

## MEDICAL INSURANCE SERIES

<b>Code No.</b>	<b>Class Title</b>	<b>Occ. Area</b>	<b>Work Area</b>	<b>Prob. Period</b>	<b>Effective Date</b>	<b>Last Action</b>
4581	Medical Insurance Representative	04	445	6 mo.	07/01/12	Rev.
4582	Medical Insurance Associate	04	445	6 mo.	07/01/12	Rev.
4583	Medical Insurance Specialist	04	445	6 mo.	07/01/12	Rev.
4584	Medical Insurance Assistant Manager	03	445	6 mo.	07/01/12	Rev.
2424	Medical Insurance Manager	03	445	6 mo.	07/01/12	Rev.

### *Promotional Line: 270*

#### Series Narrative

This series is designed for employees who examine and analyze standardized health claims/bills, and take the appropriate action to correct, collect or adjudicate these claims/bills. The procedures followed include the preparation of claim/billing forms for presentation to third party payers or the preparation of vouchers for the direct payment of claims/bills. The third party payers include Illinois Healthcare and Family Services (Medicaid), Blue Cross, Public Aid, Medicare, state, federal and local agencies, out of state agencies and non-government insurance carriers. In addition, Specialists may investigate and identify potential sources of payment for patients or potential payment from other insurance carriers or responsible liable sources. Specialists are able to apply appropriate administrative, technical, and physical safeguards to protect the privacy and security of protected health information (PHI) as mandated by the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). Medical Insurance Specialists may supervise lower level Specialists and related support staff assigned to the billing, receivables or claims processing process.

Medical Insurance personnel typically:

1. review itemized charges, claims/bills or personal data forms for accuracy and/or completeness, and make the necessary corrections
2. complete insurance claim forms, transmit, collect or adjudicate claims based on the data that is provided on itemized bills, claim worksheets or hospital admissions records, which requires the identification and interpretation of the information to be coded and recorded on the claim forms
3. review payment records and post or adjust records as required
4. make inquiries of and respond to a variety of questions from health care providers, physicians, patients, insurance plan members, insurance companies, government representatives and related interested parties
5. counsel parents and students regarding plan eligibility, enrollment requirements, benefits and payments
6. review claim to determine how benefits/claims are to be paid, billed, collected and adjudicated

DESCRIPTION OF LEVELS OF WORK**Level I: Medical Insurance Representative****4581**

Under direct supervision, the Medical Insurance Representative functions in a training capacity and is assigned routine, non-complex medical/health claims.

A Medical Insurance Representative typically –

1. for supervisor's review, interprets codes or procedure(s) performed according to coding standards, which may require the interpretation and selection of the codes provided by or to the insurance carrier
2. under direct supervision, reviews and analyzes itemized claims/bills or non-complex claim forms for consistency (i.e., ensures that services rendered by the physician or hospital are compatible with the diagnosis or treatment) and investigates discrepancies in order to determine the appropriate course of action required to accurately complete the claim processing, billing procedure or adjudication process
3. responds to a variety of questions from physicians, patients, hospitals, insurance companies, government agencies and related interested parties concerning the status of medical bills
4. corresponds with and responds to a variety of inquiries from health care providers, patients or plan members, insurance companies, government agencies and persons utilizing the services of a facility as required to identify, collect and analyzes the information to properly process simpler claim forms
5. understands hospital and/or physician billing requirements
6. maintains up-to-date understanding of billing regulations
7. tracks, reports and resolves simple third-party denials under direct guidance from supervisor
8. reviews and analyzes routine payment, capitation, adjustment or denial records and posts or adjusts records as required under direct supervision of supervisor
9. processes mail and correspondence identified to be a part of the billing and receivable function
10. completes payer specific claim forms
11. submits claim forms to payers through electronic billing systems, paper forms or other forms as required by the payer
12. performs other related duties as assigned

**Level II: Medical Insurance Associate****4582**

Under general supervision, the Medical Insurance Associate independently submits or takes the necessary actions to complete or process various types of routine insurance claim/medical claim forms.

They are also responsible for taking the necessary action to complete or process moderately complex claim/medical forms, coordinate benefits between two or more third party payers, and collect outstanding payments. Employees at this level may train lower-level staff members.

A Medical Insurance Associate typically –

1. takes the necessary action to complete, bill, collect or adjudicate moderately complex medical claims
2. posts and adjusts the benefits or financial files for persons utilizing the program
3. interprets standard, established codes provided by the various agencies or healthcare providers and adjudicates procedures according to these interpretations
4. reviews and analyzes itemized bills or claim forms for consistency (i.e., insures that services rendered by a physician or a hospital are compatible with the diagnosis or treatment, and investigates discrepancies in order to determine the appropriate course of action required to accurately complete the adjudication or billing process)
5. trains Medical Insurance Representative and related support staff
6. reviews, identifies, and analyzes sources of potential reimbursement
7. responds to a variety of questions from physicians, hospitals, government agencies, insurance companies and related interested parties concerning the status of insurance claims
8. may assist in counseling students and parents about plan eligibility, benefits and enrollment
9. corresponds with and responds to a variety of inquiries from healthcare providers, patients or plan members, insurance companies, government agencies and persons utilizing the services of the program/plan(s) as required to identify and collect the information required to complete the necessary forms or medical claims for the reimbursement to/from the various agencies
10. tracks, reports and resolves third party denials under indirect guidance from supervisor
11. collects, reviews and analyzes payment, capitation, adjustment or denial records and posts or adjusts records as required
12. reviews billing data for accuracy and/or completeness and makes the necessary corrections
13. reviews claims/bills to determine how claims/bills are to be paid
14. performs duties consistent with lower-level of series
15. performs other related duties as assigned

**Level III: Medical Insurance Specialist****4583**

Under general supervision, the Medical Insurance Specialist independently takes the necessary action to complete, bill, collect or adjudicate all types of complex medical claims and serves as the resource specialist within the unit for lower-level staff and related clerical staff. Employees at this level work closely with other supervisors and staff to determine the day-to-day priorities and procedures, and to maintain a high level of integrity within the unit. Employees at this level may supervise lower-level Medical Insurance staff and related clerical employees.

A Medical Insurance Specialist typically –

1. takes the necessary action to complete, bill, collect or adjudicate all types of complex medical claims
2. responds to a variety of questions from lower-level Medical Insurance staff and related clerical support employees concerning the proper action to be taken to complete, bill, collect, or adjudicate medical claims
3. reviews and analyzes insurance processing procedures in order to identify potential problem areas and develop a more streamlined processing procedure that increases efficiency while maintaining a high level of integrity within the unit
4. may assist with interviewing, hiring, training, and evaluating lower-level staff
5. composes activity reports for the manager that take into consideration the total volume of the unit
6. acts as liaison with patients, plan members, healthcare providers, physicians, hospitals, insurance companies, government agencies and related interested parties regarding problem claims
7. counsels students and parents about plan eligibility, benefits and enrollment
8. compiles activity reports for his or her manager that report a variety of statistics including work efficiency measures
9. performs duties consistent with the lower-level of the series
10. performs other related duties as assigned

**Level IV: Medical Insurance Assistant Manager****4584**

Under administrative direction, the Medical Insurance Assistant Manager plans, implements and revises policies related to methods and procedures.

A Medical Insurance Assistant Manager typically –

1. selects, trains, and supervises staff members; evaluates the work performance of staff and takes the appropriate disciplinary action as required

2. develops, implements, interprets, revises and enforces unit policies and procedures and/or assists with contracting or drafting benefits of the insurance plan(s)
3. determines the procedures that are to be followed in atypical circumstances
4. is responsible for the compliance of operations with all required accounting and auditing procedures, either through personal performance or the supervision of assigned staff
5. advises and consults with campus personnel or other relevant individuals about policies related to medical insurance
6. determines the adequacy of processing procedures
7. devises, revises or is responsible for the maintenance of records or record systems
8. prepares reports as required
9. corresponds with or makes direct calls regarding problem claims (i.e. responds to appeals)
10. conducts unit staff meetings
11. performs duties consistent with the lower levels of the series
12. performs other related duties as assigned

**Level V: Medical Insurance Manager****2424**

Under administrative direction, the Medical Insurance Manager assists in developing and managing policies regarding manual and electronic claims processing, follow-up, and funding management.

A Medical Insurance Manager typically—

1. plans, organizes, and controls all assigned functions
2. assists in managing staff and staff workloads
3. reviews, drafts or contracts insurance policy
4. conducts periodic reviews of business functions, both internal and external to the agency
5. coordinates activities with external claims processing entities
6. performs contract compliance reviews
7. develops requests for proposals and requests for information for services
8. writes requests for proposals, negotiates and contracts for discount agreements, claims processing and eligibility services

9. develops systems procedures and trains staff
10. prepares written correspondences to insurance companies, attorneys and patients or plan members to resolve disputes
11. interprets federal, state and agency rules and regulations
12. develops and implements unit policies and procedures
13. researches and resolves complex insurance claim issues
14. conducts quality control reviews to ensure quality claim processing
15. prepares, implements and/or monitors the unit's budget
16. performs duties consistent with the lower levels of the series
17. performs other related duties as assigned

MINIMUM ACCEPTABLE QUALIFICATIONS REQUIRED FOR ENTRY INTO:

**Level I: Medical Insurance Representative**

**4581**

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. Any one or any combination that equals **six (6) months** from the categories below:
  - a) experience within a health insurance/medical billing environment
  - b) medical billing certification from an accredited program (i.e., Certified Professional Coder (CPC); Registered Health Information Technician (RHIT); Certified Coding Specialist (CCS); Registered Health Information Administrator (RHIA); National Healthcareer Association (NHA))
  - c) college coursework in insurance/benefits administration, human resource management, health information management, finance, accounting or closely related fields such as business administration and/or business management
    - 30 semester hours equals (6) months
    - 60 semester hours equals (1) year (12 months)
    - 90 semester hours equals (2) years (24 months)
    - 120 semester hours or higher equals (3) years (36 months)

## KNOWLEDGE, SKILLS, AND ABILITIES (KSAs)

1. Customer and Personal Service — Knowledge of principles and processes for providing customer and personal services. This includes customer needs assessment, meeting quality standards for services, and evaluation of customer satisfaction.
2. English Language — Knowledge of the structure and content of the English language including the meaning and spelling of words, rules of composition, and grammar.
3. Dependability — Job requires being reliable, responsible, and dependable, and fulfilling obligations.
4. Attention to Detail — Job requires being careful about detail and thorough in completing work tasks.
5. Integrity — Job requires being honest and ethical.
6. Cooperation — Job requires being pleasant with others on the job and displaying a good-natured, cooperative attitude.
7. Adaptability/Flexibility — Job requires being open to change (positive or negative) and to considerable variety in the workplace.
8. Initiative — Job requires a willingness to take on responsibilities and challenges.
9. Self-Control — Job requires maintaining composure, keeping emotions in check, controlling anger, and avoiding aggressive behavior, even in very difficult situations.
10. Stress Tolerance — Job requires accepting criticism and dealing calmly and effectively with high stress situations.
11. Concern for Others — Job requires being sensitive to others' needs and feelings and being understanding and helpful on the job.
12. Evaluating Information to Determine Compliance with Standards — Using relevant information and individual judgment to determine whether events or processes comply with laws, regulations, or standards.
13. Interacting with Computers — Using computers and computer systems (including hardware and software) to program, write software, set up functions, enter data, or process information.
14. Basic understanding of hospital or physician billing.

**Level II: Medical Insurance Associate****4582**

## CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. Any one or any combination that equals **one (1) year (12 months)** from the categories below:
  - a) experience comparable to experience performed at the Medical Insurance Representative level or in other positions of comparable responsibility within the health insurance area
  - b) college credit for course work in insurance/benefits administration, human resource management, health information management, finance, accounting or closely related fields such as business administration and/or business management
    - 30 semester hours equals (6) months
    - 60 semester hours equals (1) year (12 months)
    - 90 semester hours equals (2) years (24 months)
    - 120 semester hours or higher equals (3) years (36 months)

*Note:* the following medical billing certifications satisfy **(6) months** of the above requirement: Certified Professional Coder (CPC); Registered Health Information Technician (RHIT); Certified Coding Specialist (CCS); Registered Health Information Administrator (RHIA); National Healthcareer Association(NHA)

## KNOWLEDGE, SKILLS, AND ABILITIES (KSAs)

1. Customer and Personal Service — Knowledge of principles and processes for providing customer and personal services. This includes customer needs assessment, meeting quality standards for services, and evaluation of customer satisfaction.
2. English Language — Knowledge of the structure and content of the English language including the meaning and spelling of words, rules of composition, and grammar.
3. Dependability — Job requires being reliable, responsible, and dependable, and fulfilling obligations.
4. Attention to Detail — Job requires being careful about detail and thorough in completing work tasks.
5. Integrity — Job requires being honest and ethical.
6. Cooperation — Job requires being pleasant with others on the job and displaying a good-natured, cooperative attitude.
7. Adaptability/Flexibility — Job requires being open to change (positive or negative) and to considerable variety in the workplace.
8. Initiative — Job requires a willingness to take on responsibilities and challenges.



9. Self-Control — Job requires maintaining composure, keeping emotions in check, controlling anger, and avoiding aggressive behavior, even in very difficult situations.
10. Stress Tolerance — Job requires accepting criticism and dealing calmly and effectively with high stress situations.
11. Concern for Others — Job requires being sensitive to others' needs and feelings and being understanding and helpful on the job.
12. Evaluating Information to Determine Compliance with Standards — Using relevant information and individual judgment to determine whether events or processes comply with laws, regulations, or standards.
13. Interacting with Computers — Using computers and computer systems (including hardware and software) to program, write software, set up functions, enter data, or process information.
14. Mathematics — Ability to add, subtract, multiply and divide whole numbers, decimals and percentages.
15. Basic understanding of hospital or physician billing.
16. Basic understanding of medical terminology.

**Level III: Medical Insurance Specialist****4583**

## CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. Any one or any combination that equals **two (2) years (24 months)** from the categories below:
  - a) experience comparable to that gained as a Medical Insurance Associate level or in other positions of comparable responsibility within the health insurance area
  - b) college credit for course work in insurance/benefits administration, human resource management, health information management, finance, accounting or closely related fields such as business administration and/or business management
    - 30 semester hours equals (6) months
    - 60 semester hours equals (1) year (12 months)
    - 90 semester hours equals (2) years (24 months)
    - 120 semester hours or higher equals (3) years (36 months)

*Note:* the following medical billing certifications satisfy **(6) months** of the above requirement: Certified Professional Coder (CPC); Registered Health Information Technician (RHIT); Certified Coding Specialist (CCS); Registered Health Information Administrator (RHIA); National Healthcareer Association (NHA)

## KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

1. Customer and Personal Service — Knowledge of principles and processes for providing customer and personal services. This includes customer needs assessment, meeting quality standards for services, and evaluation of customer satisfaction.
2. English Language — Knowledge of the structure and content of the English language including the meaning and spelling of words, rules of composition, and grammar.
3. Dependability — Job requires being reliable, responsible, and dependable, and fulfilling obligations.
4. Attention to Detail — Job requires being careful about detail and thorough in completing work tasks.
5. Integrity — Job requires being honest and ethical.
6. Cooperation — Job requires being pleasant with others on the job and displaying a good-natured, cooperative attitude.
7. Adaptability/Flexibility — Job requires being open to change (positive or negative) and to considerable variety in the workplace.
8. Initiative — Job requires a willingness to take on responsibilities and challenges.
9. Self-Control — Job requires maintaining composure, keeping emotions in check, controlling anger, and avoiding aggressive behavior, even in very difficult situations.
10. Stress Tolerance — Job requires accepting criticism and dealing calmly and effectively with high stress situations.
11. Concern for Others — Job requires being sensitive to others' needs and feelings and being understanding and helpful on the job.
12. Evaluating Information to Determine Compliance with Standards — Using relevant information and individual judgment to determine whether events or processes comply with laws, regulations, or standards.
13. Interacting with Computers — Using computers and computer systems (including hardware and software) to program, write software, set up functions, enter data, or process information.
14. Mathematics — Ability to add, subtract, multiply and divide whole numbers, decimals and percentages.
15. Complex understanding of hospital or physician billing.
16. Complex understanding of medical terminology.

**Level IV: Medical Insurance Assistant Manager****4584**

## CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. Any one or any combination of the following, totaling **three (3) years (36 months)**, from the categories below:
  - a) experience in processing medical insurance claims
  - b) college credit for course work in insurance/benefits administration, human resource management, health information management, finance, accounting or closely related fields such as business administration and/or business management
    - 30 semester hours equals (6) months
    - 60 semester hours equals (1) year (12 months)
    - 90 semester hours equals (2) years (24 months)
    - 120 semester hours or higher equals (3) years (36 months)
2. **Two (2) years (24 months)** comparable to that gained at the Medical Insurance Specialist level or in other positions of comparable responsibility within the health insurance area

## KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

1. Customer and Personal Service — Knowledge of principles and processes for providing customer and personal services. This includes customer needs assessment, meeting quality standards for services, and evaluation of customer satisfaction.
2. English Language — Knowledge of the structure and content of the English language including the meaning and spelling of words, rules of composition, and grammar.
3. Dependability — Job requires being reliable, responsible, and dependable, and fulfilling obligations.
4. Integrity — Job requires being honest and ethical.
5. Adaptability/Flexibility — Job requires being open to change (positive or negative) and to considerable variety in the workplace.
6. Tolerance — Job requires accepting criticism and dealing calmly and effectively with high stress situations.
7. Concern for Others — Job requires being sensitive to others' needs and feelings and being understanding and helpful on the job.
8. Evaluating Information to Determine Compliance with Standards — Using relevant information and individual judgment to determine whether events or processes comply with laws, regulations, or standards.

9. Interacting with Computers — Using computers and computer systems (including hardware and software) to program, write software, set up functions, enter data, or process information.
10. Mathematics — Ability to add, subtract, multiply and divide whole numbers, decimals and percentages.
11. Complex understanding of hospital or physician billing.
12. Complex understanding of medical terminology.
13. Complex Problem Solving — Identifying complex problems and reviewing related information to develop and evaluate options and implement solutions.
14. Critical Thinking — Using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems.
15. Judgment and Decision Making — Considering the relative costs and benefits of potential actions to choose the most appropriate one.
16. Law and Government — Knowledge of laws, legal codes, court procedures, precedents, government regulations, executive orders, agency rules, and the democratic political process.
17. Administration and Management — Knowledge of business and management principles involved in strategic planning, resource allocation, human resources modeling, leadership technique, production methods, and coordination of people and resources.

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**Level V: Medical Insurance Manager****2424**

## CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. Any one or any combination of the following, totaling **four (4) years (48 months)**, from the categories below:
  - a) experience in processing medical insurance claims
  - b) Bachelor's degree in insurance/benefits administration, human resource management, health information management, finance, accounting or closely related fields such as business administration and/or business management
    - 30 semester hours equals (6) months
    - 60 semester hours equals (1) year (12 months)
    - 90 semester hours equals (2) years (24 months)
    - 120 semester hours or higher equals (3) years (36 months)

2. **Two (2) years (24 months)** comparable to that gained at the Medical Insurance Assistant Manager level or in other positions of comparable responsibility within the health insurance area which included supervisory duties or specialized areas of expertise.

#### KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

1. Extensive knowledge of medical insurance claims processing
2. Extensive knowledge of medical terminology
3. Customer and Personal Service — Knowledge of principles and processes for providing customer and personal services. This includes customer needs assessment, meeting quality standards for services, and evaluation of customer satisfaction.
4. English Language — Knowledge of the structure and content of the English language including the meaning and spelling of words, rules of composition, and grammar.
5. Dependability — Job requires being reliable, responsible, and dependable, and fulfilling obligations.
6. Integrity — Job requires being honest and ethical.
7. Adaptability/Flexibility — Job requires being open to change (positive or negative) and to considerable variety in the workplace.
8. Tolerance — Job requires accepting criticism and dealing calmly and effectively with high stress situations.
9. Concern for Others — Job requires being sensitive to others' needs and feelings and being understanding and helpful on the job.
10. Evaluating Information to Determine Compliance with Standards — Using relevant information and individual judgment to determine whether events or processes comply with laws, regulations, or standards.
11. Interacting with Computers — Using computers and computer systems (including hardware and software) to program, write software, set up functions, enter data, or process information.
12. Mathematics — Ability to add, subtract, multiply and divide whole numbers, decimals and percentages
13. Complex Problem Solving — Identifying complex problems and reviewing related information to develop and evaluate options and implement solutions.
14. Critical Thinking — Using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems.

15. Judgment and Decision Making — Considering the relative costs and benefits of potential actions to choose the most appropriate one.
16. Law and Government — Knowledge of laws, legal codes, court procedures, precedents, government regulations, executive orders, agency rules, and the democratic political process.
17. Administration and Management — Knowledge of business and management principles involved in strategic planning, resource allocation, human resources modeling, leadership technique, production methods, and coordination of people and resources.