Oroville Hospital	Job Description for Certified Coder/Abstractor	Department:	**Health Information Management**
		Dept.#:	**8700**
		Last Reviewed:	05/08; 08/12
		Last Updated:	

Reports To

Director of Health Information Management

Job Summary

The DRG Coder/Abstractor will review, analyze and accurately assign ICD-9 codes as well as appropriate Cpt-4 codes for all inpatient, inpatient Medicare, ECU and outpatient health records to generate a clinical patient database as well as assuring optimum reimbursement. The DRG Coder/Abstractor will review the medical record to assure that it has been appropriately and adequately analyzed and flagged for physician assistance in completion of the medical record.

Duties

1. The DRG Coder/Abstractor is responsible for the daily coding of the Extended Care patient admissions. The admissions must be coded initially before the fifth ECU day and then the codes will be updated and finalized upon receipt of the ECU chart in the Medical Records Department. Admission diagnosis codes will be forwarded to the ECU unit clerk for transfer to the ECU face-sheet. The business office will be notified when the coding has been finalized so that a bill is produced
2. The DRG Coder/Abstractor is responsible for the accurately encoding of the ICD-9-CM codes into the abstract maintenance and patient maintenance sections of the Medical Records Menu by the use of the computer
3. The DRG Coder/Abstractor is responsible at the time of encoding the ICD-9-CM codes into the abstract file to verify and update all required items of information consistent with the current UHDDS guidelines, OSHPD guidelines, all third party guidelines and any required hospital policies and guidelines. The correct hospital admission category will be verified and appropriate abstract maintenance performed
4. The DRG Coder/Abstractor is responsible to encode the ICD-9-CM codes to establish an expected DRG for billing comparisons. The anticipated DRG is keyed into the abstract as well as being conveyed to the business office. The DRG Coder/Abstractor will review and verify that the appropriate information has been captured in the abstract upon receipt of the discharge summary and “C” or complete the abstract
5. the DRG Coder/Abstractor is expected to maintain current coding competence regarding ICD-9-CM and CPT-4 coding guidelines, hospital guidelines/requirements, OSHPD guidelines, DRG methodology as well as third party payor guidelines and policies and CMS coding guidelines as applicable

6. The DRG Coder/Abstractor will, at the time of discharge, review inpatient and outpatient medical records to insure that the required reports and signatures are included in the record; note deficiencies on the "Chart Lacks" form, send appropriate deficiency sheets
7. The DRG Coder/Abstractor will participate in the abstract reconciliation procedures at least quarterly
8. The DRG Coder/Abstractor will perform weekly chart reconciliation process and assure that the Department Assistant is notified at least weekly of charts not received in the coding office
9. Understands and utilizes CMS Physician query guidelines as necessary
10. Accurately codes and abstracts all: outpatient, inpatient, inpatient medicare and ECU Health Records utilizing ICD-9-CM and CPT-4 codes
11. Uses all applicable rules with regard to the confidential nature of the information contained in health records

Qualifications

1. At least two years experience in the medical records field with knowledge of principles and practice of ICD-9-CM and CPT classification systems, DRG methodology, and the UHDDS guidelines
2. Must have knowledge regarding the guidelines related to these coding systems, DRG methodology and the ability to follow the detailed guidelines related to their use and understands importance of proper sequencing and coding according to official coding guidelines
3. Ability to read handwritten and transcribed documents in the health record, interpret information and enter complete accurate data into a computer system
4. Comprehensive knowledge of medical diagnostic and procedural terminology required
5. Understanding of disease process, anatomy and physiology necessary for assigning accurate numeric and alpha-numeric codes
6. Must be certified in coding (or equivalent RHIT or RHIA) and proficient at coding outpatient, inpatient, inpatient Medicare and ECU health record encounters

Lifting Requirements

Light- generally lifting not more than 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs.