Payer Enrollment Specialist
Position Description

Employee:
Class Title: Payer Enrollment Specialist
Hours Worked: 8:00am- 4:30pm, M-F
Positions Supervised: N/A
Status: Full Time, Non-Exempt

Site: Administration
Title of Supervisor: Lead Billing Specialist
Date Revised: 1/31/2021

Date of Hire: February 4, 2021

Summary of Position

Under the direction of the Director of Billing, the Payer Enrollment Specialist (PES) is responsible for the coordination, completion and submission of initial and recurring provider enrollment applications with Medicare, state Medicaid programs and all commercial insurance plans for all health center providers in a range of specialties. The PES is also responsible for maintaining accurate records, updating, and amending applications as information changes including but not limited to, the additions and deletions of individual provider enrollments to the medical group's applications as necessary, submitting updates in provider credentials, demographics, physical address, and other information as requested by all health plans. In addition, the PES will also be responsible for billing and collection of insurance and self-pay accounts receivable, reconciliation of payments received with amounts posted to the billing system and works with involved parties to resolve identified billing problems or issues.

RESPONSIBILITIES AND DUTIES:

Patient/Customer Focus: Makes patients and their needs a primary focus of one's actions; shows interest in and understanding of the needs and expectations of internal and external customers; gains patient trust and respect; meets or exceeds patient's expectations. ***Core values of Patient-Focused Care: Timely answering of calls; respect: compassion, empathy, caring, non-judgmental, focusing on one patient at a time, establish trust and ensure patient satisfaction. Compassionate Care : Treating patient as if they are our family/friends: Platinum Rule (Treat others the way they want to be treated), being kind and courteous, showing empathy and not passing judgment, showing patients respect, understand patient's limitations, demonstrating professionalism even under stressful situations.***

- Research and coordinate requirements for provider/group enroll in Medicare, ~~various state~~ Medicaid Managed Medicaid, and commercial health plans and identify issues that may present with enrollment such as, determining minimum criteria required for the enrollment of new and existing group providers, processing time, backdate requests, health plan backlogs, required group enrollment documentation, and payer timeframes for submission.
- Working with PECOS, I & A, and other Medicare Enrollment portals.
- Gather, validate and maintain updated practice related information required by payers.
- Prepare, review and submit all group/individual enrollment applications and revalidation documents.
- Communicate with payer representatives regarding additional information requests, which may involve educating such representatives on the nature of services provided by health center practitioners and the applicability of certain requirements
- Communicate with billing regarding assignment priority, as needed, and assist with claims rejections based on improper provider or group enrollment.
- Report status of pending enrollment applications to the Director of Billing and various health center personnel as applicable.
- Reviews patient accounts for accuracy, make adjustments as needed including encounter rate billing adjustments.
- Reviews and submits electronic statements on a monthly basis.
- Posts payments received and reconciles system postings to lockbox &/or EOB total.

- Records NSF checks returned by bank and notifies patients of adjusted balance due.
- Receives, responds and documents all incoming account inquiries related to billing issues.
- Reviews EOB's for reasons not paid, and distributes this information as necessary to initiate transaction posting or collection of corrected patient information.
- Demonstrates ability to edit & submit insurance claims for non-encounter rate payers.
- Performs all routine and special follow-up on all assigned accounts using telephone and correspondence to affect collection of patient account balances.
- Negotiates payment terms and establishes agreed-upon payment plans for overdue account balances; monitors payment compliance with terms of established plans.
- Evaluates uncollectible accounts and makes recommendations concerning account write-offs and/or placement with an outside collection agency.
- Completes bad debt process based on the approval granted.
- Documents activities on accounts, including corrections, collection activities, etc.
- Initiates & completes account adjustments to correct account balances and/or comply with contractual and sliding fee scale requirements.
- Other duties as assigned.

<u>Quality Orientation</u>: Monitors and checks work to meet quality standards; demonstrates a high level of care and thoroughness; checks work to ensure completeness and accuracy.

- Maintain strict confidentiality of sensitive information.
- Update and maintain internal spreadsheet with provider list by health center site including all pertinent provider specific information for purposes of payer enrollment and revalidation.

<u>Technical/Professional Knowledge and Skills</u>: Possesses, acquires and maintains the technical/ professional expertise required to do the job effectively. Demonstrates knowledge through problem solving, applying professional judgment and competent performance.

- Serves as the subject matter expert for all group and individual provider enrollment related activity.
- Maintain all health center provider CAQH (Committee for Affordable Quality Healthcare) profiles and responsible for the quarterly attestation process on behalf of all health center providers.
- Responsible for establishing and updating amendments for the health center contracts with all health plans as applicable.
- Analyze and interpret information from payers related to guidelines on the completion of forms.
- Document and track the status of all pending applications in an internal Excel spreadsheet.
- Demonstrate knowledge in working with Electronic Health Records (EHR).

<u>Communication and Teamwork</u>: Participates as an active and contributing member of a team to achieve team goals. Works collaboratively with others, involves others, shares information as appropriate, shares credit for team accomplishments. *<u>Core Value of Collaborative Care:</u> teamwork, closer co-worker communication, making best use of time, positive attitude.*

- Collaborates directly with providers and various department representatives to obtain information related to practice addresses, taxonomy codes, and to secure provider and authorized official signatures.
- Supports the Director of Billing with miscellaneous projects as needed.
- Actively supports the Mission, Vision and Values of the FCHC.
- Actively participates in staff meetings, in-services and training sessions.
- Flexible to cover other office functions as needed, goes beyond their assigned role without being asked.

<u>Adaptability and Innovation</u>: Adapts well to changes in assignments and priorities, adapts behavior or work methods in response to new information, changing conditions or unexpected obstacles. Uses creativity and imagination to develop new insights into situations and applies new solutions to problems. *Core Value of Creative Care: open to change, optimistic, focus on learning and sharing.*

- Remains open to feedback for improvement.
- Suggests new ways to address issues.
- Shares office or workflow concerns and possible solutions for resolution.
- Flexibility to work overtime hours as determined by operational demand.

QUALIFICATIONS

- High school diploma or equivalent.
- 2 year Business or Healthcare Administration degree or related field from an accredited institution preferred.
- 1-3 years of experience in medical and behavioral health contracting, payer enrollment and medical billing experience preferred.
- Knowledge of CPT and ICD-10 coding.
- Knowledge of and experience working with Medicare, Medicaid and third party payers.
- Proficiency in Microsoft Office applications.
- Experience working with a personal computer and other office equipment.
- Strong written and verbal communication skills.
- Task oriented, ability to prioritize and excellent organizational skills.

PHYSICAL REQUIREMENTS:

Must be able to push, pull and assist in lifting up to 20 lbs. May be exposed to loud noises. Must be able to stand for extended periods of time, stoop, bend, reach, show manual dexterity, and clearly communicate with patients and office personnel.

Attestation:

1. I have read the duties and responsibilities for my position as listed in this Position Description.
2. I understand what is expected of me in the performance of my duties and responsibilities.
3. I am able to perform my duties and responsibilities with/without any restrictions.

Employee	Date
Supervisor	Date
Chief Executive Officer	Date Approved