VILLAGE OF HEALING SENIOR MEDICAL CODER

Village of Healing is a 501c3 community development organization with a new approach to community wellness. By focusing on healing and empowering individuals in the village, we work to eliminate social determinants of health and decrease health disparities through implementing community programming, advocacy, and collaboration. Our vision is to offer all members of the community life-empowering skills through multiple sources and mediums that will in turn heal and empower the village. We also work to ensure our constituents are equipped to lead healthy lives that thrive beyond survival.

POSITION SUMMARY:
We are seeking a Senior Medical Coder to join our team. To be responsible for abstracting office visits/procedures and claims reimbursement. Ensuring all correct compliant coding and payor guidlenes are followed. Also identifying any documentation errors to educate providers. The ideal candidate is detail-oriented with strong people skills and computer skills.

SUMMARY OF RESPONSIBILITIES:

Key Responsibilities:

- Assign ICD (International Classification of Diseases) and CPT (Current Procedural Terminology) codes to medical procedures and diagnoses based on documentation.
- Conduct quality reviews of medical records and coding accuracy to ensure compliance with regulatory requirements and organizational standards.
- Stay updated with changes in coding guidelines, regulations, and compliance requirements.
- Work closely with healthcare providers and physiciansto resolve coding-related issues and discrepancies.
- Perform coding audits, generate reports, and analyze coding trends to identify opportunities for improvement

- Accounts for coding and abstracting of patient encounters, including diagnostic and procedural information, significant reportable elements, and complications.
- Researches and analyzes data needs for reimbursement.
- Analyzes medical records and identifies documentation deficiencies.
- Reviews and verifies documentation supports diagnoses, procedures and treatment results.
- Identifies diagnostic and procedural information.
- Audits clinical documentation and coded data to validate documentation supports services rendered for reimbursement and reporting purposes.
- Assigns codes for reimbursements, research and compliance with regulatory requirements utilizing guidelines.
- Follows coding conventions. Serves as coding consultant to care providers.

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- Identifies discrepancies, potential quality of care, and billing issues.
- Researches, analyzes, recommends, and facilitates plan of action to correct discrepancies and prevent future coding errors.
- Identifies reportable elements, complications, and other procedures.
- Serves as resource and subject matter expert to other coding staff.
- Provides ongoing training to staff as needed.
- Handles special projects as requested.
- Payment posting, EOB posting, denial trending and strong communication with payors and providers.

Required Skills and Qualifications:

- Certification as a Certified Professional Coder (CPC) or Certified Coding Specialist (CCS) through AAPC or AHIMA.
- Bachelor's degree in Health Information Management, Healthcare Administration, or a related field (or equivalent experience).
- 5 plus years of experience in medical coding, with demonstrated proficiency in ICD and CPT coding systems.
- Strong understanding of medical terminology, anatomy, and physiology.
- Knowledge of healthcare compliance and regulatory requirements (HIPAA, Medicare, Medicaid).
- Excellent analytical and problem-solving skills.
- Effective communication skills and ability to work collaboratively in a team environment.

Salary: $40,000-$50,000

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