

MEDICAL SERVICES

Medical Claims Analyst

DEPARTMENT	REPORTS TO	LEVEL	EXPERIENCE	LOCATION
Medical Services	Claims Manager	Mid-Level	2+ years	Nairobi, Kenya

Role Purpose

The Medical Claims Analyst role is responsible for the accurate, timely, and compliant adjudication of medical claims submitted by healthcare providers on behalf of scheme members. It requires someone who can interpret medical documentation, apply benefit rules, identify anomalies, and contribute to the continuous improvement of ACS's claims processes. The analyst works closely with the Care Management, Provider Relations, Finance, and Client Success teams to ensure claims are processed fairly, efficiently, and in accordance with contracted terms and regulatory requirements.

Key Accountabilities

Claims Adjudication, Medical Review & Utilization Management

- Review, assess, and adjudicate inpatient, outpatient, dental, optical, pharmacy, and reimbursement claims in accordance with scheme benefits, policy terms, exclusions, limitations, and contractual provider agreements.
- Verify member eligibility, active cover status, benefit availability, and service validity before processing claims.
- Review clinical documentation including medical notes, diagnoses, ICD-10/ICD-11 codes, procedure codes, laboratory and radiology reports, discharge summaries, prescriptions, operative notes, and itemized invoices to validate claims accuracy.
- Assess medical necessity and appropriateness of services, procedures, investigations, medications, admissions, and length of stay against clinical guidelines and ACS utilization management protocols.
- Review claims against approved pre-authorizations to confirm alignment with approved treatment plans, authorized services, and applicable limits, escalating variances where required.

Claims Quality Assurance, Accuracy & Cost Management

- Review provider bills to identify overcharging, duplicate billing, incorrect tariffs, unsupported services, unbundled charges, and incorrect benefit application.
- Confirm that billed services are supported by medical documentation and match the diagnosis and treatment provided.
- Apply agreed provider tariffs, negotiated rates, package rates, discounts, and payment arrangements when processing claims.
- Identify unnecessary costs and apply appropriate claims controls to support cost management.
- Identify savings opportunities through claims review, billing corrections, tariff application, and utilization management.

Fraud, Waste & Abuse Detection

- Identify possible fraud, waste, and abuse, including fake claims, inflated bills, duplicate claims, unnecessary services, and billing for services not provided.
- Review provider and member claim patterns to identify unusual or suspicious activities.
- Escalate suspected fraud, waste, and abuse cases in line with ACS escalation procedures.
- Support investigations by providing claim reviews, documentation, and utilization reports.
- Support improvement of claims rules and system controls to prevent fraud and inappropriate payments.

Provider Management, Stakeholder Engagement & Query Resolution

- Respond to provider queries on claim status, approvals, rejections, payment issues, and documentation requirements within agreed timelines.
- Confirm provider claims are billed according to agreed tariffs, packages, discounts, and contractual terms.
- Work with the Provider Relations team to resolve billing errors, tariff issues, and recurring provider concerns.
- Work with Care Management, Finance, and Client Success teams to resolve claims-related issues and improve service delivery.
- Provide feedback on provider billing trends and areas requiring improvement.

Claims Reporting, Analytics & System Management

- Track and report on savings achieved through claims edits, overbilling recoveries, and application of contracted rates versus billed charges.
- Support scheme reporting, reconciliation, and claims performance reviews.
- Ensure accurate entry and maintenance of claims information in the claims management system.
- Participate in testing system improvements, automated claims rules, and workflow enhancements.

Key Performance Indicators

- Care Plan Management and Member Satisfaction
- Pre-Authorization Turnaround Time
- Clinical Case Review Accuracy
- Hospital Admission Management
- Discharge Planning Effectiveness
- Chronic Disease Management Outcomes
- Escalation and Critical Case Management
- Healthcare Utilization Management
- Clinical Documentation Quality
- Provider Engagement and Collaboration
- Compliance with Clinical Protocols
- Case Resolution Timeliness
- Reporting Accuracy and Timeliness
- Data Protection and Confidentiality Compliance
- Cost Containment and Care Optimization

Qualifications

- Diploma or Bachelor's Degree in Nursing, Clinical Medicine, Health Records & Information Management, Public Health, or a related health sciences field.

Added Advantage

- Professional qualifications in AIK, ACII, or Certificate in Insurance.
- Familiarity with managed care concepts, utilization review, and medical tariff structures applicable in the Kenyan market.
- Experience working with a claims management system, TPA platform, or health insurance adjudication software.
- Understanding of the Insurance Act (Cap. 487), IRA guidelines, and the Kenya Data Protection Act, 2019.

Experience

- Minimum of 2 years' relevant experience in medical insurance administration, provider relations, or healthcare scheme management, preferably within an insurance company, brokerage firm, TPA, or medical service provider network.
- Demonstrated hands-on experience reviewing clinical documentation and adjudicating medical claims is required. Experience with both inpatient and outpatient claims is preferred.

Core Competencies

- **Clinical & Coding Proficiency:** Ability to interpret medical records, ICD-10 diagnoses, CPT procedure codes, and itemized provider bills with sufficient clinical literacy to assess appropriateness, accuracy, and completeness.
- **Claims Adjudication Knowledge:** Sound understanding of health insurance policy terms, benefit structures, excesses, co-payments, exclusions, and waiting periods, and the ability to apply these consistently and correctly across a high volume of claims.
- **Fraud & Anomaly Detection:** Keen eye for overbilling, upcoding, unbundling, duplicate claims, and fraud indicators, with the analytical discipline to document findings clearly and escalate appropriately.
- **Accuracy & Attention to Detail:** Meticulous approach to reviewing documentation and making adjudication decisions, with a low error tolerance and a commitment to getting every claim right.
- **Communication & Stakeholder Management:** Clear, professional written and verbal communication for interacting with providers, members, and internal teams, particularly when delivering rejection decisions or resolving disputes.

How to apply

Send your CV and cover letter to hr@acs.co.ke with "Medical Claims Analyst" in the subject line by **2 November 2026**.