HEALTHSMART

MANAGEMENT SERVICES ORGANIZATION, INC.

POSITION SUMMARY:

The Claims Examiner position is responsible for the claims processing, adjudication and claim research, where applicable. Must meet qualitative and quantitative standards established for this position. Assist Claims Management with audits and special projects as needed.

ESSENTIAL DUTIES & RESPONSIBILITIES

- Review and adjudicate claims (paper and EDI) and resolve claim edits, using claims desk level and operational reference materials.
- Utilize our eHealthcare claims processing module in an effective and efficient manner to process claims
- Make appropriate decisions regarding the clearing of claim edits and payment of claims.
- Meet production and quality standards when processing claims and performing tasks.
- Complete the manual pricing of claims according to provider contracts and other claims pricing references.
- Interpret medical group and provider contracts to determine claims payment methodologies.
- Complete more complex claims processing tasks including**:** claim adjustments, coordinating benefits with secondary carrier, claim reversals, etc.
- Handle smaller scale projects in claims from input to output.
- Work with Claims Management to resolve difficult or complex transactions and to identify system and/or training-related opportunities that will assist in operating results improvement.
- Respond to first and second level provider inquiries, claim status calls and faxes from provider.

QUALIFICATIONS:

- High school diploma or equivalent.
- A minimum of three years of Medicare and/or Medi-Cal, Commercial and Medicare Advantage/CalDual claims processing experience
- Knowledge of medical terminology, ICD-10, CPT, HCPCS and DRG coding, required.
- A minimum of three years of experience in a managed care organization, preferred.
- Excellent knowledge of claims systems.
- Ability to demonstrate organizational, interpersonal, and communication skills.
- Ability to maintain designated production and quality standards.
- Knowledge of different providers' payment methodologies (i.e., capitation, fee for service based on RBRVS, Medi-Cal, Medicare and other n egotiated flat rates, RVS pricing, Per Diem, DRG pricing, etc.), preferred.
- Ability to deal with complex claim issues.
- Knowledge of Medicare and Medi-Cal claims processing guidelines, Title 28 Claims Settlement Practices and other regulatory requirements.
- Proficient with Microsoft Office programs including PowerPoint, Outlook, Word, Excel and common computer equipment and office hardware.
- Ability to complete tasks in a timely manner.
- Ability to communicate effectively both verbally and in writing.
- Ability to work in a demanding environment and handle multiple projects at one time.
- Strong organizational skills and detail-oriented approach to work