Managed Care Denials Specialist

Jupiter Medical Center
Job Location: Jupiter, FL
Full Time

JOB DESCRIPTION:

The Managed Care Denials Management Specialist reports to the Manger of Managed Care and is Responsible for supervising the Denials Management Program.

RESPONSIBILITIES:

- Works as the operational "owner" of the Denials Management software.
- Responsible for the oversight of the denials, audits, and appeals (post-payment) functions for
- both governmental and non-governmental insurers.
- Creates proper denials work ques within the Denials Management software.
- Writes process and workflow procedures for all denial ques within the Denials Management software.
- Monitors and ensures that all claims denial ques are being worked timely and appropriately.
- Assists with developing Key Performance Indicators (KPI's) for the Denials Management Program.
- Research governmental and non-governmental payor regulations and policies.
- Performs audits of Denials Management workflow and productivity on a regular basis for quality improvement and training purposes.
- Evaluates the ADRs, post payment audits and appeals to determine our success rate and appropriateness of documentation provided.
- Creates systematic reporting from the Denials Management software that analyzes denials to identify changes and/or trends, and reports these to the Managed Care Manager.
- Works closely with Managed Care Manager to ensure problem claim issues are documented, tracked, and presented at regularly scheduled payor meetings.
- Identifies and escalates complex, complicated, or challenging accounts to Managed Care Manager to ensure accounts are progressing effectively.
- Attends monthly payor relations meetings to resolve escalated issues.
- Coordinates unresolved claims issues with external legal vendor.
- Maintain positive working relationship with hospital departments, including Collections, HIM, Case Management, Clinical Documentation Improvement, Revenue Integrity, Patient Financial Services, Customer Service and Finance.
- Advanced knowledge of Medicare and Medicaid regulations, Compliance guidelines, ICD-10 and CPT/HCPCS coding a must.
- Knowledge of CAS codes, electronic claims editing software, UB 04 guidelines, revenue code usage, contractual adjustments, payment transactions, and credit balance resolution.
- Ability to write effective administrative claim appeals.
- Possesses and maintains working knowledge of the payor appeals and Dispute Resolution processes.
- Strong ability to troubleshoot and problem solve.

REQUIREMENTS:

- Bachelor Degree
- Clinical background as well as RHIT or Coding Certification preferred.
- Five years of hospital denials management experience.
- Knowledge of Government and Third Party Payor Regulations and Standards.
- Experience with ADRs, post payment audits and appeals processes, requirements and guidelines.

- Two to three years of Hospital Revenue Cycle experience that includes Collections, Billing and Pre-Certification processes.
- Must be familiar with medical terminology, coding processes, clinical documentation and governmental and non-governmental reimbursement methodologies.
- Must possess heighten degree of attention to detail and ability to multitask within a fast paced, result orientated environment.
- Mathematical ability and analytical skills required.
- Computer proficiency required.

FOR MORE INFORMATION/TO APPLY:

https://recruiting.adp.com/srccar/public/RTI.home?c=2167201&d=JupiterMedicalCenter#/