**Denials Management Representative**

**Position summary:**

The denials management representative is responsible for timely and accurate follow-up and appeal of denials/rejections received from third-party payers. The representative will manage their assigned work to ensure payer appeal/filing deadlines are met and achieve optimal payment for services rendered.

**Department/team:** Central billing office (CBO), accounts receivable (A/R) team

**Supervisor:** Manager and director, CBO

**Essential functions:**

* Monitors denial work queues and reports in accordance with assignments from direct supervisor. Maintains required levels of productivity while managing tasks in work queues to ensure timeliness of follow-up and appeals.
* Organizes denial/rejection related tasks to identify patterns and/or work most efficiently (e.g., by current procedural terminology, diagnosis, payer, etc.)
* Identifies and monitors negative patterns in denials/rejections. Escalates accordingly to CBO management and the impacted department(s) to avoid negative impact on reimbursement, unsuccessful appeals, and/or increased write-offs.
* Uses identified and known resources to accomplish follow-up on tasks. Identifies other means and resources to complete tasks, as applicable and appropriate.
* As needed, participates in A/R clean-up projects or other projects identified by direct supervisor or CBO management.
* Works with other departments to resolve A/R and payer issues. Communicates with other departments on issues that may have negative impact on their cash flow, timely claim reconsideration/filing, failed appeals, and/or increased denials and write-offs.
* Participates in departmental and team meetings involving discussion of A/R processes and trends.

**Qualifications/Skills:**

The ideal candidate for this position will possess the following qualifications and skills:

* Minimum of 3-5 years in a hospital or physician billing office.
* High school diploma or equivalent is required.
* Knowledge of medical terminology and billing/collection practices.
* Ability to read and interpret insurance explanation of benefits (EOBs).
* Knowledge of payer edits, rejections, rules, and how to appropriately respond to each.
* Accuracy in identifying the cause of rejections/denials and selecting the most appropriate method for resolution.
* Demonstrated proficiency with timely and successful appeals to insurance companies.
* Ability to create professional correspondence to insurance companies and patients.
* Detail oriented and able to deliver neat and organized work.
* Self-motivation and ability to demonstrate initiative, excellent time management skills, and organizational capabilities.
* Must be able to multi-task in a fast-paced environment and appropriately handle overlapping commitments and deadlines.
* Excellent analytical skills and creative problem-solving skills.
* Strong oral and written communication skills.

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