Clever Care
HEALTH PLAN

Medicare Operations Recovery Resolution Supervisor

Position Title: Medicare Operations Recovery Resolution Supervisor
Position Type: Full Time
Location: Huntington Beach, CA or Arcadia, CA
Reports To: Director of Medicare Operations

About Clever Care Health Plan

Clever Care Health Plan is a newly founded Medicare Advantage health plan serving Medicare beneficiaries in Southern California. Our employees are passionate in providing best services to our members and healthcare providers. Our three office locations are in Arcadia (Los Angeles County), Huntington Beach (Orange County) and New York City.

Job Summary

The Recovery Resolution Supervisor will work with the Director of Medicare Operations on researching issues to determine feasibility of reducing medical costs through prospective solutions of claim system processes and claim business rules. Participates in process improvement initiatives to support development of payment accuracy, audit activities, business rules and P&Ps. This position ensures regulatory compliance in the processing of all inbound claims that are within the Centers for Medicare & Medicaid Services (CMS) regulations as well as Clever Care Health Plan policies and procedures as they apply to claims processing and payment.

Functions & Job Responsibilities

- Includes claims systems utilization, capacity analyses/planning and reporting including claims-related business and systems analysis
- Audit claims payment accuracy and compliance.
- Validating accuracy of reports produced and submitted by the Claims Department.
- Responsible for researching, analyzing, documenting and coordinating the resolution of escalated and/or complex claims issues that span across multiple operational areas and requires expert knowledge of Medicare regulations.
- Proactively develops policies and procedures to ensure that all legitimate reimbursement is captured.
- Interpret provider and health plan contracts to ensure accurate payment of claims or denial of services based on the terms of the provider contract and the financial responsibility as set in the health plan contract including RBRVS and Medicare guidelines as it applies to contracted and non-contracted providers
- Identifies denial or payment variance trends and escalates to department management as appropriate for training opportunities and corrective action.
- Assists in preparing and reviewing cases for regulatory and other health plan audits.

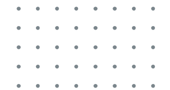
- Ensure adherence to state and federal compliance policies, reimbursement policies, and contract compliance
- Researches and interprets Medicare regulations and determines impact on entities within organization. Ensures that organization complies with federal and state reimbursement methodologies
- Assists in validating claim compliance reports
- Demonstrates a high level of integrity and innovative thinking and actively contributes to the success of the team
- Ensures processing turn-around times for claims processing are met and processed as follows; Medicare claim payments are completed as follows; 95% in 30 days (clean claims) and 60 days (unclean).
- Monitor individual performance and ensure it meets expected quality and performance objectives
- Assists in ensuring that denial/PDR/Appeal letter templates and language are appropriate and in accordance with CMS regulations.
- Assist with monitoring corrective action plans and takes appropriate interventions to return to state of compliance when necessary
- Assist with training, orientation and mentoring of new and existing claims department employees
- Communicates job expectations and improvements as needed.
- Establish and promote teamwork within the department, participating fully and with commitment
- Completes other projects and duties as assigned.

Education & Experience

- High School diploma or equivalent required. Associate degree or an equivalent combination of education and claims processing experience preferred. Bachelor's degree in related field (preferred).
- 2 years of experience in a managed care claims processing environment required

Knowledge/Skills/Abilities

- Demonstrate knowledge of applicable claims processes (e.g., end-to-end claims cycle, auto-adjudication, manual work processes, payment methodologies, rework/adjustment processes)
- Terminology, CPT, revenue codes, ICD10, HCPCS codes as it relates to claims processing adjudication. Core claims processing systems and healthcare authorization systems.
- Establish and maintain interpersonal relationships internally/externally and utilize skills by; coaching and motivating staff, handling conflict resolution, implementing project or new programs/initiatives and collaborating with other departmental subject matter experts.
- Perform in a fast-paced environment and work under pressure.
- Communicate clearly and concisely, both verbally and in writing to individuals of diverse backgrounds.
- Organize, plan and prioritize work activities, possess analytical and problem-solving skills.



- Troubleshoot claims adjudication problem areas.
- Encourage and utilize suggestions and new ideas.
- Comprehend and interpret provider contracts and Divisional Financial of Responsibility (DOFR).
- Utilize and access computer and appropriate software (e.g., Microsoft: Word, Excel, PowerPoint) and job-specific applications/systems (e.g., EZCAP Claims Processing System and Authorization system) to produce correspondence, charts, spreadsheets, and/or other information applicable to the position.

Physical & Working Environment

Typical Physical Demands.

Position requires a great amount of sitting and standing. Some lifting, stooping, bending, or reaching is required. May require lifting up to 15-30 pounds. Requires manual dexterity sufficient to operate a computer, calculator and telephone. Requires normal range of hearing and vision. Requires the ability to type and file.

Typical Working Conditions.

Work is performed in an office environment and/or remotely. The job involves frequent contact with staff and public. Work may be stressful at times. May occasionally work some irregular hours.

Qualifications:

What's in it for you?

1. A competitive compensation and benefits program.
2. Generous paid-time-off (PTO).
3. Ten paid holidays per year.
4. Excellent 401k saving plan, employer provides up to 4% match and employer contribution match is 100% immediately vested.
5. A work-life balance and much more!

Please email your resume directly to hr@ccmapd.com

Clever Care Health Plan is proud to be an Equal Employment Opportunity and Affirmative Action workplace. Individuals seeking employment will receive consideration for employment without regard to race, color, national origin, religion, age, sex (including pregnancy, childbirth or related medical conditions), sexual orientation, gender perception or identity, age, marital status, disability, protected veteran status or any other status protected by law. A background check is required.