

Desert Shores Pediatrics

Billing Manager Position Description

The Billing Manager, a key position in the Revenue Cycle, manages the claims process, including accurate and timely claim creation, follow-up and correspondence with providers, insurance inquiries/correspondence. The Billing Manager will assist in the clarification and development of process improvements and inquires, assure payments related to patient services from all sources are recorded and reconciled timely in order to maximize revenues. Other important duties include credentialing, contract negotiating, enrollment processing and reporting.

Principal Accountabilities:

- Billing and Claims-
 - . Prepares and submits clean claims to third payers either electronically or by paper.
 - . Maintains relationship with clearinghouse, including appropriate follow-up with support issues.
 - . Coordinate the process of patient eligibility through various third party sources.
 - . Coordinate collection process and tracking current collection accounts.
 - . Manage monthly statement process, to include reviewing statements and field any patient inquiries that supporting billing staff needs to escalate.
 - . Work with reception staff, ensure appropriate collection of co-pays, deductibles and self-pay fees.
 - . Coordinate and administer billing policy and procedures.
 - . Handles patient inquires and answers questions from clerical staff and insurance companies.
 - . Identifies and resolves patient billing problems.
 - . Denial and insurance follow-up management.
 - . Issues adjustments, corrected, and or/rebilled claims to third party payers.
 - . Posts insurance checks/ EOB's with accurate adjustments, transfer of responsibility and refunds as necessary.
 - . Assure coding is compliant and up to date.
 - . Maintains strictest confidentiality, adheres to all HIPAA guidelines/regulations.

- Credentialing-
 - . Maintain up-to-date credentials for each licensed provider, including verification through primary and secondary sources, records and relay credentialing information to relevant personal as needed. Keeps accurate records of provider licensure/ certification renewals.
 - . Coordinate provider enrollment in all commercial, state and federal insurance programs.
 - . Correspond with and provide updates to insurances.

- Insurance Contracts and Negotiations-
 - . Review insurance contracts for accuracy and completeness
 - . Review all insurance contracts yearly.
 - . Monitor highest volume codes, do comparison reports on payers
 - . Watch for new codes and know what's allowed within each payers contract.
 - . Knowledge of insurance guidelines, including HMO/PPO, Medicaid and other payer requirements and systems.

Job Requirements:

- . Knowledge of medical billing, CPT and ICD-10 Coding, collection practices required
- . Management skills
- . Perform multiple task effectively
- . Able to work both independently and as a team leader.
- . Capable of making timely, independent decisions.
- . Ability to work well in a team environment. Being able to triage priorities, delegate tasks if Needed, and handle conflict in a professional manner.
- . Problem-solving skills to research and resolve discrepancies, denials and appeals.

Experience:

- . Management/ team lead
- . Previous medical billing including contracts and credentialing
- . Working knowledge of CPT and ICD-10 coding systems. Coding certification preferred.
- . An Associate Degree or higher from an accredited school with credentials in billing/ coding preferred.
- . Excellent organization skills
- . Experience working with medical payers including commercial and Medicaid insurance.