



Job Specification

Position Title: CLAIMS ASSESSOR
Job Code: OPSEU - Office Administration 09, 09OAD
Job ID: 13496

Purpose of Position:

To authenticate, adjudicate and facilitate payment of claims for health care benefits and to ensure that only eligible clients receive payment.

Duties/Responsibilities:

Under the direction of a manager team leader, the job is part of a functional team, which provides assistance to clients regarding claims payment and associated policies by:

1. Validating, assessing, coding and approving payment of claims, invoices and grants and resolving rejections by:
 - Applying legislation and guidelines to OHIP fee for service (in province, out of province and out of country) medical claims, Third Party Billing Agencies, Outaouais Billing Agreement, Vision Care, Northern Health Travel Grant (NHTG), Reciprocal In-Patient Billing System (RIBS) and Reciprocal Out-Patient Billing System (ROBS), etc.;
 - Confirming eligibility of service, provider and client;
 - Requesting additional information (e.g. operative and/or emergency room reports);
 - Authenticating, adjudicating and calculating allowable amounts based on analysis of all information, and authorizing payment.

2. Investigating and independently resolving and responding to complex inquiries regarding billing irregularities, payment discrepancies, negative balances, utilization and threshold adjustments, etc. by:
 - Interpreting and applying legislation, policies and procedures and providing resolution verbally and/or in writing to ensure accurate and appropriate payment;
 - Researching records and databases, and making appropriate contacts to obtain necessary information, analyzing data, documenting findings and identifying trends/patterns requiring investigation or further action (e.g. recommending systems changes where cause is mainframe, programming of Medical Rules/Fees), and initiating investigation of suspected of fraud cases;
 - Negotiating appropriate repayment schedules to recover monies owing (e.g. negative balances);
 - Operating a networked PC and application software to query databases, preparing correspondence and reports.

3. Advising and directing clients by:
 - Researching and responding to verbal (in-person and telephone) and written inquiries clients (e.g. physicians/practitioners/hospital representatives and/or their staff, lawyers, third party agencies, general public and other ministry staff), providing detailed explanations/instructions and advice regarding rules and processes relating to services, claims submissions and payments.

4. Working co-operatively within a team by:
 - Participating in meetings/committees, sharing information, analyzing operational processes and needs and providing input into proposed changes to procedures/operations, proposing solutions and/or making suggestions for optimal use of resources to resolve backlogs, and ensure deadlines are met;
 - Assisting in the training of new and existing employees and orientation of staff to new/changed programs and processes (e.g. new technologies and policies and their implementation);
 - Acting as subject matter expert in activities related to the performance of the Claims Assessor functions (e.g. providing input and support to seminars, presentations, workshops, and training sessions);
 - Performing administrative functions, organizing workflow between areas, producing/transmitting statistical information, ordering supplies; ensuring physical security of documents, technology, etc.

This job description reflects the key responsibilities of the job. Managers have the right to assign additional related duties.

Knowledge:

Job requires detailed knowledge of relevant sections of the Ontario Health Insurance Act and Regulations to interpret and apply its intent; comprehensive knowledge of, and understanding and ability to provide accurate and consistent interpretation of the Eligibility and Portability Agreement of the Canada Health Act, Reciprocal Medical and Reciprocal Hospital Agreements, manuals (OHIP Schedule of Benefits, Claims Assessment Manual, NHTG Policy Manual, Out of Country Policy and Procedures Manual, Third Party Billing Agency Procedure Manual, Third Party Billing Agency Procedure Manual, Ministry of Community, Family and Children Services, Vision Care Manual, Outaouais Arrangement Procedures, US Current Procedure Technology (CPT) codes, etc), bulletins and directives, policies and procedures, Medical Rules and their inter-relation to validate and approve payment of claims, to resolve problems, to assess lawyers

letters, court orders and subpoenas, and to respond to detailed inquiries. Job requires knowledge of Freedom of Information and Protection of Privacy Act to determine what information can and cannot be released, and to whom and by what method it may be released. Job requires knowledge of medical terminology and human anatomy to interpret operative and emergency reports and assess complex as well as routine medical claims. Job requires working knowledge of the capabilities and operation of networked PC, printer and mainframe applications and databases *e.g. Kingston Information Management System which includes Corporate Provider Data Base, On-line Claims Correction System, Maple bi-Query Program, Registration Information Tracking System, Walker System) to accurately enter, update maintain information, to research and correct claims on-line and to prepare reports. Job requires working knowledge of graphic user interface, ministry standard applications software (word processing, electronic mail, Internet/Intranet) to prepare letters and reports, research information, and produce/complete forms. Job requires mathematical skills to prepare billings through Lawyers Enquiry Service to accurately assess and pay claims within legislated response time, to calculate fees payable and adjustments and explain financial transactions (e.g. underpayments, overpayments), to determine currency and exchange rates and convert foreign currencies to Canadian dollars and to calculate advance payment to providers and threshold/utilization adjustments. Job requires knowledge of Registration and Claims Branch program objectives, responsibilities and operations (e.g. organizational, regional and local priorities and direction, government common service standards, cut-off dates, resolution of inquiries and identification and investigation of suspected fraudulent situations. Job also requires knowledge of grammar and punctuation to compose letters, memoranda, etc.

Skills:

Job requires the ability to read and understand operative and emergency room reports, to interpret and compare information on Claims/medical bills and supporting documentation with Schedule of Benefits, to select and apply codes, rules and conditions which best correspond to description of services rendered and ensure correct assessment and payment of claims. Job requires research and analytical skills to review manual and automated records (e.g. claims history), to examine billing patterns, identify and document irregularities, take action and make recommendations regarding further investigation e.g. where fraud may be suspected) to resolve abnormal billing practices, make threshold and utilization adjustments, settle negative balance accounts, and resolve problems with provider payments. Job requires communication skills to explain payment policies and processes to clients, either verbally (in-person or in writing) to provide detailed and understandable explanations of work processes to other staff and to participate in seminars or orientation sessions. Job requires interpersonal skills, well-developed listening and interviewing skills, tact and diplomacy to ask relevant questions regarding billing irregularities, accounting problems, patient/provider registration, claims submission, eligibility issues and lists of services, to understand and respond appropriately to clients situations when dealing with sensitive and personal medical information, to interact with other work team members and to participate in operational training activities. Job requires organizational skills to manage own workload, to meet deadlines and to achieve team and organization goals.

Freedom of Action:

Job requires working in accordance with relevant legislation and policy and procedure manuals, constantly learning and keeping up to date on overall changes/revisions which occur frequently, take immediate effect, have overlapping implications and require consistent application. Job requires that most work-related problems or issues are resolved independently, by applying existing regulations and the intent of policy. Job is accountable for making decisions involving ambiguous/special circumstances and/or factor not within guidelines, by analysis of the information, determination of the nature of the problem, and deciding on the best approach for resolution. Job applies discretion when resolving contentious issues, complaints or situations which fall outside legislation, established policies and procedures, and refers contentious issues, complaints or situations to next level of authority (e.g. where physicians or practitioners report underpayments for immediate correction or where client disagrees with payment and insists on speaking with a manager). Job requires ability to co-ordinate with other areas/departments within the branch due to complexity of some program payments. Job occasionally requires participation as a member of project teams and/or local/branch committees to provide input on claims payment procedures and impacts on business processes. Errors in judgment/decision making in the application/interpretation of legislation and policies could result in significant loss of overall unit productivity since resources must be re-allocated to their research, identification and correction and could result in the involvement of the media. Ombudsman, Ontario Medical Association, and/or MPPs and lead to significant embarrassment to the ministry and loss of integrity of the claims payment process.