

Appendix A

WORK PROCESS SCHEDULE

AND

RELATED INSTRUCTION OUTLINE

Health Information Management (HIM) Hospital Coder/Coding Professional Apprenticeship

O*NET-SOC CODE: 29-2071.00

RAPIDS CODE: 2029CB

Type of Training: Competency-based

APPENDIX A

Sample Work Process Schedule and Related Instruction Outline

Health Information Management (HIM) Hospital Coder/Coding Professional Apprenticeship

O*NET-SOC CODE: 29-2071.00

RAPIDS CODE: 29-2071.00

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 occupation shall be competency-based supplemented by a minimum of 144 hours of related instruction.

3. RATIO OF APPRENTICES TO JOURNEYWORKERS

Four (4) apprentice(s) to **One (1)** journeyworker/mentor/trainer.

4. APPRENTICE WAGE SCHEDULE

Apprentices may be paid a progressively increasing schedule of wages based on a percentage of the current Hospital Coder/Coding Professional wage rate of \$_____.

1 Year Term (example):

1st 1000hrs = \$ _____
2nd 500hrs = \$ _____
3rd 500hrs +CCS = \$ _____

5. WORK PROCESS SCHEDULE (See below Work Process Schedule)

(Customized at point of hire by the Employer and Sponsor)

The Employer may modify the work processes to meet local needs prior to submitting these Standards to the appropriate Registration Agency for approval.

6. RELATED INSTRUCTION OUTLINE (See below Work Process Schedule)

(Customized at point of hire by the Employer and Sponsor)

Position Description:

The Health Information Management (HIM) Hospital Coder will use coding conventions and guidelines to abstract, analyze and accurately assign ICD (International Classification of Diseases) and ICD and CPT (Current Procedural Terminology) principle and secondary diagnostic and procedural codes to inpatient, ambulatory, and hospital outpatient medical records. The HIM Hospital Coder 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 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. Preferred candidates will hold an associate's degree or higher in Health Information Management; although those with a certificate in coding from an approved coding program will be considered.

ON THE JOB COMPETENCIES:

COMPETENCY	MEASURED BY	Score	COMMENTS
Use and maintain electronic applications and work processes to support clinical classification and coding (for example, encoding and grouping software)	Demonstrates understanding in use and application of encoder and grouper software	1 2 3 4 5	1 – Below expectation in the use of electronic applications (encoder and grouper software) 2 – Needs improvement in use of electronic applications (encoder and grouper software) 3 – Satisfactory use of electronic applications (encoder and grouper software) 4 – Proficient in electronic applications (encoder and grouper software) 5 – Exceeds expectation in use of electronic applications
Apply inpatient and outpatient diagnosis and procedure codes according to current nomenclature and demonstrate adherence to current regulations and established guidelines in code assignment (focus on assignment of first listed diagnosis, and sequencing as well as other clinical coding guidelines)	Audits indicate appropriate code and sequencing use following regulations and guidelines	1 2 3 4 5 N/A	1 – Below expectation in the application of coding guidelines and regulations 2 – Needs improvement in the application of coding guidelines and regulations 3 – Demonstrates basic understanding of coding guidelines and regulations 4 – Demonstrates proficiency in coding guidelines and regulations 5 – Excels in application of coding guidelines and regulations

COMPETENCY	MEASURED BY	Score	COMMENTS
<p>Ensure accuracy of diagnostic/procedural groupings such as DRG (Diagnostic Related Group); MS DRG (Medicare Severity); APC (Ambulatory Payment Classification) system, etc</p>	<p>Audits indicate accuracy of MS DRG/APC assignment</p>	<p>1 2 3 4 5</p>	<p>1 – Below expectation in the accuracy of DRG/APC assignment</p> <p>2 – Needs improvement in the accuracy of DRG/APC assignment</p> <p>3 – Demonstrates basic understanding DRG/APC assignment</p> <p>4 – Demonstrates proficiency in DRG/APC assignment</p> <p>5 – Excels in application of DRG/APC assignment</p>
<p>Validate coding accuracy using clinical information found in the health record</p>	<p>Audits indicate accuracy of diagnostic and procedural coding</p>	<p>1 2 3 4 5</p> <p>Audit score</p>	<p>1 – Below expectation in the accuracy of applying classification codes</p> <p>2 – Needs improvement in the accuracy of applying classification codes</p> <p>3 – Satisfactorily demonstrates accuracy in the application of classification codes</p> <p>4 – Demonstrates proficiency in the application of classification codes</p> <p>5 – Exceeds expectations in the accuracy of applying classification codes</p>
<p>Use and maintain applications and processes to support other clinical classification and nomenclature as appropriate to the work setting (e.g., DSM V (Diagnostic and Statistical Manual of Mental Disorders), SNOMED-CT (Systematized Nomenclature of Medicine – Clinical Terms)</p>	<p>Identifies correct coding nomenclature for patient type and location</p>	<p>Meets or Does not Meet</p>	<p>Comment on Does Not Meet</p>

COMPETENCY	MEASURED BY	Score	COMMENTS
<p>Resolve discrepancies between coded data and supporting documentation. Communicates with providers to ensure appropriate documentation.</p>	<p>Creates compliant physician queries</p>	<p>1 2 3 4 5 N/A</p>	<p>1 – Queries reviewed did not meet facility criteria</p> <p>2 – Queries reviewed met facility criteria at least 25% of the time</p> <p>3 – Queries reviewed met facility criteria at least 50% of the time</p> <p>4 – Queries reviewed met facility criteria at least 80% of the time</p> <p>5 – Queries reviewed met all facility criteria for compliance 100% of the time</p>
<p>Apply policies and procedures for the use of clinical data required in reimbursement and prospective payment systems (PPS) in healthcare delivery as well as changing regulations among various payment systems for healthcare services such as Medicare, Medicaid, managed care, etc.</p>	<p>Adheres to national, regional and facility-specific requirements for accurate reimbursement by payer type</p>	<p>Meets or Does not Meet</p>	<p>Comment on Does Not Meet</p>
<p>Support accurate billing through coding, chargemaster, claims management, and bill reconciliation processes</p>	<p>Reviews codes identified manually and by the chargemaster to ensure compliant billing</p>	<p>Meets or Does not Meet</p>	<p>Comment on Does Not Meet</p>
<p>Use established guidelines to comply with reimbursement and reporting requirements such as the National</p>	<p>Follows coding edits for compliance with NCCI</p>	<p>1 2 3 4 5</p>	<p>1 – Not compliant with coding edits</p> <p>2 – Needs improvement in monitoring of coding edits</p> <p>3 – Satisfactorily monitors coding edits</p>

COMPETENCY	MEASURED BY	Score	COMMENTS
Correct Coding Initiative and others			4 –Proficient in the monitoring of coding edits 5 – Proactive in resolving NCCI edits prior to billing
Compile patient data and perform data quality reviews to validate code assignment and compliance with reporting requirements such as outpatient prospective payment systems	Participates in coding audits	Meets or Does not Meet	Comment on Does Not Meet
Participate in compliance (fraud and abuse), HIPAA (Health Insurance Portability and Accountability Act of 1996), and other organization specific training.	Attends required compliance training	Meets or Does not Meet	Comment on Does Not Meet

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 coding certification domains.

RELATED INSTRUCTION OUTLINE

Hospital Coder/Coding Professional Immersion Training (Related Instruction) Outline Sample

Item	Type	Content	Hours
Program orientation	Webex	Program overview	1
VLab tutorial	Webex	VLab training	1
Pre-immersion assessment	Online assessment	Retired CCS exam questions	4
Clinical Coding Workout	Textbook and online self-directed	Inpatient, outpatient, procedure coding exercises and assessments	40
Clinical coding practice	Online self-directed	99 actual redacted medical records in the VLab to include: 25 outpatient clinic cases 14 outpatient surgery cases 16 emergency department cases 44 inpatient cases	40
Clinical coding practice	Online self-directed	50 actual redacted medical records in Solcom/EDCO to include: 4 ambulatory surgery cases 26 emergency department cases 15 inpatient cases 5 outpatient clinic cases	40
Common employability modules	Online self-directed	Common employability skills to include: <ul style="list-style-type: none"> • Communication skills • Analysis and problem-solving • Behavioral characteristics • Business knowledge • Teamwork 	10
Post-immersion assessment	Online assessment	Retired CCS exam questions	4
Meetings with Coding Trainers	Webex	Review activities, provide feedback and instruction	4
Total Immersion Training/Related Instruction hours			144

TOTAL MINIMUM HOURS 144