HEALTHSMART MANAGEMENT SERVICES ORGANIZATION, INC.

JOB DESCRIPTION

JOB TITLE:	Claims Quality Auditor - Hospital Claims
DEPARTMENT:	Finance and Reimbursement & Recovery Unit
CLASSIFICATION:	Full-Time (Exempt)
COORDINATES WITH:	CFO and AVP Reimbursement & Recovery; Coordinates with AVP and Director of Claims
EFFECTIVE:	April 2022

POSITION SUMMARY:

Monitors hospital unit facility claim processing and related activities to assure ongoing quality improvement and compliance with contractual arrangements and State and Federal regulations. Accurately reviews, inputs, and adjudicates – if necessary hospital claims in accordance with Regulatory Agency, Health Plan, Capitated Hospital Client(s) and IPA(s) contract requirements. Adheres to internal production standards and contractual obligations of the organization. Investigate and timely resolves claims issues received by (but not limited to) Providers, Vendors, Contractors, Health Plans, and Regulatory Agencies. Test claims to ensure correct interest, fee schedule and other contractual nuances are being applied.

EDUCATION & EXPERIENCE REQUIREMENTS:

1. High school graduate.
2. At least five (5) years of experience in a managed care hospital claims adjudication setting e.g., HMO/MSO, required. Must be experience in a managed care environment.
3. Strong organizational and mathematical skills.
4. Expertise in ICD-10, CPT-4, DRG calculations and HCPCS coding structure.
5. Expertise in all pricers, including APR-DRG, MS-DRG, EncoderPro.
6. Ability to generate claims status reports and understanding of EOB.
7. Definitive understanding of provider and health plan contracting, delineation of risk, medical terminology and standard industry reimbursement methodologies required.
8. Strong knowledge of DHCS, CMS, Knox-Keene and state regulations required.
9. Ability to work independently with limited supervision required.
10. Experience in training development and presentation.
11. Claims audit experience required.
12. Experienced supervisory history with strong interpersonal and problem solving skills.

SKILLS:

1. Must be detail oriented and work well with a internal and external team(s).
2. Ability to research and resolve claims issues and appropriately respond to provider, health plan, etc.
3. Implement and document process improvement opportunities.
4. Knowledge and familiarity of health plan, capitated hospital(s) and IPA benefits and contracts.
5. Diligent in maintaining tracking/monitoring and quality over-site of claims to ensure that all claims are processed and paid in timely manner.
6. After hours and weekend work as needed.

DUTIES AND RESPONSIBILITIES:

1. Audit daily processed hospital claims for facility components as outlined by organizational Policies and Procedures. Utilize appropriate system-generated reports, (pre-EOB, duplicate, denied and archived Claims, etc.,) to ensure compliance with contractual requirements and individual and departmental performance and production goals.
2. Audit adjudicated hospital claims in accordance with departmental policies and procedures, IPA contracts, Health Plan benefits and any other rules applicable to specialty claims.
3. Audit UB and CMS-1500 Claims Timeliness and Denial Reports for accuracy. Document reasons for non-compliant claims.
4. Audit UB04/facility Claims Timeliness and Denial Reports for accuracy. Document reasons for non-compliant claims. Recommend process improvement actions.
5. Audit pre-check run claims for accurate application of copays/coinsurance/deductibles.
6. Distribute audit findings and deficiencies to claims examiners for review that may possibly generate rebuttals.
7. Respond to examiner rebuttals immediately and provide reasons, including regulatory guidelines, contractual agreements, and business rules.
8. Document, track, trend findings and assist with per organizational guidelines for Senior Management.
9. Based upon trends, determine ongoing Claims Adjuster training and work with Claims Management to develop/implement training programs.
10. Conduct in-depth research of contract issues, system-related problems, claims processing Policies and Procedures, etc., to confirm cause of trends.
11. Respond to hospital claim health plan 15-day letter promptly within timeframe received after thorough research of the requests from the health plans.
12. Research health claim CAP deduction reports and requests for appropriateness and provide response to health plans.
13. Provide backup for other auditors/trainers within the Department.
14. Assist in training of new departmental staff.
15. Adhere to organizational policies and procedures.

16. Any other duties as assigned.

HealthSmart MSO, Inc.

I hereby attest that I have read and understand the job description.

_____
Print First and Last Name

_____ _____
Signature Date

_____ _____
CFO Date

_____ _____
President Date