PROVIDER DISPUTE COORDINATOR II

Position Status: Non-Exempt
Reports To: Claims Quality Supervisor
Effective Date: 06/22/21
Revised Date:
Job Level: S2

POSITION SUMMARY

Under general supervision, this position:

1. Coordinates and responds to moderate complexity level one inquiries in the Provider Dispute process
2. Assists with the coordination and completion of low to moderate complexity level two Provider Dispute cases
3. Performs administrative duties in support of the Claims Quality unit and related functions
4. Performs other duties as assigned

DISTINGUISHING CHARACTERISTICS

The Provider Dispute Coordinator II is the full working level position in the Provider Dispute Coordinator series and is distinguished from the next lower, entry and first working level Provider Dispute Coordinator I by the former's responsibility for completing moderate complexity level one and level two cases requiring greater claims business knowledge.

RESPONSIBILITIES

1. Coordinates and responds to moderate complexity level one inquiries in the Provider Dispute process, with duties including but not limited to:
    - Working within established guidelines and procedures to resolve assigned cases in compliance with regulatory timeframes and Alliance policy
    - Creating new cases in the Alliance system and attaching correspondence where applicable
    - Reviewing dispute correspondence and researching the details and history of a case, including searching for authorizations and claim history
    - Electronically preparing and distributing cases to the appropriate Alliance department
    - Tracking receipt, thoroughly documenting clear case notes, and communicating the resolution of cases to all parties involved
    - Coordinating and participating in case discussions with operational experts to develop final case determinations
    - Preparing and generating provider acknowledgement and resolution letters
    - Completing the adjustment of paid or denied low to moderate complexity claims linked to the disputed case
    - Determining if requested cases contain all required information and when cases must be voided or closed as Unable to Accept Dispute
    - Communicating effectively and efficiently, internally and externally, to ensure timely review and resolution of cases
    - Maintaining dispute information and supporting documentation in accordance with regulatory guidelines

- Attending internal meetings and preparing and presenting agenda items, as assigned
- Providing backup for other dispute staff during absences or as directed

2. Assists with the coordination and completion of low to moderate complexity level two Provider Dispute cases, with duties including but not limited to:
   - Distributing cases to appropriate departments and following up as necessary to ensure timely resolution of cases
   - Gathering and reviewing pertinent information regarding cases, such as provider concerns, supporting information related to initial decision, new information supporting dispute, supplemental information required to evaluate dispute, and application of regulatory requirements
   - Evaluating case details, thoroughly documenting case notes, and proposing a resolution decision
   - Requesting, reviewing, sorting and organizing medical records related to denied or modified authorizations for the Alliance Medical Director's review
   - Researching Alliance policy and Medi-Cal manual guidelines for case summaries and resolutions and preparing recommendations and resolution letters

3. Performs administrative duties in support of the Claims Quality Unit and related functions, with duties included but not limited to:
   - Creating new cases in the Alliance system and attaching correspondence where applicable
   - Monitoring the Claims Quality provider dispute voicemail box on a daily basis and routing calls to other staff, or following up directly with providers regarding the status of disputed cases
   - Electronically preparing and saving cases to be scanned into the system
   - Monitoring the Provider Dispute fax queue and the Claims Quality e-mail distribution list for the submission of level one or two disputes and ensuring a timely acknowledgment and case entry
   - Assisting with the review and collection of data for moderate complexity reporting as necessary for regulatory, internal, and external reporting requirements
   - Supporting and participating in process improvements, implementation of new processes, policy review and updating, and training
   - Creating and maintaining workflow instructions

4. Performs other duties as assigned.

EDUCATION AND EXPERIENCE

- High school diploma or equivalent and a minimum of two years of experience administering provider disputes or member appeals and grievances or administering provider claims in a managed care setting, health plan, or provider office (an Associate's degree or Medical Assistant Certification issued by a certifying organization approved by the Medical Board of California may substitute for one year of the required experience); or an equivalent combination of training and experience may be qualifying.

KNOWLEDGE, SKILLS, AND ABILITIES

- Working knowledge of the principles and practices of healthcare coverage and benefit structures, principles of coordination of benefits and medical billing
- Working knowledge of the principles and practices of customer service

- Working knowledge of the methods and techniques of research, analysis and reporting
- Working knowledge of and proficiency with Windows based PC systems and Microsoft Word, Excel and Outlook, and database software
- Ability to audit information and data, identify anomalies and make recommendations for correction
- Ability to apply relevant Medi-Cal, Department of Health Care Services, and Centers for Medicare & Medicaid Services claims processing guidelines and regulations
- Ability to utilize conflict resolution and problem-solving techniques
- Ability to understand and interpret policies, procedures, and regulations
- Ability to understand and analyze contractual and regulatory requirements and their application to the resolution of disputes
- Ability to define issues, evaluate options and clearly and independently document, summarize and resolve complex issues
- Ability to identify issues, conduct research, gather and analyze information, reach logical and sound conclusions, and make recommendations for action
- Ability to communicate effectively in writing, utilize proper grammar, spelling, and punctuation, and format and draft professional correspondence
- Ability to communicate clearly and effectively with providers, both verbally and in writing
- Ability to develop and assess workflows to ensure process efficiencies
- Ability to use computer software to produce statistical reports and graphs in presenting data
- Ability to quickly become familiar with providers in assigned county
- Ability to produce organized, accurate, and detail-oriented work and maintain accurate records
- Ability to facilitate meetings
- Ability to work independently with minimal supervision and as a member of a team

DESIRABLE QUALIFICATIONS

- Associate's degree in Health, Business, Social Services or a related field or certification as a Medical Assistant by a certifying organization approved by the Medical Board of California
- Experience reviewing or preparing medical records
- Experience drafting or preparing legal documents or position statements
- Working knowledge of the methods and techniques of processing and responding to provider disputes
- Working knowledge of managed healthcare
- Working knowledge of Title 22 and Title 28 utilization management and grievance regulations
- Working knowledge of physician/provider types and physician billing processes

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 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.