Government of Alberta

NON-MANAGEMENT JOB DESCRIPTION
POINT RATING EVALUATION PLAN

Working Title	Name
Practitioner Services Adjudicator	

Position Number	Reports to Position No., Class & Level	Division, Branch/Unit	Ministry
			Alberta Health

Present Class	Requested Class

Dept ID	Program Code	Project Code (if applicable)

PURPOSE: Give a brief summary of the job, covering the main responsibilities, the framework within which the job has to operate and the main contribution to the organization (see Non-Management Job Description Writing Guide **Pages 7-8**).

The mandate of the Health Insurance Programs Branch (HIP) is to administer the Alberta Health Care Insurance Plan (AHCIP) in compliance with Alberta and Canadian legislation and policy. This includes the registration of eligible Albertans, Alberta practitioners and facilities; payment of claims to Alberta practitioners and residents; and special out of province/country programs for Albertans seeking access to medically required health services not available in Alberta and/or Canada.

Reporting to the manager of the Claims Unit, the Practitioner Services Adjudicator:

- Maintains a confidential business detail and payment database for over 10,000 service providers with a high degree of accuracy and must be able to work independently.
- Establishes and maintains all Allied and Medical Services Providers, their organizations, Professional Corporations, financial details and Business Arrangement payment details and, Regional Health Authority Business Information. Decision making ability is required where limited precedents exist.
- Designates and maintains facilities for Approved Active Treatment Hospitals, Auxiliary Hospitals and Nursing Homes in using the Hospital Acts and Nursing Home Legislation.
- Adjudicates all Medical and Allied claims that are held for manual assessment for any of the assessment rule conditions related to the service provider or stakeholder. The physician annual budget is in excess of $1.4 billion and the adjudicators must correctly assess claims that reject for manual review or explain to practitioners the reason their claims have rejected from a facility/physician registration/physician skill point of view. The adjudicator must also be able to understand and explain why claims will have rejected for one or more of 770,000 edits in the claims system.

This position acts as a direct resource of information to Service Providers, Accredited Submitters, Regional Health Authorities, College of Physicians and Surgeons of Alberta (CPSA), Alberta Medical Association (AMA), all Allied Licensing Bodies and many internal government agencies. The Practitioner Services Adjudicator is responsible for interpreting and applying the terms and conditions laid down by Alberta Health, the Alberta Medical Association and the Regional Health Authorities for the Alternate Payment Plan (APP) Contracts with stringent guidelines; actioning all accredited profiles received from the CPSA with respect to the Non hospital Surgical facilities; and assigning all appropriate ward rates according to the ministerial orders.

RESPONSIBILITIES AND ACTIVITIES: The purpose of the job can be broken down in different responsibilities and end results. Each end result shows what the job is accountable for, within what framework and what the added value is. Normally a job has 4-8 core end results. For each end result, approximately 3-6 activities should be described (see Writing Guide **Pages 9-10**).

1. Adjudicates medical and allied claims that are being held for manual assessment for any of the assessment rule

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conditions related to the service provider or stakeholder.

- Interprets the appropriate assessment of the claim, the Governing Rules, and provides appropriate information regarding the payment, refusal or adjustment of the claim.
- Accessing various internal systems, reviews rules, eligibility, rates, previous correspondence, Internet research and other related information
- Referring to the 7 Schedules of Benefits, identifies procedure codes, price lists and governing rules that need to be accessed to adjudicate claims.
- Act as first level of appeal for Claims Processing/Corporate Support division claim assessment queries
- Requests reports on questionable claims and practitioner/facility set up to detect over or under payments and inconsistencies in practitioner/facility information

2. Registers service providers according to the licensing standards of Alberta Health and their governing bodies.
   - Interprets licence types, skills and the restrictions applied to them according to the correspondence received from the CPSA. Decision making ability is required where limited precedents exist and a high degree of accuracy and understanding of the documents received is critical to ensure that the claims will pay according to the Schedule of Medical Benefits
   - Maintains the monthly changes and deletions listing with respect to the physician's status with the CPSA to prevent inappropriate and or fraudulent billings
   - Creates business arrangements (BA) to determine the type of payment to be made. Ensures the accredited submitter associated with that BA is attached to prevent massive claim refusals.
   - Applies the bank, transit and account numbers from the financial institutions to the business arrangements, to ensure the timely deposits for the weekly payment runs.

3. Registers all Alternate Payment/Relationship Programs, the service providers and program/payment details.
   - Reviews and determines from the agreement what needs to be maintained in the system to accommodate the funding model it represents; the terms of the contract, the sessional hours, and rates that are required for appropriate payment to the Regional Health Authorities, Physicians, ARP organizations and Professional Corporations.
   - Ensures the contract and letters of participation are received, that all physicians identified in the contract have completed the letters, and have correctly signed the documents for payments under them as physicians or professional corporations.
   - Maintains or establishes each program according to the amended or renewed agreements on a yearly basis.
   - Ensures the business arrangements are established correctly and the physicians are established to enable them to invoice directly with direct deposits to the bank accounts requested for each individual or organization
   - Adds new participating physicians on a regular basis.

4. Establishes facilities according to guidelines received from Ministerial orders and the CPSA. .
   - Establishes Sub Acute facilities to allow multilevel payments.
   - Ensures each facility is established with the appropriate facility type and functional centres for the accurate billings of the service providers.
   - Contacts hospitals and service providers when facilities no longer have the qualifications to provide specific services or have changed from one facility type to another. Impacts would be refusals of service provider claims, reciprocal refusals, improper reporting from Regional Health Authorities, more manual assessments of claims, inaccurate Morbidity and Ambulatory Abstract Reporting (MAACAR) and Management Information System (MIS) data, incorrect data for Records of Health Costs.
   - Applies ward rates to Hospitals in Alberta for reciprocal payments. Accurate and concise information must be applied to guarantee correct payment for hospital services across Canada.

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5. Enforces Revenue Canada attachments and Maintenance Enforcement attachments to service providers, Professional Corporations and Clinics of over one million dollars a year.
   - Receives "Requirements to Pay" notifications from Revenue Canada and calculates the dollar amount to be deducted from the weekly claims payment.
   - Processes Maintenance enforcement for an attachment to be made on a service provider; attachments can be for hundreds of thousands of dollars
   - Applies Non Resident Tax of 15% for all service providers that are not Permanent residents of Canada. This deduction is made weekly from the service providers claims payment.
   - Applies Corporate Tax requirement against Practitioners

6. Communicates with stakeholders, providing information and advice.
   - Researches and responds to letters, e-mails and phone calls from Service Providers, Licensing bodies, Accredited Submitters, Clinics, Regional Health Authorities, and Recipients concerning rules, policies, benefits and/or claims.
   - Interprets rules, acts and bulletins sent to service providers for the billings that have paid or refused.
   - Investigates problematic claims from service providers, researches and evaluates their issues to determine appropriate action, and provides timely, accurate and concise information. Responses/decisions must be provided with diplomacy and tact.
   - Examines service provider's queries regarding skills and payments levels to be paid for individual skills and present the new skills and payment issue forth to Systems Support and the AMA.

7. Improve Program Policies, Procedures and Operating Systems.
   - Identify problems or weaknesses in unit policies and suggest effective solutions to support changing business rules and functions.
   - Identify and suggest solutions to streamline procedures and meet business needs within the work unit.
   - Identify inconsistencies/issues and provide recommendations/feedback or make applicable changes to enhance the design and operation of the mainframe system and other workplace tools, including the Schedule of Medical Benefits (SOMB) and the other schedules.
   - Provide assistance with special tasks/projects that are assigned.

8. Actively participates in development of self and others.
   - Participates in cross training initiatives to maximize knowledge of claims management and to ensure adequate coverage for business area.
   - Trains and coaches new staff on the registration and maintenance of service providers, facilities, and the adjudication of claims which can include delivering training on the Central Stakeholder Registry (CSR)/Claims Assessment (CLASS) /Eligibility and Premiums (EAP)/Divisional System Support (DSS) systems, SOMB navigation, medical terminology/anatomy, and the telephone roster.
   - Performs quality control for new staff and communicates progress to Team Lead.
   - Mentors new staff as complexity of job duties increases.
   - Identifies knowledge gaps for team discussion and calibration.

SCOPE: List specific information that illustrates the challenges, problem solving and creativity requirements and decision making capacity of the position. Also identify the internal or external areas the job impacts (see Writing Guide **Pages 11-12**).

Primary overall responsibilities for this position are:

- Completing claim and document processing within specified time frames and defined production benchmarks as established by the Practitioner and Facility Management Team Lead in accordance with departmental standards.
- Adjudication of medical and allied health claims that have rejected from one or more than 770,000 system edit/rule conditions, specifically related to issues with the service provider or stakeholder.

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- Answering a broad scope of complex verbal and email inquiries from practitioners, billing staff, and the general public.
- Decision-making necessitates adjudicators making 90% of decisions independently.
- Displays independence of decision making where limited precedents exist for claims/facility/practitioner skill and registration.
- Justification of Ministry's position regarding policies around facility registration and service provider criteria.

This position answers complex written and verbal inquiries from all practitioners, Licensing bodies, Accredited Submitters, Clinics, Regional Health Authorities and the general public for the purpose of answering questions that can be highly complex and technical in nature. The communication will refer to issues with claims refusals, facility designation, and service provider registration and parameters. This requires staff to make sound interpretation and accurate judgement for immediate response to the callers.

The continual change and increased level of technical complexity of modern medicine requires the incumbent to have the knowledge and experience to be able to obtain and analyze the relevant documentation and comprehend the information. New and evolving facility types, compensation models, and service provider type and skill designation create a void where limited precedents for decisions exist; appropriate stakeholder consultation must be considered. The interests of Alberta Health Services and the AMA must also be considered in the decision making processes. The consequences of errors can be significant. The potential impact to AHW can include possible precedent setting, negative public relations, financial loss and/or litigation.

KNOWLEDGE, SKILLS & ABILITIES: Include information on required diplomas and degrees along with identifying the most important knowledge factors, including knowledge about practical procedures, administrative, technical or professional techniques, technical, scientific or program related processes, etc. Detail specific training if there is an occupational certification/registration requirement for the position. Specify the type of experience required for the position (see Writing Guide **Pages 12-14**).

Education:

- Requires grade XII education with some post-secondary education, specifically in technical medical terminology, claims adjudication or social sciences.

Knowledge:

- Sound knowledge of Alberta Health legislation, regulations, policies, and procedures; and an understanding of how these impact Practitioner and Facility Management.
- Requires familiarity with all the Regional Health Authorities and Accreditation of Health Facilities.
- Comprehensive knowledge of medical and dental terminology.
- Extensive and thorough knowledge of the Schedules of Medical Benefits and Allied Health Benefits, and the governing rules and regulations.
- Strong working knowledge of Ministry programs including Claims Assessment (CLASS), Stakeholder, Eligibility and Premiums system (EAP), Automated Micrographic Image Information System (AMIIS), and Self Service Document Image Retrieval System (SSDIR).
- Strong working knowledge of MS Office (Word, Excel, Outlook and SharePoint).

Skills and Abilities:

- Excellent written and oral communication skills.
- Excellent customer service skills, both internally and externally
- Strong research and analytical skills
- Ability to extract and interpret information from numerous resources both printed and electronic.
- Strong decision and judgement skills.
- Solid interpersonal skills required to provide/obtain information from potentially hostile individuals.
- Proven ability to work independently as well as contribute effectively in a team environment.

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- Strong self-management, organization, and prioritization skills
- Ability to work in a high-pressure environment with stringent guidelines.
- Detail oriented and able to maintain a high level of ownership and accuracy on all work activities. Possesses the ability to mentor staff should the need arise.

CONTACTS: Identify the main contacts the position communicates with and the purpose of the communication (See Writing Guide **Pages 14-15**).

The Practitioner Services Adjudicator interacts with the following individuals or organizations:

- College of Physicians and Surgeons of Alberta - Purpose: Licensing information, accreditation of diagnostic facilities (lab, x-ray, stress testing, pulmonary function etc), Professional Corporation Registration information, Specialty recognition for the Province of Alberta.
- Other Provincial Health Care Licensing Bodies
- Internal and external branch and divisional stakeholders
- Alberta Licensing Bodies that are under Health Protection Act:
- College of Alberta Denturists - Purpose: Licensing information
- Alberta Dental Association and College - Purpose: Licensing information, specialty information
- Alberta College of Optometrists. - Purpose: Licensing information, specialty information
- Alberta Opticians Association - Purpose: Licensing information
- Alberta Podiatry Association - Purpose: Licensing information
- Alberta Medical Association - Purpose: claims inquiries, service provider's specialty code discrepancies and specialty assignment.
- Financial Institutions - Purpose: Banking information for application to appropriate file.
- Revenue Canada - Purpose: payment deductions for Service Providers, Clinics and 15% withholding Non-Resident Tax information.
- Hospitals - Purpose: Patient records for claims information.
- Finance and Administrative Services - Purpose: Stop payment on funds, address information for returned cheques for service providers, clinics, Regional Health Authorities
- Accredited Submitters - Purpose: to receive proper documentation before claims can come into the system for processing.