POSITION DESCRIPTION

Rev: 9/13

Job Title: Claims Analyst
Status: Non-exempt, Full Time
Department: Claims, Reports to Claims Production Supervisor

PURPOSE:

To learn Allied's Claims Processing system, the benefit structures and basic policy provisions in the Certificates of Insurance, and Allied's procedures and philosophies to process pre-approved claims. To make appropriate decisions on the claims reviewed and to convey this information through written or telephone communications with agents, insureds, providers and other external customers. To provide support to the claims staff by making phone calls to verify information and by inputting detailed data into the computer system. These duties occur in a production environment with an emphasis on sequenced activities but with fluent decision making.

ESSENTIAL FUNCTIONS:

1. Enter data obtained from claims mail (claim forms, billings, and correspondence) into the computer system, meeting departmental standards.
   a. Identify the correct insured and claimant by searching computer files.
   b. Visually review claims correspondence to determine appropriate data to be entered, i.e. provider names, dates of service, amount of billing, diagnosis, etc.
      1. Make necessary telephone calls to obtain incomplete information off bills and document on appropriate form.
   c. Review correspondence to determine if requested information has been received.
   d. Make necessary modifications or corrections to insured's claim file in computer.

2. Visually review correspondence that cannot be identified through the computer system.
   a. Initiate telephone contact in an attempt to identify.
   b. Type and mail appropriate letters.

3. Enter and verify the following information.
   a. Enter information off provider billings into a Personal Computer (PC).
   b. Enter information into the computer for drafts to vendors.

4. Fill out RX ID Form listing indications/action/diagnosis for prescriptions received for each claimant.

5. Visually review charges, access the computer system and utilize denial codes and/or type denial letters within established department guidelines and standards on the following types of claims:
   - Claims that were incurred prior to coverage dates
   - Claims that were incurred after coverage dates
   - Claims in which duplicate bills have been received

6. Review and process claims within established department guidelines and standards.
   a. Access computer system and review policy and benefit information (i.e., Certificates of Insurance) for each claimant.
   b. Make appropriate contact with external source, verbal, written letter or electronic to obtain necessary information to process the claim.

7. Receive incoming calls, reroute misdirected calls, and determine and retain those calls that need assistance.
   a. Access computer system and review policy and benefit information (i.e., Certificates of Insurance) for each call.
   b. Use the information available in the computer system to answer callers questions or address their concerns.
   c. Analyze individual claims to gather information needed to respond to callers questions and/or concerns. If the questions or concerns go beyond your scope of expertise, refer caller to higher level Analyst.
   d. Convey and explain information in courteous, efficient, and professional manner.
   e. Make call backs to callers to follow up as needed or requested within department guidelines.
   f. Be aware of possible errors or mishandlings in the claim and correct or refer to management for review.
   g. Document on proper form all communications and actions with the caller.

8. Perform any other duties as indicated by management.

JUNIOR ANALYST

ESSENTIAL FUNCTIONS:

1. Be knowledgeable of all claims procedures, guidelines and state riders, telephone procedures and equipment through initial and ongoing training.

2. Process the following types of claims within established department guidelines and standards by visually reviewing the claims and applying all Policy provisions to determine if claim is payable, if additional information is needed, or if claim should be denied:
   - New claims
   - Claims that fall within the pre-existing waiver allowance
   - Claims that are out of the contestability period
   - Claim denials for other than pre-existing
   - Claims in which initial investigation is needed
   - Claims in which discounts may be negotiated
   - Claims in which custom letters will be written
   - Premium/Billing department referrals
   - Claims in which solicited or unsolicited refund checks are received
   - Claims which require history adjustment

   a. Access computer system and review policy and benefit information (i.e., Certificates of Insurance) for each claimant.
   b. If claim is payable, review bills for possible vendor intervention.
   c. If additional information is necessary, secure information via telephone call and/or written correspondence through the word processing system.
   d. Research claims information through utilization of in-house medical resources.
   e. If unable to make a determination on the claim, refer to Supervisor, trainer or other designated person.

3. Receive incoming calls, reroute misdirected calls, and determine and retain those calls that need assistance.
   a. Access computer system and review Policy and benefit information (i.e., Certificates of Insurance) for each call.

4. Be knowledgeable of all benefit structures, basic policy provisions, guidelines and telephone procedures and equipment through initial and ongoing training.

5. Visually verify that all bills and correspondence have been entered into the computer correctly and have been matched to the insured.

ANALYST

ESSENTIAL FUNCTIONS:

1. Perform all tasks listed as essential functions in Junior Analyst position in accordance with department quality and production standards.

2. Process the following types of claims within established department guidelines and standards by visually reviewing the claims and applying all policy provisions to determine if claim is payable, if additional information is needed, or if claim should be denied:

    - Claims which involve intermediate and ending investigation
    - Claims which involve Coordination of Benefits
    - Claims which involve subrogation
    - Claims which involve Carrier or consultant referrals
    - Death claims
    - Claims which involve disability and/or extension of benefits
    - Claim denials for other than pre-existing
    - Claims which involve writing and signing custom letters
    - Underwriting Department referrals

    a. Access computer system and review policy and benefit information (i.e., Certificates of Insurance) for each claimant.
    b. If claim is payable, review bills for possible vendor intervention.
    c. If additional information or investigation is necessary, secure information via telephone call and/or written correspondence through the word processing system.
    d. Research claims information through utilization of in-house medical resources.
    e. If unable to make a determination on the claim, refer to Supervisor, trainer or other designated person.

SENIOR ANALYST

ESSENTIAL FUNCTIONS:

1. Perform all tasks listed as essential functions in Junior Analyst and Analyst positions in accordance with department quality and productions standards.

2. Visually review and provide handling instructions on claims where overpayments have been made.

3. Visually review claims for accuracy when a Claims Analyst proposes denying a claim for $7,500.00 or more. Approve or reject denial or recommend further investigation.

4. Visually review denied claims that have been contested and make recommendation or handle.

5. Visually review files which have been referred by the Claims Analysts and provide written handling instructions to the Analyst. Referred files may include questions, inactivations and proposed denials of claims.

6. Visually review files which have been referred by an officer of Allied, provide a brief overview of the claim history and handle according to their instructions.

7. Visually review bills and/or claim files using screening criteria for dispersing files with new correspondence to appropriate Analyst level.

8. Visually review claim and computer system based on correspondence received from an attorney or Insurance Department.
    a. Prepare a chronology outlining action taken on the claim and forward to the Carrier.

b. Process claims according to Carrier's instruction by calculating claims using the computer system and/or typing letters to the attorney or Insurance Department.
c. Respond to interrogatories and/or depositions either in writing, in person or through telephone contact.

9. Function as a Business Analyst in the development and management of Claim's IT systems. Such work includes the following:

- Complete business requirements involving one or more business areas by working closely with them to identify their requirements.
- Develop thorough test scenarios for each defined requirement that will test the functionality and identify any adverse impacts, and administer the tests.
- Prepare timely communication of requirements and test results that are clear and grammatically correct.
- Ensure that all documentation of requirements, results, as-is work-flows, proposed workflows, cost benefit analysis, meeting outcomes, and any necessary training materials is thorough and complete.
- Meet agreed upon timelines/deadlines and quality measures.
- Demonstrate teamwork in working with all business areas.

10. Complete Underwriting referral sheet and refer correspondence and/or files to the Underwriting Department when needed.

Each analyst would be required to demonstrate competence in the majority of all essential functions, or be competent with appropriate training. Management reserves the right to add or change the requirements of this position at any time. The number of positions available at any time is subject to business needs.

REQUIREMENTS:

1. High school graduate or equivalent.

2. One year office and telephone customer service experience.

3. Medical claims processing experience strongly preferred.

4. Knowledge and understanding of medical terminology preferred. If none, must complete a medical terminology course within six months.

5. Ability to speak, read, comprehend and follow written and verbal English instructions. Ability to communicate effectively verbally and in writing.

6. Ability to compose proper business correspondence (i.e., letters, memos and file documentation).

7. Ability to communicate in an assertive but positive manner, using excellent telephone communication skills (i.e. listening for understanding, responding accurately and professionally and expressing self clearly and courteously).

8. Demonstrated decision making abilities.

9. Ability to perform basic math skills.

10. Ability to operate a ten-key calculator and have experience with computers.

11. Minimum 30 wpm typing.

12. Ability to meet company attendance requirements.

13. Ability to sit or stand for 7.5 hours per day.

14. Ability to achieve department training standards.

15. Ability to achieve and maintain department quality and production standards.

16. Ability to work under and handle stress associated with varying workloads, deadlines and dealing with irate callers.

17. Experience commensurate with the essential functions necessary to successfully perform the job.

FACTORS IMPORTANT TO SUCCESSFUL PERFORMANCE OF POSITION:

Problem solving	Interpersonal skills
Analytical ability	Dexterity
Communication skills	Change Management

The position requires the ability to assess a problem and analyze the facts to reach appropriate claims decisions. Communication and interpersonal skills are necessary, as the position requires telephone contact and written correspondence with internal and external customers. The applicant must posses a positive attitude, be resilient and able to adapt to a changing work environment within the department and organization.

PHYSICAL DEMANDS OF POSITION:

Standing/Sitting	98% of time	Processing claims
Walking	2% of time	Walk to reference and supply area
Lifting/Carrying 10 lbs.	<1% of time	Moving files
Climbing/Balancing/ Stooping/Kneeling	<1% of time	Pull files from file room
Reaching/Handling	100% of time	Reaching for files on desk, placing data in file order, placing/removing staples
Speaking/Hearing	25% of time	Conversations to secure and give information
Seeing	100% of time	Reviewing data from charges and medical records
Color Vision	75% of time	Mail tags, form colors, clips and coding.

NOTE: Applicants who need accommodation for an interview or job testing, please request this in advance to the Human Resources Department.