U.S. Office of Personnel Management
Office of Merit Systems Oversight and Effectiveness
Classification Appeals and FLSA Programs

**Philadelphia Oversight Division**
**600 Arch Street, Room 3400**
**Philadelphia, PA 19106-1596**

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

| | |
|---|---|
| **Appellant:** | [appellant's name] |
| **Agency classification:** | Medical Records Technician<br>GS-675-7 |
| **Organization:** | Health Information Management Section<br>Management Systems Care Line<br>[name] Veterans Affairs<br>Medical Center (VAMC)<br>VA Healthcare Network [name]<br>Department of Veterans Affairs<br>[location] |
| **OPM decision:** | Medical Records Technician<br>GS-675-6 |
| **OPM decision number:** | C-0675-06-03 |

/s/ Robert D. Hendler

Robert D. Hendler
Classification Appeals Officer

August 27, 2002

Date

As provided in section 511.612 of title 5, Code of Federal Regulations (CFR), 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* (PCS's*)*, appendix 4, section G (address provided in appendix 4, section H).

Since this decision lowers the grade of the appealed position, it is to be effective no later than the beginning of the sixth pay period after the date of this decision, as permitted by 5 CFR 511.702. The servicing personnel office must submit a compliance report containing the corrected position description (PD) and a Standard Form 50 showing the personnel action taken. The report must be submitted within 30 days from the effective date of the personnel action.

The personnel office must also determine if the appellant is entitled to grade or pay retention, or both, under title 5, United States Code (U.S.C.) , 5 U.S.C. 5362 and 5363 and 5 CFR 536. If the appellant is entitled to grade retention, the two-year retention period begins on the date this decision is implemented.

**Decision sent to:**

[appellant's name]
[appellant's address]

Business Representative
[name] Union
[number], AFL-CIO
[address]
[location]

Medical Center Director
Department of Veterans Affairs
VA Healthcare Network
[name]
VA Medical Center
[address]
[location]

Director
VA Healthcare Network
[name]
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Deputy Assistant Secretary for
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## Introduction

On February 11, 2002, the Philadelphia Oversight Division of the U.S. Office of Personnel Management (OPM) accepted a classification appeal from [appellant's name]. Her position is currently classified as Medical Records Technician, GS-675-7. The appellant believes the classification should be Outpatient Coding Compliance Specialist, GS-9. We received the agency appeal administrative report on March 26 and the appellant's comments on the report on April 9 and April 15. The position is in the Health Information Management (HIMS) Section, Management Systems Care Line, [name] Veterans Affairs Medical Center (VAMC), VA Healthcare Network [name] (Veterans Integrated Service Network (VISN) [number]) at [name], Department of Veterans Affairs, [location]. We have accepted and decided her appeal under 5 U.S.C. 5112.

## General issues

In her February 7, 2002, letter, the appellant enclosed copies of a Data Capture Coordinator, GS-343-9/11, and a Coding Compliance Officer, GS-669-9/11, position description (PD). She asked that they be considered in the classification of her position since they included duties that she was performing. The appellant provided a copy of a grievance that she had filed against her activity over the accuracy of her PD which stated that she was performing coding compliance work performed by employees who occupied higher graded PD's. She also compared her educational credentials with those of employees in higher graded coding compliance positions.

The appellant said that her PD was not accurate because she does not spend 90 percent of her time coding. She stated that she spends a majority of her time creating encounter forms and educating physicians, providers, and clerks. During our appeal fact-finding, the appellant said that her co-workers, covered by the same PD, spent 90 percent of their time coding. However, she was the only one on the PD engaged in encounter form development and coding audit work.

In her April 9 response to the agency appeal administrative report, the appellant pointed to e-mails that she said showed there were higher graded positions in other VA medical centers performing coding work. She provided copies of higher graded PD's that she believed showed that she was performing higher level coding compliance work. The appellant took issue with an e-mail message in the report stating that although the appellant's PD was classifiable at the GS-7 grade level, four factors appeared to be overstated and there was likelihood that the position could be downgraded on appeal.

By law, we must classify positions solely by comparing their current duties and responsibilities to OPM PCS's and guidelines (5 U.S.C. 5106, 5107, and 5112). Other methods or factors of evaluation are not authorized for use in determining the classification of a position, such as comparison to positions that may or may not have been properly classified. Because our decision sets aside all previous agency decisions, the appellant's concerns regarding her agency's classification review process are not germane to this decision.

Implicit in the appellant's rationale is a concern that her position is classified inconsistently with other positions. The appellant highlighted portions of the PD's that she provided, saying that she was performing that work and that the highlighted duties are not performed by medical records

technicians, i.e., coding quality assurance, forms development, and provider education. As discussed in this appeal decision, reviewing medical records coding decisions made by others, responding to coding questions, training others on how to code medical procedures and diagnoses, and developing coding tools are functions covered by the GS-675 series.

Like OPM, the appellant's agency must classify positions based on comparison to OPM PCS's and guidelines. Section 511.612 of title 5 of the CFR, requires that agencies review their own classification decisions for identical, similar, or related positions to insure consistency with OPM certificates. Thus, the agency has the primary responsibility for insuring that its positions are classified consistently with OPM appeal decisions. If the appellant believes that her position is classified inconsistently with others, she may pursue this matter by writing to her agency headquarters human resources office. In so doing, she should specify the precise organizational location, series, title, grade, duties, and responsibilities of the positions in question. The agency should explain to her the differences between her position and the others, or grade those positions in accordance with this appeal decision.

**Position information**

The appellant occupies one of five identical additional positions in the VAMC [name] HIMS Section. She works with outpatient records and her co-workers deal with inpatient records. Inpatient coders assign International Classification of Disease-9-CM (ICD-9-CM) codes to the patient record (quantitative) that are supported by medical documentation entered into the patient record by providers (qualitative). Billing procedures use these codes to assign and charge services rendered. Using the encoder automated system, the inpatient coder identifies and assigns the principal diagnosis for admission Diagnostic Related Group that is used for inpatient billing.

In contrast, initial outpatient coding is done in clinics by providers, e.g., physicians and nurses, or clinic clerks. In addition to ICD-9-CM diagnosis codes, outpatient coders must input Current Procedural Terminology codes to reflect the actual services rendered. Because providers are not skilled coders, the appellant responds to their requests for technical assistance. Based on instructions from the Outpatient Compliance Coordinator, the appellant pulls samples of outpatient clinic records and conducts quantitative and qualitative reviews. She submits her findings to the coordinator which include action errors and a summary of issues. The appellant frequently assists the coordinator when the findings are shared with the outpatient clinics. The appellant similarly resolves coding issues on billing requests. She supports clinic operations, e.g., opening and closing clinics in the automated system to control computer systems access and assisting clinic staff in using automated systems. The appellant estimated that she devotes approximately 40 to 50 percent of her time to these functions.

The appellant estimates that she spends approximately 20 to 30 percent of her time developing and revising clinic encounter forms. These forms are a VISN project. The goal is to develop electronic forms that will make it easier for clinics to accurately and consistently record coding data. Other VISN's are developing forms as part of a broader program effort to eventually develop national forms. The appellant's assignments include orthopedics and audiology and speech pathology. One of her forms (rehabilitation) is being tested for VA-wide use. The appellant initially gathers data on coding practices and treatment in the specialty area from

providers, published coding guidelines, and agency practices. The VISN encounter form group reviews and comments on the forms drafted by each member. The appellant is expected to keep abreast of quarterly coding changes. The Outpatient Compliance Coordinator exercises program authority over encounter forms and updates. All forms must be reviewed and approved by the VISN 2 HIMS Manager.

The appellant estimates that she spends 20 to 30 percent of her time on providing coding education. She drafts training materials for her approved encounter forms and formally briefs providers on their use and routinely answers provider questions on encounter forms. The appellant includes researching provider questions on coding as part of her education functions.

Agency management has certified that the appellant's PD of record (#[number]) is accurate. We conducted an on-site audit with the appellant on June 13 and 14, 2002, and an interview with the appellant's supervisor, [name] on June 13. To clarify information provided during those conversations, we conducted telephone interviews with VISN 2 HIMS staff with whom the appellant works including [name], Veterans Integrated Service Network VISN [number] HIMS Manager and [name], VISN Outpatient Compliance Coordinator-VAMC [name], on June 19, and [name], Compliance Coordinator-VAMC [name], and [name], Compliance Coordinator, VAMC-[name], on June 20.

The PD of record contains the duties and responsibilities assigned by management and performed by the appellant. However, it does not accurately reflect the amount of time that the appellant spends on her major duties. The PD states that she codes records 90 percent of the time. As discussed in the Position information section, the appellant does not routinely code records. Rather, she reviews records coded by others. The PD includes duties that are rarely performed, e.g., coding new and unusual diagnoses and procedures not clearly listed in coding guidelines. In deciding this appeal, we fully considered the audit and interview findings and all information of record furnished by the appellant and her agency, including her official PD which we incorporate by reference into this decision.

**Series, title, and standard determination**

The agency has classified the position in the Medical Records Technician Series, GS-675, titled it Medical Records Technician, and determined that it is properly graded by application of the Job Family Standard for Assistance and Technical Work in the Medical, Hospital, Dental, and Public Health Group, GS-600 (GS-600 JFS). The appellant believes that she is performing two-grade interval administrative work classified to the GS-669 Medical Records Administration Series or the GS-343 Management and Program Analysis Series. In support of her rationale, the appellant points to her coding audit, encounter form development, and educating of clerks, physicians, and nurses on coding.

Medical records administrators use broad medical records management knowledge, concepts, and principles in the administrative management of medical records systems, programs, or specialty areas. Both medical records administrators and medical records technicians review and analyze records. Administrators perform analyses that go beyond the contents of individual patient records to assess the effectiveness of the medical records program. They analyze the medical data requirements of the program and develop effective methods to collect and use this

information on an institution-wide basis. Medical records administrators are responsible for planning and developing the patient information system, including developing operating methods and procedures covering all medical records functions which require an understanding of the interrelationship of record services with the rest of the facility's services. They must also apply administrative and management theories, principles, and techniques to many situations and programs.

In contrast, medical records technicians work in support of the specialist to achieve program goals. Technicians analyze individual records for completeness, use of accepted terminology, and for compliance with regulatory requirements. They follow established methods and procedures which have been developed by medical records administrators. They are primarily concerned with the application of these guidelines to specific medical records operations such as analyzing records, coding information, and abstracting information from records to answer correspondence.

The appellant performs work typical of the GS-675 occupation in that she reviews, analyzes, codes, abstracts and compiles medical records data. Typical of higher level duties in the GS-600 JFS, the appellant performs internal quality assurance work. This includes reviewing the adequacy of coding decisions made by providers and medical clerks, organizing the data for reports, and highlighting areas of interest. The appellant frequently accompanies medical records administrators to discuss clinic findings, decisions on which clinics and/or clinic staff to review, and how these reviews are structured. However, assessing the significance of issues from the medical center and/or VISN perspective and dealing with higher level managers on trends are reserved to GS-669 VISN employees. The appellant's work on encounter forms is fully covered by the GS-675 series. It requires understanding and use of established coding guidelines and methods to develop forms that make coding input easier for health care workers who are not trained and certified medical coders. Conducting briefings during the rolling out of encounter forms and responding to coding questions (i.e., education) rely on these same GS-675 knowledge and skills.

Typical of the GS-675 series, the appellant works on portions of projects devised and managed by medical records administrators. The appellant reports to the leader of the VISN outpatient coding function who manages a program that includes encounter form development and coding quality review, which is typical of GS-669 work. Characteristic of GS-675 work, the appellant identifies coding issues within clinics. She uses available tools to search for answers by contacting VISN employees in GS-669 positions, searching coding publications and on-line coding tools, and seeking guidance from the VA Coding Council that was established to respond to such inquiries. Therefore, the appellant's position is properly allocated as Medical Records Technician, GS-675, and is properly graded by application of the GS-600 JFS.

**Grade determination**

The GS-600 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. Our analysis of the work follows.

*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.

As at Level 1-4, the appellant applies 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 nonstandard medical records procedural problems, e.g., assisting providers and resolving billing issues. As discussed in the JFS, Level 1-4 knowledge is applied when performing quality assurance, compiling statistical data, collecting and organizing data for statistical reports and audits, and extracting data for statistical and other reports. The appellant's encounter form work involves applying Level 1-4 knowledge of anatomy and physiology, medical techniques, and major disease processes, diagnoses, procedures, tests, pharmaceutical operations, psychological and other specialized terms required to code diagnostic and procedural information to capture and code required medical information.

The appellant's work does not meet Level 1-5. This level involves applying a thorough and detailed knowledge of a comprehensive body of rules, procedures, and operations associated with *specialized* assignments. 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, and identifying trends and patterns for preparing reports. These functions require applying more complicated techniques, e.g., assisting professionals in retrieving data for research, diagnostic, and teaching purposes by applying complex case-mix algorithms and linking multiple sources of information such as electronic data bases and patient records.

In contrast, the appellant does not conduct or directly aid clinical research efforts. Level 1-5 work includes implementing and monitoring internal quality assurance programs. In contrast, the appellant's quality assurance work is limited to reviewing individual medical records compared against a standard. These reviews are part of on-going internal quality assurance processes rather than the wide range of quality assurance studies found at Level 1-5, e.g., quality assurance studies targeting specific program issues and trends. While the appellant highlights and reports audit issues to the Outpatient Compliance Coordinator, it is the latter position that is responsible for assessing the program implications of those findings and recommending improvements to a process.

The appellant codes and/or reviews the coding of a full range of medical conditions, diagnoses, and procedures, ranging from simple to complicated, and not just those identified and selected because of their special difficulty. Level 1-5 covers coding complicated records having a wide range of diagnoses and procedures that even skilled coders have difficulty classifying. These cases typically comprise a small portion of the records found in research and teaching institutions

that use new and experimental treatments or therapies with rapidly changing technologies. In contrast, the appellant deals with outpatient clinic coding issues that do not routinely present these characteristics. Her contacts with medical clerks and providers typically entail clarifying the reasons for certain code selections, rather than adapting coding practices to handle cases that are difficult to classify. While the PD of record states that she codes complicated records, outpatient services do not include coding the more complex diseases, conditions, and surgeries associated with in-patient specialty care.

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's position meets but does not exceed Level 2-3, the highest level described in the JFS. As at Level 2-3, the appellant is responsible for assigned clinics and projects, e.g., clinic coding reviews and developing encounter forms. She seeks assistance for new or controversial situations from the VISN medical records administration staff and/or the VA coding council. Typical of Level 2-3, she plans and carries out her work independently, following standard operating procedures and practices. Her work is reviewed for results achieved, technical soundness, and conformance with applicable regulations, policies, and requirements. For example, the appellant follows encounter form development procedures independently, referring draft forms for review and approval. She independently plans and conducts records reviews in identified clinics and provides findings and issues to the Outpatient Compliance Coordinator.

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's position meets but does not exceed Level 3-3, the highest level described in the JFS. As at Level 3-3, the appellant uses the full range of available technical instructions, manuals, agency and facility instructions, regulatory requirements, and established procedures to resolve coding issues and correct coding errors. Typical of that level, she regularly handles coding questions raised by medical clerks and providers where there are gaps in specificity, e.g., establishing codes for the new outpatient infusion program that support proper billing charges. The appellant adapts and interprets guidelines to specific cases or problems, e.g., determining

user coding needs for encounter forms and isolating quality review issues for review by the Outpatient Compliance Coordinator. She routinely uses discretion and initiative to improve the reliability of information, highlighting coding issues from her clinic reviews.

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.

As at Level 4-2, the appellant's evaluations of patient treatment for coding purposes requires technical knowledge of the complex processes involved, including, but not limited to, legal, ethical, regulatory, quality assurance, and reimbursement issues. She must use her judgment in researching, analyzing, and obtaining clarification of issues and documentation from providers. Typical of Level 4-2, she must recognize and resolve discrepancies in the record that affect medical and billing data system integrity.

Some of the appellant's work approaches Level 4-3. At that level, decisions about what needs to be done are made by determining the relevance of many facts and conditions such as information within the record, legal and regulatory requirements, and other variables. She must select the proper course of action, sometimes from among many alternatives or where standard procedures are silent on an issue. Problems approaching this complexity occasionally surface during her review of clinics handling the most complex medical procedures where she must discern interrelationships and correct inconsistencies and discrepancies in the clinic staff's understanding of and approach to coding decisions.

However, work at Level 4-3 by definition also involves performing different and varied medical processes such as reviewing the work of the VISN HIMS staff to ensure compliance with legal, regulatory, and quality requirements. In contrast, the appellant reviews the work of providers and others who are not skilled coders. As discussed previously, the outpatient clinic orientation of her duties does not include direct support to teaching and research functions or the complicated staff studies supported at Level 4-3. Although the appellant occasionally deals 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 straightforward. The appellant's choices consist primarily of consulting with the attending physician to determine if an appropriate substitute can be identified or contacting the VISN HIMS medical records administrators for guidance. If the issue cannot be resolved within the VISN, she obtains permission to query the VA Coding Council. The duties require the appellant to make factual determinations, as at Level 4-2, but not the more subjective evaluations or more demanding 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.

As at Level 5-2, the appellant analyzes medical records information for the presence of required forms, completeness of data, and compliance with quality assurance regulations. Typical of that level, she compiles the results of her records reviews that show trends in the individual clinics or actions of specific providers. The work affects the accuracy, reliability, and acceptability of information in medical records and that subsequent billing accurately reflect case history and comply with regulations and insurance coding practices.

The appellant performs some records functions that appear similar to Level 5-3. 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.

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 that she reviews. The work, in turn, affects third party billing based on these records. Unlike Level 5-3, her duties do not directly and significantly affect the design or operation of the medical records keeping system. While her encounter form and quality review work contribute to improving HIMS program effectiveness, higher level VISN HIMS positions are responsible for decisions that affect the overall program accuracy and effectiveness, e.g., revising procedures based upon the system-wide analysis of records maintenance.

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

*Factor 6, Personal contacts, and Factor 7, Purpose of contacts*

The GS-600 JFS 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 are really established during discussion and, therefore, warrants greater credit.

Most of the appellant's contacts are with providers and other medical center and clinic staff where the purpose of the contact is clear. However, the appellant's encounter form and other program contacts extend throughout the VISN, e.g., encounter form briefings. She works with providers to explain coding procedures and requirements. These latter contacts meet, but do not exceed, Level 2, the highest level described in the JFS.

*Purpose of contacts*

The purpose of the appellant's contacts meets Level B. As at that level, her contacts on encounter forms, quality reviews, and other program issues are to coordinate work and solve technical problems. Her work does not meet Level C, which involves influencing, persuading, interrogating or controlling people or groups, e.g., patients with mental conditions with whom communication is difficult.

We evaluate this factor at Level 2B and credit 75 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 involves moderate safety risks or discomforts that require special precautions, e.g., working in proximity to mentally disturbed patients where there is a possibility of physical abuse or exposure to contagious diseases that may require using protective clothing or gear. 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.

*Summary*

In summary we have evaluated the appellant's position as follows:

| ***Factors*** | ***Level*** | ***Points*** |
|---|---|---|
| 1. Knowledge required by the position | 1-4 | 550 |
| 2. Supervisory controls | 2-3 | 275 |
| 3. Guidelines | 3-3 | 275 |
| 4. Complexity | 4-2 | 75 |
| 5. Scope and effect | 5-2 | 75 |
| 6. Personal contacts and 7. Purpose of contacts | 2B | 75 |
| 8. Physical demands | 8-1 | 5 |
| 9. Work environment | 9-1 | 5 |
| Total Points | | 1,335 |

A total of 1,335 points falls within the GS-6 grade level point range of 1,105-1350 points on the Grade Conversion Table.

**Decision**

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