Appendix A.5

WORK PROCESS SCHEDULE

AND

RELATED INSTRUCTION OUTLINE

MEDICAL CODER / BILLER
O*NET-SOC CODE: 29-2071.00
RAPIDS CODE: 1114
Type of Training: Time-based

APPENDIX A.5

Sample Work Process Schedule and Related Instruction Outline

MEDICAL CODER/BILLER
O*NET-SOC CODE: 29-2071.00
RAPIDS CODE: 1114
Type of Training: Time-based

This schedule is attached to and a part of these Standards for the above identified occupation.

1. TYPE OF OCCUPATION

☐ Time-based ☐ Competency-based ☒ Hybrid

2. TERM OF APPRENTICESHIP

The term of the time-based occupation is one year with an on-the-job learning (OJL) attainment of 2080 hours, and supplemented by the minimum required 144 hours of related instruction.

3. RATIO OF APPRENTICES TO MENTORS

Consistent with proper supervision, training, safety, continuity of employment throughout the apprenticeship, the ratio of apprentices to mentors will be: two (2) apprentices may be employed in each medical office for each regularly employed Office or Business Manager or Coder/Biller Supervisor.

4. APPRENTICE WAGE SCHEDULE

Apprentices shall be paid a progressively increasing schedule of wages based on either a percentage or a dollar amount of the current hourly Medical Coder/Biller mentor wage rate, which is $ _____ per hour. The career pathway for the apprentice may include the interim credential of Certified Coding Associate (CCA®)

1st	3 months + 520 OJL hours = (fixed $ hourly wage or (60) percent)
2nd	3 months + 520 OJL hours = (fixed $ hourly wage or (70) percent)
3rd	3 months + 520 OJL hours = (fixed $ hourly wage or (80) percent)
4th	3 months + 520 OJL hours = (fixed $ hourly wage or (90) percent)

1. WORK PROCESS SCHEDULE (See attached A.5 Work Process Schedule)

2. RELATED INSTRUCTION OUTLINE (See attached A.5 Related Instruction Outline)

The organized related instruction outline below is in technical subjects related to the occupation. This instruction may be accomplished through media such as classroom, occupational or industry courses, electronic media, or other instruction approved by the Registration Agency. The related instruction provider is supported by the AHIMA Foundation 233 N. Michigan Ave. 21st Fl., Chicago, Illinois 60601

Description:
The Medical Coder/Biller will use coding conventions and guidelines to abstract, analyze and accurately assign ICD (International Classification of Diseases) and CPT (Current Procedural Terminology) principle and secondary diagnostic and procedural codes to inpatient, ambulatory, and hospital outpatient medical records. The Medical Coder/Biller 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 include ensuring services provided are coded and billed accurately, assembling and coordinating reimbursement claims for third party payers, investigating claim denials, interacting with insurance companies and patients to ensure accurate billing and payment. Requirements for this role are a high school diploma, exposure to healthcare job-related functions, and be at least 18 years of age.

A.5 WORK PROCESS SCHEDULE

This may be customized up to 20% at point of hire by the Employer and Sponsor to meet local needs prior to submitting these Standards to the appropriate Registration Agency for approval.

Note: *On-the-Learning (OJL)* competencies will be evaluated as competency-based achievements. Each of the competencies will have objectives and all competencies will be verified and signed off by assigned mentors/trainers/supervisors.

All related instruction and supplementary training will be structured in accordance with Certified Coding Associate (CCA®) certification domains.

During the term of apprenticeship, the Apprentice shall receive such instruction and experience, in all branches of the occupation, as is necessary to develop a practical and versatile worker. Major processes in which Apprentices will be trained (although not necessarily in the order listed) and approximate hours (not necessarily continuous) to be spent in each are as follows:

Certified Medical Coder/Biller **Work Processes**	**Approximate OJL Hours**
Receptionist Duties Handle incoming and outgoing calls/e-mails to and from Physicians, department administrative assistants, the billing office, compliance office and others; mail, fax, and handle correspondence.	**100**
Office Procedures Care and maintain office equipment; develop and maintain mailing lists and tickler file; inventory management; use Query database to retrieve information.	**100**
Insurance Coding Use and understand format, conventions, guidelines and rules of ICD-10-CM diagnostic and procedural coding; coding of insurance forms using ICD-10-CM and CPT; process and complete all insurance forms; code diagnoses and procedures.	**1,000**
Medical Records Retrieving and filing of medical records; keep medical records updated; locate data in and abstract information from medical records.	**200**
Health Care Reimbursement Comply with regulations related to fraud and abuse; compare non-government payers versus government payers; compare other prospective payment systems; understand and comprehend reimbursement cycle; apply facility based codes (i.e., Diagnostic Related Groups, Ambulatory Payment Classifications, and Resource Utilization Groups).	**500**

Miscellaneous Investigate health plan payment denials and write claims appeal; understand and follow claim rejection and resolution process; use coded data in strategic planning/reporting; perform qualitative and quantitative analysis of health records to evaluate compliance with regulations and standards; research coding updates; examine review systems.	**180**
Total Hours	**2080**

A.5 RELATED INSTRUCTION OUTLINE

Related Instruction Provider: AHIMA Foundation
Methods: Distance Delivery, Electronic Media

The related instruction outlines the courses that provide the technical ability that supplements the on-the-job training. It is through the combination of both the on-the-job training and the related technical instruction that the apprentice can reach the skilled level of the occupation. Under a registered apprenticeship, 144 hours of related instruction each year of the apprenticeship is recommended. The following is the suggested course curriculum during the term of apprenticeship.

RELATED INSTRUCTION OUTLINE

Medical Coder/Biller Immersion Training (Related Instruction) Outline

Item	Type	Content	Hours
Program orientation with tutorials for Litmos and VLab	WebEx	Program overview	2
Medical Terminology	Online self-directed	This course covers medical terminology, symbols and abbreviations, and the application of this new language in the field of health care. While terms are covered as they relate to body structure and function, the main focus is on medical vocabulary and being able to construct terms using word parts such as roots, suffixes, and prefixes.	45
Anatomy, Physiology & Human Disease	Online self-directed	This course provides an overview to the anatomical structures and physiology of the human body. Each body system is discussed in terms of the major anatomical structures and function including how each system participates in homeostasis of the body. In addition, the course discusses selected major pathologies, including disease definitions and causes, signs and symptoms, diagnostic procedures, and possible treatments. Finally, the course discusses common issues and changes that occur in each body system through the life span.	45

Item	Type	Content	Hours
Pathophysiology and Pharmacology	Online self-directed	Emphasis is placed on the disease processes affecting the human body via an integrated approach to specific disease entities. Included will be the study of causes, diagnosis and treatment of disease as well as an understanding of the basic principles of pharmacology.	45
Healthcare Delivery Systems	Online self-directed	An introduction to the organization, financing and delivery of health care services, this course gives an overview of the organization and activities of hospitals, nursing homes, mental health and ambulatory care centers, home health agencies, and hospices. Apprentices will also learn about the educational preparation and responsibilities of health care professionals and government regulations.	45
Healthcare Data Content and Structure	Online self-directed	This course introduces apprentices to the contents, use and structure of the health record, including data and data sets. It explains how these components relate to primary and secondary record systems and gives an overview of the legal and ethical issues applicable to health information.	45
Medical Law and Ethics	Online self-directed	This course introduces apprentices to legal and ethical issues related to the health care setting. This course provides an overview of the laws and professional requirements that regulate the delivery of health care, including HIPAA, the Patient's Bill of Rights, and standard of care. Apprentices will also gain an understanding of the ethical and moral issues that health care professionals may encounter.	45
Basic ICD Coding Part 1	Online self-directed	This course provides the apprentice with the basic principles of the ICD-10-CM Coding and Classification System, including the following of guidelines, proper sequencing of codes and the impact on reimbursement.	45
Basic ICD Coding Part 2	Online self-directed	A continuation of Part 1 of the Basic ICD Coding course, Part 2 focuses on ICD-10-PCS coding. This course emphasizes practice in the assignment of valid ICD-10-PCS procedure codes.	45
Basic CPT Part 1	Online self-directed	An introduction to basic coding concepts using CPT/HCPCS coding/classification systems, this course emphasizes practice in the assignment of valid diagnostic and procedure codes in an ambulatory care setting. The course covers procedural	45

Item	Type	Content	Hours
		terminology in current use, evaluation and management services, medicine, HCPCS Levels II and III and CPT Category II and III Codes.	
Basic CPT Part 2	Online self-directed	A continuation of Part 1 of the Basic CPT/HCPCS Coding course, Part 2 utilizes higher level, more complex examples (case studies, records and scenarios). This course covers surgery coding, anesthesia coding, radiology coding, pathology and laboratory coding, and reimbursement in the ambulatory setting. Students are assigned exercises to complete using Nuance Healthcare's Clintegrity 360 encoder.	45
Reimbursement Methodology	Online self-directed	Emphasis is placed on the uses of coded data and health information in reimbursement and payment systems appropriate to all healthcare settings and managed care. Students are exposed to the contemporary prospective payment systems used by the U.S. government and other key health plans that comprise most patients' source of payment for healthcare services.	45
Professional Coding Practice		This course offers apprentices the ability to practice coding in real-world professional coding scenarios. Apprentices step through more than six different settings to complete 101 online coding exercises using either codebooks or the 3M Encoder. In addition, using official coding guidelines, preparing for a career, keeping code sets current, and applying standards of ethical behavior are covered.	60
Post-immersion assessment	Online assessment	Retired CCA exam questions	4
Meetings with Coding Trainers	WebEx	Review activities, provide feedback and instruction	4
Total Related Instruction hours			**565**

WORK PROCESSES COMPETENCY DETAIL FOR MEDICAL CODER/BILLER ROLE

COMPETENCY	*MEASURED BY*	*Score*	*COMMENTS*
Interpret healthcare data for code assignment	Audits indicate accuracy of diagnostic and procedural coding	1 2 3 4 5 Audit score	1 – Below expectation in the accuracy of applying classification codes 2 – Needs improvement in the accuracy of applying classification codes 3 – Satisfactorily demonstrates accuracy in the application of classification codes 4 – Demonstrates proficiency in the application of classification codes 5 – Exceeds expectations in the accuracy of applying classification codes
Incorporate clinical vocabularies and terminologies used in health information systems	Demonstrates understanding of clinical vocabularies	Meets or Does not Meet	Comment on **Does Not Meet**
Abstract pertinent information from medical records and consults reference materials to facilitate code assignment	Audits indicate compliance with abstracting policies	1 2 3 4 5	1 – Below expectation in meeting abstracting requirements 2 – Needs improvement in meeting abstracting requirements 3 – Satisfactory meets abstracting requirements 4 – Proficient in abstracting requirements 5 – Exceeds expectations in abstracting requirements
Apply inpatient coding guidelines appropriately	Audits indicate appropriate code and sequencing following regulations and guidelines	1 2 3 4 5 N/A	1 – Below expectation in the application of inpatient coding guidelines and regulations 2 – Needs improvement in the application of inpatient coding guidelines and regulations 3 – Demonstrates basic understanding of inpatient coding guidelines and regulations 4 – Demonstrates proficiency in inpatient coding guidelines and regulations 5 – Excels in application of inpatient coding guidelines and regulations
Ensure accuracy of diagnostic/procedural groupings such as DRG (Diagnostic Related Group); MSDRG (Medicare Severity); APC (Ambulatory Payment Classification) system, etc	Audits indicate accuracy of MSDRG/APC assignment	1 2 3 4 5	1 – Below expectation in the accuracy of DRG/APC assignment 2 – Needs improvement in the accuracy of DRG/APC assignment 3 – Demonstrates basic understanding DRG/APC assignment 4 – Demonstrates proficiency in DRG/APC assignment 5 – Excels in application of DRG/APC assignment

COMPETENCY	*MEASURED BY*	*Score*	*COMMENTS*
Sequence codes for optimal reimbursement	Audits indicate appropriate code sequencing	1 2 3 4 5 Audit score	1 – Below expectation in sequencing codes 2 – Needs improvement in sequencing codes 3 – Satisfactory sequences codes 4 – Proficient in sequencing codes 5 – Exceeds expectation in sequencing codes
Evaluates and reconciles National Correct Coding Initiative edits	Follows coding edits for compliance with NCCI	1 2 3 4 5	1 – Not compliant with coding edits 2 – Needs improvement in monitoring of coding edits 3 – Satisfactorily monitors coding edits 4 – Proficient in the monitoring of coding edits 5 – Proactive in resolving NCCI edits prior to billing
Apply outpatient coding guidelines appropriately	Audits indicate appropriate code and sequencing following regulations and guidelines	1 2 3 4 5 N/A	1 – Below expectation in the application of outpatient coding guidelines and regulations 2 – Needs improvement in the application of outpatient coding guidelines and regulations 3 – Demonstrates basic understanding of outpatient coding guidelines and regulations 4 – Demonstrates proficiency in outpatient coding guidelines and regulations 5 – Excels in application of outpatient coding guidelines and regulations
Validate medical necessity using LCD and NCD	Audits indicate appropriate use of LCD and NCD in coding	Meets or Does not Meet	Comment on **Does Not Meet**
Submit claim forms in a timely manner. Evaluate and respond to claim denials.	Compliant with claim submission and claim denials policy	Meets or Does not Meet	Comment on **Does Not Meet**
Retrieve, assemble and analyze medical records quantitatively and qualitatively for deficiencies	Meets timeliness and accuracy of record analysis	1 2 3 4 5	1 – Not compliant with record analysis 2 – Needs improvement in record analysis 3 – Satisfactorily analyzes medical records 4 – Proficient in record analysis 5 – Proactive in identifying record analysis deficiencies
Retrieve patient-specific information from other sources (ancillary departments, physician offices, master patient index, etc.)	Follows policy on information and data collection	Meets or Does not Meet	Comment on **Does Not Meet**

COMPETENCY	*MEASURED BY*	*Score*	*COMMENTS*
Identify discrepancies between coded data and supporting documentation. Clarify documentation through proper physician query	Creates compliant physician queries	1 2 3 4 5 N/A	1 – Queries reviewed did not meet facility criteria 2 – Queries reviewed met facility criteria at least 25% of the time 3 – Queries reviewed met facility criteria at least 50% of the time 4 – Queries reviewed met facility criteria at least 80% of the time 5 – Queries reviewed met all facility criteria for compliance 100% of the time

Note: ***On the job competencies, will be evaluated as competency-based achievements. Each of the competencies will have objectives and all competencies will be verified and signed off by assigned journeyworker/mentors/trainers/supervisors.***

All related instruction and supplementary training will be structured in accordance with Certified Coding Associate (CCA) exam domains.