# Coding Charges & Denial Specialist- Remote

**Houston Methodist Specialty Physician Group**
Job Location: Houston, TX
Full Time, Day Shift, Remote

**JOB SUMMARY:**

The Coding Charges and Denial Specialist is responsible for coordinating and monitoring the coding specific clinical charges and denial management and appeals process in a collaborative environment with TMHPO Revenue Cycle management and clinical partners at various Methodist facilities. This position will be responsible for working assigned specialties that may include but are not limited to: primary care, general surgery, neurosurgery, neurology, orthopedics, cardiology, CV surgery, medicine, ENT, plastic surgery, OBGYN, and radiation oncology.

The incumbent combines clinical, business, and regulatory knowledge and skill to reduce significant financial risk and exposure caused by front end claim edits and retrospective denial of payments for services provided. This position will be responsible for reviewing and addressing customer service inquiries as they relate to coding and charge capture.

The incumbent collaborates with physicians, TMHPO Revenue Cycle personnel and payers to successfully clear front end claim edits, appeal clinical denials, and address customer service inquiries. Additionally, the Coding Charges & Denials Specialist collaborates with TMHPO Revenue Cycle management to develop meaningful appeal strategies to include reference material for staff, letter templates, regular feedback for revenue cycle coding staff and functions as clinical subject matter expert related to coding denials and appeals.
This position can work remotely in the Houston Metropolitian area.

**PRIMARY JOB RESPONSIBILITIES:**

PEOPLE 25 %

1. Communicates openly in a transparent and professional demeanor during all interactions with customers and co-workers while providing clear and concise communication of trending and findings to both front line team members and senior executives. (EF)
2. Communicates to partners, revenue cycle staff, customers, and third party payers by telephone, in meetings, email, and other necessary forms of communication in a clear, effective, and timely manner while additionally providing proactive updates on initiatives that involve time and effort from peers and other employees. ( EF)
3. Functions as an educational liaison to clinical staff and revenue cycle staff as needed on payer denials, denial reason and trending, interpretation of payer manuals, medical policies and local/national coverage determinations. (EF)

SERVICE - 20 %

1. Performs data mining and reporting activities that identify net positive impactful opportunities in denials and adjustments for the individual facilities and the System. (EF)
2. Works assigned claim edit and follow up Epic Work Queues and meet the assigned productivity standards on a daily basis as well as assigned patient account Epic work queues and respond with resolutions within the expected time frame. (EF)
3. Acts as a liaison for issues affecting various teams (coding, revenue integrity, AR follow up, etc.) of the revenue cycle while also providing support when IT related or systematic changes are needed. (EF)
4. Complies with Business Practice Standards of performance. (EF)

QUALITY/SAFETY - 25 %

1. Analyzes data from various sources (medical records, claims data, payer medical policies, etc.), determines the causes for denials of payment and partners with management to implement strategies to prevent future denials. ( EF)
2. Integrates the payer medical policies, case specific medical documentation, and claims information into a concise appeal letter, including appropriate medical records submission. (EF)
3. Performs timely review of medical records and remittances for denials in order to determine root cause and appropriateness. (EF)

FINANCE 20%

1. Partners with TMHPO Revenue Cycle leadership and peers and clinical operations to reduce denials. This includes reviewing claim edits and denials and/or inquiries referred from other departments and assists in identifying root causes. (EF)
2. Investigates the validity of the reasons for the denials and determines the need for or feasibility of submitting appeals. ( EF)

3. Works with TMHPO Revenue Cycle management and staff to ensure claim edit/denial trending data is accurate and that all metrics are reported appropriately including specific CPT/HCPCS, denial reasons, and appeals, Monitors recovery of payments, monitors trends to identify corrective measures needed to prevent future edits/denials. (EF)
4. Analyzes claim edits/denials to identify new trends, opportunities, and educational feedback as needed. This includes, but not limited to feedback to coding, clinical service areas, physicians, and other revenue cycle staff. Makes recommendations to TMHPO Revenue Cycle leadership on operations, root causes, and assists in development of strategies to avoid future claim edits and denials. (EF)

GROWTH/INNOVATION - 10 %

1. Provides education to revenue cycle team and attend monthly billing staff meetings as appropriate.
2. Accountable for ongoing professional growth and development to maintain coding certification while remaining current on all coding and regulatory updates in addition to participating in educational activities.

**QUALIFICATIONS:**

EDUCATION REQUIREMENTS

- High School diploma or equivalent education (examples include: GED, verification of homeschool equivalency, partial or full completion of post-secondary education, etc.)

EXPERIENCE REQUIREMENTS

- Minimum 5 years of certified coding experience with coding denials and AR follow up experience preferred.

CERTIFICATES, LICENSES AND REGISTRATIONS REQUIRED

- Active certification from AAPC, AHIMA or approved Specialty Society Coding Certification.

**PREFERRED EDUCATION/EXPERIENCE/SPECIALIZED SKILLS/CERTIFICATION:**

- Strongly preferred in health care-related, clinical, legal or regulatory field.
- Coding certification, CCS or CPC strongly preferred.
- Knowledge and understanding of relevant service-line or care-line accreditation standards, (e.g. Joint Commission, College of American Pathologists, etc.) is a plus.
- Working experience in Epic EHR preferred

**FOR MORE INFORMATION/TO APPLY:**

https://www.houstonmethodistcareers.org/job/coding-charging-denial-specialist-medical-museum-tower-administrative-houston-methodist-sp-12-13295/