Job Description

JOB TITLE: Insurance Billing Coder
DEPARTMENT: Billing
STATUS: Non-exempt
REPORTS TO: Business Office Manager

POSITION SUMMARY

The Insurance Billing Coder is responsible for processing all insurance claims, i.e., private, Medicare, Workers' Compensation, PPO, and HMO, including secondary claims. All claims will be coded with CPT and ICD-9 codes according to the findings in the medical record. General duties include verification of benefits and regularly working the aging reports. Understand managed care contracts and reimbursement process. At all times, this position maintains the strictest confidentiality and follows the HIPAA rules and regulations.

A review of this description has excluded the marginal function of the position that are incidental to the performance of fundamental job duties. This job description in no way states or implies that these are the only duties to be performed by the employee occupying this position. Employees will be required to follow any other job-related instructions and to perform other job-related duties requested by their supervisor.

RESPONSIBILITIES

- Demonstrates, performs an understanding of insurance collections to include: payment in full, overpayment reviews and approvals, next action on correspondence
- Handle patient calls in support of collections activities to include financial review payment plans and complaints
- Perform in-depth account review such as: correspondence research, secondary claims billing, payment review, contractual adjustments and modify insurances/demographic information in compliance with billing policies and procedures for appropriate next required action
- Responsible for managing Accounts Receivable (A/R) and staying within acceptable metrics boundaries
- Perform, identify, collect, and confirm insurance coverage to include obtaining prior authorization, third party liability and coordinator of benefits in collaboration with Precertification Specialist
- Possess an excellent working knowledge of HCPCS, CPT, ICD-9, ICD10 codes, medical terminology, and clinical documentation
- Evaluate medical record documentation, discharge position, and assign coding that accurately reflects services rendered to the patient
- Ensure that medical, diagnostic, and procedural codes and other documentation accurately reflect and support the visit
- Correct failed claim errors to billing edits directly related to coding errors
- Post all payments, by line-item, received for physician's professional services into the practice management system including co-payments, insurance payments, and patient payments in accordance with practice protocol with an emphasis on accuracy to ensure maximum patient satisfaction and profitability. All payment batches must be balanced in both their dollar value of payments and adjustments prior to posting
- Post all credit and debit adjustments to patient accounts with strict adherence to the department guidelines
- Review the physician's coding at charge entry to ensure compliance with Medicare guidelines and to ensure accurate and timely reimbursement
- Provide customer service both on the telephone and in the office for all patients and authorized representatives regarding patient accounts in accordance with practice protocol. Patient calls regarding accounts receivable should be returned within 2 business days to ensure maximum patient satisfaction.

- Verify all demographic and insurance information in patient registration of the practice management system at the time of charge entry to ensure accuracy, provide feedback to other front office staff members and to ensure timely reimbursement
- Follow-up on all outstanding insurance claims in accordance with practice protocol with an emphasis on maximizing patient satisfaction and practice profitability
- Provide information pertaining to billing, coding, managed care networks, insurance carriers and reimbursement to physicians, managers, and subordinates
- Follow-up on all returned claims, correspondence, denials, account reconciliations and rebills within five working days of receipt to achieve maximum reimbursement in a timely manner with an emphasis on patient satisfaction
- Recommend accounts for outside collection when internal collection efforts fail in accordance with practice protocol
- Process refunds to insurance companies and patients in accordance with practice protocol
- Reconcile the incoming lockbox deposits in accordance with practice protocol as required to ensure timely payment posting
- Monitor reimbursement from managed care networks and insurance carriers to ensure reimbursement consistent with contract rates
- Proficiency with all facets of the medical practice management system including patient registration, charge entry, insurance processing, advanced collections, reports, and ledger inquiry
- Effectively communicate with clinic staff, and in certain instances providers, when code assignments are not specific or documentation is inadequate, or unclear for coding purposes; offers opportunity to submit corrected documentation
- Understand billing requirements for all payers and participate in ensuring claims are accurate prior to submission
- Assist with training of staff on billing requirements for new and established payers
- Understand insurance regulations and guidelines to include CMS guidelines in order to effectively discuss outstanding claims with payers related to slow payments, underpayments, denials and to ensure claims are processed compliantly and paid appropriately
- Assist in establishing accounts for EFT/ACH payments for the practice
- Assist with monitoring of professional and payer publications and websites to remain current on coding changes relevant to the practice and communicate these changes to the team
- Assist with maintaining active status for all providers by successfully completing initial and subsequent credentialing packages as required by hospitals, surgery centers, commercial payers, Medicare, and Medicaid
- Works collaboratively with all other departments to ensure a positive patient experience
- Other duties, as assigned

KNOWLEDGE, SKILLS, AND ABILITIES

- Knowledge of commercial insurance plans and Medicare and Medicaid regulations
- Good working knowledge of medical necessity rules, local coverage determination policies, and any other payer specific guidelines
- Extensive knowledge of CPT and ICD-10 coding
- Ability to understand and interpret clinical documentation, as well as the department billing process at a detailed level
- Ability to multitask and remain focused while managing a high-volume, time-sensitive workload
- Detail oriented with above average organizational skills
- Knowledge of common office computer programs; Word, Excel, Internet
- Skill in communicating effectively with patients, clinics, and coworkers
- Ability to apply common sense understanding to carry out instructions furnished in written, oral, or diagram form.

- Must be able to work independently or as part of a team

EDUCATION/EXPERIENCE REQUIRED

- High School Diploma or GED
- Certified Professional Coder (CPC) Certification or Certified Medical Coder (CMC) preferred but will consider candidates with extensive experience coding charts
- ICD-10CM Certification desired
- 2+ years of current physician coding experience
- Experience coding orthopedic surgery and/or pain care highly desirable