

**CLASSIFICATION APPEAL DECISION
U.S. OFFICE OF PERSONNEL MANAGEMENT
CHICAGO OVERSIGHT DIVISION**

APPELLANT: **[Appellant]**

REPRESENTATIVE: [Representative]

POSITION NUMBER: 2746-A

AGENCY CLASSIFICATION: Medical Records Technician (OA)
GS-675-6

POSITION LOCATION: Department of Veterans Affairs
[Installation]
[Activity]
[City, State]

OFFICE OF PERSONNEL **Medical Records Technician (OA)**
MANAGEMENT DECISION: **GS-675-6**

OPM decision number: C-0675-06-01

This appellate decision constitutes a certificate that is mandatory and binding on administrative, certifying, payroll, and accounting offices of the Government. It is the final administrative decision on the classification of the position, not subject to further appeal. It is subject to discretionary review only under the conditions and time limits specified in Part 511, Subpart F, of Title 5, U.S. Code of Federal Regulations.

/s/

FREDERICK J. BOLAND
CLASSIFICATION APPEALS OFFICER

9/3/97

DATE

INFORMATION CONSIDERED

- Appellant's memo dated April 2, 1997, her letter dated May 15, 1997, and her responses to our requests for additional information.
- Agency letter dated April 17, 1997, and its enclosures.
- Copy of the official description of the appellant's position.
- Copy of the official description of the appellant's supervisor's position.
- Copy of the appellant's performance standards.
- Copy of the organization chart and statement of functions for the [Activity].
- Telephone discussion of the appellant's duties with her on August 28 and with her supervisor on August 29, 1997.
- OPM classification certificate dated January 13, 1994, for position number 2746-0, Medical Records Technician, GS-675-6, at the [Installation], [City, State].

EVALUATION CRITERIA

- OPM *Medical Records Technician, GS-675, Series* standard, dated November 1991.
- OPM *Office Automation Grade Evaluation Guide*, dated November 1990.

INTRODUCTION

The appellant is assigned to position number 2746-A, which is located in the [Activity], [Installation], [City, State]. The position was classified by the [Installation] on November 5, 1996, as Medical Records Technician (OA), GS-675-6. It is basically a redescription of a position certified at the GS-6 grade level by OPM in 1994 to which additional duties have been added. The appellant feels she was given insufficient credit for new duties added to the position since the 1994 certification. She believes the additional knowledge requirements of the new duties and their impact on the complexity, scope, and personal contacts (Factors 1, 4, 5, and 6 of the classification standard) involved in the work warrant a higher grade.

JOB INFORMATION

The appellant is one of about 18 workers in the [Activity], which is headed by a GS-8 supervisor and which, in addition to the appellant, includes two other GS-6 Medical Records Technicians, three GS-6 Billing Clerks, a GS-5 Release of Information Clerk, and about 10 other clerks at the GS-3/4 levels. The position's original duties (i.e., those that it shares with certified position number 2746-0) fall into three areas: (1) analyzing and ensuring the completeness, accuracy, and legal/regulatory compliance of medical forms and information documenting confinements, diagnoses, procedures, and treatments;

(2) coding diagnoses treated and procedures performed to ensure optimal patient care and facility reimbursement; and (3) compiling and recording medical records data for future reference.

The new duties, which are the subject of the appeal and which were added subsequent to OPM's certification of position 2746-0 in 1994, largely include:

- reviewing medical and administrative records and contacting appropriate Regional Office personnel to resolve patient complaints concerning determination of inpatient hospitalizations (which may be related to treatment for service-connected conditions, documented exposure to ionizing radiation, Agent Orange, or environmental contaminants);
- reviewing medical records and charts to obtain information regarding symptoms, diagnostic and therapeutic procedures, medications, expected treatment plan, diagnoses, expected length of stay, and discharge plans and communicating this information to insurance company clinical reviewers in order to obtain pre-admission certification, authorization for admission, and certification for length of stay;
- preparing correspondence and copying medical records for the purpose of appealing cases of total or partial denial of payment (based on medical necessity and level of care appropriateness), following up on correspondence regarding inpatient billing, and contacting insurance companies and patients to secure information required for accurate billing; and
- preparing bills for reimbursable health insurance for inpatient care by examining insurance data, diagnostic and procedural codes, sensitivity of the information, and related data such as discharging bed section, treating service, units charged, rate type, and revenue codes.

ANALYSIS AND FINDINGS

SERIES AND TITLE DETERMINATION

The position's original and new duties both fall within the Medical Records Technician, GS-675, series, which includes specialized work concerned with processing and maintaining medical records for compliance with regulatory requirements and reviewing, analyzing, coding, abstracting, and compiling medical records data. The GS-675 series also includes corresponding with patients, authorized representatives, insurance companies, and other parties concerning information found in medical records.

The appellant's analysis, review, and coding of medical records, as well as her detailed review of medical bills and preparation of related correspondence, is primarily dependent upon practical knowledge of medical records procedures and references, the organization and consistency of medical records, and basic knowledge of human anatomy, physiology, and medical terminology. These are characteristic requirements of the Medical Records Technician occupational series. Her position also demands some skill in composing correspondence and familiarity with fiscal (billing) procedures and automated systems used within her section. These additional requirements, though, are secondary

to and less demanding than the specialized medical records knowledge she must possess to effectively perform her duties. Consequently, the position's GS-675 series and title remain essentially as stated in the January 13, 1994, OPM decision, with one adjustment. The parenthetical designation *Office Automation* (or *OA*) is appended to the title to reflect new requirements of typing proficiency (at least 40 words per minute) and significant knowledge of office automation systems. Accordingly, the position is properly titled *Medical Records Technician (OA)*.

GRADE DETERMINATION

Work demanding less than a substantial (at least 25 percent) amount of time is not considered in classifying a position. Similarly, acting, temporary, and other responsibilities that are not regular and continuing are not considered. (Temporary assignments of sufficient duration, though, are sometimes recognized in accordance with agency discretion by temporary promotion if higher graded duties are involved, by formal detail, or by performance award).

The position's original duties were evaluated at the GS-6 level using the Medical Records Technician, GS-675, classification standard. The same standard applies to the new duties, as explained in the Series and Title Determination section of this decision. The new duties cannot be higher graded than the original duties unless they involve a substantially higher level of complexity, which they do not, for the reasons given below.

The GS-675 standard is written in Factor Evaluation System (FES) format. Under FES, work must be fully equivalent to the factor-level described in the standard to warrant credit at that level's point value. If work is not fully equivalent to the overall intent of a particular level described in the standard, a lower level and point value must be assigned, unless the deficiency is balanced by an equally important aspect of the work that meets a higher level.

Factor 1: Knowledge Required by the Position

This factor assesses the nature and extent of information or facts that employees must understand to do acceptable work (e.g., steps, procedures, practices, rules, policies, theories, principles, and concepts) and the nature and extent of the skills needed to apply those knowledges.

The appellant makes a number of claims pertaining to the knowledge requirements of both the position's original and new duties. The proper credit level under this factor for the original duties, which have not materially changed since certification of position 2746-0 in 1994, was determined to be Level 1-4. Consequently, her claims concerning those duties (such as gathering qualitative and quantitative data and coding highly specialized and complicated diagnosis and procedures and operations), are not again addressed.

Regarding the new duties (summarized in the Job Information section of this decision), the appellant believes Level 1-5 is warranted because she must consult with outside coders in what she feels are difficult coding situations and must communicate with insurance company clinical reviewers when obtaining pre-admission certification, authorization for admission, and certification for length of stay. This involves, as stated in the position description, detailed chart review to obtain information

regarding symptoms, diagnostic and therapeutic procedures, medications, expected treatment plan, etc. However, none of this demands greater knowledge than the original duties, which require similar in-depth chart reviews to ensure appropriate sequence, specificity, and comprehensiveness of diagnoses treated and procedures performed during an episode of care.

At Level 1-4, the appellant is already credited with practical knowledge 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. Level 1-4 also recognizes the more extensive knowledge required to resolve non-standard medical records procedural problems. In contrast, Level 1-5 Technicians apply a thorough knowledge of medical records activities, operations, and regulations associated with *specialized* assignments. Level 1-5 Technicians aid in a wide range of quality assurance studies, code complicated medical records, or make recommendations to improve procedures for compiling and retrieving medical records information.

As noted in OPM's 1994 decision:

At Level 1-5, employees aid in a wide range of research and quality assurance studies, set up and maintain special registries of select disease types (e.g., cancerous tumors), code the more complicated medical records, and make recommendations to improve procedures for compiling and retrieving medical record information. In contrast, the appellant does not conduct or directly aid clinical research efforts. In addition, her 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 recommend improvements to a process. Finally, the appellant codes a full range of medical conditions, diagnoses, and procedures - some simple and some complicated - not just those identified and selected because of their special difficulty.

The new duties similarly lack a substantial (demanding at least 25 percent of the time) amount of specialized assignments such as elementary studies of record systems, policies, and procedures. Rather they concern the same procedural and factual issues common to the original duties, though their purpose is somewhat different as discussed under Factor 5, and rely on the same types and level of knowledge for the resolution of problems encountered. For example, the appellant's contacts with outside coders (other VA Technician's who coded a current patient's records and nursing home or insurance company technicians) typically entail clarifying the reasons for certain code selections, rather than adapting coding practices to handle cases that are difficult to classify. Since the new duties impose no significantly higher level of specialized knowledge on the position, no higher credit is warranted under this factor.

We evaluate this factor at Level 1-4 and credit 550 points.

Factor 2: Supervisory Controls

This factor covers the nature and extent of direct and indirect controls exercised by the supervisor, the employee's responsibility, and the review of completed work. Controls are exercised by the supervisor in the way assignments are made, instructions are given to the employee, priorities and deadlines are set, and objectives and boundaries are defined. Responsibility of the employee depends upon the extent to which the employee is expected to develop the sequence and timing of various aspects of the work, to modify or recommend modification of instructions, and to participate in establishing priorities and defining objectives. The degree of review of completed work depends

upon the nature and extent of the review, e.g., close and detailed review of each phase of the assignment, detailed review of the finished assignment, spot-check of finished work for accuracy, or review only for adherence to policy.

The appellant does not dispute the assignment of Level 2-3, the highest level typically encountered in Medical Records Technician work, to her position. Level 2-3 is the appropriate level, as explained in OPM's previous decision, and remains unchanged since the new duties involve no greater responsibility than already credited.

We evaluate this factor at Level 2-3 and credit 275 points.

Factor 3: Guidelines

This factor covers the nature of guidelines and the judgment needed to apply them.

The appellant does not dispute the assignment of Level 3-3, the highest level typically encountered in Technician work, to her position. Level 3-3 is the appropriate level, as explained in OPM's previous decision, and remains unchanged since specific guidelines, policies, and procedures apply to the new duties.

We evaluate this factor at Level 3-3 and credit 275 points.

Factor 4: Complexity

This factor covers the nature, number, variety, and intricacy of tasks, steps, 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 appellant claims that her evaluations of patient treatment for appropriate medical necessity are extensively complex determinations; that her chart analysis and selection of appropriate codes requires technical knowledge of the complex processes involved, including, but not limited to legal, ethical, regulatory, quality assurance, and reimbursement issues; and that many times she must use her judgment in researching, analyzing, and obtaining clarification of issues and documentation from doctors, nurses, and physician assistants.

Claims similar to these were addressed in the 1994 decision, which found the original duties exceeded Level 4-2, but fell short of Level 4-3. The 1994 decision noted:

This above described portion of appellant's work meets Level 4-3 of the standard which requires that decisions about what needs to be done are accomplished by determining the relevance of many facts and conditions such as information within the record, legal and regulatory requirements, and other variables and thereafter selecting the proper course of action, sometimes from among many alternatives or where standard procedures are silent on an issue.

However, work at Level 4-3 by definition also involves performance of different and varied medical processes such as responding to patient, physician, and appropriate third party inquiries; maintaining registries of select diseases by type; carrying out quality assurance, research, or other special project studies; or periodically reviewing the work

of the [Activity] staff to ensure compliance with legal, regulatory, and quality requirements. The work of appellant does not include such additional duties and responsibilities.

In addition, though the appellant occasionally must deal with situations where the proper ICD-9-CM codes for new or previously unencountered diagnoses or procedures are difficult to determine, the procedures for dealing with such situations are relatively limited and straightforward. The appellant's choices consist primarily of consulting with the attending physician to determine if an appropriate substitute can be identified or informing her supervisor that she has encountered a situation lacking an appropriate code that needs to be resolved. On rare occasion, the appellant may consult with an outside coding expert designated by the Department of Veterans Affairs as a resource to assist with particularly difficult coding situations.

Similarly, nothing in the new duties suggests they demand a substantial amount of the appellant's time to independently analyze and interpret complicated inconsistencies or discrepancies, or that the new duties otherwise fully meet Level 4-3 requirements. Rather, they typically entail following straightforward procedures, e.g., in using or obtaining authoritative opinions from other staff regarding appropriate coding strategies when billing insurance companies. The appellant's letters requesting insurance companies to reconsider denials of payment are straightforward requests for reimbursement. Samples furnished by the appellant at our request, for example, ask for reimbursement for specific procedures instead of facility charges when a company objects to in-patient treatment. Other letters simply note that pre-certification was, in fact obtained, or not necessary according to earlier discussion with a company representative. The new duties require the appellant to make factual determinations, as at Level 4-2, but not the more subjective evaluations or more insightful analyses characteristic of the next higher level.

We evaluate this factor at Level 4-2 and credit 75 points.

Factor 5: Scope and Effect

This factor covers the relationship between the nature of the work (i.e., the purpose, breadth, and depth of the assignment) and the effect of work products or services both within and outside the organization. Only the effect of properly performed work is considered.

In support of her claim to higher credit, the appellant states that she must ensure the validity and reliability of data essential for credentialing and privileging of physicians, quality management, and facility reimbursement. She also claims that she must resolve inconsistencies, discrepancies, and non-routine problems.

Claims similar to these were addressed in regard to the original duties in the 1994 decision, which were found equivalent to Level 5-2. The 1994 decision noted:

Though the appellant performs some records functions that appear similar to Level 5-3, these functions differ in scope. 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 record-keeping system. As such, the work focuses on problems, discrepancies, and inconsistencies that occur during the processing of individual records, rather than the broader non-routine problems, discrepancies, and inconsistencies caused by policies, practices, procedures, and processes affecting the local medical record-keeping program and its associated medical record services. Finally, the appellant is not involved in a number of different, varied, and specialized record

processes typical of Level 5-3 such as responding to patient, physician, or third party inquiries, maintaining select disease registries, or carrying out quality assurance, research, or other special project studies.

The purpose of the position's newly assigned duties is to apply specific rules and procedures to ensure records and billings accurately reflect case history and comply with regulations and insurance coding practices. Unlike Level 5-3, the work does not entail a substantial amount of time resolving non-routine problems, contrary to the appellant's unsupported claims.

We evaluate Scope at Level 5-2.

The appellant states that her work has a direct affect on medical records keeping and the accuracy, timeliness, and reliability of some of the medical records services and the [Installation's] annual budget.

As at Level 5-2, the appellant's properly performed work directly affects the accuracy and timeliness, reliability, and acceptability of information in, and the further processing of, the records and bills that she reviews. Unlike Level 5-3, neither the original nor new duties directly and significantly affect the design or operation of the medical records keeping system, e.g., as would advising on the revision of procedures based upon the system-wide analysis of records maintenance.

We evaluate Effect at Level 5-2.

We evaluate this factor at Level 5-2 and credit 75 points.

Factor 6: Personal Contacts and Factor 7: Purpose of Contacts

The Medical Records Technician standard treats Factors 6 and 7 together. Contacts credited under Factor 6 must be the same contacts considered under Factor 7. Factor 6 (Levels 1 to 2) includes face-to-face contacts and telephone and radio dialogue with persons not in the supervisory chain. Levels of this factor are based on what is required to make the initial contact, the difficulty of communicating with those contacted, and the setting in which the contact takes place (e.g., the degree to which the employee and those contacted recognize their relative roles and authorities). Factor 7 (Levels A to B) addresses the purpose of personal contacts, which may range from factual exchange of information to situations involving significant or controversial issues and differing viewpoints or objectives.

Personal Contacts

The appellant indicates she meets with the general public almost daily and claims the purpose of such meetings is usually unclear at first and really established during discussion and, therefore, warrants greater credit.

While the position's original duties involve contact with patients or their representatives, they take place, as noted in the 1994 decision, in Level 1's highly structured setting where it is clear from the outset that factual information concerning medical history, insurance and financial status, etc., must be collected. The new duties extend the position's contacts to clinical reviewers at insurance companies, which are also routine contacts, but require the appellant to explain VA procedures and

requirements that the reviewer may be unfamiliar with or not understand, and to relate these to the insurance company's own procedures and requirements that differ from the VA's. These latter contacts are equivalent to, but do not exceed, Level 2's moderately unstructured setting.

Purpose of Contacts

The purpose of the position's original, Level 1 contacts was evaluated at Level B in OPM's 1994 decision. The purpose of the new, Level 2 contacts is to secure or provide factual information to bring requests for reimbursement within insurance company documentation requirements, as at Level A, rather than to coordinate work and solve technical problems, as at Level B.

According to the table on page 17 of the standard, Level 1B equates to 60 points and Level 2A equates to 45 points. The appellant receives credit for the higher combination.

We evaluate this factor at Level 1B and credit 60 points.

Factor 8: Physical Demands

This factor covers the requirements and physical demands placed upon the employee by the work assignment. This includes physical characteristics and abilities and physical exertion involved in the work.

Level 8-1 work is sedentary and presents no special physical demands. Level 8-2 work involves considerable walking, stooping, bending, and climbing. The appellant's work is sedentary and free of special physical demands.

We evaluate this factor at Level 8-1 and credit 5 points.

Factor 9: Work Environment

This factor considers the risks and discomforts in the employee's physical surroundings or the nature of the work assigned and the safety regulations required.

Level 9-1 work is in an office setting. Level 9-2 work, though not described in the standard, involves moderate safety risks or discomforts that require special precautions. The appellant's work is performed in an office setting and requires no special safety precautions.

We evaluate this factor at Level 9-1 and credit 5 points.

Factor Level Point Summary

Factor	Level	Points
1	1-4	550
2	2-3	275
3	3-3	275
4	4-2	75
5	5-2	75
6 & 7	1B	60
8	8-1	5
9	9-1	5
	Total	1320

The table above summarizes our evaluation of the appellant's work. As shown on page 8 of the standard, a total of 1320 points falls within the GS-6 grade range (1105 - 1350).

DECISION

The proper classification of the appellant's position is Medical Records Technician (OA), GS-675-6.