Mission Statement: ***"Our goal is to provide education and process development to enhance communication and understanding among all individuals involved in the documentation and coding of the health record to ensure the clinical reliability and integrity of the health care data."***

Title: Clinical Coding Analyst | **Revised: July 1, 2020**

Reports to: Director, Operations | **Status: Exempt**

JOB SUMMARY:

The Clinical Coding Analyst is a credentialed coder, HIM professional, and/or Registered Nurse who is responsible for pre-bill inpatient chart reviews specific to MS DRG assignment. The analyst is responsible for identifying revenue opportunities and compliance risks based on the *Official ICD-10-CM/PCS Guidelines for Coding and Reporting, AHA Coding Clinics,* disease process, procedure recognition, and clinical knowledge.

JOB PROGRESSION: (Based on level of expertise, quality standards, and individual progression)

Tier	Daily Chart Volume	Bonus Opportunity
0	Training – 0	No
1	10-15	No
2	20-25	No
3	30-35	Yes
4	35-40	Yes
5	40+	Yes

ESSENTIAL FUNCTIONS:

- Clinical Coding Analyst are assigned to a specific client(s) and has primary responsibility of the daily pre-bill chart reviews and communication to the client(s) within a 24-hour time frame for each chart reviewed.
- Provides daily client volumes to Manager no later than 7:15 EST
- Reviews the electronic health record to identify both revenue opportunities and potential coding compliance issues-based ICD-10-CM/PCS coding rules, *AHA Coding Clinics*, and clinical knowledge.
- Provide verbal review on all cases with a potential MS DRG recommendation and/or physician query opportunities with the Enjoin Physician(s) via telephone call prior to submitting recommendations to the client.

- Ensures that the daily work list is uploaded into the MS DRG Database for assigned client(s) and enter required data elements for each patient recommendation into MS DRG Database.
- Prepares and composes all recommendations, including increased reimbursement, decreased reimbursement, and "FYI" for each account and communicates that to the client within 24 hours of receiving and reviewing the electronic medical record.
- Follows internal protocol on all client questions and rebuttals on cases reviewed within 24 hours of receipt.
- Responsible for review and appeal, if warranted, on Medicare and/or third-party denials on charts processed through the MS DRG Assurance program.
- Responsible for reviewing inclusions and exclusions specific to 30 Day Readmissions and Mortality quality measures on specific cohorts for traditional Medicare payers for specific clients.
- Maintains IT access at all client sites that have been assigned by ensuring that log on and passwords have not expired.
- Maintain current knowledge of ICD-9-CM and ICD-10-CM/PCS code changes, *AHA Coding Clinic*, and Medicare regulations.
- Utilizes internal resources, such as TruCode, Enjoin I10 Wiki, and CDocT.
- Must achieve a minimum of 30 chart reviews per day with an accuracy rate above 95% within the first year of employment.
- Adhere to all company policies and procedures
- Participation in company and/or department meetings
- Participation on client calls as needed

COMPANY EXPECTATIONS/GOALS:

- Complete mandatory annual HIPAA and Compliance Training in a timely manner
- Maintain confidentiality in all matters to include patient care, physician and employee matters
- Maintain accurate and reliable organizational records
- Maintain professional relationships with appropriate officials; communicate honestly and completely; behave in a fair and nondiscriminatory manner in all professional contacts
- Assure the accuracy of data, work, or information and contribute ideas and suggestions to improve approaches, methodologies, and productivity.
- Maintain professional relationship with customers focusing on high level of customer satisfaction
- Adhere to a personal plan of professional development and growth through professional affiliations, activities and continuing education
- Support overall strategic goals of the company

HOME OFFICE REQUIREMENTS:

- Must have a quiet and secure space when reviewing protected health information (PHI).
- Enjoin encrypted computer with high-speed internet connection.
- Telephone and printer/scanner.
- Company will provide access to TruCode encoder system and resources to perform job duties.

EDUCATION, TRAINING, AND EXPERIENCE:

- AHIMA coding credential of CCS or CDIP or ACDIS credential of CCDS is required.
- Graduate of an accredited Health Information Technology or Administration program preferred with AHIMA credential of RHIT or RHIA.
- Minimum of 7 to 10 years of acute inpatient hospital coding and/or auditing experience in a large tertiary hospital required. Consulting experience preferred.

- Experience with CDI (Clinical Documentation Improvement) programs preferred.
- AHIMA Approved ICD-10 CM/PCS Trainer preferred. Knowledge of ICD-10 CM/PCS required.
- Graduate of an accredited program of nursing preferred with a minimum of 3-5 years of hospital nursing experience in various clinical areas.
- Experience with electronic health records (i.e., Cerner, Meditech, Epic, etc.) required.
- Experience working remotely required.
- Excellent oral and written communication skills required.
- Must demonstrate analytical ability, initiative, and resourcefulness.
- Ability to work independently required.
- Excellent planning and organizational skills required.
- Teamwork and flexibility required.
- Be proficient in Microsoft Office Word and Excel programs.