Date: July 15, 2021
Job Description: Claims Coding Analyst
Reporting to: Operations Supervisor

Overview:
Claims Coding Analyst should be detailed-oriented, analytical and self-motivated. Coding Analyst must be able to handle multiple deadlines in a fast paced environment with minimal supervisor. Responsible for consistently and accurately analyzing data in accordance with policies, procedures and guidelines as outlined by the company policy. Review claims according to all CMS and DMHC guidelines. Review, research and ability to process complex claims data. Implementation of Correct Coding guidelines via the Virtual Examiner Program. Ensuring proper edits are applied.

Primary Responsibilities:
1. Review application of correct coding edits within the Virtual Examiner Program.
2. Provide expertise or general claims support by reviewing, researching, investigating, negotiating, processing and adjusting claims
3. Authorize appropriate payment or refer claims to investigators for further review
4. Analyze and identify trends and provides reports as necessary
5. Consistently meet established productivity, schedule adherence, and quality standards
6. Accurately process professional and hospital claims
7. Analyze and adjudicate claims to ensure accurate payment
8. Meet Department Quality and Accuracy Standards.
9. Interfaces with other departments to obtain necessary information required for resolution of claims
10. Advise management of any claim issues or inappropriate and/or incorrect billing
11. Train other examiners
12. Assist with SOP development
13. Other duties assigned by management
14. Responsible for editing and adjusting of EDI claims
15. Identify and pend claims that require referrals to all support areas (eligibility, Medical management etc.) for evaluation or correction of data, tracking these claims to ensure that they are returned and resolved within regulatory guidelines
16. Achieve stringent quality goals of 98% administrative accuracy and 99% financial accuracy to contribute to achieving client performance expectations
17. Responsible for ODAG, Part C and MTR submissions Monthly/Quarterly.
18. Analyze Hospital claims for correct payment using the DRG (Diagnosis-Related Group), Skilled Nursing, Home Health and Dialysis claims.

Required Qualifications:
Certified Professional Coder (CPC)
An education level of at least a high school diploma or GED
Minimum Experience: Three (3) years prior medical claims processing experience required claims

Preferred Qualifications:
Ability to multi-task, this includes ability to understand multiple products and multiple levels of benefits within each product
Prior Medicare, Commercial, ERISA and HMO experience preferred
Skilled in Excel