UW HEALTH JOB DESCRIPTION

CODING AUDIT AND DENIALS COORDINATOR

Job Code: 300133	**FLSA Status: Non-Exempt**	**Mgt. Approval: R. Buol**	**Date: October 2022**
Department: Rev Cycle - Coding		**HR Approval: B. Haak**	**Date: October 2022**

JOB SUMMARY

The Coding Audit and Denials Coordinator is responsible for developing, implementing, and managing a centralized program to promote greater efficiency with completing, tracking, and reporting coding denials and retrospective audit reviews to determine appropriate appeal of patient accounts. The coordinator combines clinical, business, and regulatory-knowledge and skill to reduce significant financial risk and exposure caused by denial and audit of claims billed for rendered services. Through continuous assessments, problem identification, and education, this individual facilitates the quality of health care delivery in areas of inpatient coding, DRG, outpatient, professional coding (inpatient and outpatient), medical necessity, government, and commercial payor requirements. Furthermore, the individual routinely analyzes data related to payor audit and denial trends specific to coding-denial and takeback concerns. This individual participates in the UW Health External Audit Committee by responding to requests for coding consultation related to coding denials by initiating and routing appeal letters, and other recovery audit activities. This position works closely with Coding and CDI as well as key stakeholders across Revenue Cycle.

The coordinator will monitor appeal denials will also review contract language to determine whether the insurance company's reimbursement policy conflicts with UW Health's contract with the payor. The individual will engage Managed Care Contracting, Reimbursement Management, and Legal related to contract breaches specific to coding audits and denials.

The position acts as a liaison and resource for staff questions related to timely filing and the appropriateness of the denial. The position will escalate issues to management if deadlines are missed, payor responses are not received, or gaps are identified in the process.

MAJOR RESPONSIBILITIES

- Completes review of appropriate post-claim denials or post-payment audits; initiating and routing coding and clinical appeal letters for appropriate patient accounts.
- Reviews and analyzes current audit information to identify opportunities for improvement within UW Health and payers.
- Responds to all internal and external requests for information, data, and/or education specific to coding audits and denials.
- Maintains reporting specific to audit statuses, identifying firm and payor patterns to better manage payor issues proactively on all external audits in HealthLink
- Update and maintain audit tracking spreadsheets and software applications.
- Scan and maintain all documentation as needed
- Develop and maintain procedural documentation
- Identify and resolve system and payer issues that result in payment delays, incorrect payments
- Serve as a Business Office liaison with other UW Health departments, third party payers, and other parties in a problem solving or information capacity.
- Monitor deadlines and ensure all parties meet timely filing for appeal deadlines
- Assist with audits involving any third-party commercial payor
- Participate in payor meetings to discuss appeal progress and identify trends with payer processing appeals to resolve cases
- Establish and enforce UW Health audit policies including pre-payment requirements. Communicate these requirements to audit review company representatives.
- Provide information to outside auditors about UW Health charging practices, coding and documentation conventions, as well as billing policies and procedures.
- Collect and analyze data from audits and concurrent reviews to identify recurring problems

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

JOB REQUIREMENTS

Education	Minimum	Associate's Degree in Business, Paralegal Studies, Coding, Communications, or other related field. Two (2) years of relevant experience in Compliance, Coding, Health Information Management, insurance denials, or Legal experience may be considered in lieu of an Associate's degree in addition to the experience below.
	Preferred	Bachelor's Degree in Business, Legal Studies, Communications, Healthcare or related field
Work Experience	Minimum	Three (3) years' experience within the healthcare field performing any variety of

		organizational, administrative, or process improvement functions.
	Preferred	• Experience in compliance, coding, insurance denials, and/or a legal setting • Experience or background in denial management • Experience working with 3rd party payors
Licenses & Certifications	Minimum	
	Preferred	
Required Skills, Knowledge, and Abilities		• Excellent oral and written communication skills. • Establish and maintain professional and cooperative relationships • Efficient and effective analytical skills. • Ability to research regulatory requirements. • Effective human relations abilities. • Proficiency with Microsoft applications (Word, Excel, Access) and other applicable software and data base management applications. • Effective problem-solving abilities. • Strong ability to effectively collaborative alliances and promotes teamwork. • Previous experience with Epic EMR

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 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may only be a negligible amount, a job is in this category when it requires walking or standing to a significant degree.	**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:				

Note: The purpose of this document is to describe the general nature and level of work performed by personnel so classified; it is not intended to serve as an inclusive list of all responsibilities associated with this position.