Job Description

Job Summary

Conduct the necessary audits of medical record to verify the physicians have appropriately documented the diagnoses then code these diagnoses in ICD-10 for Medicare Risk Adjustments/Medicare Advantage. Evaluate medical information (Outpatient/Inpatient) documentation from a clinical standpoint for evidence of the possibility of additional medical conditions that may not have been documented in the past, and ensure accurate coding of the encounter data and recommend processes for accurate coding practices. This process involves a very strong understanding of medical coding.

- Ascertain that medical record documentations have accurate diagnoses and conditions to assure not to up-code, fraudulently or misrepresent the patient condition and ensure compliance to prepare for random CMS medical records audit
- HEDIS coding and record collection
- Report Coding discrepancies patterns identified within the chart review process to the Coding Project Manager and identify corrective measures regarding compliance problems, and suggests corrective measure to the physician in understanding of what is needed regarding documentation compliance

Provider Education
- Provide detailed summary to make adjustments to correct improperly paid claims and document the correct coding to be utilized

Management Feedback:
- Communicate quality issues to direct supervisor & COO, Team Leaders and other Managers.
- Provide recommendations to management based on audit findings

Management reports:
- Prepare management summary reports of audit findings

Additional Responsibilities:
- Provide support to the Management as required.
- Maintains detailed knowledge of coding guidelines and regulations

Qualification Experience and Skills Required Experience:
- Must have CPC or CCS certification
- Five (5) years coding experience.
- Multi-Specialty coding experienced required.
- Outpatient/Clinic billing experience required.
- Physician billing office supervisory experience preferred
- Knowledgeable in Hierarchical Condition Categories (HCC) concepts and documentation guidelines.
- Knowledge in MACRA reporting
- High School degree required. Some college preferred.

Skills:
- Proficiency in medical billing systems.
- Knowledge in coding methodology State and Federal Billing Guidelines.

- Demonstrated expertise in current multi-specialty CPT, ICD-10, and HCPCS coding principles and practices including modifiers.
- Knowledge in Evaluation and Management Documentation guidelines. Performs E & M audit.
- Understanding of ICD-10-CM
- Knowledgeable about medical terminology, disease processes, and pharmacology
- Ability to develop effective and professional training programs for staff.
- Proven ability to interact with physicians and support staff.
- Excellent verbal and written communication skills.
- Proficient in Word, Excel, & Power Point as applicable.
- Ability to drive own transportation.