ELEMENT CARE

TITLE: Utilization Review RN Manager **EFFECTIVE:** May 20, 2019

JOB FUNCTION: Medical **FLSA STATUS:** Exempt

GENERAL SUMMARY:

Incumbent reviews and analyzes information to make medical determination. Applies clinical knowledge to assess the medical necessity, level of services and/or appropriateness of care in cases requiring prospective, concurrent or retrospective utilization review. Reviews proposed hospitalization, home care and inpatient/outpatient treatment plans for medical necessity and efficiency in accordance with contract rules and organizational guidelines, policies, practices and procedures to facilitate quality and cost effective care. Coordinates with physicians, evaluates care plans and discharge plans, monitors clinical activities, identifies alternative levels of care when requested is not covered, identifies cost effective protocols and develops guidelines for coverage of benefits.

Essential Responsibilities:

- Utilizes established criteria to authorize inpatient admissions, diagnostic testing and ambulatory services.
- Communicates determinations to appropriate department.
- Monitors inpatient care.
- Coordinates, directs and performs concurrent and retrospective reviews.
- Coordinates an interdisciplinary approach to support continuity of care.
- Consults with physicians, health care providers and outside agencies regarding continued care/treatment or hospitalization.
- Identifies and recommends opportunities for cost savings and improving the quality of care across the continuum. Develops and collects data, and trends utilization of health care resources.
- Actively participates in the discussion and notification processes that result from the medical record reviews. Prepares notification letters of denied and negotiated days within the established time frames.
- Assists in the identification and reporting of potential quality improvement issues. Responsible for assuring these issues are reported to the Quality Improvement Department.
- Performs other duties as assigned.

Job Specification:

- Current Licensure as a Registered Nurse in the Commonwealth of Massachusetts.
- Minimum 5 years managed care or health plan experience.
- Minimum 5 years experience negotiating provider contracts.
- Minimum 3 years experience ensuring compliance with adjudication payment rules and coding guidelines.
- Previous case management experience preferred.
- Demonstrated experience in utilization management, discharge planning or transfer coordination.
- Exemplary clinical documentation skills; critical thinking skills; data analytics.
- Must be able to demonstrate computer proficiency skills and work independently as a self- starter in a fast paced production and metrics driven environment.
- Detail oriented and highly organized.
- Clinical utilization decision making software experience preferred.