EQUALITY HEALTH

JOB DESCRIPTION

Position Title: **Risk Adjustment Program Manager**
Reports To: **Senior Director, Clinical Quality Improvement**
Division: **QPoint**
Department: **Administration**
Classification: **Exempt**
Revision Date: **February 17, 2019**

Position Summary:
Equality Health is an Arizona-based population healthcare company focused on improving care delivery for underserved populations through culturally-sensitive programs that improve access, quality, and patient trust. Our mission is to ensure diverse populations receive quality healthcare that improves and enriches their lives. We have developed our product portfolio around centralized technology, services and network designs intended to organize a better healthcare delivery system for cultures that have struggled with integrating into the traditional one-size-fits-all U.S. healthcare system.

The Risk Adjustment Program Manager will lead QPoint's risk adjustment efforts to achieve effective documentation and coding practices while maintaining and/or improving provider relationships. This individual is a crucial contributor and will identify and maximize practice and process improvement opportunities, provider performance trends, educate providers and their practices, audit and train coding team resources and review medical charts to perform coding work.

Responsibilities:
- Develop practice and process to review practice documentation, coding, performance trends, and identify areas for practice improvement
- Develop tools, workflows and metrics to ensure that the accuracy and completeness of coding and documentation is improved
- Educate coders, providers and their staff on coding and documentation guidelines and updates, with emphasis on improving highly accurate and specific documentation consistent with national regulations and practice
- Perform chart reviews and decipher if they are accurate and complete in support of patient risk adjustment score accuracy
- Lead and conduct practice documentation and coding audits for RAF compliance
- Review medical records, patient medical history and physical exams, provider orders, progress notes, consultation reports, diagnostic reports, operative and pathology reports and discharge summaries in order to verify:
    - Diagnosis codes are supported by documentation according to ICD-10 CM guidelines
    - Diagnosis codes for each chronic or major medical condition have been captured and submitted within the permitted timeframe
    - Correlated conditions and confirmation of treatments based on medication list
    - Diagnosis codes unsubstantiated by the record should be eliminated
    - Clinical indicators and query providers to capture the severity of illness of the patient
- Deliver effective training by preparing clear and concise tools (presentations, webinars, audit summaries, tip sheets, etc.)

- Develop professional plans and materials that support the educational and training needs of the medical practice by collaborating with internal departments
- Ascertain that documentation and coding efficiency and accuracy is improved by performing independent audits of provider and clinical records and offshore coding teams
- Coordinate activities and information exchange with health plan partners
- Ensure compliance with established protocols and procedures are maintained in the associated platforms and systems
- Ensure compliance with all applicable federal, state and/or county laws and regulations related to coding and documentation guidelines for risk adjustment
- Review medical record documentation using the Healthcare Effectiveness Data and Information Set (HEDIS) to collect and measure providers' performance on quality of care
- Demonstrate leadership and professionalism, especially while engaging with physicians, mid-level providers and staff to help them understand the value in accurate and complete coding and documentation for their practice

Required Knowledge, Education & Experience:

- Bachelor's degree in a related field of study; or, an equivalent combination of education and/or experience
- Minimum seven (7) years of experience in a directly related position
- Mastery of CMS HCC Risk Adjustment coding and data validation requirements
- Proven knowledge and understanding of medical terminology, pharmacology, body systems, anatomy, physiology, and concepts of disease processes as well as clinical practice and processes
- Proven knowledge and understanding of ICD-10-CM coding guidelines
- Proficient with Microsoft Office applications and web-based technologies
- Demonstrated ability to utilize a variety of electronic medical records systems
- Must possess high degree of accuracy, efficiency, and dependability

Highly Preferred Skills, Abilities & Qualifications:

- Mastery of HHS-HCC Risk Adjustment coding and data validation requirements (Preferred).
- One or more coding certifications such as CPC, CPC-H, CCS-P, CCS, or CRC
- Able to establish and maintain positive and effective work relationships with a diverse network of physicians, administrative leadership and staff
- Excellent verbal, written and interpersonal communication skills; highly collaborative team approach
- Successful record of managing multiple projects with demonstrated ability to work independently in rapidly-changing environments
- Strong problem-solving skills, including the ability to systematically analyze problems, draw relevant conclusions and devise appropriate courses of action
- Able to convey complex or technical information in a manner that others can understand and understand and interpret complex information from others
- Demonstrated ability to handle highly sensitive and confidential information in compliance with Health Insurance Portability and Accountability Act (HIPAA), and company confidentiality policies and procedures