

GENERAL DESCRIPTION OF CLASS

The MEDICAL RECORD SPECIALIST reviews, abstracts, and codes diagnosis and treatment information from short stay and inpatient medical records for the purpose of providing patient information for appropriate billing of health care services, as input to research on specialized health care subjects, for registration with national and state registries, to provide data for research and to ensure hospital compliance with Federal, State, and Joint Commission on Accreditation of Hospitals and the American College of Surgeons regulations and guidelines.

DISTINGUISHING FEATURES

This is a single classification and not currently part of a series of classes.

DUTIES AND RESPONSIBILITIES

The duties listed below are not inclusive but characteristic of the type and level of work associated with this class. Individual positions may perform all or some combination of the duties listed below as well as other related duties.

1. Medical Record Review

Reads, analyzes and reviews medical records of inpatients and short stay patients following discharge from hospital. Verifies and enters patient demographic information into computer abstracting and coding system. Analyzes medical record for diagnoses, procedures, cancer staging and diagnostic related group (DRG).

2. Medical Record Abstraction and Coding

Determines principal and secondary diagnoses and treatment procedures for multiple medical specialties. Codes diagnosis, treatment, procedure, followup and outcome information using standardized coding systems. Consults medical and coding reference books as necessary to determine most appropriate code(s) and calculates appropriate Diagnostic Related Group (DRG). Completes physician attestation form on Medicare cases and routes to Physician Liaison for physician signature. Enters other information into the computer system as required. Revises diagnosis and treatment codes in computer coding system, if necessary.

3. Tumor Registry Follow-up, Case Finding and Report Preparation

Reviews medical records to determine if patient is diagnosed with or being treated for cancer. Extracts information such as size and location of tumor(s), cell type, stage of disease, extent of disease and what parts of the body are involved, treatment plan and individual patient response to treatments. Contacts physicians to resolve ambiguous or conflicting medical information. Maintains computer data base including annual follow-up information for each patient treated.

Reviews a variety of medical reports, patient attendance records from various tumor clinics and patient admission diagnosis listings to identify cancer cases which must be registered. Prepares annual Cancer Activity Report under the direction of the hospital cancer committee detailing all cancer cases abstracted during the year. Prepares studies on specific cancer types for long-term and short-term studies. Prepares reports upon request from physician on various research topics.

4. General Office Support

Answers section phones. Provides diagnosis and treatment procedure codes to other agency personnel. Completes record tracking logs and maintains computer software updates. Assists Physician Liaison to obtain physician signature on physician attestation form for Medicare patients. Provides cancer patient follow-up to outside hospitals or caregivers, as appropriate.

5. Physician Liaison

Contacts responsible attending physician for review and signature on physician attestation form for Medicare patients. Delivers medical records to physician's office or clinic to obtain signatures. Reviews medical record with physician to resolve questions or disagreements with coding and returns medical records to department to be recoded and new DRG's assigned as necessary. Prepares lists of discharged patients' medical records that department has not received or does not have sufficient information for abstracting and coding.

6. Miscellaneous

Utilizes trade journals and training seminars to learn about and understand changing medical technology, new diseases, new treatments, new drugs, and experimental procedures used in clinics, hospitals, and research facilities.

RELATIONSHIPS WITH OTHERS

Employees in this class have daily in person, written, and telephone contact with physicians, hospital cancer registries and other medical and agency personnel to obtain, clarify, and exchange information. Requests for diagnosis and treatment codes from other sections in the agency are received by telephone throughout the day. Review of medical records with physicians often requires patience and diplomacy to resolve problems or disagreements on coding.

SUPERVISION RECEIVED

Employees in this class receive general supervision from an administrative superior. Work is reviewed for accuracy, completeness, and adherence to medical record regulations and guidelines, through regular meetings, and ongoing quality management studies. The Oregon Medical Professional Review Organization routinely reviews medical records for accuracy of coding and DRG assignment. Federal and State agencies may spot-check medical records for accuracy of coding, DRG assignments, and hospital compliance with JCAH guidelines and Federal and State laws. The American College of Surgeons Cancer Program Manual provides standards and operational guidelines.

The Joint Commission on the Accreditation of health care organizations provides regulations and guidelines for the establishment and maintenance of complete medical records. Federal laws and guidelines apply to confidentiality of medical records, record keeping, and reimbursement requirements for the Medicare benefit system. State laws, Administrative Rules, and agency policies and procedures provide guidelines for confidentiality of medical records, retention of records, reporting of specific medical statistics, and completion of work. Medical dictionaries, textbooks and the International Classification of Disease, Ninth Edition, Clinical Modification drug formularies, the American Medical Association current Procedure Terminology, SEER Cancer Staging manual provide reference information and guidelines for appropriate codes for diagnosis and cancer staging.

GENERAL INFORMATION

Positions in this class are primarily found in hospitals and health institutions. They require the willingness to work in the environment associated with the position's location and purpose and to work for long periods at a work station, reading a computer terminal screen, in an environment including the noise and temperature variations necessary for computer equipment, and to work overtime.

KNOWLEDGE AND SKILLS (KS)

General knowledge of medical record keeping regulations, principles and practices.

General knowledge of medical terminology, disease processes, and anatomy and physiology sufficient to evaluate, abstract, and code specific diagnosis and treatment information from patient's medical file.

General knowledge of written English sufficient to evaluate medical records.

General knowledge of medical coding and cancer staging systems.

Basic knowledge of disease processes as they relate to cancer.

Skill in the use of medical dictionaries, textbooks, and the International Classification of Diseases Clinical Modification coding manual as references.

Skill in communicating orally with a variety of people to obtain, clarify, or exchange information.

Skill in the use of computer health data systems.

SPECIAL QUALIFICATIONS

Employees in this class must be eligible to take or have passed the national accreditation exam for an Accredited Record Technician (ART) certificate, and must maintain the certification through obtaining periodic continuing education credits.

NOTE: The KNOWLEDGE and SKILLS are required for initial consideration. Some duties performed by positions in this class may require different KS's. No attempt is made to describe every KS required for **all** positions in this class. Additional KS requirements will be explained on the recruiting announcement.

Adopted 4/90

Revised 12/93