Pershing General Hospital is an Equal Opportunity Employer & Drug and Alcohol Free Workplace

All PGH positions are Safety Sensitive

CAREER OPPORTUNITY

Job Title: **HIM Coder**
FLSA Status: **Full Time Non Exempt**
Reports To: **Revenue Cycle Manager**
Location: **Business Office**
Number of Openings: **1**

Position Overview

The incumbent performs highly technical and specialized functions for Pershing General Hospital. The employee reviews, analyzes, and codes diagnostic and procedural information that determines Medicare, Medicaid and private insurance payments. The primary function of this position is to perform ICD-10-CM, CPT and HCPCS coding for reimbursement. The coding function is a primary source for data and information used in health care, and promotes provider/patient continuity, accurate database information, and the ability to optimize reimbursement. The coding function also ensures compliance with established coding guidelines, third party reimbursement policies, regulations and accreditation guidelines.

General Responsibilities

- Exhibits behaviours that are consistent with the Mission, Philosophy, and Values of Pershing General Hospital and Nursing Home as well as the culture and objectives of Pershing General Hospital and Nursing Home. All employees are expected to work as needed in providing health and wellness services in the communities within Pershing General Hospital and Nursing Home.
- The incumbent assigns and sequences ICD-10-CM/CPT/HCPCS codes to diagnoses and procedures for documented information. Assures the final diagnoses and operative procedures as stated by the physician are valid and complete. Abstracts all necessary information from health records to identify secondary complications and co-morbid conditions.
- Abstracts all necessary information and assigns codes (ICD-10/ CPT/HCPCS), which most accurately describe each documented diagnosis, surgical procedure and special therapy or procedure according to established guidelines.
- The incumbent determines the final diagnoses and procedures stated by the physician or other health care providers are valid and complete.
- Quantitative analysis – Performs a comprehensive review for the record to assure the presence of all component parts such as: patient and record identification, signatures and dates where required, and other necessary data in the presence of all reports which appear to be indicated by the nature of the treatment rendered.
- Qualitative analysis – Evaluates the record for documentation consistency and adequacy. Ensures that the final diagnosis accurately reflects the care and treatment rendered. Reviews the records for compliance with established third party reimbursement agencies and special screening criteria.
- Analyzes provider documentation to assure the appropriate Evaluation & Management (E & M) levels are assigned using the correct CPT code.
- Performs all duties according to established safety procedures.
- Other responsibilities and duties as assigned on occasion, based upon PGH need or requirements.
- Wears identification while on duty. Adheres to dress code, appearance is neat and clean. Completes annual education requirements. Maintains regulatory requirements, including all state and federal regulations. Maintains and ensures patient confidentiality at all times. Reports to work on time and as scheduled. Attends annual review and performs departmental inservices. Works at maintaining a good rapport and a cooperative working relationship with physicians, departments and staff. Represents the organization in a positive and professional manner. Attends committee, QI and management meetings, as appropriate. Ensures compliance with policies and procedures regarding department operations, fire, safety, and infection control. Complies with all organizational policies regarding ethical business practices.

Qualifications

- High School Graduate or equivalent. Two years of coding experience using ICD-10-CM or equivalency. CCS, CCS-P or CPC certification is required. The incumbent is expected to enroll in continuing education courses to maintain certification. Six to twelve months would be required to become proficient in most phases of the job.

Technical Skills:

- Advance knowledge of medical terminology, abbreviations, techniques and surgical procedures; anatomy and physiology; major disease processes; pharmacology; and the metric system to identify specific clinical findings, to support existing diagnoses, or substantiate listing additional diagnoses in the

medical record.

- Advance knowledge of medical codes involving selections of most accurate and description code using the ICD-10-CM, CPT, and HCPCS coding.
- Skill in correlating generalized observations/symptoms (vital signs, lab results, medications, etc.) to a stated diagnosis to assign the correct ICD-10-CM code.
- Advance knowledge of medical codes involving selection of most accurate and descriptive code using the CPT codes for billing of third party resources.
- Extensive knowledge of official coding rules established by the American Medical Association (AMA), and the Center for Medicare and Medicaid Services (CMS) for assignment of diagnostic and procedural codes.
- Knowledge of CPSI Electronic Health Record in order to analyze encounters and notify providers of data that needs corrections through EHR broadcasts, notifications and templates.
- Must have good math skills and effective communication skills.
- Must be knowledgeable of the fiscal requirements, policies, and procedures of federal and state programs.
- Requires the knowledge of the business use of computer hardware and software to ensure the effectiveness and quality of the processing and presentation of data.
- Requires skill in the use of a wide variety of office equipment including: computer, scanner, calculator, facsimile, copy machine, and other office equipment as required.
- Must be able to follow instructions and work independently.
- Review of work and subsequent procedures would detect most significant errors of job functions. However, more serious errors could result in inefficient operations and loss of revenue.
- Because information in the health record is the basis for reimbursement as well as clinical decision-making, coding entries must be complete and accurate. The amount of reimbursement depends on the correct coding of diagnoses and procedures and appropriate assignment. The work has a direct effect on medical record keeping and a direct impact on the accuracy, documentation, timeliness, reliability and acceptability of information in the medical record services.
- Work has considerable impact on the quality of patient care, reliability of research data, compliance and the maximization of Third-Party reimbursement.
- Intermediate proficiency for computer skills including Microsoft Outlook, Word and Excel, navigate and utilize internet-based programs.
- Must have good written and verbal communication skills.
- Must be able to travel out of town for training when required.
- Must maintain an organized workstation and paperwork for efficiency of work.
- Must be detail oriented in daily work and reporting.
- Duties are highly complex, varied, require planning and coordinating several activities at one time, and demand the use of problem solving skills and analysis of circumstances to develop appropriate actions.
- Is subject to frequent interruptions, in person and by phone, which require varied response.

How to Apply

Completed applications may be submitted to Human Resources
Cindy Hixenbaugh, HR Director – cindy@pershinghospital.org
Only qualified individuals being considered will be contacted for an interview.