

U.S. Office of Personnel Management
Division for Human Capital Leadership & Merit System Accountability
Classification Appeals Program

Atlanta Field Services Group
75 Spring Street, SW., Suite 1018
Atlanta, GA 30303-3109

Classification Appeal Decision
Under section 5112 of title 5, United States Code

Appellant: [appellant's name]

Agency classification: Medical Records Technician
GS-675-6

Organization: [name]
[name] Branch
[name] Division
Administrative Services
[name] Army Medical Center
Department of the Army
[location]

OPM decision: Medical Records Technician
GS-675-6

OPM decision number: C-0675-06-04

/s/ Robert D. Hendler

Robert D. Hendler
Classification and Pay Claims
Program Manager

April 11, 2006

Date

As provided in section 511.612 of title 5, Code of Federal Regulations, this decision constitutes a certificate that is mandatory and binding on all administrative, certifying, payroll, disbursing, and accounting officials of the Government. The agency is responsible for reviewing its classification decisions for identical, similar, or related positions to ensure consistency with this decision. There is no right of further appeal. This decision is subject to discretionary review only under conditions and time limits specified in the *Introduction to the Position Classification Standards*, appendix 4, section G (address provided in appendix 4, section H).

Decision sent to:

[appellant's name]
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[union]
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Introduction

The Atlanta Field Services Group of the U.S. Office of Personnel Management (OPM) accepted a classification appeal on December 12, 2005, from [appellant's name]. His position is currently classified as Medical Records Technician, GS-675-6, and is located in the [name] Branch, [name] Division, Administrative Services, [name] Army Medical Center, Department of the Army, [location]. The appellant requests that his position be upgraded to GS-7. We received the complete appeal administrative report on January 13, 2006. We have accepted and decided the appeal under section 5112(b) of title 5, United States Code (U.S.C.).

General issues

The appellant filed a formal grievance against his agency requesting his position description (PD) be rewritten and classified as Medical Records Technician, GS-675-7. The local Civil Personnel Advisory Center (CPAC) updated his PD but determined the job was properly classified at the GS-6 grade level. The appellant then elevated his grievance and, as a result the servicing Civilian Personnel Operations Center reviewed the position and agreed with the CPAC's determination.

The appellant is officially assigned to PD number [number]. He believes his PD is still not accurate because it does not properly describe the complexities of the duties he performs. He states that due to the size and number of specialties and services provided by the facility, increased knowledge is required by medical records technicians at [NAME]AMC. The appellant's supervisor has certified the accuracy of the PD.

A PD is the official record of the major duties and responsibilities assigned to a position by a responsible management official; i.e., a person with authority to assign work to a position. A position is the duties and responsibilities that make up the work performed by an employee. Classification appeal regulations permit OPM to investigate or audit a position and decide an appeal on the basis of the duties assigned by management and performed by the employee. We classify a real operating position, and not simply the PD. We find that the PD of record contains the major duties assigned to and performed by the appellant and we incorporate it by reference into this decision

The appellant identified the size of the facility and volume of services he supports as his rationale supporting a higher grade for the position. However, volume of work cannot be considered in determining the grade of a position (*The Classifier's Handbook*, chapter 5). Therefore, issues raised by the appellant regarding the increased volume of work may not be considered in the classification of his position.

The appellant compares his position to GS-7 medical record technician positions he believes exist at other Army activities. By law, we must classify positions solely by comparing his current duties and responsibilities to OPM standards and guidelines (5 U.S.C. 5106, 5107, and 5112). Since the comparison to standards is the exclusive method for classifying positions, we cannot compare the appellant's position to others, which may or may not be classified correctly, as a basis for deciding the appeal.

In adjudicating this appeal, our only concern is to make our own independent decision on the proper classification of the position. Therefore, we have considered the appellant's statements

only insofar as they are relevant to making that comparison. Since our decision sets aside any previous agency decision, any actions previously taken by the agency in their review of the appellant's position are not germane to the classification appeal process.

Like OPM, the appellant's agency must classify positions based on comparison to OPM standards and guidelines. However, the agency also has primary responsibility for ensuring that its positions are classified consistently with OPM appeal decisions. If the appellant considers his position so similar to others that they all warrant the same classification, he may pursue the matter by writing to his human resources office. In doing so, he should specify the precise organizational location, classification, duties, and responsibilities of the positions in question. If the positions are found to be basically the same as his, the agency must correct their classification to be consistent with this appeal decision. Otherwise, the agency should explain to him the differences between his position and the others.

The record shows the appellant's documented work schedule entails performing medical records technician duties two days a week and three days each week performing union duties. The schedule varies throughout the year with some schedules including less of his work week being spent completing Medical Records work and more of his time spent on union activities. Since we only classify the assigned mission work of the agency; only the 40 percent of time spent by the appellant performing this work is considered.

In reaching our classification decision, we have carefully reviewed all information furnished by the appellant and the agency, including the PD of record. We also conducted a telephone audit with the appellant and interviewed his current supervisor.

Position information

The [name]AMC provides comprehensive health care to service members and their families for all branches of the military. Within the [name]AMC reside numerous specialty clinics, such as Cardiology, Hematology/Oncology, Obstetrics/Gynecology, Inpatient Psychiatry and Behavioral Health Services, Pulmonology and Endocrinology. In addition, the [name]AMC houses a Neonatal Intensive Care Unit Nursery and a Cardiac Catheterization Laboratory. The facility has a capacity of approximately 255 beds.

The appellant is assigned to the [name] Branch and handles records of this group of patrons. His primary duties are to perform medical record analysis, data abstraction, and diagnostic and procedural coding functions to facilitate administrative documentation and reporting of health care services given to patients during their stay at the [name]AMC, i.e., those admitted for 24 hours and longer. He works under the general supervision of the Medical Records Administrator (Medical Records Administrator, GS-669-11) and receives technical assistance and direction from the Lead Medical Records Technician (Lead Medical Records Technician, GS-675-7). In addition to the appellant, there are 5 other GS-6 Medical Records Technicians in his work group.

The technicians receive patient records for an entire day of discharges, and work independently on these records through completion. Recent records show [name]AMC discharges an average of 1,000 patients per month (or 32 a day). The standard processing time for a single record is 24-minutes from start to finish (or approximately 2.5 records each hour).

The PD indicates the handling of each record is a five part process, with each part being completed before moving to the next action. The steps involved in processing of a medical record includes (1) receiving and reviewing inpatient treatment records, (2) reading and analyzing record information, (3) abstracting significant information, (4) selecting and assigning a Diagnosis Related Groups (DRG) code, and (5) identifying and processing selected records for quality improvement. If additional information or clarification is required, the process is placed on hold until the issue is resolved. The summary of duties within the five part process follows.

The appellant reviews the patient's medical record to ensure it contains complete information, e.g., pathology, radiology, neurology, and therapy reports, and that the required signatures are present. He checks for correct assembly of the documents within the record and then analyzes the record for deficiencies and inconsistent information. The appellant uses his knowledge to recognize diagnosis and procedures for numerous types of diseases, illness, injuries, and conditions to ascertain if the treatment was given for new or existing conditions. When there is missing, incomplete, or inconsistent information, the appellant contacts health care providers who are responsible for the medical documentation. Once the patient's record is in order, the appellant prepares an inpatient occurrence checklist to index primary care elements. Next, the appellant initiates a coversheet that provides a synopsis of the health care services rendered during the patient's admission. The diagnosis and procedures are prioritized, e.g., principle, secondary, and tertiary, in descending order allowing for a "ready reference of medical care" that can be used by a variety of health care providers.

The appellant selects and assigns a DRG code that most accurately describes the diagnosis and procedures. The codes are found in the International Classification of Disease, 9th Revision (ICD-9), which is a universal medical code reference guide. In some cases, the appellant may return files to the provider if there is a question selecting the proper code based on the descriptive information found in the file. He ensures Medical Expense and Performance Reporting System (MEPRS) codes are correct. MEPRS is the standard cost accounting system for the Military Health System (MHS), containing Tri-Service financial, personnel, and workload data from reporting medical and dental treatment facilities worldwide. The appellant enters the data and information into the automated reporting system. The record is then reviewed by the Lead Medical Records Technician and then forwarded to the Medical Records Administrator for final review and disposition.

Series, title, and standard determination

The agency classified the appellant's position in the Medical Records Technician Series, GS-675, titled it Medical Records Technician, and used the Job Family Standard (JFS) for Assistance and Technical Work in the Medical, Hospital, Dental, and Public Health Group, GS-600. The appellant does not contest the title, series, or standard determination and, based on careful analysis of the record, we concur.

Grade determination

The JFS is in Factor Evaluation System (FES) format. Under the FES, positions are evaluated by comparing the duties, responsibilities, and qualifications required with nine factors common to nonsupervisory General Schedule positions. A point value is assigned to each factor in accordance with the factor-level descriptions. For each factor, the full intent of the level must be met to credit the points for that level. The total points assigned for the nine factors are converted

to a grade by reference to the grade conversion table in the PCS. Under the FES, each factor level description in a standard describes the minimum characteristics needed to receive credit for the described level. Therefore, if a position fails to meet the criteria in a factor level description in any significant aspect, it must be credited at a lower level.

The appellant disagrees with the agency's evaluation of Factor 1, 3, 4 and 5. Based on careful review of the record, we agree with the agency's crediting of Levels 2-3, 6/7-1a, 8-1, and 9-1, and have so credited the position. Consequently, our evaluation will address the contested factors.

Factor 1, Knowledge Required by the Position

This factor measures the nature and extent of information or facts that an employee must understand to do acceptable work and the nature and extent of the skills necessary to apply that knowledge. The agency credited Level 1-4.

At Level 1-4, employees apply knowledge of, and skill in applying, an extensive body of rules, procedures, and operations of well-established medical records procedures, regulations, and principles to carry out a variety of medical records functions such as analyzing, coding, reviewing, and compiling data. They analyze medical records, maintain special registries, perform quality assurance, compile statistical data, code diagnostic and operative/procedural information, and extract data for statistical and other reports.

At Level 1-5, employees apply a thorough and detailed knowledge of, and skill in applying, a comprehensive body of rules, procedures, and operations, e.g., medical terminology, procedures, anatomy, medical record classification systems coding techniques, and computerized data entry and retrieval systems. They make recommendations to improve procedures for compiling and retrieving medical records information. They identify specific clinical findings, support existing diagnoses, or substantiate listing additional diagnoses in the medical record, and code complicated medical records that are difficult to classify. Employees plan, organize, and maintain special registries, gather and represent data graphically, and make a variety of basic statistical computations. They identify possible trends and patterns for preparing reports and manage medical records.

Level 1-4 is met. Consistent with this level, the appellant uses an extensive knowledge of anatomy, physiology, and medical terminology, procedures, tests, diagnoses, services, and treatments to capture and code required medical information. The appellant also uses knowledge of diagnosis and procedures of numerous types of disease, illness, and injuries to determine whether treatment is for a new or preexisting condition. Typical of Level 1-4, the work requires a broad knowledge of guides and procedural manuals regarding to coding, reporting, processing, and handling medical record information sufficient to accurately document patients records for such purposes as historical documentation, continuity of care, billing, data reporting and collection, and medical research. The appellant's knowledge required to resolve nonstandard medical records procedural problems such as obtaining additional or missing information from health care providers is typical of this level of work.

The appellant's work does not meet Level 1-5. Each position consists of duties and responsibilities which comprise a portion of the mission work assigned to the organization in which the position is located. The appellant works in a medical setting that does not require

application of thorough and detailed knowledge of medical records activities, operations, and regulations associated with specialized assignments characteristic of this level. Unlike Level 1-5, the appellant's work does not involve assisting in a wide range of research and quality assurance studies, establishing and maintaining special registries of select disease types (e.g., cancerous tumors), and making recommendations to improve procedures for compiling and retrieving medical record information. Typical of Level 1-4, the appellant's quality assurance work, is limited to reviewing individual medical records compared against a standard and does not involve studies to assess the adequacy of or recommended improvements to a process typical of Level 1-5. Such functions are the responsibility of higher graded positions in [name]AMC.

Level 1-4 is credited for 550 points.

Factor 3, Guidelines

This factor covers the nature of guidelines and the judgment employees need to apply them. The agency credited Level 3-2.

At Level 3-2, employees use a number of procedural and regulatory guidelines that specifically cover the assigned work. Judgment is used to identify and select, from a number of similar guidelines and work situations, the most appropriate guidelines, references, and procedures to apply when making minor deviations or adapting guidelines to specific cases. Employees refer situations that do not readily fit instructions or other applicable guidelines to the supervisor or a designated employee for resolution.

At Level 3-3, guidelines used by the employee consist of a variety of technical instructions, technical manuals, medical facility regulations, regulatory requirements, and established procedures. Guidelines are not completely applicable to some of the work or have gaps in specificity. Judgment is used to adapt and interpret guidelines to apply to specific cases or problems; uses discretion and initiative to decide on the appropriate course of action to correct deficiencies and improve the reliability of the information; and may, within the framework established by higher authority, develop approaches to apply to new regulatory requirements, or to adapt to new technology.

The appellant's work meets Level 3-2. As at this level, numerous guides are available that provide procedures and methods for processing, coding, assembling, and reporting medical information. Guides include the American Medical Association's Current Procedural Terminology (CPT), ICD-9, DRG, Physician's Desk Reference for Medication, and medical dictionary, as well as numerous Department of Defense, Army, and medical center policies and regulations. In selecting and assigning a DRG code that most accurately describes a diagnosis and procedure related to the patient's treatment, the appellant uses judgment to identify and select from the provider's written text the most appropriate codes to apply to a recorded being entered into the system. Typical of this level, the appellant is required to make minor deviations or adapt guidelines to specific cases; however, the appellant is restricted to codes that are contained in manuals, e.g., ICD-9.

Level 3-3 is not met. Unlike Level 3-3, the appellant has access to specific guidelines when coding patient records. In addition, there are established policies, procedures and precedents available to assist him in following the appropriate course of action to correct deficiencies and improve the reliability of the information. The guidelines are specific to the case in point and do

not require, as is typical at Level 3-3, that he devise new or revised methods for processing the records. In addition, the appellant's work does not require or permit him to use the scope of judgment to adapt and interpret guidelines to the extent intended at Level 3-3. Functions and responsibilities for matters typical of Level 3-3 are reserved to higher graded positions at [NAME]AMC.

Level 3-2 is credited for 125 points.

Factor 4, Complexity

This factor covers the nature, number, variety, and intricacy of the tasks, processes, or methods in the work performed; the difficulty in identifying what needs to be done; and the difficulty and originality involved in performing the work. The primary components of this factor are nature of assignment, what needs to be done, and difficulty and originality involved. The agency evaluated this factor at Level 4-2.

At Level 4-2, work consists of related steps, processes, or standard explanation of methods, such as compiling, recording, and reviewing medical records data. The employee decides what needs to be done by choosing from a few recognizable alternatives, such as determining the relevance of many facts and conditions of information within the medical record, legal and regulatory requirements, and other variables. The employee recognizes inconsistencies in the medical records; and applies prescribed medical records procedures and methods to validate that the record contains information.

At Level 4-3, work consists of different, varied, and unrelated medical record processes and methods, including reviewing the work of other employees to verify compliance with regulatory requirements. The employee determines the relevance of many facts and conditions, and determines the appropriate action from many alternatives. The employee identifies and analyzes medical records problems and issues and determines their interrelationships and the appropriate methods and techniques needed to resolve them.

Level 4-2 is met. Comparable to this level, the appellant's work involves the review, analysis, coding, and reporting of diagnostic and treatment information documenting health care services provided to patients from the time of hospital admission to the time of discharge. The appellant makes decisions relevant to selecting the most appropriate code and DRG. Like Level 4-2, the appellant must recognize inconsistencies in the medical records. For example, if he determines that the incorrect MEPRS code has been assigned, the record is returned to the appropriate admissions staff to correct the error.

Level 4-3 is not met. Unlike the appellant's work, Level 4-3 involves performing different and varied medical processes including reviewing the work of the staff to ensure compliance with legal, regulatory, and quality requirements. The appellant states that he is required to review the work of co-workers primarily through a peer-review process. However, the record shows the supervisor discontinued this process in October, 2005, and as such, may no longer be considered as work currently assigned to and performed by the appellant. The appellant also states that he routinely reviews work of other medical providers at the [name]AMC, e.g., physicians and admittance clerks. However, the appellant is not reviewing the work of skilled coders and the work he is performing does not include direct support to teaching and research functions or complicated staff studies supported at Level 4-3. Such work is substantially more complex than

peer review since it is intended to focus on identifying and resolving programmatic issues and not whether individual records have been coded correctly. Although the appellant occasionally deals with situations where the proper ICD-9 codes for new or previously unencountered diagnoses or procedures are difficult to determine, the procedures for doing so are straightforward. The appellant's choices consist primarily of consulting with the attending physician to determine an appropriate substitute or by contacting the Medical Records Administrators for guidance. While the duties require the appellant to make factual determinations, as at Level 4-2, they do not routinely require making the more subjective decisions or more demanding analyses characteristic of Level 4-3 which are reserved to other [name]AMC positions.

Level 4-2 is credited for 75 points.

Factor 5, Scope and Effect

This factor covers the relationship between the nature of the work and the effect of the work products or services both within and outside the organization. Effect measures such things as whether the work output facilitates the work of others, provides timely services of a personal nature, or impacts on the adequacy of research conclusions. The concept of effect alone does not provide sufficient information to properly understand and evaluate the impact of the position. The scope of the work completes the picture allowing consistent evaluations. The JFS states only to consider the effect of properly performed work. The agency credited Level 5-2.

At Level 5-2, the work involves performing assignments according to specific rules or procedures that represent a significant segment of the medical records function for the organization. The work affects the accuracy, timeliness, reliability, and acceptability of information in the medical record.

At Level 5-3, the work involves performing a variety of specialized medical records tasks, and resolving problems according to established criteria, e.g., processing medical records and data that involve inconsistencies, discrepancies and other non-routine problems. At this level, the work involves developing, maintaining and monitoring special registries that assist physicians in the care and treatment of patients. The work affects the accuracy and reliability of medical records, which in turn affect the outcome of research efforts, the outcome of internal and external audits, the quality of information physicians receive on such things as readmission and legal claims, and the quality of patient care rendered.

Level 5-2 is met. As at this level, the appellant's work involves applying specific rules or procedures for processing inpatient's records. Typical of Level 5-2, the appellant receives patient records for an entire day of admissions, and using [name]AMC's five part processing procedure described earlier, the appellant processes the assigned records to completion. Comparable to Level 5-2, the results of the appellant's work affects the accuracy, timeliness, reliability, and acceptability of information abstracted from the medical record in terms of accreditation, fiscal reimbursement, provider productivity, and quality/continuity of care.

Level 5-3 is not met. The appellant's duties directly affect individual medical records by ensuring that they are processed and maintained in accordance with prescribed guidelines and requirements. The purpose of the appellant's work is to provide valid, complete, and accurate medical record information to the medical records system. The work focuses on problems,

discrepancies, and inconsistencies that occur during the processing of individual records, rather than the broader nonroutine problems, discrepancies, and inconsistencies caused by policies, practices, procedures, and processes affecting the local medical records program and its associated medical record services. The appellant also is not involved in a number of different, varied, and specialized record processes typical of Level 5-3 such as maintaining select disease registries, or carrying out quality assurance, research, or other special project studies as discussed previously in this decision.

Level 5-2 is credited for 75 points.

Summary

<i>Factor</i>	<i>Level</i>	<i>Points</i>
1. Knowledge required by the position	1-4	550
2. Supervisory controls	2-3	275
3. Guidelines	3-2	125
4. Complexity	4-2	75
5. Scope and effect	5-2	75
6. & 7. Personal contacts and Purpose of contacts	1-a	30
8. Physical demands	8-1	5
9. Work environment	9-1	<u>5</u>
<i>Total Points</i>		1,140

A total of 1,140 points falls within the GS-6 point range (1,105 to 1,350 points) on the Grade Conversion Table in the JFS.

Decision

The position is properly classified as Medical Records Technician, GS-675-6.