



**Job Title:** Medical Documentation Analyst  
**Department:** Network Management  
**Reports To:** Director, Network Management  
**FLSA Status:** Exempt

**Summary** Responsible for conducting clinical chart audits for the purpose of identifying and submitting documented diagnoses to Medicare/Medicaid for health plan members. Interacts with a variety of internal and external clients including health care executives, physicians, and provider office personnel. Offers support in the Medical Risk Adjustment department, focusing on provider education and educational material development. Assists in all the functions within the department to ensure that all of the delegated duties are processed smoothly, efficiently and effectively.

**Essential Duties and Responsibilities** include the following.

- Reviews high volume of medical records to determine if specific disease conditions were overlooked in billing.
- Adheres to all official coding rules and CMS guidelines for risk adjustment reporting and ensures accuracy, completeness, specificity and appropriateness of diagnosis information.
- Completes HEDIS chart review.
- Completes appropriate paperwork and documentation regarding claim/encounter diagnosis information.
- Demonstrates analytical and problem-solving ability regarding review of submitted diagnosis codes versus actual services provided to the patient.
- Performs analysis from the chart reviews for provider education training.
- Works with other members of the organization to ensure the smooth processing of the chart review functions.
- Assists in the development of educational materials.
- Provides articles for the quarterly coding newsletter.
- Performs other duties as assigned by Management.
- Places emphasis on compliance with Risk Adjustment procedures and protocol, internal controls, and maintaining the highest level of workplace behavior.

**Qualifications** To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

**Certificates, Licenses, Registrations**

Certified Coding Specialist through AAPC, BAMC or AHIMA, specifically in ICD-9-CM and CPT Evaluation and Management coding.

**Education and/or Experience**

Associate's degree (A. A.) or equivalent from two-year College or technical school; or six months to one year related experience and/or training; or equivalent combination of education and experience.

**Other Skills and Abilities**

Previous auditing experience desirable.

**Other Qualifications**

At least 3 years previous experience in Managed Care and Medicare required; Prior HCC experience with Medicare Risk Adjustment and at least 4 years experience in medical coding required.