Effective Date: June 14, 2015
Modified Effective: February 25, 2024

STATE OF WISCONSIN
CLASSIFICATION SPECIFICATION

MEDICAL CLAIMS SPECIALIST CLASSIFICATION SERIES

I. INTRODUCTION

A. Purpose of This Classification Specification

This classification specification is the basic authority under ER 2.04,. Wis. Admin. Code, for making classification decisions relative to present and future paraprofessional positions located within the Department of Health Services. This classification specification will not specifically identify every eventuality or combination of duties and responsibilities of positions that currently exist, or those that result from changing program emphasis in the future. Rather, it is designed to serve as a framework for classification decision-making in this occupational area.

Classification decisions must be based on the "best fit" of the duties within the existing classification structure. The "best fit" is determined by the majority (i.e., more than 50%) of the work assigned to and performed by the position when compared to the class concepts and definition of this specification or through other methods of position analysis. Position analysis defines the nature and character of the work through the use of any or all of the following: definition statements; listing of areas of specialization; representative examples of work performed; allocation patterns of representative positions; job evaluation guide charts, standards or factors; statements of inclusion and exclusion; licensure or certification requirements; and other such information necessary to facilitate the assignment of positions to the appropriate classification.

B. Inclusions

This classification series encompasses paraprofessional positions which, for a majority of time will perform financial activities involved in the billing and collection of accounts for services provided or purchased under the uniform fee system within the Department of Health Services. These positions conduct a wide range of tasks including processing and managing medical insurance claims, processing provider payments, determining responsible party ability to pay for unpaid balances following the uniform fee system and completing appropriate collection activities. Work performed requires a working knowledge of administrative codes, policies, uniform billing procedures, collection procedures and accounting principles.

C. Exclusions

Excluded from this series are the following types of positions:

1. Positions which meet the statutory definitions of supervisor and/or management as defined in Wis. Stats. 111.81(19) and (13), as interpreted and administered by the Wisconsin Employment Relations Commission.

2. Positions that perform professional duties as defined in Sec. 370.030 of the Wisconsin Human Resources Handbook, for the majority of the time (more than 50%).

3. Positions that spend the majority of their time working in the financial program area and are better classified as Financial Specialists.

4. All other positions that are more appropriately identified by other classification specifications.

D. Entrance and Progression Through This Series

Employees enter positions within this classification series competition. Progression to the Senior level may occur through reclassification as the employee satisfactorily attains the specified training, education, and experience and performs the full scope of duties identified as the Senior level. Movement to the Advanced level requires competition.

E. Terminology Used in This Classification Specification

Paraprofessional**:** See the "Glossary of HR Terms as used by DPM"

Routine: Work of repetitive nature, a customary procedure without deviation from the established norm. This does not necessarily denote simple work.

Semi-routine: Work that is a mixture of complex and repetitive duties where the majority of the time is spent on repetitive duties.

II. DEFINITIONS

MEDICAL CLAIMS SPECIALIST

This is the entry level positions. Positions perform paraprofessional work related to medical insurance claims processing within the Department of Health Services. Positions allocated to this level work under close supervision progressing to general supervision. Work includes developing the knowledge of the medical insurance program area or developing the knowledge of processing collections following the uniform fee system. Positions fit into one of the following allocations, or may perform a combination of both:

1) Billing Specialist:

Positions perform a combination of routine to semi-routine tasks such as claims database maintenance, information validation, claims review, claims editing, claims processing, medical insurance billing, reconciliation, data collection, and reporting. Positions may also review and process Prior Authorization requests, Health Check Screens, and Certified Public Expenditure reports. Work requires general knowledge of the medical insurance billing process and general familiarity with medical terminology. Work requires the ability to learn uniform billing procedures as established nationally, as well as, specific billing requirements established by various third party

payers. These positions maintain strong working relationships with the DHS inpatient facilities, other state agencies, counties, and third party payers.

2) Collections Specialist:

Positions perform a combination of routine to semi-routine tasks such as investigating, coordinating, and pursuing collections, preparing legal documents including promissory notes, judgments, tax off sets, etc. for collection of accounts for services provided or purchased under the uniform fee system within the Department of Health Services. Work requires general knowledge of the medical insurance billing to confirm all insurances have been properly billed before pursing collections from the responsible party. All collection activities follow the uniform fee system to determine the responsible parties' ability to pay. These positions maintain strong working relationships with the DHS inpatient facilities, OLC, other state agencies, counties, and third party payers.

MEDICAL CLAIMS SPECIALIST– SENIOR

This is the full performance level for positions that have the necessary experience, training and knowledge in these duties. Employees work under general supervision to provide specialized administrative program assistance related to the management of the billing/collections systems and processes. Positions at this level perform work similar to that described at the Medical Claims Specialist level but perform semi routine to complex tasks. Additionally, the position responsibilities at this level include making decisions regarding ability to pay, acting as a second reviewer, coordinating with legal counsel regarding collections, revising medical claims procedures/processes and assisting in making recommendations to update policy improvements. Positions will coordinate with Bureau of Information Technology Services (BITS) staff to resolve data entry issues, data processing issues, and verify software applications are processing in compliance with uniform billing requirements. Positions will coordinate with Medicaid/Forward Health, Medicare and third party insurance to resolved electronic claims processing issues.

MEDICAL CLAIMS SPECIALIST – ADVANCED

This level is for a singular position. Positions will complete and approve payment processing into the accounts receivable; coordinate with Medicaid/Forward Health, Medicare and third party insurances to resolve electronic payment processing issues; assist with monitoring accounts receivables; and, complete various reporting as required. The position will serve as the final reviewer of the most complicated transactions completed by lower level staff; be responsible for authoring or modifying any unit required procedures (including compliance with other laws such as state laws, the federal Health Insurance Portability and Accountability Act, or similar); and, may function as the agency subject matter expert for this programmatic area.

This position may also, for less than a majority of the time, perform duties described at the Senior level and may also be a Lead worker (Lead work involves a permanently assigned responsibility to train, assist, guide, instruct, assign and review the work of a group of lower level Medical Claims Specialist and/or Financial Specialist. Lead workers do not have supervisory authority as defined under s. 111.81(19), Wis. Stats.).

Work is performed under general supervision.

III. QUALIFICATIONS

The qualifications required for these positions will be determined at the time of recruitment. Such determinations will be made based on an analysis of the goals and worker activities performed and by an identification of the education, training, work, or other life experience which would provide reasonable assurance that the knowledge and skills required upon appointment have been acquired.

IV. ADMINISTRATIVE INFORMATION

This classification was created effective June 14, 2015 and announced in Bulletin OSER-0392-CC/SC as a result of the Financial Specialist classification series Personnel Management Survey. It was created to describe that positions that provide paraprofessional support for the Department of Health Services. Positions were previously classified as Financial Specialist.

This classification was modified effective February 25, 20204, and announced in bulletin DPM-0618-CC/SC, to update the language in the advanced level.

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