Denials Management Coordinator

Lewiston, IL

Summary

The Denials Management Coordinator is responsible for applying fundamental knowledge of billing, coding and payer requirements as it relates to researching, analyzing, and resolving denials, contractual underpayments and credits. This job requires regular outreach to payers and internal stakeholders.

Responsibilities:

- Triaging incoming variance inventory
- Validating appeal criteria is met in compliance with departmental policies and procedures
- Composing technical denial language for reconsideration, including both written and telephonic
- Ensuring high level of competence in process and payer knowledge to overcome objections that prevent payment of the claim
- Gaining commitment for payment through concise and effective appeal composition
- Identifying problem accounts/processes/trends and escalate as appropriate
- Utilizing effective documentation standards that support a strong historical record of actions taken on the account
- Resolving the account (posting correct contractual adjustments, posting other non-cash related Explanation of Benefits (EOB) information, updating the patient accounts as appropriate
- Submitting uncollectible claims for adjustment timely and correctly
- Resolving claims impacted by payer recoupments, refunds, and posting errors
- Meeting and maintaining established departmental performance metrics for production and quality
- Maintaining working knowledge of workflow, systems, and tools used in the department
- Practicing and adhering to the Code of Conduct philosophy and Mission and Value Statement
- Maintaining collaborative approach to problem solving working with other revenue cycle teams and revenue generating areas
- Other duties as assigned
- Resolving accounts to 0 insurance balance

Qualifications

Education and Experience:

- 2 Year Degree or 6 years healthcare experience
- Six or more years of experience in health care billing functions
- Ability to perform assigned tasks efficiently and in timely manner.
- Ability to work collaboratively and effectively with people.
- Exceptional communication and interpersonal skills.
- Basic skills - demonstrates ability to organize, perform and track multiple tasks accurately in short timeframes; able to work quickly and accurately in a fast-paced environment while managing multiple demands; able to work both independently and collaboratively as a team player; demonstrates adaptability, analytical and problem solving skills, and attention to detail

Knowledge, Skills, and Abilities:

- Completes appropriate actions needed for an effective appeal including conducting authorization research, rebilling, and balance write off or transfer to the next responsible party.
- Utilizes systems, various documents and reports to identify and correct errors accurately and within established deadlines.
- Escalates issues as appropriate.
- Corresponds with third party payers, hospital departments, and patients to obtain information required for denial resolution following payer timelines.
- Releases information following Federal, State and Hospital guidelines.
- Uses assigned work queues and prioritization standards and guidelines to perform denial resolution follow up.
- Uses reference material to troubleshoot payer issues and increase understanding of denial resolution techniques.
- Reference payer websites as needed.

For more Information / To Apply:

https://pm.healthcaresource.com/cs/cmmc#/job/22738