Clever Care
HEALTH PLAN

PDR and Appeals Specialist

Position Title: PDR and Appeals Specialist
Position Type: Full Time
Location: Arcadia, CA or Huntington Beach, CA
Reports To: Claims Manager

About Clever Care Health Plan

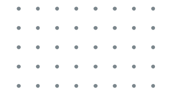
Clever Care Health Plan is a newly founded Medicare Advantage health plan serving Medicare beneficiaries in Southern California. Our employees are passionate in providing best services to our members and healthcare providers. Our three office locations are in Arcadia (Los Angeles County), Huntington Beach (Orange County) and New York City.

Job Summary

The Provider Dispute Resolution and Appeals Specialist ("Specialist") is responsible for processing provider appeals and disputes accurately and timely. The Specialist assesses and completes appropriate documentation for tracking/trending data. Conducts all pertinent research to respond and process incoming provider appeals and disputes in accordance with all established CMS Medicare Advantage regulatory, contractual and departmental guidelines. Communicate to Provider in writing, for all disputes utilizing system formatted letters in a clear and concise manner in accordance with all guidelines set by the department. The Specialist processes the claim(s) accordingly within the claim system while following department processes. Interface with internal departments and external resources and organizations. Prepares and assist with departmental reports as needed.

Functions & Job Responsibilities

- Properly distinguishes between a provider dispute and a provider appeal. Confirm each provider appeals are correctly identified for appropriate tracking and reporting
- Updates tracking system to ensure cases are processed timely and appropriate actions are taken
- Reviews and processes provider appeal and dispute determinations according to CMS, contractual and processing guidelines. Issue appropriate documentation and payments accurately and timely.
- Corresponds with delegated entity as needed to obtain appropriate records or payment information
- Prepares appropriate documentation and submit to IRE when provider appeals result in adverse determination and/or untimely. Ensure IRE responses requiring effectuation are processed timely and accurately.
- Processes/Adjudicates claim(s) according to departmental procedures



- Review written dispute requests received from providers of denied or incorrect payments based on contractual arrangements with providers and non-contractual providers regarding either Professional or Institutional Claims
- Interpret provider and health plan contracts to ensure accurate payment of claims or denial of services based on the terms of the provider contract and the financial responsibility as set in the health plan contract including RBRVS and Medicare guidelines as it applies to contracted and non-contracted providers
- Adjust claims, as appropriate, including calculation of interest and penalties due when applicable
- Communicate to Provider in writing, for all disputes utilizing system formatted letters in a clear and concise manner in accordance with all guidelines set by the department
- Meets and consistently maintains quality and productivity standards as defined by the Management.
- Identifies denial or payment variance trends and escalates to department management as appropriate for training opportunities and corrective action.
- Assists in preparing and reviewing cases for regulatory and other health plan audits.
- Actively participates in ongoing training to support company and department initiatives.
- Supports department initiatives in improving processes and workflow efficiencies
- Adheres to all regulatory and company standards, as described in the Employee Handbook and departmental Policies and Procedures.
- Complies with company's time and attendance policy.
- Ensure the privacy and security of PHI (Protected Health Information) as outlined in the department policies and procedures relating to HIPAA Compliance.
- Foster good corporate relations by practicing good customer service principles (i.e., positive attitude, helpful, etc.) and teamwork.
- Ensures processing turn-around times for claims processing are met and processed as follows; Medicare claim payments are completed as follows; 95% in 30 days (clean claims) and 60 days (unclean).
- Establish and promote teamwork within the department, participating fully and with commitment
- Completes other projects and duties as assigned.

Education & Experience

- High School diploma or equivalent required. Associate degree or an equivalent combination of education and claims processing experience preferred.
- 2+ years experience processing Medicare Advantage provider appeals from all types of providers (hospitals, physicians, ancillary)
- 2+ years experience in examining all types of medical claims, preferably Medicare Advantage claims
- 2 years of experience in HIPAA requirements required. Knowledge of: CMS and/or DMHC claims processing guidelines or regulations.

Knowledge/Skills/Abilities

- Terminology, CPT, revenue codes, ICD10, HCPCS codes as it relates to claims processing adjudication. Core claims processing systems and healthcare authorization systems.
- Working knowledge of claims processing systems (EZCAP preferred).
- Working knowledge of medical terminology, standard coding and reference publications, CPT, HCPC, ICD-9, ICD-10, DRG, etc.
- Understanding of different payment methodology such as Medicare PPS (MS-DRG, APC, etc.), Medicare Physicians fee schedule, Per Diem, etc.,
- Understanding of Division of Financial Responsibility on how they apply to claims processing
- Familiarity with billing and coding edits, coordination of benefits, MA Organization, Determination, Appeals and Grievance procedures
- Proven problem-solving skills and ability to translate knowledge to the department.
- Working knowledge of Microsoft Office Programs (Outlook, Excel and Word)
- Excellent verbal and written communication skills.
- Strong Organizational Skill and ability to multitask
- Attention to Detail.
- Ability to use 10 keys.
- Establish and maintain interpersonal relationships internally/externally and utilize skills by; coaching and motivating staff, handling conflict resolution, implementing project or new programs/initiatives and collaborating with other departmental subject matter experts.
- Perform in a fast-paced environment and work under pressure.
- Communicate clearly and concisely, both verbally and in writing to individuals of diverse backgrounds.
- Organize, plan and prioritize work activities, possess analytical and problem-solving skills.
- Troubleshoot claims adjudication problem areas.
- Encourage and utilize suggestions and new ideas.
- Comprehend and interpret provider contracts and Divisional Financial of Responsibility (DOFR).
- Utilize and access computer and appropriate software (e.g., Microsoft: Word, Excel, PowerPoint) and job-specific applications/systems (e.g., EZCAP Claims Processing System and Authorization system) to produce correspondence, charts, spreadsheets, and/or other information applicable to the position.

Physical & Working Environment

Typical Physical Demands.
Position requires a great amount of sitting and standing. Some lifting, stooping, bending, or reaching is required. May require lifting up to 15-30 pounds. Requires manual dexterity sufficient to operate a computer, calculator and telephone. Requires normal range of hearing and vision. Requires the ability to type and file.

Typical Working Conditions.
Work is performed in an office environment and/or remotely. The job involves frequent contact with staff and public. Work may be stressful at times. May occasionally work some irregular hours.

Qualifications:

What's in it for you?

1. A competitive compensation and benefits program.
2. Generous paid-time-off (PTO).
3. Ten paid holidays per year.
4. Excellent 401k saving plan, employer provides up to 4% match and employer contribution match is 100% immediately vested.
5. A work-life balance and much more!

Please email your resume directly to hr@ccmapd.com

Clever Care Health Plan is proud to be an Equal Employment Opportunity and Affirmative Action workplace. Individuals seeking employment will receive consideration for employment without regard to race, color, national origin, religion, age, sex (including pregnancy, childbirth or related medical conditions), sexual orientation, gender perception or identity, age, marital status, disability, protected veteran status or any other status protected by law. A background check is required.