires a certification only at higher grade levels must meet the certification requirement before they can be promoted to the higher-grade levels.

(3) MRTs who are appointed on a temporary basis, prior to the effective date of the qualification standard, may not have their temporary appointment extended, or be reappointed on a temporary or permanent basis, until they fully meet the basic requirements of the standard.

(4) MRTs initially grandfathered into this occupation, who subsequently obtain additional education that meets all the basic requirements of this qualification standard, must maintain the required credentials as a condition of employment in the occupation.

(5) Employees who are retained as a MRT under this provision and subsequently leave the occupation lose protected status and must meet the full VA qualification standard requirements in effect at the time of reentry as a MRT.

f. **Physical Requirements.** See VA Directive and Handbook 5019, Employee Occupational Health Service.

g. **English Language Proficiency.** MRTs (Coder) must be proficient in spoken and written English as required by 38 U.S.C. § 7403(f).

5. GRADE REQUIREMENTS.

a. **Titles and Specialties**

(1) **Titles.** All individuals assigned to this occupation must be assigned to one of the approved parenthetical titles, as described in subparagraph (2) below.

(2) **Specialized Areas for Medical Records Technician (Coder).** For purposes of this qualification standard, the specialty areas for MRT (Coder) have been grouped into multiple parenthetical titles. Titles include:

(a) Medical Records Technician (Coder-Outpatient);

(b) Medical Records Technician (Coder-Inpatient); or,

(c) Medical Records Technician (Coder-Outpatient and Inpatient).

(3) **Medical Records Technician (Clinical Documentation Improvement Specialist) (CDIS).** The MRT (CDIS) assignments are positions above the journey level.

(a) MRT CDIS (Outpatient);

(b) MRT CDIS (Inpatient); or,

(c) MRT CDIS (Outpatient and Inpatient).

(4) **Medical Records Technician (Coder) Auditor.** The MRT (Coder) Auditor assignment is a position above the journey level.

(5) **Lead and Supervisory Medical Records Technician (Coder) Assignments.** Lead and Supervisory MRT (Coder) assignments are positions above the journey level.

(a) Lead MRT (Coder);

(b) Supervisory MRT (Coder); or,

(c) Supervisory MRT (Coder) Consolidated Coding Unit (CCU).

6. GRADE DETERMINATIONS AND ASSIGNMENTS.

a. **Medical Records Technician (Coder-Outpatient)**

(1) **Medical Records Technician (Coder-Outpatient), GS-4**

(a) **Experience or Education.** None beyond basic requirements.

(b) **Assignment.** Employees at this level serve as entry level MRTs (Coder) and receive close guidance from more experienced MRTs (Coder). Outpatient MRTs (Coder) select and assign codes from current versions of ICD Clinical Modification (CM), CPT, and HCPCS classification systems. MRTs (Coder) review record documentation to abstract all required medical, surgical, ancillary, demographic, social and administrative data, and query clinical staff, as appropriate, with close guidance from higher level MRTs (Coder). They use various computer applications to abstract records, assign codes, and record and transmit data. They ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(2) **Medical Records Technician (Coder-Outpatient), GS-5**

(a) **Experience.** One year of creditable experience equivalent to the next lower grade level;
OR,

(b) **Education.** Successful completion of four years of education above high school leading to a bachelor's degree from an accredited college or university

recognized by the U.S. Department of Education, with a major field of study in health information management or a related degree with a minimum of 24 semester hours in health information management or technology.

(c) **Assignment.** Employees at this grade level serve as developmental level 1 MRTs (Coder) and receive guidance from more experienced MRTs (Coder) for more complex coding procedures. Outpatient MRTs (Coder) select and assign codes to outpatient episodes of care, and/or inpatient professional services from current versions of ICD CM, CPT, and HCPCS classification systems. They review record documentation to abstract all required medical, surgical, ancillary, demographic, social and administrative data, and query clinical staff, as appropriate, with guidance from higher level MRTs (Coder). They use various computer applications to abstract records, assign codes, and record and transmit data. They ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(d) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i.   Ability to use health information technology and software products used in MRT (Coder) positions (e.g., the electronic health record, coding and abstracting software, etc.).

ii.   Ability to navigate through and abstract pertinent information from health records.

iii.   Knowledge of the ICD CM, PCS Official Conventions and Guidelines for Coding and Reporting, and CPT guidelines.

iv.   Ability to apply knowledge of medical terminology, human anatomy/physiology, and disease processes to accurately assign codes to outpatient/ambulatory surgery records, based on health record documentation.

v.   Knowledge of The Joint Commission requirements, Centers for Medicare and Medicaid Services (CMS), and/or health record documentation guidelines.

vi.   Ability to manage priorities and coordinate work, in order to complete duties within required timeframes, and the ability to follow-up on pending issues.

(3) **Medical Records Technician (Coder-Outpatient), GS-6**

(a) **Experience.** One year of creditable experience equivalent to the next lower grade level.

(b) **Assignment.** Employees at this grade level serve in developmental level 2 positions as MRTs (Coder) and receive intermittent monitoring. Outpatient MRTs

(Coder) may perform coding on outpatient episodes of care and/or inpatient professional services. They select and assign codes from current versions of ICD CM, CPT, and HCPCS classification systems. They review record documentation to abstract all required medical, surgical, ancillary, demographic, social and administrative data, and query clinical staff, as appropriate, with limited guidance from higher level MRTs (Coder). They utilize various computer applications to abstract records, assign codes, and record and transmit data. They also ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(c) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Ability to analyze the health record to identify all pertinent diagnoses and procedures for outpatient coding and evaluate the adequacy of the documentation.

ii. Ability to determine whether health records contain sufficient information for regulatory requirements, are acceptable as legal documents, are adequate for continuity of patient care, and support the assigned codes. This includes the ability to take appropriate actions if health record contents are not complete, accurate, timely, and/or reliable.

iii. Ability to apply laws and regulations on the confidentiality of health information (e.g., Privacy Act, Freedom of Information Act, and Health Insurance Portability and Accountability Act (HIPAA)).

iv. Ability to accurately apply the ICD CM, procedure coding system (PCS) Official Conventions and Guidelines for Coding and Reporting, and CPT guidelines to coding scenarios.

v. Comprehensive knowledge of current classification systems, such as ICD CM, CPT, and HCPCS, and skill in applying said classifications to outpatient episodes of care, and/or inpatient professional services based on health record documentation.

(4) **Medical Records Technician (Coder-Outpatient), GS-7**

(a) **Experience.** One year of creditable experience equivalent to the next lower grade level.

(b) **Assignment.** Employees at this grade level serve as developmental level 3 MRTs (Coder) and receive minimal monitoring. Outpatient MRTs (Coder) perform coding on outpatient episodes of care and/or inpatient professional services. They select and assign codes from current versions of ICD CM, CPT, and HCPCS classification systems. They review record documentation to abstract all required

medical, surgical, ancillary, demographic, social and administrative data, with minimal guidance from higher level MRTs (Coder). They review and abstract clinical data from the record for documentation of diagnoses and procedures to ensure it is adequate and appropriate to support the assigned codes. They also review provider health record documentation to ensure that it supports the diagnostic and procedural codes assigned and is consistent with required medical coding nomenclature. MRTs in this assignment also query clinical staff with documentation requirements to support the coding process. They use various computer applications to abstract records, assign codes, and record and transmit data. They also ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(c) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Skill in applying current coding classifications to a variety of specialty care areas for outpatient episodes of care and/or inpatient professional services to accurately reflect service and care provided based on documentation in the health record.

ii. Ability to communicate with clinical staff for specific coding and documentation issues, such as recording diagnoses and procedures, ensuring the correct sequencing of diagnoses and/or procedures, and verifying the relationship between health record documentation and coder assignment.

iii. Ability to research and solve coding and documentation related issues.

iv. Skill in reviewing and correcting system or processing errors and ensuring all assigned work is complete.

(5) **Medical Records Technician (Coder-Outpatient), GS-8**

(a) **Experience.** One year of creditable experience equivalent to the next lower grade level.

(b) **Assignment.** This is the journey level for this assignment. Outpatient MRTs (Coder) at this level perform the full scope of outpatient coding including ambulatory surgical cases, diagnostic studies and procedures, outpatient encounters, and/or inpatient professional services. Outpatient duties consist of the performance of a comprehensive review of documentation within the health record to accurately assign ICD CM codes for diagnoses, CPT/HCPCS codes for surgeries, procedures and evaluation, and management services. They independently review and abstract clinical data from the record for documentation of diagnoses and procedures to ensure it is adequate and appropriate to support the assigned codes. They code all complicated and complex disease processes,

patient injuries, and all procedures in a wide range of ambulatory settings and specialties. They also directly consult with the clinical staff for clarification of conflicting, incomplete, or ambiguous clinical data in the health record. MRTs (Coder) must abstract, assign, and sequence codes into encoder software to support medical necessity, resolve encoder edits, and ensure codes accurately reflect services rendered.

They also review provider health record documentation to ensure that it supports the diagnostic and procedural codes assigned and is consistent with required medical coding nomenclature. They also query clinical staff with documentation requirements to support the coding process. They enter and correct information that has been rejected, when necessary. MRTs (Coder) ensure audit findings have been corrected and refiled. They also use various computer applications to abstract records, assign codes, and record and transmit data. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(c) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Ability to analyze the health record to identify all pertinent diagnoses and procedures for coding and to evaluate the adequacy of the documentation. This includes the ability to read and understand the content of the health record, the terminology, the significance of the findings, and the disease process/pathophysiology of the patient.

ii. Ability to accurately perform the full scope of outpatient coding, including ambulatory surgical cases, diagnostic studies and procedures, and outpatient encounters, and/or inpatient professional fee services coding.

iii. Skill in interpreting and adapting health information guidelines that are not completely applicable to the work or have gaps in specificity, and the ability to use judgment in completing assignments using incomplete or inadequate guidelines.

b. **Medical Records Technician (Coder-Inpatient)**

(1) **Medical Records Technician (Coder-Inpatient), GS-4**

(a) **Experience or Education.** None beyond basic requirements.

(b) **Assignment.** Employees at this level serve as entry level MRTs (Coder) and receive close guidance from more experienced MRTs (Coder). Inpatient MRTs (Coder) select and assign codes from current versions of ICD CM and the PCS, and/or, CPT and HCPCS classification systems for inpatient facility and/or professional services. They review record documentation to abstract all required medical, surgical, ancillary, demographic, social and administrative data, and query clinical staff, as appropriate, with close guidance from higher level MRTs (Coder). They also use various computer applications to abstract records, assign

codes, and record and transmit data. They ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(2) **Medical Records Technician (Coder-Inpatient), GS-5**

    (a) **Experience.** One year of creditable experience equivalent to the next lower grade level;

OR,

    (b) **Education.** Successful completion of a bachelor's degree from an accredited college or university recognized by the U.S. Department of Education, with a major field of study in health information management or a related degree with a minimum of 24 semester hours in health information management or technology.

    (c) **Assignment.** Employees at this grade level serve as developmental level 1 MRTs (Coder) and receive guidance from more experienced MRTs (Coder) for more complex coding procedures. Inpatient MRTs (Coder) select and assign codes from current versions of ICD CM, PCS, and/or CPT and HCPCS classification systems for inpatient facility and/or professional services. They review record documentation to abstract all required medical, surgical, ancillary, demographic, social and administrative data, and query clinical staff, as appropriate, with guidance from higher level MRTs (Coder). They utilize various computer applications to abstract records, assign codes, and record and transmit data. They also ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

    (d) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

        i. Ability to use health information technology and various office software products used in MRT (Coder) positions (e.g., the electronic health record, coding and abstracting software, etc.).

        ii. Ability to navigate through and abstract pertinent information from health records.

        iii. Knowledge of the ICD CM and PCS Official Conventions and Guidelines for Coding and Reporting.

        iv. Ability to apply knowledge of medical terminology, human anatomy/physiology, and disease processes to accurately assign codes to inpatient records based on health record documentation.

v. Knowledge of The Joint Commission requirements, CMS, and/or health record documentation guidelines.

vi. Ability to manage priorities and coordinate work to complete duties within required timeframes and the ability to follow-up on pending issues.

(3) **Medical Records Technician (Coder-Inpatient), GS-6**

(a) **Experience.** One year of creditable experience equivalent to the next lower grade level.

(b) **Assignment.** Employees at this grade level serve in developmental level 2 positions as MRTs (Coder) and receive intermittent monitoring. Inpatient MRTs (Coder) select and assign codes from current versions of ICD CM, PCS, and/or CPT and HCPCS classification systems for inpatient facility and/or professional services. They review record documentation to abstract all required medical, surgical, ancillary, demographic, social and administrative data, and query clinical staff, as appropriate, with limited guidance from higher level MRTs (Coder). They use various computer applications to abstract records, assign codes, and record and transmit data. They also ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(c) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Ability to analyze the health record to identify all pertinent diagnoses and procedures for coding and to evaluate the adequacy of the documentation.

ii. Ability to determine whether health records contain sufficient information for regulatory requirements, are acceptable as legal documents, are adequate for continuity of patient care, and support the assigned codes. This includes the ability to take appropriate actions if health record contents are not complete, accurate, timely, and/or reliable.

iii. Ability to apply laws and regulations on the confidentiality of health information (e.g., Privacy Act, Freedom of Information Act, and HIPAA).

iv. Ability to accurately apply the ICD CM and PCS Official Conventions and Guidelines for Coding and Reporting to various coding scenarios.

v. Comprehensive knowledge of current classification systems, such as ICD Clinical Modification (CM) and PCS, CPT, and HCPCS, and skill in applying said classifications to inpatient records based on health record documentation.

vi. Knowledge of complication or comorbidity/major complication or comorbidity (CC/MCC), and POA indicators to obtain correct Medicare Severity Diagnosis Related Group (MS-DRG).

(4) **Medical Records Technician (Coder-Inpatient), GS-7**

    (a) **Experience.** One year of creditable experience equivalent to the next lower grade level.

    (b) **Assignment.** Employees at this grade level serve as developmental level 3 MRTs (Coder) and receive minimal monitoring. Inpatient MRTs (Coder) select and assign codes from current versions of ICD CM, PCS, and/or CPT and HCPCS classification systems for inpatient facility and/or professional services. They review and record documentation to abstract all required medical, surgical, ancillary, demographic, social and administrative data, with minimal guidance from higher level MRTs (Coder). They review and abstract clinical data from the record for documentation of diagnoses and procedures to ensure it is adequate and appropriate to support the assigned codes. They review provider health record documentation to ensure that it supports the diagnostic and procedural codes assigned and is consistent with required medical coding nomenclature. They query clinical staff with documentation requirements to support the coding process. They use various computer applications to abstract records, assign codes, and record and transmit data. They ensure audit findings have been corrected and refiled.
MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

    (c) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

       i. Skill in applying current coding classifications to a variety of inpatient specialty care areas to accurately reflect service and care provided based on documentation in the health record.

       ii. Ability to communicate with clinical staff for specific coding and documentation issues, such as recording diagnoses and procedures, the correct sequencing of diagnoses and/or procedures, and the relationship between health record documentation and code assignment.

       iii. Ability to research and solve coding and documentation related issues.

       iv. Skill in reviewing and correcting system or processing errors and ensuring all assigned work is complete.

       v. Ability to abstract, assign, and sequence codes, including complication or comorbidity/major complication or comorbidity (CC/MCC), and POA indicators, to obtain correct MS-DRG.

(5) **Medical Records Technician (Coder-Inpatient), GS-8**

    (a) **Experience.** One year of creditable experience equivalent to the next lower grade level.

(b) **Assignment.** This is the journey level for this assignment. Inpatient MRTs (Coder) select and assign codes from current versions of ICD CM, PCS, and/or CPT and HCPCS classification systems for inpatient facility and/or professional services. Inpatient duties consist of the performance of a comprehensive review of documentation within the health record to assign ICD codes for diagnosis, complications/major complications, comorbid/major comorbid conditions, surgery, and procedures for accurate assignment of diagnosis related groups (DRG), and/or assigning CPT/HCPCS codes for inpatient professional services. They independently review and abstract clinical data from the record for documentation of diagnoses and procedures to ensure it is adequate and appropriate to support the assigned codes. They code all complicated and complex medical/specialty diseases processes, patient injuries, and all medical procedures in a wide range of inpatient settings and specialties. They directly consult with the clinical staff for clarification of conflicting, incomplete, or ambiguous clinical data in the health record. They must abstract, assign, and sequence codes into encoder software to obtain correct DRG, support medical necessity, resolve encoder edits, and ensure codes accurately reflect services rendered. They review provider health record documentation to ensure that it supports diagnostic and procedural codes assigned and is consistent with required medical coding nomenclature. They query clinical staff with documentation requirements to support the coding process. They also enter and correct information that has been rejected, when necessary. They correct any identified data errors or inconsistencies. They ensure audit findings have been corrected and refiled. They use various computer applications to abstract records, assign codes, and record and transmit data. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(c) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Ability to analyze the health record to identify all pertinent diagnoses and procedures for inpatient coding and to evaluate the adequacy of the documentation. This includes the ability to read and understand the content of the health record, the terminology, the significance of the comments, and the disease process/pathophysiology of the patient.

ii. Ability to accurately perform the full scope of inpatient coding, including inpatient discharges, surgical cases, diagnostic studies and procedures, and inpatient professional services.

iii. Skill in interpreting and adapting health information guidelines that are not completely applicable to the work or have gaps in specificity, and the ability to use judgment in completing assignments using incomplete or inadequate guidelines.

c. **Medical Records Technician (Coder-Outpatient and Inpatient)**

(1) **Medical Records Technician, GS-4**

(a) **Experience or Education.** None beyond basic requirements.

(b) **Assignment.** Employees at this level serve as entry level MRTs (Coder) and receive close supervision from more experienced MRTs (Coder). They select and assign codes from current versions of ICD CM, PCS, CPT, and HCPCS classification systems to both inpatient and outpatient records. They review record documentation to abstract all required medical, surgical, ancillary, demographic, social and administrative data, and query clinical staff, as appropriate, with close guidance from higher level MRTs (Coder). They use various computer applications to abstract records, assign codes, and record and transmit data. They ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(2) **Medical Records Technician (Coder-Outpatient and Inpatient), GS-5**

(a) **Experience.** One year of creditable experience equivalent to the next lower grade level;

OR,

(b) **Education.** Successful completion of a bachelor's degree from an accredited college or university recognized by the U.S. Department of Education, with a major field of study in health information management, or a related degree with a minimum of 24 semester hours in health information management or technology.

(c) **Assignment.** Employees at this grade level serve as developmental level 1 MRTs (Coder) and receive guidance from more experienced MRTs (Coder) for more complex coding procedures. Selects and assigns codes from current versions of ICD CM, PCS, CPT, and HCPCS classification systems to both inpatient and outpatient records. They review record documentation to abstract all required medical, surgical, ancillary, demographic, social, and administrative data, and query clinical staff, as appropriate, with guidance from higher level MRTs (Coder). They use various computer applications to abstract records, assign codes, and record and transmit data. They ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(d) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Ability to use health information technology and various office software products used in MRT (Coder) positions (e.g., the electronic health record, coding and abstracting software, etc.).

ii. Ability to navigate through and abstract pertinent information from health records.

iii. Knowledge of the ICD CM, PCS Official Conventions and Guidelines for Coding and Reporting, and CPT guidelines.

iv. Ability to apply knowledge of medical terminology, human anatomy/physiology, and disease processes to accurately assign codes to inpatient and outpatient episodes of care based on health record documentation.

v. Knowledge of The Joint Commission requirements, CMS, and/or health record documentation guidelines.

vi. Ability to manage priorities and coordinate work to complete duties within required timeframes, and the ability to follow-up on pending issues.

(3) **Medical Records Technician (Coder-Outpatient and Inpatient), GS-6**

(a) **Experience.** One year of creditable experience equivalent to the next lower grade level.

(b) **Assignment.** Employees at this grade level serve in developmental level 2 positions as MRTs (Coder) and receive intermittent monitoring. MRTs (Coder) perform a combination of inpatient and outpatient coding duties. They select and assign codes from current versions of ICD CM, PCS, CPT, and HCPCS classification systems to both inpatient and outpatient records. They review record documentation to abstract all required medical, surgical, ancillary, demographic, social, and administrative data, and query clinical staff, as appropriate, with limited guidance from higher level MRTs (Coder). They use various computer applications to abstract records, assign codes, and record and transmit data. They ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(c) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Ability to analyze the health record to identify all pertinent diagnoses and procedures for coding and to evaluate the adequacy of the documentation.

ii. Ability to determine whether health records contain sufficient information for regulatory requirements, are acceptable as legal documents, are adequate for continuity of patient care, and support the assigned codes. This includes the ability to take appropriate actions if health record contents are not complete, accurate, timely, and/or reliable.

iii. Ability to apply laws and regulations on the confidentiality of health information (e.g., Privacy Act, Freedom of Information Act, and HIPAA).

iv. Ability to accurately apply the ICD CM, PCS Official Conventions and Guidelines for Coding and Reporting, and CPT Guidelines to various coding scenarios.

v. Comprehensive knowledge of current classification systems, such as ICD CM, PCS, CPT, HCPCS, and skill in applying classifications to both inpatient and outpatient records based on health record documentation.

    vi. Knowledge of complication or comorbidity/major complication or comorbidity (CC/MCC) and POA indicators to obtain correct MS-DRG.

(4) Medical Records Technician (Coder-Outpatient and Inpatient), GS-7

    (a) **Experience.** One year of creditable experience equivalent to the next lower grade level.

    (b) **Assignment.** Employees at this grade level serve as developmental level 3 MRTs (Coder) and receive minimal monitoring. MRTs (Coder) perform a combination of inpatient and outpatient coding duties. Selects and assigns codes from current versions of ICD CM, PCS, CPT, and HCPCS classification systems to both inpatient and outpatient records. They review record documentation to abstract all required medical, surgical, ancillary, demographic, social, and administrative data with minimal guidance from higher level MRTs (Coder). They review and abstract clinical data from the record for documentation of diagnoses and procedures to ensure it is adequate and appropriate to support the assigned codes. They review provider health record documentation to ensure that it supports the diagnostic and procedural codes assigned and is consistent with required medical coding nomenclature. They also query clinical staff with documentation requirements to support the coding process. They use various computer applications to abstract records, assign codes, and record and transmit data. They ensure audit findings have been corrected and refiled. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

    (c) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

        i. Skill in applying current coding classifications to a variety of inpatient and outpatient specialty care areas to accurately reflect service and care provided based on documentation in the health record.

        ii. Ability to communicate with clinical staff for specific coding and documentation issues, such as recording inpatient and outpatient diagnoses and procedures, the correct sequencing of diagnoses and/or procedures, and the relationship between health record documentation and code assignment.

        iii. Ability to research and solve coding and documentation related issues.

        iv. Skill in reviewing and correcting system or processing errors and ensuring all assigned work is complete.

        v. Ability to abstract, assign, and sequence codes, including complication or comorbidity/major complication or comorbidity (CC/MCC), and POA indicators to obtain correct MS-DRG.

(5) Medical Records Technician (Coder-Outpatient and Inpatient), GS-8

    (a) **Experience.** One year of creditable experience equivalent to the next lower grade level.

(b) **Assignment.** This is the journey level for this assignment. MRTs (Coder) at this level perform the full scope of inpatient and outpatient coding duties. MRTs (Coder) select and assign codes from current versions of ICD CM, PCS, CPT, and HCPCS classification systems to both inpatient and outpatient records. Inpatient duties consist of the performance of a comprehensive review of documentation within the health record to assign ICD CM and PCS codes for diagnosis, complications/major complications, comorbid/major comorbid conditions, surgery, and procedures for accurate assignment of DRGs. Outpatient duties consist of the performance of a comprehensive review of documentation within the health record to accurately assign ICD CM codes for diagnosis and complications, and CPT/HCPCS codes for surgeries, procedures, evaluation and management services, and inpatient professional services. They independently review and abstract clinical data from the record for documentation of diagnoses and procedures to ensure it is adequate and appropriate to support the assigned codes. They code all complicated and complex medical/specialty diseases processes, patient injuries, and all medical procedures in a wide range of ambulatory/inpatient settings and specialties. They directly consult with the clinical staff for clarification of conflicting, incomplete, or ambiguous clinical data in the health record. They abstract, assign, and sequence codes into encoder software to obtain correct diagnosis-related DRG, support medical necessity, resolve encoder edits, and ensure codes accurately reflect services rendered. They review provider health record documentation to ensure that it supports diagnostic and procedural codes assigned, and is consistent with required medical coding nomenclature. They query clinical staff with documentation requirements to support the coding process. They enter and correct information that has been rejected, when necessary. They correct any identified data errors or inconsistencies. They also ensure audit findings have been corrected and refiled. They use various computer applications to abstract records, assign codes, and record and transmit data. MRTs (Coder) may be assigned to a single facility or region, such as a consolidated coding unit.

(c) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i.   Ability to analyze the health record to identify all pertinent diagnoses and procedures for coding and to evaluate the adequacy of the documentation. This includes the ability to read and understand the content of the health record, the terminology, the significance of the comments, and the disease process/pathophysiology of the patient.

ii. Ability to accurately perform the full scope of outpatient coding, including ambulatory surgical cases, diagnostic studies and procedures, and outpatient encounters, and inpatient facility coding, including inpatient discharges, surgical cases, diagnostic studies and procedures, and inpatient professional services.

iii. Skill in interpreting and adapting health information guidelines that are not

completely applicable to the work, or have gaps in specificity, and the ability to use judgment in completing assignments using incomplete or inadequate guidelines.

(6) **Medical Records Technician (Clinical Documentation Improvement Specialist (CDIS-Outpatient)), GS-9**

    (a) **Experience.** One year of creditable experience equivalent to the journey grade level of a MRT (Coder-Outpatient);

    OR,

An associate's degree or higher and three years of experience in clinical documentation improvement (candidates must also have successfully completed coursework in medical terminology, anatomy and physiology, medical coding, and introduction to health records);

    OR,

Mastery level certification through AHIMA or AAPC and two years of experience in clinical documentation improvement;

NOTE: See the definitions section of this standard (paragraph 2g above) for a detailed definition of mastery level certification.

OR,

Clinical experience, such as Registered Nurse (RN), Medical Doctor (M.D.), or Doctor of Osteopathy (DO), and one year of experience in clinical documentation improvement.

    (b) **Certification.** Employees at this level must have either a mastery level certification or a Clinical Documentation Improvement Certification.

NOTE: See the definitions section of this standard (paragraph 2g and 2h) for a detailed definition of mastery level certification and clinical documentation improvement certification.

    (c) **Assignment**. For all assignments above the journey level, the higher-level duties must consist of significant scope, complexity (difficulty), range of variety, and be performed by the incumbent at least 25% of the time. Outpatient CDISs must be able to perform all duties of a MRT (Coder-Outpatient). CDISs serve as the liaison between health information management and clinical staff. They are responsible for facilitating improved overall quality, education, completeness, and accuracy of health record documentation through extensive interaction with clinical, coding, and other associated staff to ensure clinical documentation supports services rendered to patients, appropriate workload, and resource allocations. They review documentation and facilitate modifications to the health record to ensure accurate complexity of care and utilization of resources. They identify opportunities for documentation improvement by ensuring that diagnoses and procedures are documented to the highest level of specificity, accurately address all acute and

chronic conditions, and reflect the true health status of patients. They recommend changes and/or updates to medical center policy pertaining to clinical documentation improvement. They serve as a technical expert in health record content and documentation requirements. They query clinical staff to clarify ambiguous, conflicting, or incomplete documentation. They review appropriateness of and responses to queries through review of query reports. They are responsible for performing reviews of the health record documentation, developing criteria, collecting data, graphing and analyzing results, creating reports, and communicating orally and/or in writing to appropriate leadership and groups. They obtain appropriate corrective action plans from responsible clinical service directors and recommend improvements or changes in documentation practices when applicable. They adhere to established documentation requirements as outlined by accrediting agencies guidelines, regulations, policies, and medical-legal requirements. They monitor trends in the industry and/or changes in regulations that could or should impact coding and documentation practices and identify who may require education. They are responsible for the development and implementation of active training/education programs (i.e., seminars, workshops, short courses, informational briefings, and conferences) for all clinical staff to ensure the CDIS program objectives are met. They provide training in small or large groups, educating clinical staff about current documentation standards and improvement techniques including accurate and ethical documentation practices. They apply applicable coding conventions and guidelines to accurately reflect medical necessity and level of service or procedure performed in the outpatient setting.

(d) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Knowledge of coding and documentation concepts, guidelines, and clinical terminology.

ii. Knowledge of anatomy and physiology, pathophysiology, and pharmacology in order to interpret and analyze all information in a patient's health record, including laboratory and other test results, to identify opportunities for more precise and/or complete documentation in the health record.

iii. Ability to collect and analyze data and present results in various formats, which may include presenting reports to various organizational levels.

iv. Ability to establish and maintain strong verbal and written communication with providers.

v. Knowledge of regulations that define healthcare documentation requirements, including The Joint Commission, CMS, and VA guidelines.

vi. Extensive knowledge of coding rules and regulations to include current

clinical classification systems (such as ICD, CPT, and HCPCS).

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Knowledge of CPT Evaluation and Management (E/M) criteria to ensure the correct selection of E/M codes that match patient type, setting of service, and level of E/M service provided.
Knowledge of training methods and teaching skills sufficient to conduct continuing education for staff development. The training sessions may be technical in nature or may focus on teaching techniques for the improvement of clinical documentation issues.

(7) **Medical Records Technician (Clinical Documentation Improvement Specialist (CDIS - Inpatient)), GS-9**

(a) **Experience.** One year of creditable experience equivalent to the journey grade level of a MRT (Coder-inpatient);

OR,

An associate's degree or higher, and three years of experience in clinical documentation improvement (candidates must also have successfully completed coursework in medical terminology, anatomy and physiology, medical coding, and introduction to health records);

OR,

Mastery level certification through AHIMA or AAPC, and two years of experience in clinical documentation improvement;

NOTE: See paragraph 2g above for a detailed definition of mastery level certification.

OR,

Clinical experience such as RN, M.D., or DO, and one year of experience in clinical documentation improvement.

(b) **Certification.** Employees at this level must have either a mastery level certification or a clinical documentation improvement certification.

NOTE: See paragraph 2g and 2h for a detailed definition of mastery level certification and clinical documentation improvement certification.

(c) **Assignment**. For all assignments above the journey level, the higher-level duties must consist of significant scope, complexity (difficulty), range of variety, and be performed by the incumbent at least 25% of the time. Inpatient CDISs must be able to perform all duties of a MRT (Coder-Inpatient). CDISs serve as the liaison between health information management and clinical staff. They are

responsible for facilitating improved overall quality, education, completeness, and accuracy of health record documentation through extensive interaction with clinical, coding, and other associated staff to ensure clinical documentation supports services rendered to patients, appropriate workload is captured, and resources are properly allocated. They review documentation and facilitate modifications to the health record to ensure accurate severity of illness, risk of mortality, complexity of care, and utilization of resources. They identify opportunities for documentation improvement by ensuring that diagnoses and procedures are documented to the highest level of specificity. They recommend changes and/or update medical center policy pertaining to clinical documentation improvement. They serve as a technical expert in health record content and documentation requirements. They query clinical staff to clarify ambiguous, conflicting, or incomplete documentation. They review appropriateness of and responses to queries through review of query reports. They perform reviews of the health record documentation, developing criteria, collecting data, graphing and analyzing results, creating reports, and communicating orally and/or in writing to appropriate groups and leadership. They obtain appropriate corrective action plans from responsible clinical service directors and recommend improvements or changes in documentation practices, when applicable. They adhere to established documentation requirements as outlined by accrediting agencies guidelines, regulations, policies, and medical-legal requirements. They monitor trends in the industry and/or changes in regulations that could or should impact coding and documentation practices and identify who may require education. They are responsible for the development and implementation of active training/education programs (i.e., seminars, workshops, short courses, informational briefings, and conferences) for all clinical staff to ensure the CDIS program objectives are met. They provide training in small or large groups, educating clinical staff about current documentation standards and improvement techniques, including accurate and ethical documentation practices. They apply applicable coding conventions and guidelines to identify the principal and secondary diagnoses, and complete significant procedures to accurately reflect the patient's hospital course and DRG assignment in the inpatient setting.

(d) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Knowledge of coding and documentation concepts, guidelines, and clinical terminology.

ii. Knowledge of anatomy and physiology, pathophysiology, and pharmacology in order to interpret and analyze all information in a patient's health record, including laboratory and other test results, to identify opportunities for more precise and/or complete documentation in the health record.

iii. Ability to collect and analyze data and present results in various formats, which may include presenting reports to various organizational levels.

iv. Ability to establish and maintain strong verbal and written communication with providers.

v. Knowledge of regulations that define healthcare documentation requirements, including The Joint Commission, CMS, and VA guidelines.

vi. Extensive knowledge of coding rules and regulations, to include current clinical classification systems such as ICD CM and PCS. They must also possess a knowledge of complication or comorbidity/major complication or comorbidity (CC/MCC), MS-DRG structure, and POA indicators.

vii. Knowledge of severity of illness, risk of mortality, and complexity of care.

viii. Knowledge of training methods and teaching skills sufficient to conduct continuing education for staff development. The training sessions may be technical in nature or may focus on teaching techniques for the improvement of clinical documentation issues.

(8) **Medical Records Technician (Clinical Documentation Improvement Specialist (CDIS-Outpatient and Inpatient)), GS-9**

(a) **Experience.** One year of creditable experience equivalent to the journey grade level of a MRT (Coder-Outpatient and Inpatient);

OR,

An associate's degree or higher, and three years of experience in clinical documentation improvement (candidates must also have successfully completed coursework in medical terminology, anatomy and physiology, medical coding, and introduction to health records);

OR,

Mastery level certification through AHIMA or AAPC and two years of experience in clinical documentation improvement;

NOTE: See paragraph 2g for a detailed definition of mastery level certification.

OR,

Clinical experience such as RN, M.D., or DO, and one year of experience in clinical documentation improvement.

(b) **Certification.** Employees at this level must have either a mastery level certification or a clinical documentation improvement certification.

NOTE: See paragraph 2g and 2h for a detailed definition of mastery level certification and clinical documentation improvement certification.

(c) **Assignment.** For all assignments above the journey level, the higher-level duties must consist of significant scope, complexity (difficulty), range of variety, and be performed by the incumbent at least 25% of the time. CDISs must be able to perform all duties of a MRT (Coder-Outpatient and Inpatient). CDISs serve as the liaison between health information management and clinical staff. They are responsible for facilitating improved overall quality, education, completeness and accuracy of health record documentation through extensive interaction with clinical, coding, and other associated staff to ensure clinical documentation supports services rendered to patients, appropriate workload is captured, and resources are properly allocated. They review documentation and facilitate modifications to the health record to ensure accurate severity of illness, risk of mortality, complexity of care, and utilization of resources. They identify opportunities for documentation improvement by ensuring that diagnoses and procedures are documented to the highest level of specificity, accurately address all acute and chronic conditions, and reflect the true health status of patients. They recommend changes and/or update medical center policy pertaining to clinical documentation improvement. They serve as a technical expert in health record content and documentation requirements. They query clinical staff to clarify ambiguous, conflicting, or incomplete documentation. They review appropriateness of and responses to queries through review of query reports. They review health record documentation, develop criteria, collect data, graph and analyze results, create reports, and communicate orally and/or in writing to appropriate groups and leadership. They obtain appropriate corrective action plans from responsible clinical service directors and recommend improvements or changes in documentation practices, when applicable. They adhere to established documentation requirements as outlined by accrediting agencies guidelines, regulations, policies, and medical-legal requirements. They monitor trends in the industry and/or changes in regulations that could, or should, impact coding and documentation practices and identify who may require education. They are responsible for the development and implementation of active training/education programs (i.e., seminars, workshops, short courses, informational briefings, and conferences) for all clinical staff to ensure the CDIS program objectives are met. They provide training in small or large groups, educating clinical staff about current documentation standards and improvement techniques, including accurate and ethical documentation practices. They apply applicable coding conventions and guidelines to identify the principal and secondary diagnoses and complete significant procedures to accurately reflect the patient's hospital course and DRG assignment in the inpatient setting. These are also applied to accurately reflect medical necessity and level of service or procedure performed in the outpatient setting.

(d) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Knowledge of coding and documentation concepts, guidelines, and clinical

terminology.

ii. Knowledge of anatomy and physiology, pathophysiology, and pharmacology to interpret and analyze all information in a patient's health record, including laboratory and other test results to identify opportunities for more precise and/or complete documentation in the health record.

iii. Ability to collect and analyze data and present results in various formats, which may include presenting reports to various organizational levels.

iv. Ability to establish and maintain strong verbal and written communication with providers.

v. Knowledge of regulations that define healthcare documentation requirements, including The Joint Commission, CMS, and VA guidelines.

vi. Extensive knowledge of coding rules and regulations, to include current clinical classification systems such as ICDCM and PCS, CPT, and HCPCS. They must also possess knowledge of complication or comorbidity/major complication or comorbidity (CC/MCC), MS-DRG structure, and POA indicators.

vii. Knowledge of severity of illness, risk of mortality, complexity of care for inpatients, and CPT Evaluation and Management (E/M) criteria to ensure the correct selection of E/M codes that match patient type, setting of service, and level of E/M service provided for outpatients.

viii. Knowledge of training methods and teaching skills sufficient to conduct continuing education for staff development. The training sessions may be technical in nature or may focus on teaching techniques for the improvement of clinical documentation issues.

(9) **Medical Records Technician (Coder) Auditor, GS-9**

(a) Auditor assignments can be established for any of the coder subspecialties (outpatient, inpatient, or outpatient and inpatient combined). The subspecialty will be reflected in the title, e.g., MRT (Coder) Auditor (Outpatient).

(b) **Experience.** One year of creditable experience equivalent to the journey grade level of a MRT (Coder).

(c) **Certification.** Employees at this level must have a mastery level certification.

NOTE: See paragraph 2g for a detailed definition of mastery level certification.

(d) **Assignment.** For all assignments above the journey level, the higher-level duties must consist of significant scope, complexity (difficulty), range of variety, and be performed by the incumbent at least 25% of the time. Auditors must be able to perform all duties of a MRT (Coder). Auditors serve as experts of current coding conventions and guidelines related to professional and facility coding.

Auditors perform audits of encounters to identify areas of non-compliance in coding. They facilitate improved overall quality, completeness, and accuracy of coded data. They provide recommendations on appropriate coding and are responsible for maintaining current knowledge of the various regulatory guidelines and requirements. They assist facility staff with documentation requirements to completely and accurately reflect the patient care provided. They provide technical support in the areas of regulations and policy, coding requirements, resident supervision, reimbursement, workload, accepted nomenclature, and proper sequencing. They directly consult with the clinical staff for clarification of conflicting or ambiguous clinical data. They use computer applications with varied functions to produce a wide range of reports, to abstract records, and review assigned codes. They perform prospective and retrospective coding audits and use results to identify documentation, coding inadequacies, and re-educate clinical and coding staff based on audit results. They act independently to plan, organize, and perform auditing with emphasis on data validation, analysis, and generation of reports. They assist in the development of guidelines for data quality, consistency, and monitoring for compliance to improve the quality of clinical, financial, and administrative data. They ensure that all coded data is fully documented and supported. They maintain statistical database(s) to track the results and validate the program. They identify patterns and variations in coding practices with regular reports to the medical staff and management.

(e) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Advanced knowledge of current coding classification systems such as ICD, CPT, and HCPCS for the subspecialty being assigned (outpatient, inpatient, outpatient and inpatient combined).

ii. Ability to research and solve complex questions related to coding conventions and guidelines in an accurate and timely manner.

iii. Ability to review coded data and supporting documentation to identify adherence to applicable standards, coding conventions and guidelines, and documentation requirements.

iv. Ability to format and present audit results, identify trends, and provide guidance to improve accuracy.

v. Skill in interpersonal relations and conflict resolution to deal with individuals at all organizational levels.

(10) **Lead Medical Records Technician (Coder), GS-9**

(a) Lead coder assignments can be established for any of the coder subspecialties

(outpatient, inpatient, outpatient and inpatient combined). The subspecialty will be reflected in the title, e.g., Lead MRT (Coder-Outpatient).

(b) **Experience.** One year of creditable experience equivalent to the journey grade level MRT (Coder).

(c) **Certification.** Employees at this level must have a mastery level certification.

NOTE: See paragraph 2g for a detailed definition of mastery level certification.

(d) **Assignment.** For all assignments above the journey level, the higher-level duties must consist of significant scope, complexity (difficulty), range of variety, and be performed by the incumbent at least 25% of the time. Lead MRTs (Coder) must be able to perform all duties of a MRT (Coder). Lead MRTs (Coder) review coding and assist MRTs (Coder) in ensuring timeliness and improving coding accuracy; provide coding guidance to various levels of staff to promote consistency in practice and compliance with coding rules and regulations; initiate, prepare, and maintain various reports, and analyze data; and may also coordinate, assign, and monitor workflow. They provide input for performance evaluations and hiring. They orient and instruct new coding personnel and/or students on coding, abstracting, and use of the electronic health record and encoder software. They ensure audit findings and claim denials related to coding errors are resolved and/or daily coding rejects corrected for accurate billing and data collection. They monitor trends and/or changes in regulatory and policy requirements affecting coding practices and identify educational needs. They develop coding training materials and present a curriculum encompassing ongoing training initiatives. They provide assistance with coding inquiries from providers, MRTs (Coder), billers, and other facility staff. Lead MRTs whose assignments involve two or more MRT specialty areas will be assigned the parenthetical title for the predominant specialty area. Lead MRTs (Coder) may be at a facility or in a consolidated coding unit (CCU).

(e) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Ability to work with a team to provide technical guidance, plan, organize, and coordinate activities in order to effectively complete job duties of assignment, such as distributing workload, monitoring the status and progress of work, monitoring accuracy of work, etc.

ii. Advanced knowledge of current coding classification systems for the subspecialty being assigned (outpatient, inpatient, outpatient and inpatient combined) and the ability to research and solve complex questions related to coding conventions and guidelines in an accurate and timely manner.

iii. Ability to effectively communicate, both orally and in writing, in order to

meet program objectives.

    <u>iv.</u> Knowledge of training methods and the ability to provide training to new coding staff.

    <u>v.</u> Ability to collect and analyze data and present results in various formats, which may include presenting reports to various organizational levels.

    <u>vi.</u> Leadership skills, including interpersonal relations and conflict resolution between employees, managers, and clinical staff.

(11) **Supervisory Medical Records Technician (Coder), GS-10**

    (a) Supervisory coder assignments can be established for any of the coder subspecialties (outpatient, inpatient, outpatient and inpatient combined). The subspecialty will be reflected in the title, e.g., Supervisory MRT (Coder-Outpatient).

    (b) **Experience.** One year of creditable experience equivalent to the next lower grade level.

    (c) **Certification.** Employees at this level must have a mastery level certification.

    NOTE: See paragraph 2g for a detailed definition of mastery level certification.

    (d) **Assignment.** For all assignments above the journey level, the higher-level duties must consist of significant scope, complexity (difficulty), range of variety, and be performed by the incumbent at least 25% of the time. Supervisory MRTs (Coder) are responsible for supervising coding staff at the facility level. Supervisory MRTs (Coder) must be able to perform all duties of a MRT (Coder). The supervisory coder is responsible for the supervision, administrative management, and direction of coding staff. They are responsible for program management of a coding section/unit to ensure performance monitors are established and met. They perform a full range of supervisory responsibilities, to include evaluating the performance of subordinate staff, approving sick and annual leave requests, identifying educational or training needs, resolving employee complaints, and taking disciplinary actions, when necessary. They inform higher level management of anticipated vacancies or increases in workload. They recommend employees for promotions, reassignments, recognitions, retention or release of probationary employees, or other changes of assigned personnel. They make decisions on the selection of employees for vacant or new positions. They serve as an expert coding resource to ensure accuracy and integrity of all coding. They collaborate with revenue, compliance, and other departments to support coding accuracy that is consistent with the official guidelines for coding and reporting. They resolve claim edits referred to coding management and monitor reports for outstanding services, rejects, or uncoded episodes of care for inpatients and/or outpatients. The supervisory coder ensures claim denials related to coding errors are resolved, and/or daily coding rejects are corrected for accurate billing and data collection. They provide education to clinical and coding staff. They assess current audit findings and evaluate impact to coding and documentation practices. They oversee the reporting of coding and

documentation audit results to leadership. They collect and prepare data for studies involving inpatient stays and outpatient encounters for clinical evaluation purposes, prepare and maintain a variety of complex records and daily, monthly, or "on demand" reports, as requested. The supervisory coder creates and monitors outpatient reports, inpatient case mix reports, top DRGs, and key performance indicators to identify patterns, trends, and variations. They investigate and evaluate potential causes for changes or problems and collaborate with the appropriate staff to effect resolution or explain variances. They participate in the formulation of objectives and strategies utilizing coded data to support goals for patient care, teaching, research, and optimizing management of resources. Supervisory MRTs whose assignments involve two or more MRT specialty areas will be assigned the parenthetical title for the predominant specialty area.

(e) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

i. Ability to perform a full range of supervisory duties, to include recommending awards, approving leave, evaluating work, resolving staff issues, and assigning, planning, and coordinating work to ensure duties are completed in an accurate and timely fashion.

ii. Advanced knowledge of current coding classification systems such as ICD, CPT, and HCPCS for the subspecialty being assigned (outpatient, inpatient, outpatient and inpatient combined).

iii. Ability to provide or coordinate staff development and training.

iv. Leadership and managerial skills, including skill in interpersonal relations and conflict resolution to deal with employees, team leaders, and managers.

v. Ability to collect and analyze data, identify trends, and present results in various formats.

(12) **Supervisory Medical Records Technician (Coder) (Consolidated Coding Unit (CCU)), GS-10**

(a) **Consolidated Coding Unit (CCU).** Supervisory coder (CCU) assignments can be established for any of the coder subspecialties (outpatient, inpatient, outpatient and inpatient combined). The subspecialty will be reflected in the title, e.g., Supervisory (Coder-Outpatient) CCU.

(b) **Experience.** One year of creditable experience equivalent to the next lower grade level.

(c) **Certification.** Employees at this level must have a mastery level certification.

NOTE: See paragraph 2g for a detailed definition of mastery level certification.

(d) **Assignment.** For all assignments above the journey level, the higher-level duties must consist of significant scope, complexity (difficulty), range of variety,

and be performed by the incumbent at least 25% of the time. Supervisory MRTs (Coder) (CCU) are responsible for supervising coding staff within an entire network or region, such as a consolidated coding unit or VISN coding pool. They collaboratively work with the Chief HIM at each facility within the assigned region/network in order to coordinate work related to the consolidated coding unit and resolve any problems which could impede the progress of the unit. They coordinate and maintain effective communication with the medical centers and CPAC within an assigned region/network in order to accomplish coding assignments for the consolidated coding unit. Supervisory MRTs (Coder) (CCU) must be able to perform all duties of a MRT (Coder). The supervisory coder performs a full range of supervisory responsibilities, to include evaluating the performance of subordinate staff, approving sick and annual leave requests, identifying educational or training needs, resolving employee complaints, and taking disciplinary actions. They inform higher level management of anticipated vacancies or increases in workload. They recommend employees for promotions, reassignments, recognitions, retention or release of probationary employees, or other changes of assigned personnel. They make decisions on the selection of employees for vacant or new positions. They serve as an expert coding resource to ensure accuracy and integrity of all coding. They collaborate with revenue, compliance, and other departments to support coding accuracy that is consistent with the official guidelines for coding and reporting. They resolve claim edits referred to coding management and monitor reports for outstanding services, rejects, or uncoded discharges for inpatients and/or outpatients. They resolve claim denials related to coding errors and ensure coding corrections and rebilling, as required. They provide education to clinical and coding staff. They assess current audit findings activities and evaluate impact to coding and documentation practices. The supervisory coder oversees the reporting of coding and documentation audit results to leadership. They collect and prepare data for studies involving inpatient stays and outpatient encounters for clinical evaluation purposes, prepare and maintain a variety of complex records and daily, monthly, or "on demand" reports, as requested. They create and monitor outpatient reports, inpatient case mix reports, top DRGs, and key performance indicators to identify patterns, trends, and variations, investigate and evaluate potential causes for changes or problems, and take appropriate steps, in collaboration with the appropriate staff, to effect resolution or explain variances. They participate in the formulation of objectives and strategies using coded data to support goals for patient care, teaching, research, and optimizing management of resources.

(e) **Demonstrated Knowledge, Skills, and Abilities.** In addition to the experience above, the candidate must demonstrate all of the following KSAs:

     i.   Ability to perform a full range of supervisory duties, to include recommending awards, approving leave, evaluating work, resolving staff issues, and assigning, planning, and coordinating work to ensure duties are completed in an accurate and timely fashion.

     ii.   Advanced knowledge of current coding classification systems such as ICD, CPT, and HCPCS for the subspecialty being assigned (outpatient, inpatient, outpatient and inpatient combined).

     iii.   Ability to provide or coordinate staff development and training.

     iv.   Leadership and managerial skills, including skill in interpersonal relations and conflict resolution to deal with employees, team leaders, and managers.

     v.   Ability to collect and analyze data, identify trends, and present results in various formats.

7. DEVIATIONS.

a. The appointing official may, under unusual circumstances, approve reasonable deviations to the grade determination requirements for MRTs in VHA whose composite record of accomplishments, performance, and qualifications, as well as current assignments, warrants such action, based on demonstrated competence to meet the requirements of the proposed grade.

b. Under no circumstances will the certification requirements be waived.

c. The placement of individuals in grade levels or assignments not described in this standard must be approved by the Under Secretary for Health, or designee, in VHA Central Office.

RESPONSIBLE OFFICE: Human Resources and Administration/Operations, Security and Preparedness (HRA/OSP) (006), Office of the Chief Human Capital Officer (OCHCO) (05), Recruitment and Placement Policy Service (059)