

Job Title: Utilization Review Specialist
Requisition Number: JO-1508-3129
Grade: 12
Salary Range: \$71,716.00 - \$91,750.00
Promotion Potential: No
Agency: Dept of Health Care Finance
Location: 441 4th St NW (One Judiciary Square)
Area of Consideration: Open to the Public
Opening/Closing Date: 8/13/2015 - 8/27/2015

Job Summary

This position is located in the Department of Health Care Finance (DHCF), Office of Senior Deputy/Medicaid Director, Division of Program Integrity. The position organizes, implements, and evaluates health care utilization review and utilization control activities intended to ensure proper payment procedures and to prevent and detect abuse and possible fraud by persons who provide and receive services financed by DHCF.

Conducts and reviews audits of independent providers to identify incorrect utilization and billing practices. Prepares tracks and reviews recoveries of provider payments. Identifies areas at high risk of misutilization, underutilization and over utilization of DHCF financed programs.

Conducts utilization review of Medicaid claims data and performs utilization review activities, such as prior authorizations and medical necessity. Selects audit samples, prepares audit criteria and coordinates audit activities with other team members to ensure audit timeliness.

Develops and prepares audit analysis and deficiencies reports as well as complies supporting documentation. Identifies the need for and develops and implements methods to modify or create analysis criteria to identify and/or quantify provider and recipient abuse, mis-utilization or overutilization of health care services.

Develops recommendation or intervention strategies to correct or prevent abusive practices, including proposals to recover inappropriately paid moneys or to suspend or terminate program participation. Assists with the reviewing and analyzing program utilization data and/or medical documentation (i.e. patient charts and evaluate services provided or received to assess compliance with DHCF program policies, standards and appropriateness of services and/or medical necessity.

Conducts on-site inspections, interviews providers and recipients; reviews requests to determine appropriateness of authorization of services and/or payments for various health care services delivered based on medical necessity and appropriateness of services and coverage guidelines.

Coordinates utilization management activities with DHCF program areas (i.e. long term care programs,etc) . Drafts procedures to accommodate changes in systems and program policy. Assist in proposing changes to the Medicaid Management Information System (MMIS) to correct errors, provide effective monitoring and maintain appropriate reimbursements through updating computerized files.

Drafts payment demand letters in accordance with policy guidelines; initiates and tracks recoupment actions for all provider recoupments. Remains abreast of all rules and laws applicable to DHCF financed health care programs. Reviews training material based on audit deficiencies to educate providers on policies and procedures.

Participates in provider education activities directed at improving the quality of health care provided to recipients and/or program integrity issues.

Performs other duties as assigned.

Collective Bargaining Unit: This position is in the collective bargaining unit represented by AFSCME 2401 and may require a union fee through payroll deduction.

Promotion Potential: None

Duration of Appointment: Career Service (Permanent)

Tour of Duty: Monday - Friday 8:15 am - 4:45 pm

Qualifications

Skill in evaluating and applying health care utilization management principles, methods and tools, including: health services research; multiple data analysis methods to detect over-, under-, and mis-utilization of services by beneficiaries and providers; application of computer-based algorithms to detect health care fraud, waste and abuse; multiple coding sets used in standard health care administrative data sets; and the development and implementation of fraud and abuse detection techniques;.

Knowledge of medical terminology, procedural and diagnoses coding systems and claim submission procedures. Knowledge of health care billing standards and procedures. Knowledge of statistics and quantitative analysis methods to analyze health services utilization data. Knowledge of the office's mission, goals, programs, and administrative and operating procedures.

Skill in exercising tact, discretion and skill in dealing with persons at various grade levels and job categories. Skill in analyzing problems, interpreting guidelines and choosing between alternative selecting appropriate solutions.

Skill in communicating effectively, both in writing and orally to ensure accurate and timely completion of all support staff assignments. Skill in composing correspondence requiring broad knowledge of administrative procedures and practices. Knowledge of correspondence management processes in order to ensure the appropriate execution of all correspondence pertaining to office operations and activities.

Knowledge of principles, concepts, and technique related to the planning, organization and implementation office management systems to maintain the orderly flow of work in the office. Skill in establishing and maintaining effective relationships with co-workers, supervisors, and representatives of activities studied to resolve routine problems and provide advice and assistance on routine matters.

Licensure, Certifications and other requirements

None

Education

Bachelor's Degree or an equivalent combination of education and experience is preferred

Work Experience

3 years or more of experience preferred

OR

To be creditable, at least one (1) year of specialized experience must have been equivalent to at least the next lower grade level in the normal line of progression for the occupation in the organization.

Work Environment

Office work is performed in an adequately lighted heated and ventilated office environment. On site beneficiary and provider investigation work is performed in the homes of health care beneficiary and may involve visits to the offices of health care providers