

Code: 1116

Title: MEDICAL INSURANCE VERIFICATION COORDINATOR

SUMMARY: Verifies members Third Party Liability (TPL) medical insurance information for cost avoidance or post payment recoveries and enters into a database system and maintains all related documentation files. Researches invoices made to members, accepts or denies service charges and makes appropriate coordination and notification to provider, member or staff associate regarding outcome of decision.

DUTIES/RESPONSIBILITIES: (Work assignments may vary depending on the department's needs and will be communicated to the applicant or incumbent by the supervisor.)

Verifies third party medical insurance/benefit coverage information (eligibility, co-pays, pharmacy, and mental health) for cost avoidance or post payment recoveries of AHCCCS and ALTCS services through telephone, fax, and the use of automated systems and by direct data entry (Ledscats, AHCCCS & Social Security Administration);

Contacts health insurance agencies to obtain Third Party Liability information to verify coverage;

Enters and updates Third Party Liability (TPL) and Coordination Of Benefits (COB) information into the QMACS database system;

Maintains appropriate screens on QMACS database system and inputs and retrieves data and produces computer reports;

Prepares and sends approval notification letters to members;

Researches information and prepares correspondence, memoranda, operations manuals, and other documents;

Notifies appropriate department sections/divisions (Case Management, Member Services, Utilization Management) staff and state agency (AHCCCS) of additions, updates, and/or changes to a member's third party medical insurance information;

Researches Third Party Liability (TPL) and Medicare insurance/benefit eligibility on new enrollments for AHCCCS Ambulatory and Long Term Care (LTC);

Researches co-pay reimbursement requests, reviews for completeness and accuracy, prepares appropriate documentation and processes for payment;

Researches prior payment pharmacy statements for delivery of prescriptions to members in Skilled Nursing Facilities (SNF);

Calculates PHS coverage payments and determines payment to provider in accordance to and within the guidelines of department policies and in compliance with applicable Federal and State statutes and regulations and County and department policies and procedures;

Researches provider invoices made to members and verifies eligibility on date of service, and QMACS Claims systems for prior payment or denials and if not previously billed, sends notification to provider of member eligibility for payment coverage for submission of proper forms;

Negotiates prices and payment arrangements directly with providers on members behalf;

Reports repeat non-compliant providers to the Pima Health System Corporate Compliance Division for appropriate action;

Handles, follows up and resolves staff's (Case Managers, Members Services, Utilization Management) inquiries involving member TPL eligibility, disenrollment, and/or co-pay pharmacy and medical assistance;

Compiles statistical and operational data and prepares reports;

Participates in the development of new unit operating procedures and/or reviews and makes recommendations or changes to existing unit policies and procedures;

Represents the work unit in meetings with other department sections/divisions, other County personnel, and/or other outside agencies;

Answers telephone calls and inquiries, directing callers to appropriate resources as required or resolves problems which require explanation of County, Departmental, or rules and policies.

KNOWLEDGE & SKILLS:

Knowledge of:

- AHCCCS and Medicare coordination of benefits and cost sharing rules;
- medical claims payable coordination of benefits guidelines;
- medical insurance terminology and benefit packages;
- applications of automated information systems;
- bookkeeping principles and practices;
- policies and procedures for the billing, adjustment and payment of medical accounts;
- computerized financial management, record keeping and filing systems;
- business English, spelling, grammar, punctuation, and composition;
- research techniques and report writing;
- principles and techniques of data entry in alphabetic and numeric data entry systems;
- automated medical record-keeping and filing systems.

Skill in:

- coordination of benefits and cost sharing rules pertaining to AHCCCS and Medicare;
- verifying and obtaining information and making determinations by applying rules and regulations;
- entering information into and retrieving information from database records;
- negotiating payment arrangements and effectively communicating requirements and expectations;
- resolving patient financial issues and concerns;
- coordinating and prioritizing multiple tasks, projects and activities;
- researching and compiling information and writing and preparing reports;
- communicating effectively.

MINIMUM QUALIFICATIONS:

EITHER:

(1) Two years of experience verifying medical insurance coverage involving denying and/or accepting coverage and an Associates Degree or an Advanced or Basic Certificate from an accredited college, university, or vocational/technical school in either Accounting, Administrative and Office Support, Business, or Data Entry. (Two years of additional medical claims experience may be substituted for the educational requirement.)

OR

(2) Two years experience as a Medical Claims Examiner II with Pima County.

OR

(3) Three years experience as a Medical Claims Examiner I or Medical Business Office Support Specialist with Pima County.

OTHER REQUIREMENTS:

Physical/Sensory Requirements: Physical and sensory requirements will be determined by position.

This class specification is intended to indicate the basic nature of positions allocated to the class and examples of typical duties that may be assigned. It does not imply that all positions within the class perform all of the duties listed, nor does it necessarily list all possible duties that may be assigned.