CLINICAL DENIAL SPECIALIST

Job Code: 440034	**FLSA Status: Non-Exempt**	**Mgt. Approval: D. Christiansen**	**Date: August 2022**
Department: Rev Cycle - Denial Mgmt & Reimbursement		**HR Approval: B. Haak**	**Date: August 2022**

JOB SUMMARY

The Clinical Denial Specialist performs advanced level work related to clinical denial management. The individual is responsible for managing claim denials related to referral, authorizations, notifications, non-coverage, medical necessity, and others as assigned. The Clinical Denial Specialist conducts comprehensive reviews of the claim denial, account/guarantor notes associated with the denial, and the medical record to make determinations if a revised claim needs to be submitted, if a retro authorization needs to be obtained, if a written appeal is needed, or if no action is needed.

The Clinical Denial Specialist writes and submits professionally written appeals which include compelling arguments based on clinical documentation, third-party payer medical policies, and contract language. Appeals are submitted timely and tracked through final outcome. The incumbent will also handle audit-related / compliance responsibilities and other administrative duties as required.

This incumbent will actively manage, maintain, and communicate denial / appeal activity to appropriate stakeholders and report suspected or emerging trends related to payer denials to Revenue Cycle management. Additionally, the Clinical Denial Specialist anticipates and responds to a wide variety of issues/concerns. The incumbent works independently to plan, schedule, and organize activities that directly impact hospital and physician reimbursement and assists in creating and maintaining documentation of key processes. This role is key to securing reimbursement and minimizing organizational write offs.

MAJOR RESPONSIBILITIES

Core Responsibilities:

- Research payer denials related to referral, pre-authorization, notifications, medical necessity, non-covered services, and billing resulting in denials and delays in payment.
- Independently write professional appeal letters.
- Submit detailed, customized appeals to payers based on review of medical records and in accordance with Medicare, Medicaid, and third-party guidelines as well as UW Health policies and procedures.
- Submit retro-authorizations in accordance with payor requirements in response to authorization denials.
- Identify denial patterns and escalate to management as appropriate with sufficient information for additional follow-up, and/or root cause resolution.
- Make recommendations for additions/revisions/deletions to work queues and claim edits to improve efficiency and reduce denials.
- Review payor communications, identifying risk for loss reimbursement related to medical policies and prior authorization requirements; escalates potential issues to clinical stakeholders, managed care contracting, and Revenue Cycle leadership as appropriate.
- Identify opportunities for process improvement and actively participate in process improvement initiatives.

Customer Service Standards:

- Support co-workers and engage in positive interactions.
- Communicate professionally and timely with internal and external customers.
- Demonstrate friendliness by smiling and making eye contact when greeting all customers.
- Provide helpful assistance in anticipating and responding to the needs of our customers.
- Collaborate with customers in planning and decision making to result in optimal solutions.
- Ability to stay calm under pressure and deal effectively with difficult people

ALL DUTIES AND REQUIREMENTS MUST BE PERFORMED CONSISTENT WITH THE UW HEALTH PERFORMANCE STANDARDS

JOB REQUIREMENTS

Education	Minimum	Associate degree in a business or healthcare related field. Two (2) years of relevant experience may be considered in lieu of a degree in addition to the required experience below.
	Preferred	Bachelor's Degree or graduate of LPN or RN program
Work Experience	Minimum	Two (2) years recent experience in professional business writing, hospital case management and/or hospital prior authorization.
	Preferred	• Epic experience in either Resolute Hospital or Professional Billing • Three (3) years of experience in a healthcare revenue cycle or clinic operations role with one (1) of those years being in a role which included claim-related appeal writing. • Experience with medical and insurance terminology, CPT, ICD coding structures, and billing forms (UB, 1500)
Licenses & Certifications	Minimum	N/A
	Preferred	Current LPN or RN licensure
Required Skills, Knowledge, and Abilities		• Focus on continuous process improvement • Ability to make good judgments in demanding situations • Ability to react to frequent changes in duties and volume of work • Effective communication skills • Extensive writing capabilities / efficiencies • Ability to listen empathetically • Ability to write professional appeal letters • Ability to organize details logically and accurately • Ability to construct an effective argument related to the medical necessity for a hospital service. • Ability to effectively communicate in writing. • Ability to communicate with multiple levels in the organization (e.g, managers, physicians, clinical and support staff) • Ability to maintain a strong relationship with various clinical and non-clinical team members to positively affect financial outcomes • Ability to manage multiple tasks with ease and efficiency • Self-starter with a willingness to try new ideas • Ability to work independently and be result oriented • Positive, can-do attitude coupled with a sense of urgency • Effective interpersonal skills, including the ability to promote teamwork • Strong problem-solving skills • Ability to ensure a high level of customer satisfaction including employees, patients, visitors, faculty, referring physicians and external stakeholders • Ability to use various computer applications including EPIC • Excellent PC operating skills (keyboard, mouse) and use of MS Office • Broad knowledge of health care business office practices and principles • Basic math skills and knowledge of general accounting principles • Maintain confidentiality of sensitive information • Knowledge of Business Office policies and procedures • Knowledge of Medicare, Medicaid and third-party reimbursement methodologies • Knowledge of local, state and federal healthcare regulations

AGE SPECIFIC COMPETENCY (Clinical jobs only)

Identify age-specific competencies for direct and indirect patient care providers who regularly assess, manage and treat patients.

Instructions: Indicate the age groups of patients served either by direct or indirect patient care by checking the appropriate boxes below. Next,

☐	Infants (Birth – 11 months)	☐	Adolescent (13 – 19 years)
☐	Toddlers (1 – 3 years)	☐	Young Adult (20 – 40 years)
☐	Preschool (4 – 5 years)	☐	Middle Adult (41 – 65 years)

	School Age (6 – 12 years)		Older Adult (Over 65 years)

JOB FUNCTIONS

Review the employee's job description and identify each essential function that is performed differently based on the age group of the patient.

PHYSICAL REQUIREMENTS

Indicate the appropriate physical requirements of this job in the course of a shift. *Note: reasonable accommodations may be made available for individuals with disabilities to perform the essential functions of this position.*

	Physical Demand Level	**Occasional** Up to 33% of the time	**Frequent** 34%-66% of the time	**Constant** 67%-100% of the time
X	**Sedentary:** Ability to lift up to 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers and small tools. Although a sedentary job is defined as one, which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.	**Up to 10#**	**Negligible**	**Negligible**
	Light: Ability to lift up to 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers and small tools. Although a sedentary job is defined as one, which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.	**Up to 20#**	**Up to 10#** or requires significant walking or standing, or requires pushing/pulling of arm/leg controls	**Negligible** or constant push/pull of items of negligible weight
	Medium: Ability to lift up to 50 pounds maximum with frequent lifting/and or carrying objects weighing up to 25 pounds.	**20-50#**	**10-25#**	**Negligible-10#**
	Heavy: Ability to lift up to 100 pounds maximum with frequent lifting and/or carrying objects weighing up to 50 pounds.	**50-100#**	**25-50#**	**10-20#**
	Very Heavy: Ability to lift over 100 pounds with frequent lifting and/or carrying objects weighing over 50 pounds.	**Over 100#**	**Over 50#**	**Over 20#**
List any other physical requirements or bona fide occupational qualifications:				