# Dr. Assal Yousif

**Healthcare Management**

***PERSONAL DETAILS***

*Nationality: American*
*Date of Birth: 11.24.1986*
*Marital Status: Married*

***Languages***

English: *Native*

Arabic: *Working Professional*


*00971559130528*

*assal.yousif.ay@gmail.com*

*United Arab Emirates*

*www.linkedin.com/in/dr-assal-y-59695099*


## SKILLS

- Presentation and Training
- Pricing and contracting
- PBM Automation
- Medical Coding and Adjudication
- Data analysis

## ADDITIONAL SKILLS

Excellent interpersonal and negotiation skills

Medical underwriting and risk assessment experience

Project Management

Leadership and Team Work

Knowledge of regulator regulations

Customer Service Patient Relations case management

## ABOUT ME

*Skilled and experienced healthcare professional. Specializing in financial analysis, healthcare pricing, network management and healthcare economics. Also, provider payment methodologies and healthcare products.*

*My years 8+ of experience in Revenue Cycle Management, Medical Operations and Network Departments has provided me well rounded background in the healthcare industry.*

## *E X P E R I E N C E*

**PROVIDER/HEALTHCARE RELATIONS MANAGER**

AXA-GULF

Abu Dhabi, UAE — October 2017-to Date

Primary:

- Developing Medical Provider Relations and building relations with key stakeholders in medical providers.
- Development and implementation of the Access strategic plan to meet customer and patient needs with product sales team
- Development of strategy, programs and collateral to support education of physicians/hospitals/practices on matters related to reimbursement and market access
- Training and Onboarding of New providers
- Wellness Programs Project Management
- Developing Provider Networks to meet customer and business needs through expert knowledge of market providers.
- Perform data analysis and utilize financial acumen to identify opportunities to leverage scale and drive cost savings.

Secondary

- Negotiates commercially beneficial terms for AXA with Providers.
- Assist and help in medical complex cases to ensure proper medical case management for the insured members and negotiates discounts on same.
- Implement procurement strategic action plans and communicate identified issues for agreement on resolution actions.
- Conducts Provider Quality and suitability assessments for Network Inclusion/Exclusion or Network categorization changes
- Implement Investigations and Audit strategic action plans supporting FWA activity
- Monitors provider billing and utilization behaviors to identify opportunities for improvements to clinical practice and billing
- Reviews existing contract terms to identify areas for improvement on commercial terms and operational efficiency
- Supports reconciliation activity.
- Ensures compliance with legal and regulatory requirements, represents AXA as required with external regulatory/ Health organizations.
- Enhancing customer experience as part of AXA Strategy 'Payer to Partner'.
- Provide guidance and expert medical direction to the medical claim's teams, insurance departments of the medical providers.
- Review final draft for clinical governance and approval adjudication
- Representing AXA effectively both in front of providers as well as customer
- PMB automation support

**ASSISTANT MANAGER-ONSITE OPERATIONS**

ACCUMED (ABU DHABI POLICE CLINIC AND AMBULANCE AND PUBLIC SAFTEY)

Abu Dhabi, UAE — 2016-Oct. 2017

Primary responsibilities

- Promotes a culture of continuous improvement through use of Lean methodology, coaching, tools, data analysis, reliability, sustainability and spread. Manages and supports a portfolio of strategic projects using the performance improvement mode. Ensures all performance improvement activities are in compliance with regulatory and accreditation bodies.
- Assumed complete responsibility for management of the clinic and organization and oversight of all personnel charged with operations.
- Established necessary departments and conducted meetings with department heads to ensure effective leadership
- Improved customer service
- Enhanced the quality of care provided to residents and families
- Nurtured and educated existing staff in efforts to improve care provided
- monitoring all key performance measures for provider
- providing operational support to services teams
- ensuring follow up of provider billing policies and procedures
- complete monthly assessment of overall provider standing and provide its analysis and create an action plans based on findings.
- provide support to their teams regarding any escalations related to RCM s and provide resolution plan and follow up support when required,
- set the expectations for team relationships and milestones.
- Handling onsite operations in terms of planning, overseeing deliverables and staff management and acting as the client key designated point of contact for any complaints of delivery related issues
- Ensuring high quality customer service is provided at all items
- Address staff defaults through Performance Improvement Planning

- Ensure that the monthly clients claim submission cycles are timely and to highest regulator and payer compliance and quality of claim processing as per agreed service agreement levels and key performance indicators.
- Audit the claims processed by the team and provide proper feedback and guidance to the team members.
- Educate and advise Claims Units on proper coding standards and billing rules, documentation, procedures, and requirements
- Develops and updates procedures manuals to maintain standards for correct coding, minimize the risk of incorrect billing/coding, and optimize revenue
- Ensure to justify with documents and billing rules the stand formulated on coding related disputes with Payer
- Review and negotiate provider contracts
- Handle final reconciliation negotiations

**SUPERVISOR-MEDICAL CLAIMS**

ACCUMED (ABU DHABI POLICE CLINIC AND AMBULANCE AND PUBLIC SAFTEY)

Abu Dhabi, UAE — 2015-to 2016

Primary Responsibilities:

- Ensure that the monthly clients claim submission cycles are timely and to highest regulator and payer compliance and quality of claim processing as per agreed service agreement levels and key performance indicators.

- Lead a medical team of 13, who are responsible for data entry, coding, medical review and pharmacy claims.
- Plan the work schedule & assign appropriate shifts to the staff. Ensure the correct staffing levels are met for each shift.
- Record the team members' productivity & attendance and report it back to direct manger & HR.
- Provide a daily report to the direct manger on the offsite unit's process progression.
- Assist the team members by answering their queries and be able to report back to the direct manger any urgent issues that could affect the process.
- Be able to process and investigate high value claims and to make any necessary correction when needed.
- Ensure that while performing the medical evaluation of the claim files to have the medical ethics respected at all times.
- Responsible for new joiners training and assistance.
- Audit the claims processed by the team and provide proper feedback and guidance to the team members.
- Audit the pending queries raised by the team and provide proper feedback to the team members and to others departments to assure the improvement of the clients claim submission.
- Secondary Responsibilities:
- Be able to communicate with the other departments within the company in very professional manner.
- Conduct meetings and provide training sessions to our clients based on management decision.
- Ensure that internal and external communication requirements are being adhered to in a timely and professional manner.
- Conduct meetings with health insurance companies and health regulators and to attend any necessary training based on the business need.
- Support the other units within the operations department (coding and data entry) based on the business need, especially during submissions (end of the month).
- To support the management's decisions for any new changes that may occur at the company.
- Implement policies & procedures based on the company's rules all the time.
- Ensure that business decisions and processes are documented in a professional way.
- Travel within UAE as and when required as per the business need.
- Ensure that high quality customer service is provided at all times.
- Other related tasks assigned by the line manager.

**Accomplishments:**

- Reduced rejection Rate from 37% to 13%
- Received token of Appreciation for Abu Dhabi Police Clinic for outstanding performance
- HAAD audit results 96.8%
- Created Client Specific Manuals and SOP

**OFFICER –AUTHORIZATION AND CASE MANAGEMENT**

DAMAN

Abu Dhabi, UAE — 2013-2015

Primary Responsibilities:

- Evaluate the medical need for the requested services both locally and internationally, according to my medical knowledge, accepted medical coding rules, medical guidelines and the policy schedule of benefits.
- responsible for receiving, evaluating and escalating second opinion cases and case management
- Report suspected cases of fraud or abuse of the healthcare providers to the MIAD department.

- Answer calls/emails for re-evaluation of medical cases and reply to issues any provider may have and try and resolve them to my best capacity.
- Evaluates medical necessity and correlates consistencies in the diagnosis, procedure and drug codes/descriptions stated on the paper claims, according to accepted medical coding rules and adjudication rules with focus on IP claims.
- Assists supervisor in auditing of paper claims for correctness of processing and completeness of batch.
- Reports suspected fraud and abuse claims of a provider to superiors.

**CASE MANGER**

PILOT POSITION (6 MONTHS HEALTH POINT HOSPITAL)

**DAMAN**

Primary Responsibilities:

- Case managers onsite navigate the patient's healthcare needs seeking better quality, efficiency and resources management while monitoring the delivery of care.
- Review, evaluate and monitor the process of care delivery;
- Coordinate the delivery of services according to the medical condition and the clinical pathway.
- Enhance the communication between Daman and providers by timely intervene and ease of accessibility;
- Eliminate task and intervention duplication;
- Share Daman's guidelines in approving /rejecting medical services with the providers to incorporate adherence to guidelines and other standardized practice tools.
- Review of services to ensure that they are medically necessary, provided in the most appropriate care setting, as per quality standard
- Track the inpatient admissions to determine that each day of the hospital stay is necessary and that care is being rendered at the appropriate level
- Review medical records after the patient's discharge to track appropriateness of care and to manage the utilization.
- Verify eligibility- Check that the patient is covered under the health plan before rendering medical services.
- Regularly report the impact of CM activities
- Function as a facilitator and coordinator of member care and services.
- Identify areas to enhance integration of processes between Daman and providers
- Cover/reject health care services rendered/planned for insured members as per the patient's schedule of benefits.
- Be thorough with medical audit operational procedures, Insurance Policies, Regulator guidelines and Insurance Policy on fraud and Abuse and monitor their adherence so that work is carried out in a controlled manner
- Educate and advise Claims Units on proper coding standards and billing rules, documentation, procedures, and requirements
- Develops and updates procedures manuals to maintain standards for correct coding, minimize the risk of fraud and abuse, and optimize revenue recovery
- Carryout day-to-day operations of Onsite Audit of Paid Claims to detect misuse/abuse/fraud and ensure that work processes are implemented as designed and comply with established standards and procedures and desired recoveries/ results are achieved
- Be thorough with medical audit operational procedures, Insurance Policies, Regulator guidelines and Insurance Policy on fraud and Abuse and monitor their adherence so that work is carried out in a controlled manner

**MEDICAL OFFICER**

2011- 2013

- Maintained record of all underwriting data as per the required underwriting systems.
- Monitored customer visits and evaluated all financial statements.
- Maintained knowledge of all recent events and trends within the underwritten industry.
- Collected all information from clients and calculated risk for all individual policy.
- Evaluated policy applications as per medical report and age.
- Collected information from various specialists and prepared appropriate reports.
- Gathered information for insurance products and assessed risk involved.
- Calculated premium for customers through analyzing all actuarial information.
- Monitored all applications and approved and disapproved applications after performing risk assessment.
- Developed and maintained professional relationship with call center teams.

## *E D U C A T I O N A L  B A C K G R O U N D*

**MBBS- Bachelor of Medicine, Bachelor of Surgery**

KCM — 2005-2011

**CPHQ course 2019**

National Association for Healthcare Quality

**SAS** Management Consultancy

Daman— 2014

References Upon Request