



# Chief of Revenue Cycle

**Job Code:** CRC - 131  
**Revision Date:** Dec 21, 2018

**Salary Range:**

\$42.23 - \$69.09 Hourly  
\$3,378.40 - \$5,527.20 Biweekly  
\$87,844.00 - \$143,705.00 Annually

**FLSA:** Exempt

## Overview

We are an agency committed to innovative behavioral health services in trauma-informed care that promote healing and recovery to instill a sense of empowerment and foster a lifelong sense of resilience.

## General Description

The purpose of this job is to enhance the quality of member management and satisfaction, while assisting with the continuity of care and analyzing the cost-effectiveness of services provided, implement current and future strategies to bill insurance companies, minimize Bad Debt (BD) allowance, improve cash flow and manage the company's insurance receivables. This position should make recommendations for policy and procedure enhancements to improve financial performance, ensuring consistency and maximizing revenue collections. The Chief of Revenue Cycle is responsible for the coordination, implementation, evolution and oversight of the Benefit Assistance Program, Pre-Authorization, Credentialing, Utilization Management and Reimbursement Departments. This position is responsible for management of daily managerial operations pertaining to the Benefit Assistance Program, Pre-Authorization, Credentialing, Utilization Management and Reimbursement departments; including, but not limited to, training, development of processes that maximize quality while utilizing appropriate resources within the members' benefit plans and established contracts.

The Chief of Revenue Cycle is responsible for credentialing all professionals employed by Emergence Health Network or who contract with Emergence Health Network. The Chief of Revenue Cycle ensures professionals are processed appropriately prior to participating in the service delivery system. The Credentialing Program will be responsible for accepting and coordinating all applications for credentialing, re-credentialing and coordinating the credentialing committee review process for the Behavioral Health (BH), child and family, Substance Abuse (SA), Primary Care (PC), Integrated Health Care and Intellectual Developmental Disorders (IDD) Providers.

UMUR Department is the vehicle through which EHN ensures that people receive quality, cost effective services in the most appropriate treatment setting, and in a timely manner. The UMUR Department strives to achieve a balance between the needs and well-being of persons in need of mental health services and the demand for services and availability resources. UM is a critical component of the DSHS MH Resiliency and Disease Management (RDM) initiative.

This class works under administrative supervision, developing and implementing programs within organizational policies and reports major activities to executive level administrators through conferences and reports.

### **Duties and Responsibilities**

**The functions listed below are those that represent the majority of the time spent working in this position. Management may assign additional functions related to the type of work of the position as necessary.**

- Supervises, directs, and evaluates assigned staff, processing employee concerns and problems, directing work, counseling, disciplining, and completing employee performance appraisals. Provides Coaching and employee development.
- Serves as a subject matter expert and role model for staff, demonstrating quality customer service and consistently maintaining a positive work environment.
- Evaluates procedures, authority, and accountability. He/she works in collaboration with other departments in day-to-day cross-functional activities.
- Coordinates, assigns, reviews work and establishes work schedules; maintains standards; monitors status of work in progress; inspects completed work assignments; answers questions; gives advice and direction as needed.
- Responsible for implementing, preparing and disseminating reports to all identified departments.
- Acts as a project manager for the review, development and implementation for electronic claims receipt and submission; including updates and transitions to new software as encounter data reporting.
- Ensures the daily activities of the billing departments are operating effectively and efficiently and ensures the department is applying and enforcing credit and collection policies to minimize revenue adjustments.
- Understands and promotes the principles of Utilization Management to facilitate the right care at the right time in the right setting. Completes
- Utilization and Concurrent Review through the collaboration of internal departments, Medicaid, Medicaid Managed Care Companies,
- Medicare Advantage Plans, and other third-party insurance companies.
- Ensures that department staff performs pre-admission, concurrent and retrospective clinical reviews to evaluate appropriateness of admission need for continued stay, length of stay, and utilization of resources both accurately and in a timely manner.
- Proactively oversees UMUR screening process and ensures referral process is initiated for identified individuals.
- Acts as a resource for UMUR team members for clinical issues, non-clinical concerns and/or trends.
- Builds and maintains relationships with providers, local agencies/organizations and hospitals.
- Ensures strict adherence to departmental standards of confidentiality of medical and proprietary information.
- Provides expertise in the evaluation of appeals/grievances and ensures timely resolution.
- Collaborates with IT in developing financial dashboards for levels of management to review outcomes due to services provided.
- Collaborates with Quality Assurance to ensure review through the UM Committee. This will include review of a sample of cases as well as aggregate and individual data available through MBOW applications and EHR reports.
- Ensures the Credentialing department maintains the organization's records, ensuring compliance with regards to employee, contract, and facility credentialing.
- Implements corporate policies, practices and initiatives to educate revenue cycle teams and their customers in the areas of billing compliance, payer requirements and industry trends and changes.
- Collaborates with all staff in continuous improvement of health information documentation, medical necessity validation and clinical authorization processes.

- Participates in work-flow re-engineering to maximize cash flow by increasing recovery rate on outstanding claims and decreasing cost per claim to minimize corporate costs and increase efficiencies.
- Compiles and prepares various reports for management to analyze trends and make recommendations.
- Conducts regular and periodic meetings with the team, to ensure the implementation of all revenue cycle team plans, programs and projects adhering to prescribed deadlines and schedules.
- Monitors all complex customer (patient, office and provider) complaints and issues involving Benefit Assistance, Credentialing, Pre-Authorization, UMUR and Reimbursement departments.
- Collaborates with Revenue Cycle Manager to resolve any/all Payor issues related to insurance claim payment.
- Ensures the Revenue Cycle Department will comply with Cost-sharing rules, Social Security rules and guidelines.
- Monitors any non-covered individuals and ensure notification was provided to all appropriate parties.
- Evaluates Revenue Cycle on a regular basis (e.g. quarterly) to determine its effectiveness in facilitating access, managing care, improving outcomes and providing useful data for resource allocation, quality improvement and other management decisions.
- Ensures the procurement of all necessary documentation for credentialing are received within a timely manner from the provider and Human Resources.
- Responsible for reviewing the application for completeness and verifying documentation being submitted collaborates with 3rd party clients, vendors and credentialing department. If any non-licensed providers will be billing individually under the contract, a non-licensed provider profile will need to be included along with verification that each non-licensed practitioner providing services for the organization meets the eligibility criteria specified and is receiving appropriate supervision.
- Develops and executes internal audits for all programs.
- Effectively communicates with identified staff to ensure a positive client and employee experience.
- Performs other duties as assigned.

### **Minimum Education and Experience Requirements**

Requires a Bachelor's Degree in Health, Business, Public Administration or related field, supplemented by eight (8) years of progressively responsible experience; or possession of any equivalent combination of education, training, and experience which provides the requisite knowledge, skills, and abilities.

Substantial experience expertise in the development of utilization policies, procedures and programs.

Community mental health system and/or primary integration with behavioral health experience.

Experience with trauma-informed services; cognitive behavioral therapies, including DBT; and motivational therapies including the use of incentives, preferred.

### **Required Knowledge and Abilities**

Knowledge of trauma-informed theories, principals, and practices (includes multi-faceted understanding of concepts such as community trauma, intergenerational and historical trauma, parallel processes, and universal precautions), preferred.

### **Physical Demands**

Performs sedentary work that involves walking or standing some of the time and involves exerting up to 10 pounds of force on a regular and recurring basis or sustained keyboard operations.

### **Unavoidable Hazards (Work Environment)**

- None

### **Special Certifications and Licenses**

- Must possess and maintain a valid state Driver's License with an acceptable driving record.
- Must be able to pass a TB, criminal background and drug screen.

### **Americans with Disabilities Act Compliance**

Emergence Health Network is an Equal Opportunity Employer. ADA requires Emergence Health Network to provide reasonable accommodations to qualified persons with disabilities. Prospective and current employees are encouraged to discuss ADA accommodations with management.

### **Other Job Characteristics**

- Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.
- Credentialed, certified, and licensed professionals with adequate training in person-centered, family centered, trauma informed, culturally-competent and recovery-oriented care.

**Note:** This Class Description does not constitute an employment agreement between the Emergence Health Network and an employee and is subject to change by the Emergence Health Network as its needs change.