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| **SITHU** **COC, ICD-10-CM Proficiency****Assistant Manager – Medical Coding**Email: sithu.334502@2freemail.com  |  |

Having a work experience of 17 years in Medical Billing & Coding [Hospital & Outpatient (Fee-for-service)], Medical Coding – HCC, Specialist in Analysis of Professional claims including all Specialties & Hospital claims, Denial Management and Credentialing (Providers, Clinics, Insurances etc.) since 1999.

I aspire for a challenging career in IT industry - as a part of integrating all back office operations for Health Care Organizations in US or elsewhere practicing the coding procedures, where I can get opportunities to be more creative and responsible for obtaining a challenging position in the field of Medical Billing & Coding, Medical Claim Analysis and Credentialing. Considering my experience I can utilize my extensive computer and medical apparel knowledge and strong organizational abilities.

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| Professional Qualifications Summary |

* 17 years of experience in Health care organizations as Medical Biller & Coder, including Denial Management and Credentialing.
* Extreme knowledge with regard to Medical Coding guidelines and coding techniques (ICD-9-CM, ICD-10-CM, ICD-Pdx, CPT-4, HCPCS and DRG's).
* CPC-H (Certified Professional Coder – Hospital). Changed to COC (Certified Outpatient Coder), Proficiency Certificate in ICD-10-CM from AAPC. Ample experience as a Senior Medical Coder & QC in a variety of clinical settings.
* Proficient in physician coding, outpatient coding, and HCC coding.
* Strong knowledge of Anatomy & Physiology, Advanced Medical Terminology and Pharmacology.
* Very efficient in Microsoft Office (Word, Excel and PowerPoint).
* Able to type 65+ wpm and 350+ dpm.
* Effective communication and interpersonal skills.
* Perform audit coding of disease and injury diagnoses, acuity of care and procedures.
* References used for coding include American Medical Association of Physicians the Current International Classification of Diseases (ICD-9-CM) & ICD-10-CM; Current Procedural Terminology (CPT); ICD-10-PCS, Health Care Common Procedure Coding System (HCPCS); Physicians' Desk Reference.
* Knowledge of Medical Terminology, Anatomy and Physiology.
* Broad Medical Experience also includes: Billing, Reimbursement, HIPAA rules, Insurance Verification, Scheduling and Report Creation.
* Key Strengths: Communication, Leadership and Interpersonal Skills; Multi-tasking and Overall Resourcefulness.
* Responsible for compiling data from medical records to document patient condition and treatment according to standardized coding specification.
* Reviewed medical records and abstracted ICD-9-CM, ICD-10-CM, ICD-Pdx, CPT, DRG and HCPCS codes.
* Consulted on practices to ensure optimal reimbursement and compliance for organization's clients.
* Ongoing development of Excel reports to record drug codes used during ER visits.

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| Licensure/Certification |

* Certified Professional Coder – Hospital (CPC-H), American Academy of Professional Coders (AAPC) – August 2014.
* Certified Outpatient Coder (COC), American Academy of Professional Coders (AAPC) – Renewed on 31st January 2016.
* Proficiency Certificate in ICD-10-CM, American Academy of Professional Coders (AAPC) – 22nd December 2015.

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| **Affiliations** |

* American Academy of Professional Coders (**AAPC**)

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| **Professional Experience:** |

* + **Assistant Manager – Medical Coding [HCC & OP]** in Armendale Healthcare Technologies Pvt. Ltd., Technopark, Thiruvananthapuram from March 2014 to till date.
	+ **Team Lead - Medical Coding [HCC coding]** in Ariva Med Data Infotech Pvt. Ltd., Technopark, Thiruvananthapuram from July 2011 to March 2014.
	+ **Team Lead – (Claim Analysis) Analysis of Payment in Hospital – DRG based & Contract Rates – Analysis of Payment in Specialty based – Referred by Providers including all specialties including Contestation of Institutional & Professional claims and Denial Management** in Ariva Med Data Infotech Pvt. Ltd., Technopark, Thiruvananthapuram from June 2008 to October 2012.
	+ **Team Lead - Credentialing – Credentialing of Providers, Insurances, Clinics & Hospitals** in Ariva Med Data Infotech Pvt. Ltd., Technopark, Thiruvananthapuram from June 2010 to July 2011.
	+ **Team Lead - Medical Billing & Coding (Fee-for-service claims) - Hospital & Outpatient – Insurance (Govt. plans, Private plans, Workers’ comp etc.) & Non insurance claims (Paid by Member) – Analysis of QC in billing, Sending claims to insurances Electronically & Paper wise. Downloading the ERAs/EOBs and posting those in the corresponding accounts of members. Analyzing denials in ERAs/EOBs correcting and resending. Analyzing the status of claims and follow-up should be done. If balance member eligibility, bill those to members or inform to collect upfront by appointment schedule of members** in Avida Mednet Pvt. Ltd., PMG, Thiruvananthapuram from January 2006 to May 2008.
	+ **Medical Billing & Coding – (Fee for service) claims – IP & OP –** Follow-up should be done from Claim level to the end process. Doing the Coding as per guidelines. Sending claims to insurances Primary & Secondary. Denials in ERAs/EOBs correcting and sending. Analyzing the claim status of claims and follow-up should be done. If balance member eligibility, billing those to membersin Med Data Infotech Pvt. Ltd., Pettah, Thiruvananthapuram from November 1999 to December 2005.
	+ **Computer Instructor (MS OFFICE)** in Softech Computer Centre, Pallimukku, Kollam from May 1999 to November 1999.

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| Responsibilities in Armendale Healthcare Technologies Pvt. Ltd.: (2014 – till date) |

* + Analyzing the Accuracy in assignment of ICD-9-CM, ICD-10-CM and/or CPT-4 code(s), ICD-10-PCS and sequence diagnoses and procedures as per patient’s medical record.
	+ Assure the assignment of complete, accurate, timely and consistent codes by the medical coding unit.
	+ Reconcile clinical notes, patient encounter form, and health information for compliance with HIPPA rules.
	+ Provide coding and documentation advice to the coding unit, clinical and professional staff.
	+ Analyze billing to improve coding data accuracy for Medicare compliance reimbursement.
	+ Ensure coded data accurately reflects service provided, based on documentation, guarding against fraud and abuse.
	+ Appointment checking on Future dates. Preparing the patient profile sheets with drop down codes and suspected codes for confirmation at the time of appointment. Updating the patient information with insurance details as per the appointment.
	+ Analyzing the Encountered list diagnoses of the members on the corresponding date and analyze the whole charts for the HCC diagnoses missed which was reported earlier and enquire provider about the dropped down diagnoses existing or not for chronic cases.
	+ Creating EDI file and sent claims through Gateway EDI in Organization Tax ID and corresponding PCPs Tax ID.
	+ Analyze the status of those claims in Organization Tax ID & PCP Tax ID whether accepted or not.
	+ Analyze the MRA file whether the reported HCC diagnoses were accepted by insurance.
	+ Preparing reports as per the request from clients.

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| Responsibilities in Ariva Med Data Infotech Pvt. Ltd.: (2013 – 2014) |

* + Analyzing the Accuracy in assignment of ICD-9-CM and/or CPT-4 code(s) and sequence diagnoses and procedures as per patient’s medical record.
	+ Assure the assignment of complete, accurate, timely and consistent codes by the medical coding unit.
	+ Reconcile clinical notes, patient encounter form, and health information for compliance with HIPAA rules.
	+ Provide coding and documentation advice to the coding unit, clinical and professional staff.
	+ Analyze billing to improve coding data accuracy for Medicare compliance reimbursement.
	+ Ensure coded data accurately reflects service provided, based on documentation, guarding against fraud and abuse.
	+ Analyzing the Encountered list diagnoses of the members on the corresponding date and analyze the whole charts for the HCC diagnoses missed which was reported earlier and enquire provider about the dropped down diagnoses existing or not for chronic cases.
	+ Creating EDI file and sent claims through Gateway EDI in Organization Tax ID and corresponding PCPs Tax ID.
	+ Analyze the status of those claims in Organization Tax ID & PCP Tax ID whether accepted or not.
	+ Analyze the MRA file whether the reported HCC diagnoses were accepted by insurance.
	+ Informing the confirmation of HCC drop down codes to providers by prior appointment.
	+ Preparing reports as per the request from clients.

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| Responsibilities in Ariva Med Data Infotech Pvt. Ltd.: (2008 – 2012) |

* + Analyze the payment issued by Insurance in Hospital claims (DRG’s, ICD-Vol-3 & CPT codes), Specialty claims referred by Provider to specialists (Coding issues, ICD-9-CM, HCPCS, CPT codes and contract fee rate) as per patient’s medical record.
	+ Assure the assignment of complete, accurate, timely and consistent codes by the medical coding unit.
	+ Analyze the service fund files and review the contested claims done by my team members whether those are valid claims for reimbursement.
	+ Analyze the payment issued by Insurance in Hospital claims (DRG’s, ICD-Vol-3 & CPT codes), Specialty claims referred by Provider to specialists (Coding issues & CPT codes contract fee rate) as per patient’s medical record.
	+ Assure the assignment of complete, accurate, timely and consistent codes by the medical coding unit.
	+ Analyze the service fund files and review the contested claims done by my team members whether those are valid claims for reimbursement.
	+ Analyzing and informing about the High Cost Claims achieved by the members so as to aware of the PCPs.
	+ Analyzing and preparing the reports as per the request of clients.

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| Responsibilities in Ariva Med Data Infotech Pvt. Ltd.: (2010 – 2011) |

* + Credentialing of Hospitals/Clinics, Insurances & Credentialing of Providers.
	+ Includes Enrollment of Providers, Providers to Insurance Enrollment and Providers Enrollment to Hospital. Collecting updated information from Providers including CVs, Medical License, Liability Insurance, Professional Work History including past to present.
	+ Providers Medical License, Liability Insurance, Insurance Enrollment etc., up-to date before the insurances expires.

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| Responsibilities in Avida Mednet Pvt. Ltd.: (2006 – 2008) |

* + Analyze the Accuracy in assignment of ICD-9-CM, CPT-4 codes, sequence diagnoses & procedures as per patient medical record.
	+ Assure the assignment of complete, accurate, timely & consistent codes by the medical coding unit.
	+ Reconcile clinical notes, patient encounter form, and health information for compliance with HIPAA rules.
	+ Provide coding and documentation advice to the coding unit, clinical and professional staff.
	+ Analyze billing to improve coding data accuracy for Medicare compliance reimbursement.
	+ Ensure coded data accurately reflects service provided, based on documentation, guarding against fraud and abuse.
	+ Conduct training, in-service and other education regarding diagnosis, procedure code assignment, and regulatory requirement.
	+ Submit reimbursement claims to insurance companies and government entities.
	+ Collect patient payments and maintain billing records.
	+ Prepare Accounts Receivable adjustments for processing and approval.
	+ Collect self-pay account balances, work off A/R, review EOBs and establish payment plans.
	+ Working knowledge of payers: Contract insurance, HMOs, PPOs, Medicare/Medicaid, Workers Comp.
	+ Sending Electronic & Paper Claims.
	+ Appointment Verification & Diagnoses Updating through E-clinic software.
	+ EOB posting: (Explanation of benefits) - Payment Entry from Patient & Insurance Companies.
	+ Preparing Patient Bills - Sending bills to patient for collecting the balance amounts.
	+ Preparing Check Request – Preparing refund bills for the additional amounts paid by patient/insurance companies.
	+ Preparing refund bills for the additional amounts paid by patient/insurance companies.
	+ Insurance Enquiries: Enquiring about the delay in payments.
	+ Reconciliation of Bank Statements with the payments we received.

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| Responsibilities in Med Data Infotech Pvt. Ltd.: (1999 – 2005) |

* + Analyze the Accuracy in assignment of ICD-9-CM, CPT-4 codes, sequence diagnosis & procedures per patient medical record.
	+ Assure the assignment of complete, accurate, timely & consistent codes by the medical coding unit.
	+ Reconcile clinical notes, patient encounter form, and health information for compliance with HIPPA rules.
	+ Provide coding and documentation advice to the coding unit, clinical and professional staff.
	+ Analyze billing to improve coding data accuracy for Medicare compliance reimbursement.
	+ Ensure coded data accurately reflects service provided, based on documentation, guarding against fraud and abuse.
	+ Conduct training, in-service and other education regarding diagnosis, procedure code assignment, and regulatory requirement.
	+ Submit reimbursement claims to insurance companies and government entities.
	+ Collect patient payments and maintain billing records.
	+ Prepare Accounts Receivable adjustments for processing and approval.
	+ Collect self-pay account balances, work off A/R, review EOBs and establish payment plans.
	+ Working knowledge of payers: Contract insurances, HMOs, PPOs, Medicare/Medicaid, Workers’ Compensation.
	+ Sending claims via Electronic and Paper wise.
	+ Appointment Verification & Diagnoses Updation through E-clinic software.
	+ EOB posting: (Explanation of benefits) - Payment Entry from Patient & Insurance Companies.
	+ Preparing Patient Bills - Sending bills to patient for collecting the balance amounts.
	+ Preparing Check Request – Preparing refund bills for the additional amounts paid by patient/insurance companies.
	+ Insurance Enquiries: Enquiring about the delay in payments.
	+ Reconciliation of Bank Statements with the payments we received.

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| **Work Related Skills:** |

* + Have strong organizational and problem solving skills with an ability to work independently.
	+ Ability to deal effectively and professionally with others.
	+ Organizational and Time management, Interpersonal Communication, Research, Proficient computer and Analytical skills.
	+ Long-term experience and expertise in handling MS Office. Medical Coding experience in Medisoft Network Professional Windows version 7.0, Claimate Prime, Greys EHR/billing software etc in Windows platform.
	+ Sending emails to clients.

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| **Educational Qualifications:** |

| **BACHELORS DEGREE** | **COLLEGE / INSTITUTION** | **UNIVERSITY** | **DIVISION / GRADE** | **YEAR OF PASSING** |
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| DCA & Office Management | IHRDE | IHRDE, TRIVANDRUM, INDIA. | A | 1997 |
| Bachelor of Science (PHYSICS) | Sree Narayana College for Women, Kollam, Kerala, India. | UNIVERSITY OF KERALA, INDIA. | A | 1994 |

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| **Extra-curricular Activities and Interests:** |

* + Interested in hearing music, stitching, traveling, gardening, social/charity service and establishing public relations.

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| **Other Relevant Information:** |

* + Date of Birth : 20 January 1974
	+ Languages known : English, Hindi and Malayalam (Mother Tongue).
	+ Email : sithu.334502@2freemail.com