Occupation: Medical Records and Health Information Technicians/Medical Coders	ONET Code 29-2071.00
	RAPIDS Code 1114

OCCUPATIONAL OVERVIEW

Potential Job Titles: Coding professional, medical coder, hospital coder, coding auditor, certified coding professional, coding validator, coder, health information clerk, health information specialist, health information technician, medical records analyst, medical records technician, registered health information technician (RHIT), medical records and health information technician, clincal data analyst

Occupational Context: The Coding Professional is responsible for assigning clinical classification codes for medical services. The coding professional effectively uses abstracting databases, internal and external audit results, QIO reports and revenue cycle edit/ denial information and serves as a resource to the clincial team. This position requires effective interaction with coding staff, clinical staff, and different levels of management throughout the healthcare system.

Occupational Purpose: The Coding Professional will use coding conventions and guidelines to abstract, analyze, and accurately assign ICD (International Classification of Diseases), CPT (Current Procedural Terminology), and other classification systems (e.g., SNOMED, ICD-O, DSM V) principle and secondary diagnostic and procedural codes to inpatient, ambulatory, and outpatient medical records. The Coding Professional will query physicians when diagnosis is unclear, audit records, and perform peer reviews. This position must utilize encoder, grouper, and other Health Information Management software often including Electronic Health Records. Job requirements may include a current credential such as RHIA (Registered Health Information Administrator), RHIT (Registered Health Information Technician), CCA (Certified Coding Associate) or other designated credential from a nationally recognized organization.

Occupational Pathways: Promotional paths – coding manager, coding trainer, HIM manager
Transitional paths – DRG validator, health information technician

Attitudes & Behaviors: The coding professional must be able to process and synthesize information effectively and efficiently, maintain high levels of patient confidentiality and ensure effective interaction with both coding staff and different levels of management throughout the healthcare system.

Prerequisites for Apprenticeship:

Certification or Licensure

Credential	Awarding Body	Timing Before, During or After Apprenticeship
Certified Coding Associate (CCA)	American Health Information Management Association (AHIMA)	After
Certified Coding Specialist (CCS)	AHIMA	After
Registered Health Information Administrator (RHIA)	AHIMA	After
Registered Health Information Technician (RHIT)	AHIMA	After
Certified Professional Coder (CPC)	American Association of Professional Coders (AAPC)	After
Certified Coding Specialist - Physician Based (CCS-P)	AHIMA	After
Certified Inpatient Coder (CIC)	AAPC	After
Certified Outpatient Coder (COC)	AAPC	After

Trade Associations and Labor Organizations:

American Health Information Management Association (AHIMA)
American Association of Professional Coders (AAPC)

Accreditors:

Commission on Accreditation for Health Informatics and Information Management (CAHIIM)

Commission on Healthcare Management Education (CAHME)

Size of Current Workforce: 188,660		
Number of additional job openings predicted (2014-2024): 71,200		
Median Salary (2014): $52,677		
Job Function 1: Properly applies diagnosis and procedure codes to medical charts, records and related documents		
Job Function 2: Supports documentation of care for services provider reimbursement process to ensure timely and accurate payment		
Job Function 3: Maintains accurate and complete patient health records		
Job Function 4: Ensures compliance with healthcare law, regulations and standards related to information protection, privacy, security and confidentiality		
Job Function 5: Maintains appropriate technology solutions including health information systems to support health care delivery and organizational priorities		

CROSS-CUTTING COMPETENCIES (These come from the Competency Model Clearinghouse)

Personal Effectiveness Competencies

	Relevance (Using Lumina Beta Credentials Framework)	0	1	2	3	4	5
	Interpersonal Skills			X			
	Integrity					X	
	Professionalism				X		
	Initiative				X		
	Reliability						
	Dependability & Reliability						
	Adaptability & Flexibility				X		
	Lifelong Learning					X	

Academic Competencies

	Relevance (Based on Lumina Beta Credentials Framework)	0	1	2	3	4	5
	Reading						
	Writing						
	Mathematics						
	Science & Technology						
	Communication						
	Critical & Analytical Thinking				X		
	Basic Computer Skills					X	

Workplace Competencies

	Relevance (Based on Lumina Beta Credentials Framework)	0	1	2	3	4	5
	Teamwork						
	Customer Focus						
	Planning & Organization						
	Creative Thinking						
	Problem Solving & Decision Making						
	Working with Tools & Technology						
	Scheduling & Coordinating						
	Checking, Examining & Recording						
	Business Fundamentals						
	Sustainable Practices						
	Health & Safety						

Certifications Available		
Certified Coding Associate (CCA)		
Certified Coding Specialist (CCS)		
Registered Health Information Administrator (RHIA)		
Registered Health Information Technician (RHIT)		
Certified Professional Coder (CPC)		
Certified Coding Specialist - Physician Based (CCS-P)		
Certified Inpatient Coder (CIC)		
Certified Outpatient Coder (COC)		

WORK PROCESS SCHEDULE		ONET Code 29-2071.00 RAPIDS Code 1114

Job Title

Company Contact:

Apprenticeship Type: (competency based, time based, hybrid)

Minimum Time Requirements (or time range):

Required Certifications:

JOB FUNCTION	Core/ Optional	OJT	RI
JOB FUNCTION 1: Properly applies diagnosis and procedure codes to medical charts, records and related documents	Core		
Competency 1a: Enters or confirms code(s) associated with medical diagnosis(es), procedures, and services			
Competency 1b: Ensures medical codes reflect medical record documentation			
JOB FUNCTION 2: Supports documentation of care for services provider reimbursement process to ensure timely and accurate payment	Core		
Competency 2a: Ensures accuracy of diagnosis/procedural groups such as DRG (Diagnosis Related Group), MSDRG (Medical Severity), APC (Ambulatory Payment Classification), etc.			
Competency 2b: Communicates with physicians or other care providers to ensure appropriate documentation			
Competency 2c: Applies policies and procedures to comply with changing regulations among various payment systems for healthcare services, such as Medicare, Medicaid, managed care, etc.			
Competency 2d: Applies policies and procedures for the use of clinical data required in reimbursement and prospective payment systems (PPS) in healthcare delivery			
Competency 2e: Supports accurate billing through coding, chargemaster, claims management and bill reconciliation processes			
Competency 2f: Ensures accuracy of diagnostic/procedural groupings such as DRG and APC			
Competency 2g: Resolves discrepancies between coded data and supporting documentation			
JOB FUNCTION 3: Maintains accurate and complete patient health records	Core		
Competency 3a: Compiles patient data and performs data quality reviews to validate code assignment and compliance with reporting requirements			
Competency 3b: Ensures that medical records are complete, including medical history, care or treatment plans, tests ordered, test results, diagnosis and medications taken			
Competency 3c: Verifies consistency between diagnosis and treatment plans, procedures and services			
JOB FUNCTION 4: Ensures compliance with healthcare law, regulations and standards related to information protection, privacy, security and confidentiality	Core		
Competency 4a: Participates in compliance (fraud and abuse), HIPAA (Health Insurance Portability and Accountability Act of 1996), and other organization specific training			
Competency 4b: Validates coding accuracy using clinical information found in the health record			
Competency 4c: Adheres to current regulations and establish guidelines in code assignment (focus on assignment of principle diagnosis, principle procedure, and sequencing as well as other clinical coding guidelines			

Competency 4d: Uses established guidelines to compy with reimbursement and reporting requirements such as the National Correct Coding Initiatve and others			
JOB FUNCTION 5: Maintains appropriate technology solutions including health information systems to support health care delivery and organizational priorities	Optional		
Competency 5a: Specifies, refines, updates, produces and makes available a formal approach to implement information and communication technology solutions necessary to develop and operate the health information system architecture in support of the organization			
Competency 5b: Stays apprised of innovative solutions for integration of new technology into existing products, applications or services			
Competency 5c: Identifies and clarifies user needs (internal and external customers) and organizational policies to ensure system architecture and applications are in line with business requirements			
Competency 5d: Uses and maintains applications and processes to support other clinical classification and nomenclature as appropriate (eg. DSM-V - Diagnostic and Statistical manual of Mental Disorders - SNOMED-CT - Systemized Nomenclature of Medicine -Clinical terms, etc.)			
JOB FUNCTION 6:			
JOB FUNCTION 7:			
JOB FUNCTION 8:			

Job Function 1: Properly applies diagnosis and procedure codes to medical charts, records and related documents		LEVEL	Required	Optional
	RELATED INSTRUCTION			
	Skills			
	Use of computer systems			
	Accurate data entry			
	Intepreting medical records or notes to determine appropriate codes			
	Knowledge & Understanding			
	Medical diagnosis codes (ICD-10, DSM V, etc.)			
	Medical procedure codes (CPT, ICD-10-PCS, etc.)			
	Use of and interoperability between health information systems			
	A&P, disease process, medical terminology, pathophysiology			
	Tools & Technologies			
	Electronic medical records			
	Electronic encoders			
	Health information systems			
	Computers, faxes, phones, handheld devices			
	Printers			
	Competency a: Enters or confirms code(s) associated with medical diagnosis(es), procedures, and services	Basic	X	
	Performance Standards			
	Identifies correct patient record			
	Selects correct codes for patient diagnoses, procedures or services			
	Enters or confirms data from patient chart in electronic health information system			
	Seeks clarification about notes, diagnoses or treatments when appropriate			
	Competency b: Ensures medical codes reflect medical record documentation	Basic	X	
	Performance Standards			
	Accurately assign MSDRGs and APCs			
	Query physicians/care providers when appropriate			

Job Function 2: Supports documentation of care for services provider reimbursement process to ensure timely and accurate payment		LEVEL	Required	Optional
	RELATED INSTRUCTION			
	Skills			
	Data entry			
	Customer services			
	Communication with care providers and other medical professionals			
	Ability to read insurance guidelines, policies and procedures			
	Ability to memorize standard codes			
	Knowledge & Understanding			
	Medical diagnosis, services and procedures			
	Insurance company and payment system policies and regulations regarding payment and reimbursement			
	Medical ethics and prevention of medical or billing fraud			
	Policies and procedures for use of clinical data in reimbursement and prospective payment systems			
	Tools & Technologies			
	Computer-based electronic health records			
	Encoders			
	Health information systems			
	Handheld devices			
	Competency a: Ensures accuracy of diagnosis/procedural groups such as DRG (Diagnosis Related Group), MSDRG (Medical Severity), APC (Ambulatory Payment Classification), etc.	Basic	X	
	Performance Standards			
	Reviews medical records to ensure accuracy and completeness of diagnostic/procedural codes			
	Identifies errors or misalignment in diagnostic/procedural codes and seeks clarification			
	Helps identify appropriate code for unusual or complex diagnosis or procedures			
	Competency b: Communicates with physicians or other care providers to ensure appropriate documentation	Basic	X	
	Performance Standards			
	Explains the need for accurate coding and helps care provider identify accurate codes			
	Respectfully challenges codes when errors or potential errors or inconsistencies are identified			
	Explains coding policies related to federal, state or individual insurance payment system requirements			
	Follows appropriate reporting procedures when concerned about instances of potential medical fraud			
	Queries physician for clarification prior to code assignment when there is conflicting or incomplete information in the health record, and creates physician queries in a compliant manner			
	Competency c: Applies policies and procedures to comply with changing regulations among various payment systems for healthcare services, such as Medicare, Medicaid, managed care, etc.	Basic	X	
	Performance Standards			
	Conducts research to clarify policies and regulations regarding payment systems			
	Reads professional notices or literature to identify changes or potential in policies or regulations			
	Identifies internal policies or practices that are inconsistent with current payment system policies or regulations			
	Creates or updates internal policies to conform with current payment system requirements			
	Educates others about payment system policies and regulations			
	Competency d: Applies policies and procedures for the use of clinical data required in reimbursement and prospective payment systems (PPS) in healthcare delivery	Basic	X	
	Performance Standards			
	Identifies proper codes to ensure accurate and timely reimbursement			
	Identifies errors prior to submitting records to payment systems to ensure timely processing			
	Follows up on reimbursement processing to ensure timely handling and to resolve questions or disputes quickly			
	Maintains accurate patient and account reimbursement records			
	Submits reimbursement claims in a timely manner and in accordance with payer policies			
	Competency e: Supports accurate billing through coding, chargemaster, claims management and bill reconciliation processes	Basic	X	

	Performance Standards			
	Maintains accurate account records			
	Identifies inconsistencies between diagnosis, procedures and services codes and payer reimbursement			
	Ensures that accounts are up-to-date and flags delinquencies			
	Troubleshoots and resolves delinquencies			
	Resolves claim disputes			
	Competency f: Ensures accuracy of diagnostic/procedural groupings such as DRG and APC	Basic	X	
	Performance Standards			
	Ensures that the correct diagnostic/procedural grouping codes are used			
	Identifies coding errors and provides correct code			
	Notifies care provider of coding errors or discrepancies			
	Competency g: Resolves discrepancies between coded data and supporting documentation	Basic	X	
	Performance Standards			
	Reviews patient records to ensure that appropriate documentation exists to support medical codes and claims			
	Identifies inconsistencies between codes and supporting documentation			
	Identifies missing documentation and takes initiative to locate it or inform care provider about missing documentation			
	Questions coding that is not supported by documents, results or diagnosis and offers correct alternatives			
	Reports instances of suspected medical fraud, incompetence or malpractice to appropriate authorities			

Job Function 3: Maintains accurate and complete patient health records	LEVEL	Required	Optional
RELATED INSTRUCTION			
Skills			
Data entry			
Interpreting medical notes to identify medical diagnoses, services or procedures			
Identifying discrepencies and follows established procedures for clarification			
Knowledge & Understanding			
Components of a complete medical record			
Basic medical terminology, diagnosis and procedures			
Services and procedures typically associated with medical diagnoses			
Federal and state laws and regulations related to medical integrity, billing and fraud prevention			
HIPAA/patient privacy laws			
Federal state laws, regulations and standards regarding accuracy and completeness of medical records			
Tools & Technologies			
Computer and electronic health records and health information systems.			
Competency a: Compiles patient data and performs data quality reviews to validate code assignment and compliance with reporting requirements	Basic	X	
Performance Standards			
Reviews records to ensure that information fields are accurate and complete			
Reviews files and notes to identify missing information and complete medical record			
Seeks appropriate authorization or information from care provider to complete files or reports as necessary			
Audits patient records to ensure accuracy and consistency between codes, supporting documentation and reimbursement claims			
Identifies instances of missing or inaccurate codes and provides training on the appropriate use of codes for future situations			
Competency b: Ensures that medical records are complete, including medical history, care or treatment plans, tests ordered, test results, diagnosis and medications taken	Basic	X	
Performance Standards			
Reviews medical file carefully and thoroughly			
Identifies missing elements of medical record			
Seeks information or assistance to complete medical record			
Requests supplemental information from care provider when records are incomplete			
Confirms patient identity to ensure that records or results are placed in the correct medical record			
Competency c: Verifies consistency between diagnosis and treatment plans, procedures and services	Basic	X	
Performance Standards			
Thoroughly reviews records to confirm consistency between treatment plans, procedures and services			
Identifies instances of inconsistency and seeks to resolve them			
Provides recommendations for correct coding based on diagnosis and care plans			

Job Function 4: Ensures compliance with healthcare law, regulations and standards related to information protection, privacy, security and confidentiality		LEVEL	Required	Optional
	RELATED INSTRUCTION			
	Skills			
	Reads, understands, and applies healthcare policies and regulations			
	Interprets and applies regulations to ensure conformance with privacy and integrity standards			
	Explains healthcare law, regulations and standards to care providers and other healthcare service providers			
	Knowledge & Understanding			
	State, federal and local laws, policies and regulations regarding data security, data accuracy and data integrity			
	Policies of healthcare payers, including Medicaid, Medicare and private insurance companies			
	Tools & Technologies			
	Electronic medical records and health information systems			
	Competency a: Participates in compliance (fraud and abuse), HIPAA (Health Insurance Portability and Accountability Act of 1996), and other organization specific training	Basic	X	
	Performance Standards			
	Participates regularly in compliance training programs and courses			
	Informs others of compliance requirements, including changes in requirements			
	Reviews organizational policies and ensures conformance to legal requirements			
	Adheres to compliance and privacy policies			
	Alerts appropriate authority when instances of potential fraud, abuse or privacy breech are identified			
	Competency b: Validates coding accuracy using clinical information found in the health record	Basic	X	
	Performance Standards			
	Identifies codes that align with clinical information in health record			
	Audits records to ensure that correct codes were utilized based on clinical notes, test results, etc.			
	Seeks correction in instances where codes do not align with or are not supported by clinical information found in health record			
	Competency c: Adheres to current regulations and establish guidelines in code assignment (focus on assignment of principle diagnosis, principle procedure, and sequencing as well as other clinical coding guidelines	Basic	X	
	Performance Standards			
	Correctly applies codes associated with various diagnoses, procedures and services			
	Identifies correct code sequencing based on clinical records			
	Identifies and corrects incorrect codes or code sequencing based on diagnosis and clinical record			
	Competency d: Uses established guidelines to compy with reimbursement and reporting requirements such as the National Correct Coding Initiatve and others	Basic	X	
	Performance Standards			
	Demonstrates understanding of reimbursement guidelines			
	Enters codes correctly in accordance with reimbursement and reporting requirements			
	Identifies coding mistakes and corrects or seeks guidance			

Job Function 5: Maintains appropriate technology solutions including health information systems to support health care delivery and organizational priorities	LEVEL	Required	Optional
RELATED INSTRUCTION			
Skills			
Supporting and reviewing research to identify new or improved system or software solutions to improve medical record maintenance			
Understanding needs and priorities of the healthcare organization to help in the selection of appropriate healthcare information management systems			
Explaining use of health information management systems and instructs others on its use			
Knowledge & Understanding			
Capacity, strengths and weaknesses of various healthcare information systems			
Healthcare information management and electronic records systems			
Clinical terminology			
Classification systems to include ICD-10, CPT, DSM-V, etc.			
Interoperability requirements and limitations			
Tools & Technologies			
Computers, tablets and hand-held communication devices			
Electronic records software			
Healthcare information systems software			
Competency a: Specifies, refines, updates, produces and makes available a formal approach to implement information and communication technology solutions necessary to develop and operate the health information system architecture in support of the organization	Intermediate		X
Performance Standards			
Understands the specifications of technology solution in use within the organization			
Communicates to appropriate authorities the benefits or limitations of the current health information system			
Makes recommendations to improve current system or procure upgrades or new systems			
Competency b: Stays apprised of innovative solutions for integration of new technology into existing products, applications or services	Intermediate		X
Performance Standards			
Understands the benefits and limitations of the health information system currently in use			
Reads trade publications to know about new solutions or products in the marketplace			
Interacts with other professionals to understand problems or solutions others in the industry are facing or have implemented			
Seeks information from product vendors, as appropriate and authorized			
Communicates to managers and care providers about solutions, products, applications or services that would help the organization meet its goals			
Competency c: Identifies and clarifies user needs (internal and external customers) and organizational policies to ensure system architecture and applications are in line with business requirements	Advanced		X
Performance Standards			
Maintains familiarity with and quickly references organizational policies			
Seeks information from users regarding their needs or concerns about the current or newly planned system			
Recommends corrections, new configurations or solutions to help organizations improve reporting and meet their business goals			
Competency d: Uses and maintains applications and processes to support other clinical classification and nomenclature as appropriate (eg. DSM-V - Diagnostic and Statistical manual of Mental Disorders - SNOMED-CT - Systemized Nomenclature of Medicine -Clinical terms, etc.)	Basic	X	
Performance Standards			
Looks up information and codes in ICD-10, CPT, DSM V, SNOMED-CT, etc.			
Uses correct nomenclature based on ICD-10, CPT, DSM V, SNOMED-CT, etc.			
Identifies instances of incorrect nomenclature and seeks correction or clarification			
Identifies instances of misalignment between diagnostic, service or procedure codes based on information in ICD-10, CPT, DSM V, SNOMED-CT, etc.			