

SAN DIEGO COUNTY OFFICE OF EDUCATION
Personnel Commission

CLASS TITLE: CLAIMS EXAMINER II, Grade 54

DEFINITION:

Under general supervision, performs a variety of complex claims and customer service related duties pertaining to the administration of the self-funded indemnity fringe benefit plans; analyzes and processes Medical claims; for payment of claims; provides assistance to member districts and providers regarding claims issues.

REPRESENTATIVE DUTIES:

This position description is intended to describe the general nature and level of work being performed by the employee assigned to the position. This description is not an exhaustive list of all duties, responsibilities, knowledge, skills, abilities, and working conditions associated with the position. Incumbents may be required to perform any combination of these duties. All requirements are subject to possible modification to reasonably accommodate individuals with a disability.

ESSENTIAL FUNCTIONS:

Provides customer services, including providing information to hospitals, physicians and member participants regarding eligibility, benefits and claims status.

Analyzes and determines if services provided are covered under the claimant's plan.

Reviews and analyzes coordination of benefits (COB) to determine payment eligibility.

Calculates payment due to claimant.

Verifies deductible and co-payment amounts, benefit limits, stop-loss limits and maximum benefit limits.

Updates computerized member records with claims information for preparation of the Explanation of Benefits statement, as well as payment.

Processes and distributes claims payment in accordance with specific provisions of multiple benefit plans.

Adheres to standard industry practices and procedures related to claims payment processing.

Responds to telephone and written inquiries regarding benefit and claims questions from district members and providers.

Logs and records financial data for third party liens, lifetime maximums and stop-loss carriers.

Prepares and distributes claims reports to stop-loss and third party liability carriers.

Communicates with physicians and dentists on claims issues.

Assists in third party liability identification, tracking and subrogation.

Communicates with contracted vendors including preferred provider organization (PPO), utilization review, and large case management vendors.

Updates supervisor on vendor operations.

Acts as a resources to other staff and districts.

Provides feedback and input relating to the improvement of the on-line benefit plan and claims data system.

Acts as a technical back-up for the JPA software and network.

Assists in organizing work assignments and setting work priorities.

Participates in the technical training of other Claims processing staff.

Acts as the lead in the absence of the supervisor.

NON-ESSENTIAL FUNCTIONS:

Performs related duties as required.

KNOWLEDGE AND ABILITIES:

KNOWLEDGE OF:

Insurance policies and procedures.

Principles and practices of medical and vision claims adjustment and analysis.

Medical, and vision terminology, acronyms and abbreviations.

Medical, and vision coding.

ABILITY TO:

Remain current on laws relating to insurance and claims administration.

Interpret and apply specific complex regulations.

Analyze claims according to fringe benefit plan provisions.

Utilize computerized recordkeeping and fiscal reporting systems.

Exercise independent judgment.

Communicate effectively orally and in writing.

Effectively utilize problem-solving and conflict-resolution skills

Work effectively independently and as part of a team with minimum supervision

Organize and prioritize work.

Exercise appropriate judgment in making decisions.

Maintain confidentiality of information.

Demonstrate attendance sufficient to complete the duties of the position as required.

Complete routine tasks thoroughly, accurately and with attention to detail

EDUCATION AND EXPERIENCE:

A combination of training and experience which clearly demonstrates possession of the knowledge, skills and abilities listed above. A typical qualifying background would include five (5) years' experience involving the application of insurance principles and procedures including analyzing and adjusting medical, dental, and vision claims, processing claims payments, and explaining and providing assistance with claims issues. Experience utilizing a computerized recordkeeping system is also required. College-level coursework in business administration or a related field may be considered as partial fulfillment of the work experience requirement.

CREDENTIALS, CERTIFICATES, LICENSES OR OTHER REQUIREMENTS:

A valid California Driver's License

WORKING CONDITIONS & PHYSICAL ABILITIES:

Office setting.

Must be able to hear and speak to exchange information; see to perform assigned duties; sit and/or stand for extended periods of time; possess dexterity of hands and fingers to operate a computer and other office equipment; kneel, bend at the waist, and reach overhead, above the shoulders and horizontally, to retrieve and store files and supplies; lift light objects.

DISTINGUISHING CHARACTERISTICS:

The classification of Claims Examiner I is distinguished from the higher level classification of Claims Examiner II in that the Claims Examiner I will be assigned the less technically complex claims assignments, typically related to compensation and collision, small bodily injury, and third party property liability. The Claims Examiner II classification will be assigned the more complex claims assignments, typically involving lawsuits, significant bodily injuries, and employment practices, and may be involved in claims mediation. The Claims Examiner II may perform additional administrative duties in the absence of the supervisor.

Established	Approved by the Personnel Commission	Revised	FLSA Status	Classified Support Salary Grade
06/2015	June 10, 2015	6/2018	Non-Exempt	54