Appeals Audit Specialist

McLaren Health Care
Job Location: Michigan
Full Time, Days

JOB SUMMARY:

Responsible for timely and accurate processing, follow-up, and appeal of audits and denial activity received from payers and/or auditors. Provides support to both internal and external customers for denial/appeals activities and audits. Assists with monitoring and auditing activities, reviews outcomes and communicates findings as appropriate. Collaborates with ICM departments/staff, as well as external departments in support of timely issue resolution, process improvement initiatives, and response to inquiries to payer denials.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Supports activities consistent with Integrated Care Management Denials across all MHC subsidiaries.
- Accountable for achieving care management outcomes and fulfills the obligation and responsibilities of the role to support the clinical team.
- Collaborates with the Denials Appeals RN to ensure payer appeal/filing deadlines are met and achieve optimal payment for services rendered.
- Ability to write appeals demonstrating accuracy/proficiency in referencing support from the medical record documentation and coding guidelines with timely and successful submissions.
- Assists in identifying denial trends and selecting the most appropriate method for resolution.
- Provides support in response, tracking and completion of all payer audit/denial/appeal activity to ensure that timelines in the process are met, including requests for medical record documentation and the filing of responses and appeals.
    - Appropriately documents denial/appeal activities; oversees and documents payer and third-party payer contractors (including federal and state payer) activities.
    - Monitors and suggests modifications to workflows to maintain effective, timely and efficient processes.
    - Assists with reconciliation process to verify accuracy and completeness of payers' take-backs and rebilling based upon denial/appeal findings and maintains documentation of such activity.
    - Provides recommendations for improvements, based on denial/appeal results and assist in implementing action plans. Assists subsidiaries with tracking, reporting, and developing action plans, as necessary.
    - Assists in performance of follow-up reviews to assess adequacy of implemented action plans.
    - Logs, tracks, refers and closes appeals timely.
- Participates in the revenue cycle process (Central Business Services – CBS) to ensure both compliance and the maximization of appropriate reimbursement on denied/appealed cases based on medical record documentation and coding guidelines.
- Participates on assigned designated corporate and subsidiary committees, to evaluate denial/appeal outcomes improvement
- Attends continuing education sessions to maintain competency and knowledge of regulations in denials, utilization management, care management, clinical documentation, and leadership skills and participates in ongoing leadership training offered by ACMA.
- Performs other related duties as required and directed.

REQUIRED QUALIFICATIONS:

- Registered Health Information Technician (RHIT), Licensed Practical Nurse (LPN), hospital biller, or associate degree.
- 5 years' health care experience

PREFERRED QUALIFICATIONS:

- Bachelor's degree in healthcare related field
- ACMA or ACDIS memberships
- Certified Medical Coder, Certified in Healthcare Compliance, Certified Coding Specialist, or Certified Clinical Documentation Specialist certifications

FOR MORE INFORMATION/TO APPLY:

https://mclarenhlth.taleo.net/careersection/mclaren_external_career_section/jobdetail.ftl?job=22007659&tz=GMT-04%3A00&tzname=America%2FNew_York