CLAIMS CUSTOMER SERVICE REPRESENTATIVE

Position Status: Non-Exempt
Reports To: Claims Manager - Provider Support
Effective Date: 04/20/00
Revised Date: 07/13/23
Job Level: S2

POSITION SUMMARY

Under general supervision, this position:

1. Acts as a frontline customer service representative and researches, resolves, and responds to inquiries regarding claims issues from providers and Alliance staff
2. Processes various claim types and conducts research and analysis related to claims resolution
3. Maintains current knowledge of claims processes, procedures, and related documentation, assists in developing and maintaining internal operating procedures, and recommends coding and reimbursement changes in the Alliance's claims processing system
4. Performs other duties as assigned

RESPONSIBILITIES

1. Acts as a frontline customer service representative and researches, resolves, and responds to inquiries regarding claims issues from providers and Alliance staff, with duties including but not limited to:
    - Responding to provider telephone inquiries via direct calls, the automatic call distribution (ACD) line, emails, and faxes related to the status of claims
    - Adjusting claims as required based upon information provided by providers and Alliance staff
    - Reviewing and analyzing claims inquiries, claims tracers, pended claims, explanation of benefits, and reports to resolve claims issues both within the Claims Department and with other Alliance departments
    - Researching policies and procedures in collaboration with other Claims Staff and other Alliance departments to resolve claims questions for providers
    - Attending meetings with providers to resolve claims issues, as directed by the Claims Managers
    - Modifying suspended claims and adjusting paid and denied claims, as necessary
    - Assisting Claims Technicians with research and resolution of claims issues, including adjusting or reversing of paid/denied claims
    - Maintaining a Provider/Claims linkage relationship with assigned providers, monitoring claims activity, identifying potential billing or processing issues, and serving as the point of contact for those assigned providers
    - Providing education to billers and providers by conducting in-service trainings in collaboration with Provider Service Representatives
    - Working as part of the Claims team to maintain the Department's Administrative Quality Indicator goal of answering all ACD calls within 30 seconds
    - Running Provider Report Cards and Comparison Reports as requested by Claims and Provider Services staff

2. Processes various claim types and conducts research and analysis related to claims resolution, with duties including but not limited to:
    - Verifying claim status and reviewing claims documents for required data elements
    - Performing claims and authorization research verbally and via e-mail
    - Performing electronic claims processing by report and by exception
    - Applying correct procedural codes, modifiers, manual pricing, coordination of benefits, and billing limits with appropriate payment status and override notation, per established procedures
    - Making pricing and adjudication decisions based upon the review and analysis of claims inquiries, claims tracers, pended claims, explanation of benefits, batch reports, and other reports to resolve claims issues
    - Applying payment rules per provider/health plan contracts
    - Researching claims history for duplicates and to determine benefit limitations for services and if further benefits are available
    - Maintaining phone log and Weekly Pre-Check Run Reports related to assigned providers
    - Identifying processing issues and escalating to the Lead Claims Customer Service Representative, Claims Supervisors or Managers, as appropriate

3. Maintains current knowledge of claims processes, procedures, and related documentation, assists in developing and maintaining internal operating procedures, and recommends coding and reimbursement changes in the claims processing system, with duties including but not limited to:
    - Reviewing updates made to internal processes and procedures and related documentation, such as Medi-Cal Provider Manuals, Medi-Cal Provider Bulletin Updates, Operating Instruction Letters, and the Claims Department Manual and providing input and feedback regarding revisions
    - Researching policies and procedures both in the Department and with other Alliance departments
    - Ensuring internal operating procedures and work instructions align with Alliance policies
    - Making recommendations related to coding and reimbursement changes in the claims processing system based upon implementation of new policies and procedures

4. Performs other duties as assigned

EDUCATION AND EXPERIENCE

- High School Diploma or equivalent and a minimum of two years of experience performing claims processing in a Medi-Cal or managed care environment (an Associate's degree may substitute for one year of the required experience); or an equivalent combination of education and experience may be qualifying

KNOWLEDGE, SKILLS AND ABILITIES

- Working knowledge of the methods and techniques of medical claims processing
- Working knowledge of general administrative procedures and standard business office practices and equipment
- Working knowledge of the principles and practices of customer service
- Working knowledge of and the ability to read medical insurance Explanation of Benefits

- Working knowledge of Windows-based PC systems and Microsoft Word, Outlook and Excel, and database systems
- Some knowledge of Medi-Cal and prepaid health programs
- Ability to effectively and clearly document, summarize and resolve concerns and inquiries related to claims issues and recognize those issues requiring escalation to a higher-level staff member
- Ability to gather and evaluate information, ask appropriate questions, and utilize problem solving skills
- Ability to utilize a variety of computer systems, including the Alliance information system and external websites and databases
- Ability to demonstrate strong organizational skills and attention to detail
- Ability to perform extensive phone work in a professional manner and meet productivity and quality standards for calls
- Ability to proofread documents for accuracy and completeness
- Ability to process claim data of all claim types comprehensively, accurately, and efficiently
- Ability to conduct research, gather and interpret information and data, identify issues of concern, make logical recommendations for action, and escalate to higher level Claims staff as appropriate
- Ability to understand, interpret, explain, and apply policies and procedures
- Ability to perform basic mathematical calculations, including percentages
- Ability to efficiently utilize a 10-key calculator
- Ability to assist with the development of training materials, prepare training materials for provider in-service trainings and workshops, and conduct training
- Ability to work independently with minimal supervision and as a member of a team

DESIRABLE QUALIFICATIONS

- Working knowledge of medical terminology and related procedure and diagnostic coding, such as CPT-4, ICD-9, HCPCS and methods of accessing resource tools
- Working knowledge of the Medi-Cal program

WORK ENVIRONMENT

- Ability to sit in front of and operate a video display terminal for extended periods of time
- Ability to bend, lift and carry objects of varying size weighing up to 10 pounds
- Ability to work effectively in a remote work environment
- Ability to travel to different locations in the course of work

This position description, and all content, is representative only and not exhaustive of the tasks that an employee may be required to perform. Employees are additionally held responsible to the Employee Handbook, the Alliance Standard Knowledge, Skills and Abilities and the Alliance Code of Conduct. The Alliance reserves the right to revise this position description at any time.