Cow Creek Government Office

Position Description

Position Title: Revenue Cycle Manager

Department: CCH&WC

Reports To: Clinic Director

FLSA Designation: Non-Exempt

Date Written/Revised: July 2020

POSITION PURPOSE:

The Revenue Cycle Manager is responsible for the direction of daily operations and procedures that ensure that all insurance claims are coded and billed correctly as well as followed up on in a timely manner to ensure prompt resolution of the claims. The Revenue Cycle Manager is responsible for managing patient accounts in this highly complex, multi-disciplinary ambulatory clinic environment. The incumbent shall train other members of CCH&WC team and shall participate in all functions of the coding and billing cycle. The incumbent shall also function as a resource for clinic providers and staff and will assist with coding and billing questions and quality assurance activities. The Revenue Cycle Manager is responsible for the managerial responsibilities of the Revenue Cycle staff. Partner with CCH&WC contractors for current revenue cycle (such as Greenway) and make recommendations for improvement to Clinic Director and Chief Health Officer.

ESSENTIAL FUNCTIONS:

1. Exercise the full range of supervisory duties of Revenue Cycle staff; including but not limited to overall work planning, schedules, priorities, work assignments, progress of the work and problem areas as they arise. Resolve complaints or minor grievances; work with employees on matters related to less than adequate performance, keep employees informed of management policies and goals.

2. Establish working relationships with the providers from each clinic to assist with coding and billing guidelines. Provide education, training, & instruction to providers on coding updates and/or coding questions or issues that the providers may encounter.

3. Complete specific contracting applications with insurance companies for CCH&WC providers, including tracking when contract was received, completed by provider and mailed to proper agency. Track effective date of each contract and provider numbers assigned by each agency.

4. Assist with the preparation of an annual budget and manage the department consistent with approved budgetary goals.

5. Develop and maintain procedures for efficient and accurate processing of encounters. Ensure all encounters are processed and submitted with pertinent information to the insurance carriers on a weekly basis. Coordinate the paper document or electronic record review flow related to billing and patient accounts.

6. Identify and establish relationships with third party insurers, which will improve patient claims review.

7. Oversee timeliness of insurance collections, billing efficiency, payment posting accuracy, and reconciliation of accounts receivables from third party insurance payers.

8. Provide timely, complete and accurate month-end reports, provider statistical data, insurance carrier data, accounts receivable reports, and any reports requested for auditing purposes to the Chief Health Officer and Clinic Director.

9. Ensure that coders are reviewing patient ambulatory encounters for each provider and assuring that the appropriate ICD-10-CM & CPT codes are used and appropriately reflected in the chart note for code assignment as outlined by the CMS guidelines. Assure medical necessity billing guidelines are met by providers.

10. Ensure that all applicable billing forms are received with the most accurate data and adequately reflect the services rendered before claim submission to insurance companies.

11. Analyze and track claim denials, rejections, and payer info requests to identify and implement revenue enhancement opportunities. This includes, but is not limited to, calling the appropriate provider or department staff for clarification of patient encounter data and working with health plans for claim reviews.

12. Assist department staff in various functions required to monitor and to collect delinquent insurance reimbursement of claims. Ensure resubmission of eligible claims and attach any information required by insurance companies to reprocess claims.

13. Lead regular quality assurance activities for the department. Arrange coding reviews and documentation meetings with Revenue Cycle Staff and Medical Providers/Staff to clarify documentation issues. Create and maintain meeting minutes for compliance purposes.

14. Perform table maintenance for practice management system, including fee schedule, service codes, provider information updates, and other needed system function updates or setup.

15. Provide a yearly revenue forecast of potential third party billing revenue from factual data to assist with organizational yearly budgeting.

16. Responsible for working with the Oregon Health Authority on the 100% FMAP reporting, and any additional services/reports, to help maximize additional sources of 3rd party revenue.

17. Responsible for working with the Indian Managed Care Entity (IMCE) on assessment, reporting and any additional services/reports, to help maximize additional sources of 3rd party revenue.

18. Responsible for keeping staff apprised of current Medicare, Medicaid, and commercial insurance plan rules and regulations as they apply to an FQHC and Tribal-compact organization to ensure department compliance.

19. Research insurance company rules and policies on what services and types providers they will cover. This may include researching OARs and ORS definitions of scope of practice for a given provider and services they perform, including research on possible new services.

20. Attend required trainings, seminars, conferences, 3rd Party Revenue workshops, OHA Tribal or FQHC meetings.

21. Other related duties as assigned.

SPECIFIC JOB KNOWLEDGE, SKILL AND ABILITY:

- Supervision experience managing clinic personnel, coding and billing personnel.
- Strong problem solving, decision making, team building, process improvement, leadership and time management skills required.
- Excellent interpersonal communication skills both written and verbal.
- Proficient use of computers including electronic medical records, MS Office applications.
- Knowledge and experience in QI/QA. Data analytics.
- Knowledge of HIPPA.
- Technical knowledge and understanding of medical terminology and anatomy, encountered in daily routing of abstracting coding data from a variety of medical and financial forms and sources.
- Technical knowledge, skill and understanding of the American Medical Association developed CPT coding system in order to acquire, interpret, and resolve problems based on information derived from system monitoring reports to be carried over to the required billing forms.
- Technical knowledge, skill and understanding of the concepts of the coding system, International Classification of Diseased, Tenth Revision, Clinical Modification (ICD-10-CM) form classification of diseases and/or procedures.
- Knowledge and understanding of the CDT coding.
- Knowledge and understanding of HCPCS coding.
- Knowledge and understanding of the behavioral health services, DSM-V.
- Ability to develop and evaluate policies and procedures.
- Skill in planning, directing, and administering efficient departmental procedures and to professionally direct staff in day to day activities, including tracking multiple projects.
- Knowledge of Centers for Medicare and Medicaid Services (CMS) Federally Qualified Health Centers (FQHC) and the Prospective Payment System (PPS) reimbursement methodology.

QUALIFICATIONS:

- **Required** to possess a High School Diploma or Equivalent. (*Must submit copy of diploma or transcripts with application.)*

- **Required** to possess an Associate's Degree in Medical Office Systems Technology or Business-related field **OR** a minimum of four (4) years of equivalent combination of specialized training and experience demonstrating technical knowledge of medical terminology and the CPT and ICD-10-CM coding systems. (*Must submit degree, transcripts or training certificates with application*.)

- **Required** to possess and be able to maintain (at the incumbent's own expense) one of the following nationally recognized professional medical coding certification. Either the AAPC (CPC) or AHIMA (CCS-P).

- **Required** to possess demonstrated knowledge of Medical Terminology.

- **Required** to have knowledge and experience in third party reimbursement, internal audits, budgeting, financial analysis, and management information systems.

- **Required** to submit to and clear an Alcohol/Drug Screen and random testing as per policy.

- **REQUIRED** to submit to a background and character investigation, as per Tribal policy. Following hire must immediately report to Human Resource any citation, arrest, conviction for a misdemeanor or felony crime.

- **REQUIRED** to submit to annual TB skin testing and adhere to immunization policy in accordance with the Centers for Disease Control immunization recommendations for healthcare workers.