POSITION DESCRIPTION *(Please Re[...] tructions on the Back)*

1. Agency Position No.	402-9455-A
2. Reason for Submission	☒ Redescription ☐ New ☐ Reestablishment ☐ Other
Explanation *(Show any positions replaced)*	Replaces Claims Assistant GS-998-6 #402-9408-A classified 6/25/04.
3. Service	☐ Hdqtrs ☒ Field
4. Employing Office Location	Maine
5. Duty Station	Togus
6. OPM Certification	
7. Fair Labor Standards Act	☐ Exempt X☑ Nonexempt
8. Financial Statements Required	☐ Executive Personnel ☐ Employment and Financial
9. Subject to IA Action	☑ Yes ☐ No
10. Position Status	☒ Competitive ☐ Excepted *(Specify in Remarks)* ☐ SES (Gen.) ☐ SES (CR)
11.	☒ ☐ ☐ Neither
12. Sensitivity	☒ 1-Non-Sensitiv ☐ 2-Noncriti ☐ 3-Critical ☐ 4-Special
13. Competitive Level Code	
14. Agency Use	

15. Classified/Graded by	Official Title of Position	Pay Plan	Occupational	Gra	Initial	Date
a. U.S. Office of Personnel Management						
b. Department, Agency or Establishment						
c. Second Level Review						
d. First Level Review	CLAIMS ASSISTANT	GS	998	7	WJ	4/7/05
e. Recommended by Supervisor or Initiating Office	Billing Technician	GS	0998	7		

16. Organization Title of Position *(If different from the official title)*

17. Name of Employee *(if vacant, specify)*

18. Department, Agency, or Establishment: Department of Veteran Affairs	c. Third Subdivision: Business Office Service Line
a. First Subdivision: VAM&ROC	d. Fourth Subdivision: Patient Accounts Section, MCCF
b. Second Subdivision: Togus, Maine 04330	e. Fifth Subdivision: Billing Office

19. Employee Review — This is an accurate description of the major duties and responsibilities of my position.

Signature of Employee *(optional)*

20. **Supervisory Certification.** *I certify that this is an accurate statement of the major duties and responsibilities of this position and its organizational relationships, and that the position is necessary to carry out Government functions for which I am responsible. This certification is made with the knowledge that this information is to be used for statutory purposes relating to appointment and payment of public funds, and that false or misleading statements may constitute violations of such statues or their implementing regulations.*

a. Type Name and Title of Immediate Supervisor
THOMAS R. SPEARS, Patient Accts. Manager
Signature [signature] Date 4/5/2005

b. Typed Name and Title of Higher-Level Supervisor or Manager *(optional)*
KATHLEEN P. BURNHAM, Acting BSL Mgr.
Signature [signature] Date 4/4/05

21. **Classification/Job Grading Certification.** *I certify that this position has been classified/graded as required by Title 5, U.S. Code in conformance with standards published by the U.S. Office of Personnel Management or, if no published standards apply directly, consistently with the most applicable published standards.*

Typed Name and Title of Official Taking Action
W. LORING HR Spec (Classification)
Signature [signature] Date 4-7-05

22. Position Classification Standards Used in Classifying/Grading Position
Assistance Work in the Legal + Kindred Group, GS-0900, August 2001.

Information for Employees. The standards, and information on their application, are available in the personnel office. The classification of the position may be and corrected by the agency or the U.S. Office of Personnel Management. Information on classification/job grading appeals, and complaints on exemption from FLSA, is available from the personnel office or the U.S. Office of Personnel Management.

23. Position Review	Initials	Date	Initials	Date	Initials	Date	Initial	Date	Initial	Date
a. Employee *(optional)*										
b. Supervisor										
c. Classifier										

24. Remarks Accretion of duties - Reflects current status of functions assigned to this position.

25. Description of Major Duties and Responsibilities *(See Attached*

MEDICAL CARE COLLECTION FUND BILLING TECHNICIAN
MEDICAL CARE COLLECTION FUND

Position functions as a billing technician in the MCCR Section, which is a first and third party reimbursable program. Authorized by law, this program requires VA to recover a reasonable value of the cost of medical care rendered to veterans who are not entitled as VA beneficiaries or are found to be able to pay the costs of care or have private health plans; eligible veterans who have claims against third parties or employers; veterans of Allied governments with whom agreements have been made; active duty personnel in the Armed Services; humanitarian cases; and employees of other Federal agencies who receive treatment, as approved by the Secretary of Veterans Affairs.

Principal Duties and Responsibilities:

Incumbent is responsible for performing all types of third party billing for a wide range of programs including Medicare billing, Commercial Insurance billing, Veterans Workers Compensation, Tort Feasor, ChampVA, Tricare, Employee OWCP, Interagency, Sharing Agreement, Non-VA (Fee), Ineligible Humanitarian; and for First-Party Co-payment bills. Each of these billing programs has different coverages, billing rates, and billing requirements. The incumbent must first determine if services are billable under each program based on whether coverage exists for the services provided. A wide range of determining factors must be reviewed to determine if coverage exists and to ensure that accurate, complete and compliant billing of the services takes place. Many medical services are only covered by specific plan types, or for specific diagnoses or under very specific circumstances. Billers must also review claim filing time limits under the program or insurance plan; review SC and NSC determinations; and review the available charges for the services, the type of professional provider providing the services, and the location of the services provided to determine if both institutional and professional charges can appropriately be billed.

Billers must adhere to all Medicare, HIPPA, and industry-standard compliance rules and regulations to ensure that only medically necessary, fully-documented, and appropriately handled medical care is billed to all third party payers. Inappropriately billed services could bring charges of fraud and abuse and billers are held directly responsible for inappropriately billed services. Third party payers have the right to audit provider records if they suspect that inappropriately billed services were paid. An example of the research required to ensure compliant billing is physical therapy billing. If the patient was referred for physical therapy by his primary care physician, the biller may have to review medical records for a range of dates of care to determine if the physical therapy services are billable. Did the physician order the services based on a billable diagnosis, did the physical therapist evaluate the patient and did he set up a specific treatment plan, did the physician who ordered the PT re-evaluate the patient every 30 days and certify that additional treatment is necessary? All documentation must be reviewed and all billing criteria must be met before billing the physical therapy services or the physicians' visits.

The biller must also review a complex system of VA reasonable charges and billing rates, and based on the coded services being billed, determine what type of charge; institutional and/or professional services should be billed. Billing of professional services requires determining if the provider of services (MD, PA, NP,CSW, etc) is credentialed and independently billable for their professional services under Medicare and/or the insurance plan regulations; and determining if the services were provided in a provider-based location (hospital) or in a non-provider based location (CBOC or contracted clinic). Provider based hospitals may often be billable for both institutional and professional charges; however, a further review of the services provided must be done to determine if individual items or components of the services are separately billable under the insurance plan, or are they bundled into a comprehensive payment. Medicare and commercial insurance carrier billing standards and requirements differ for institutional billing and professional billing. The biller must understand and adhere to such billing compliance issues as "global surgery periods" and what is billable within the pre-op and post-op period, etc. Billing at VA facilities differs from private hospital and private professional billing in that VA hospitals employ their physicians and other providers. Since all services are billed under the VA facility's tax ID, VA billers must perform billing based on a thorough knowledge of both institutional and professional billing requirements and be able to distinguish and easily shift from one set of standards to another when billing each unique encounter.

The incumbent must determine what information is needed on the claim form for each unique billing situation and this information can vary widely based on the payer; the provider of the services; and the type of service being billed, including the location and circumstances surrounding the care being provided. For Medicare and Medicare supplement plan billing, the biller must determine under what circumstances modifiers, revenue codes, occurrence codes, condition codes, and value codes should be used to further describe the services billed. Certain types of services billed will require a referring physician on the bill and dates indicating the onset of symptoms and date referred. Other ancillary and adjunct services may only be billable when there is an indication of an underlying systemic disease. Additional information regarding the provider treating the patient for the systemic disease may need to be included on the claim. Billers must determine when to include and when not to include additional information to the claim. For inpatient medicare billing, billers must track Medicare benefit periods to determine if the days being billed are covered days under the patient's current Medicare benefit period. Compliant billing means that claims must be accurate, complete, timely and can only be submitted for covered services.

The biller must determine if billable services require pre-authorization; and if required, will initiate contact with the insurance carrier to obtain authorization. Biller provides sufficient, selected information to third party carrier to grant authorization for prospective payment. Biller may refer certain cases to attending physician or utilization review staff

for addition review. Biller initiates process of obtaining authorization and follows-up with required second opinion cases. Services requiring pre-authorization vary according to insurance plan but will minimally include inpatient admissions, outpatient surgery, and some outpatient diagnostic tests. If the insurance plan is managed care, a referral from the patient's in-network primary care physician may also be required prior to billing. The patient will be contacted and requested to obtain a referral.

When a patient has more than one insurance plan coverage for a service, the biller must determine primary, secondary, and/or tertiary order of billing. A complex set of Medicare and National Association of Insurance Commissioners (NAIC) Coordination of Benefit regulations must be followed when billing for medical services. To determine which payer is primary, a review of the patient and spouse's work history, (working or retired) and types of insurance coverage (employer group plan vs. Medicare, COBRA, etc.) must be done.

Billers perform the first level of review of all outpatient medical care provided in all clinics at this facility and the CBOC's to determine if services are billable. Billers perform audits of all outpatient medical encounters by clinic using Quadramed Code Me processes. They determine if the services are potentially billable based on existing insurance coverage, the care provided is for a non-service connected condition, and clinic encounter has been closed correctly. After careful review, the biller forwards billable services to coding for coding action. Billers also flag non-billable services based on specific criteria and remove these events from all databases tracking billable episodes of care. Ongoing communication between the biller and coder is required to resolve issues such as missing, and uncoded medical encounters, and denials based on incorrect/invalid codes. Billers must have knowledge of correct coding guidelines and Medicare coding guidelines to assist coding in resolving coding denial issues. Bill Me lists are processed to facilitate billing of services after coders have completed coding for all services provided on that day. Any services from clinics that were not closed out timely, and are captured by the biller after the Bill Me process is complete, are referred back to coding for additional coding.

The incumbent must also correct, resubmit, cancel, and/or process claims to secondary payers, for all Medicare remittance advice requests. Medicare coverage and processing requirements are stringent and claims often require a large amount of re-work to process the claim through Trailblazers, (the Medicare intermediary). The biller must often research a wide range of Medicare billing manuals, Local Coverage Determination Decisions, and other commercially produced Medicare billing guides such as the "UB-92 Editor" to determine if the reject/denial is correctable and how to correct it. The biller must provide feedback to the station compliance officer regarding services provided that have been denied by Medicare for not meeting medical necessity requirements. This information is often used by the compliance officer to determine provider training needs.

Some rejects may be caused by technical problems that can not be corrected by the biller. The biller must have sufficient knowledge and/or must conduct sufficient research to determine the underlying cause of each reject/denial and use independent judgment to resolve each issue.

Biller performs monthly Compliance and Business Integrity (CBI) audit of billed claims to identify claims that do not meet billing compliance standards for billable services, and to ensure that coded diagnosis and CPT codes match PCE records and are appropriately linked.

Biller performs monthly audit of AARP billed claims to ensure that only services meeting medicare coverage standards have been billed. Reviews records to ensure that bills for concurrent care services, (patient is receiving medical services from VA provider and local medical doctor for the same diagnoses), is not billed.

Biller works closely with accounts receivable staff to resolve denial issues. He/she assists with required research, and if required, submits corrected claims.

Biller creates, cancels, and/or edits patient means test co-payment charges after notification of a change in patient eligibility. Biller also monitors and adjusts patient billing clock when appropriate.

Biller attends regularly scheduled VA Chief Business Office (CBO), Health Information Management (HIMS), and VA Compliance-sponsored professional training covering coding, billing, and compliance issues. Biller must keep abreast of billing process changes and must train new billers on all billing processes and procedures.

Incumbent obtains and completes necessary legal forms to pursue billing for worker's compensation, no-fault insurance, and tort feasor. He/she advises veteran of VA's role and contacts employer insurer, or attorney, as required. Submits billing and required copies of medical records and keeps Regional Counsel informed of progress of each case. Biller is required to maintain close liaison with attorneys and Regional Counsel to protect our leins in these cases.

Biller determines appropriate person to obtain consent for the release of medical information and determines what must be released. Ensures that appropriate consent and signature is obtained for release of medical record information pertaining to alcohol or drug abuse, sickle cell anemia, and HIV testing/infection as required by the Health Information Privacy and Portability Act (HIPPA). Completes legal requests, such as affidavits, as requested. Abstracts information from record and prepares photocopies.

Maintains control to ensure that billings are processed within the established timeframes to ensure that VA obtains reimbursement in an expeditious manner.

Prepares written correspondence in response to inquiries from insurers, attorneys, employers, etc. Also, prepares correspondence to initiate third-party claims, such as worker's compensation, tort feasor, etc.

Incumbent maintains computer database regarding medical/administrative date pertinent to the billing record. Is responsible for maintaining and supporting the ADP security Program as outlined in VA policy.

Factor 1. Knowledge Required by the Position

Incumbent must have a thorough knowledge of medical terminology, signs, symbols, approved abbreviation, anatomy and physiology; American Medical Association Correct Coding Guidelines for ICD-9, CPT, and HCPC's coding classification systems as well as the appropriate system to apply to medical record information. Must have a thorough knowledge of Medicare Coding Guidelines and how Medicare requirements differ from Correct Coding Guidelines, as well as, a thorough knowledge of when each should be used. Must be able to recognize signs, symptoms, and positive physical/diagnostic findings that relate to specific disease processes. Biller must possess full knowledge of all VA regulation, public laws, directives, policy memorandums, etc. regarding billing and reimbursement from veterans and third-party payors, eligibility and the Privacy Act and local policies regarding the release of medical information. Must have a thorough knowledge of medical record forms and formats and be able to not only read but also understand medical record entries in order to accurately respond to requests from outside sources. Must have skill in developing and maintaining control mechanism to accurately identify pending workload accomplishments. Must have a thorough knowledge of computer security. The incumbent must have an understanding of and skill in using a personal computer integrated into mainframe with specialized knowledge of billing associated functions. Also, must have knowledge of state and federal statutes relating to worker's compensations, no-fault insurance, tort feasor, victims of personal crime and interagency billing. Must have knowledge of a myriad of health insurance contracts and legal liabilities. Also, must have knowledge of utilization review procedures and understand their involvement in the MCCF process.

Biller must have full knowledge of all information required to complete claim forms for the full range of billable medical services provided at this facility, it's community-based outpatient clinics, and contracted providers of services. Biller must be knowledgeable of the full range of variables and determining factor's that vary information requirements for billable services. Biller must fully understand and recognize the differences in billing information requirements for Medicare, Tricare, ChampVA, Tort Feasor (Accident), Worker's Compensation, Non-VA, Interagency, Employee OWCP, and Ineligible Humanitarian Billing.

Biller must possess full knowledge of the UB-92, HCFA 1500, and other industry standard billing forms, the screen locators to place required information, and the correct field locations of required information for printed and electronically transmitted forms. Biller must fully understand the correct use of modifiers and under what circumstances to use condition, occurrence, and value codes that define significant events, insurance coverage conditions, and clinical or monetary data that may affect payer processing and payment of claims.

Biller must have full knowledge of all Medicare Compliance standards as they relate to the billing and coding of third party claims to ensure that only medically necessary, fully-documented and covered services are billed. Biller must be knowledgeable of Health Information Portability and Privacy Act (HIPPA) regulations as they relate to the privacy of medical information and the requirements for standardized claim form information.

Biller must possess a broad knowledge of CMS (Medicare) coverage standards, and Local Coverage Determinations currently in place for Trailblazers (Texas Medicare Intermediary). Biller must possess a broad knowledge of a wide range of commercial health insurance plans and knowledge of the standardized coverage under each type of plan; i.e. (Medicare supplement, HMO, PPO, Comprehensive Major Medical, Employer Group Health, etc.).

Biller must have a full knowledge of Medicare and National Association of Insurance Commissioners (NAIC) Coordination of Benefit regulations to determine the order of billing when patients' have more than one insurance coverage, i.e. (primary, secondary, tertiary).

Biller must have full knowledge of the use of the Quadramed Claim Scrubber and be fully knowledgeable of the Quadramed Code Me/Bill Me process. Biller must be fully capable of performing audits of PCE Clinic records using the Code Me/Bill Me Process to identify billable services for coding and assign a reason not billable to non-billable services.

Biller must have knowledge of the Medicare remittance advice work list function in VISTA. He/She must be knowledgeable of Medicare claim reject and denial messages, as well as, be capable of resolving reject and denial issues. Biller must also have knowledge of the claims status awaiting resolution (CSA) function in VISTA and must be capable of resolving billing rejects resulting from the transmission of Medicare and commercial insurance claims.

Biller must have knowledge of the rate types associated with different types of billing programs such as Reasonable Charges, Tort Rates, Interagency Billing Rates, and CMAC rates. Biller must know when to use each rate type. Biller must

also possess a full knowledge of Reasonable Charge rates that are currently used for billing Medicare and commercial insurances. He/she must be fully aware of the differences in billing requirements for institutional charges versus professional charges and must understand how these charges relate to provider-based locations (hospitals) and non-provider based locations (CBOC's and contracted professional providers).

Factor 2 Supervisory Control

Supervision is provided by the Chief, MCCF, MCCF Service. The supervisor defines objectives, priorities, overall goals, deadlines, and provides guidance only on unusual assignments or those without precedent. Employee works independently planning, organizing, carrying out assignments, and handles usual problems and deviations in the work using established policies, instructions, and accepted practices. Considerable reliance is placed upon the technician's knowledge of billing/eligibility/coding/compliance functions, laws, medical records, legal issues, etc. Many guidelines apply to the work, requiring judgment and interpretation in their application. Completed work is subject to periodic review for conformance to requirements.

Factor 3 Guidelines

The incumbent uses a variety of guidelines as references to assist in accomplishing various aspects of the work performed. These guidelines include Medicare coverage and claims processing manuals; Ingenix UB-92 Editor; American Medical Association CPT and ICD-9 coding books; Ingenix HCPCS Level 2 coding books; NAIC Coordination of Benefits regulations; Medicare Compliance Regulations; and various insurance carrier contract and coverage publications. These manuals and publications only provide limited, non payer-specific billing guidance.

Since insurance plans' coverage guidelines and billing requirements vary widely and change constantly, billers must adapt and adjust billing practices by identifying and contacting new sources of information; using their own billing experience and knowledge and developing new solutions to resolve complex billing problems. As health care costs have increased, Medicare and insurance carriers are requiring more information regarding the services being billed, however, the type of information and format for supplying this information is not standardized. Billers, therefore, have few guidelines to reference when billing medical services that meet the individualized requirements of the hundreds of different insurance carriers currently being billed. Billers must also adapt non-industry standard billing software to provide all information required in the format and form locator locations required by individual insurance carrier claims processing offices.

In order to maximize collection potential, the biller uses knowledge of health care and insurance industry payment practices and coding knowledge to provide more specific codes and modifiers in order to obtain maximum insurance reimbursement.

Factor 4 Complexity

In the performance of the many and varied functions of this position, the employee must determine many facts and conditions to know how to best pursue each case for maximum reimbursement, taking into account the medical record documentation, the legal aspects, the eligibility issues, etc. Much of the duties involve different processes, which require innovative approaches to accomplish the tasks. These decisions have a direct impact on reimbursement to this facility and require individual judgment and interpretation. Decisions regarding priorities must frequently be made as the workload changes, even daily, through control mechanisms; the employee is responsible for completing the many tasks in a timely manner.

Medicare billing is considered to be exceptionally complex as it exists in the private sector. Two years ago, Medicare implemented an improved system for the processing and payment of outpatient claims called the Outpatient Prospective Payment System (OPPS). Under this system, Medicare is now requesting much more detail on claims, including highly-detailed HCPCS codes in place of industry-standard CPT codes; and an increased use of modifiers, condition codes, value codes, and occurrence codes. Billing software in the private sector is much more sophisticated than VA software. In the private sector, revenue codes, and many condition, value and occurrence codes are linked to specific CPT and Diagnosis combinations. These linked codes auto-populate the bill and eliminate much of the research that is currently being done by billers in VA facilities. Since VA billers work without many of the tools available to their private sector counter-parts, the complexity of Medicare billing in VA far outweighs that experienced in the private sector.

Unlike their private-sector counterparts, billers at VA facilities must bill for both institutional and professional charges. For almost every encounter in a VA facility, both an institutional and professional charge can be billed. These two types of charges are billed on different forms, have different informational requirements, and are subject to different coding and billing rules and regulations. VA billers must be skilled at distinguishing between the requirements for both charge systems and must produce bills that meet the requirements for both.

The structure of private hospitals and practices has been set up to maximize insurance billing and collection practices. The organizational structure and business practices currently existing in VA hospitals differs from those existing in private practice in many critical areas that impact Medicare and commercial insurance billing. Billers must routinely find work-around solutions to billing

problems either because our software does not provide the flexibility to place information required by some insurers on claims or because the care provided to our patients is handled differently in VA hospitals than private hospitals in respect to utilization review issues. To bill and collect effectively, services provided must be more fully documented by VA providers to provide the additional information required by medicare and commercial insurances. Billers must often contact medical providers and perform extensive research to obtain documentation to justify the medical necessity of care for which they are billing.

Patient's insurance and demographic information is routinely updated before the patient arrives for treatment at private facilities and professional practices. At VA facilities, this is rarely done because of concerns about patient wait times, etc. Billers must attempt to capture information and bill for services that were not captured by software because necessary insurance and demographic information was not in our systems at the time the patient was seen for care. At that point, capturing all information for billing is a manual process that often requires extensive research and rework by billers.

Patients are often admitted as inpatients for medical and surgical services that are normally performed in an outpatient setting at private hospitals. These inpatient admissions are normally considered "not medically necessary" and are not authorized by insurance carriers. Inpatient length-of-stays at VA facilities are also often longer than insurance carriers approve for the services provided. Billers must weigh responsibilities for meeting collection goals with the equally important responsibility of performing compliant billing for only covered and medically necessary services. Since billers in VA facilities encounter software and business practice impediments not present in the private sector, they must be innovative in capturing information, providing required information in a format acceptable to insurance carriers, and in proving the medical necessity of services provided.

Factor 5. Scope and Effect

It is critical that work is performed skillfully and accurately to ensure that maximum reimbursement is obtained from the varied billing programs.

Factor 6. Personal Contacts

Contacts are conducted in person, by telephone, and/or by written correspondence with veterans, their familities, regional counsel, private attorneys, insurance carriers, employers, veterans' service officers, VA staff at all levels including administrative and professional and clinical staff both at this facility and other VA facilities, and other government agencies.

Factor 7 Purpose of Contacts

The employee must obtain/exchange information to enable accurate preparation of billing and the necessary follow-up, and protect the Medical Center's interest as a lien claimant in liability cases while maintaining the integrity of the VA as a whole. Also for the purpose of problem solving and coordination of work efforts to accomplish the duties of this position in a timely and accurate manner to expedite collection processes.

Factor 8 Physical Demands

The work is performed mainly in a sedentary manner, however, walking, standing, reaching, bending, pulling and carrying of medical records is required.

Factor 9 Work Environment

The work environment involves everyday risks and/or discomforts which require normal safety precautions typical of various hospital offices.