https://phoenixvirtualstaff.com.ph/job/pre-claim-review-specialist/

Pre-Claim Review Specialist

Hiring organization
Phoenix Virtual Solutions

Employment Type
Full-time

Job Location
Remote work possible

Working Hours
Follows the Client Schedule

Date posted
August 15, 2026

Description

The Pre-Claim Review Specialist / Billing Coordinator is responsible for ensuring the accuracy, completeness, and compliance of all billing-related activities before claims are submitted to insurance payers. This role serves as a critical link between clinical, billing, and administrative teams by performing pre-bill audits, managing claim denials, overseeing prior authorizations, monitoring accounts receivable, coordinating credentialing activities, and ensuring compliance with Medicare, Medicaid, commercial payer, and regulatory requirements.

The position also supports revenue cycle management by identifying billing issues before submission, reducing claim denials, improving reimbursement turnaround times, and maintaining accurate documentation throughout the patient care and billing lifecycle.

Responsibilities

- Pre-Bill Audit: Conduct pre-bill audits for all insurance claims to verify accuracy, completeness, and compliance prior to submission.
- Accounts Receivable Management: Monitor accounts receivable (A/R) and perform follow-up actions on outstanding claims older than 90 days.
- Prior Authorizations: Prepare, submit, and track prior authorization requests for services requiring insurance approval.
- Billing Team Coordination: Coordinate and participate in regular meetings with outsourced billing partners to review performance, resolve issues, and ensure alignment.
- Denial Management: Manage claim denials, including root cause analysis, correction, and resubmission as appropriate.
- ADR Packet Preparation: Assist with preparation of Additional Documentation Request (ADR) packets, ensuring all required materials are included and compliant.
- Consent Form Review: Review patient consent forms for completeness and compliance prior to billing and care initiation.
- Referral Documentation Management: Ensure all referral documentation is obtained and properly filed at the start of care.
- Medical Coding: Conduct medical coding for home health services, collaborating with clinical staff to ensure accuracy and compliance with ICD and CPT guidelines.
- Overlapping Provider Resolution: Address and resolve issues related to overlapping providers, coordinating with clinical and billing teams as necessary.
- Appeal Submission: Prepare and submit appeals for denied claims, including compiling supporting documentation and tracking outcomes.
- EVV Oversight: Oversee Electronic Visit Verification (EVV) processes, ensuring all visits are accurately documented and compliant with state and federal requirements.
- EVV Troubleshooting: Troubleshoot EVV issues, including resolving discrepancies, assisting staff with EVV system usage, and communicating with EVV vendors as needed.

- Credentialing Management: Manage credentialing processes for new insurance payers, including application submission, tracking status, responding to requests for information, and maintaining documentation.
- Insurance Network Expansion: Research and identify new insurance opportunities, initiate and facilitate credentialing and contracting processes to expand agency payer network.
- Regulatory & Payer Knowledge: Maintain up-to-date knowledge of payer requirements, regulatory changes, and industry best practices.
- Staff Support & Guidance: Provide support and guidance to staff regarding billing, coding, documentation standards, EVV compliance, and credentialing procedures.
- Recordkeeping: Maintain accurate records and documentation for all responsibilities in accordance with agency policy and regulatory requirements.
- Leadership Communication: Communicate regularly with agency leadership regarding status of billing, compliance, credentialing, and EVV activities.
- Billing Reporting: Prepare and deliver weekly reports to management detailing billing amounts processed in the current and prior weeks.
- Claim Escalation: Escalate claims with unresolved issues to appropriate internal or external parties, and provide status updates on escalated claims.
- Notice of Admission (NOA) Tracking: Monitor and ensure the timely submission of the Notice of Admission (NOA) to CMS within the required regulatory timeframe to prevent reimbursement penalties
- Perform other duties and administrative tasks as assigned

Qualifications

- 2–3 years of experience in **medical billing, healthcare revenue cycle management, claims processing, or related healthcare administration**.
- Experience with **home health billing**, including Medicare, Medicaid, and commercial insurance claims.
- Hands-on experience with **WellSky**.
- Strong knowledge of **pre-bill review, claims processing, denial management, and appeals**.
- Experience with **EVV (Electronic Visit Verification)** compliance, including reviewing and resolving visit discrepancies.
- Knowledge of **medical coding**, including ICD and CPT guidelines.
- Experience handling **prior authorizations, referrals, consent forms, and billing documentation**.
- Knowledge of payer requirements and healthcare billing compliance.
- Strong attention to detail and ability to identify billing and documentation errors before claim submission.
- Strong organizational, analytical, and communication skills.
- Ability to handle PHI and maintain **HIPAA compliance and confidentiality**.