

REDWOODS RURAL HEALTH CENTER

JOB TITLE: Billing Associate

JOB DESCRIPTION: Under the direction of the Chief Financial Officer (CFO), ensure effective billing systems to optimize revenue from diverse sources, including patient payments, as well as multiple private and public payors. Duties include claims processing, reporting, follow-up, monitoring of payments and other Accounts Receivable (A/R), working claims denials, processing patient statements and carrying out effective pre-collections and collections processes to ensure payments are received in a timely way. Play an integral role in the transition from a legacy practice management system to a new system and support training and meaningful use of the system and associated reports by all staff.

JOB DUTIES AND RESPONSIBILITIES:

- Respects and abides by the mission of Redwoods Rural Health Center.
- Responsible for billing, payment posting, statements, claims and denial management for multiple public and private payor sources.
- Initiates and reconciles all electronic and paper Medicare and Medi-Cal billing.
- Oversees the collection process.
- Responsible for monitoring and reporting on all Accounts Receivable (A/R).
- Responds to billing inquiries from staff and patients.
- Supports the effective roll-out, training and maintenance of a new electronic practice management system.
- Ensures system-generated reports are accurate and carries out other analysis or reporting, as needed.
- Follow-up on non-payment of bills to include, but not limited to, writing claims inquiries, correcting errors and re-submitting claims.
- Participates actively in training activities not only those specific to the revenue cycle, but as needed for all staff of the Health Center.
- Performs coding audits as directed by the CFO to assure the appropriate submission of billing and diagnosis codes.
- Performs other duties as assigned.

EDUCATIONAL REQUIREMENTS:

- Minimum of a 2-year college degree, certification in medical/dental billing protocols or equivalent work experience.
- Bachelors degree and billing or medical coding certificate preferred.

REQUIRED EXPERIENCE AND SKILLS:

- Minimum of three years of experience in a hospital, clinic or private medical practice supporting revenue cycle or operations. Proficiency with scheduling, billing and/or practice management software applications.

- Prior experience in claims processing and claims denial management in a community health center environment preferred.
- Effective communicator with proficient English (written and verbal).
- Computer literate with all basic workforce office applications (MS Office applications, Outlook).
- Experience with the implementation of electronic medical records and practice management systems preferred (with a preference for experience in NextGen).
- Demonstrated ability to respond effectively to requests for reports, including an ability to structure a problem, collect necessary data, analyze the data and interpret the findings.
- Demonstrated ability to learn complex computer software applications.
- Ability to take initiative and to exercise independent and sensible judgment; demonstrates decision-making and problem-solving expertise.
- Ability to collaborate and work effectively with the management team, patients, the public, community members and external agencies.
- Working knowledge of ICD-9 and CPT coding structures
- Working knowledge Medicare, Medi-Cal and other public programs.
- Demonstrated competency in understanding payor program policies and procedures – with an ability to translate that information to other staff and leadership.
- Strong customer service orientation – both in dealing with the public and with colleagues.
- Discretion and ability to maintain confidential information.

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