UMUR Lead

Job Code: UMURLD - 124
Revision Date: Dec 21, 2018

Salary Range:
$30.01 - $49.10 Hourly
$2,400.80 - $3,928.00 Biweekly
$62,429.00 - $102,128.00 Annually

FLSA: Exempt

Overview

We are an agency committed to innovative behavioral health services in trauma-informed care that promote healing and recovery to instill a sense of empowerment and foster a lifelong sense of resilience.

General Description

Under the direction of the Director of Clinical Services, the Lead UMUR is responsible for the coordination, implementation, evolution, and oversight of the Utilization Managers. The Utilization Management program includes Prior Authorization, Utilization and Concurrent Review. The Utilization Management program collaborates with the Medicaid Managed Care companies, Medicare Advantage, and other third party insurance companies and their providers. The role of the Lead UM Manager is to promote the clinical quality and cost effectiveness of prior authorization and concurrent review functions. The Lead UM Manager is the responsible for the evaluation of the appropriateness services and ensuring medical necessity is warranted. The Lead UM Manager facilitates according to evidence-based criteria or guidelines, and under the provisions for the applicable health plan. The Lead UM Manager addresses new clinical activities or inpatient admissions based on the analysis of a case, but may relate to ongoing provision of care, especially in an inpatient setting.
UM describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews if necessary, as well as appeals introduced by the provider, payer or patient.

This class works independently, under limited supervision, reporting major activities through periodic meetings.

Duties and Responsibilities

The functions listed below are those that represent the majority of the time spent working in this position. Management may assign additional functions related to the type of work of the position as necessary.

- Conducts reviews using clinical information submitted by providers, direct contact with providers, review of medical persons with a serious mental illness

- Manages the Adverse Determination/Medicaid Fair Hearing processes per outlined policy and procedure;
- May conduct retrospective reviews and review of data to detect outliers;
- May conduct utilization review and grant authorization decisions limited to continued stays, including overrides and add-on services, for individuals who are already receiving authorized services from EHN when the request is complete, accurate, and clearly falls within the DSHS UM Guidelines. Any requests for authorization that do not clearly meet the guidelines must be fully reviewed by the Utilization Manager;
- Utilizes UNIFORM ASSESSMENT review form to authorize uniform assessments;
- Submit authorization reports (overrides, 60 day authorizations, underutilized, MFH, service utilization, monthly authorized uniform assessment count ….) as requested;
- Utilizes the Uniform Assessment Guidelines, Utilization Management Inpatient Admission Program and Plan for 3rd Party Payers
- Maintain continuous communication with all EHN departments regarding assessments
- Participates in provider training on the UM process, monitors provider adherence to UM Guidelines and provides consultation when needed
- Reviews data to detect outliers and unusual patterns of utilization and recommends interventions
- Administers Behavioral Health benefits by performing precertification and concurrent reviews for inpatient hospitalization if applicable
- Work with the LMHA, managed care plans, or third party payers
- Manage utilization data, ensure clinical documentation is provided for continued stay reviews, activities are non-duplicative and utilization related data is being received, collected, and summarized
- Attend treatment team meetings (as needed) to ensure criteria for admissions, continued stay, and discharges are met and make appropriate decisions regarding treatment
- Provide to Hospital UM Staff written notification of all requests for action, such notifications would include approval of acute initial/admission bed days, continuing bed days, sub-acute bed days, third payer follow-up, and any requests for transfer to another hospital and request for discharge from hospital
- Perform scheduled reviews to achieve continuum of medical necessity based on identified needs and goals
- Appeal to the 3rd Party Payers regarding continued stays, and/or discharges requiring sufficient justification
- Request from the hospital a level of care determination, continued stay review, and/or discharge information when EHN patient admitted
- Coordination of doctor to doctor and/or peer reviews and communicate outcomes of review to designated parties
- Track and monitor 3rd party payer reimbursements to hospital
- Ensure LMHA's hospital allocation is appropriate and reconciled with third party payer reimbursement
- Communicate to hospital 3rd party insurance coverage
- Employee shall maintain compliance with all Joint Commission training requirements relevant to job duties, including but not limited to those dealing with use of restraints and physical holding of individuals receiving services.
- Performs other duties as assigned.

Minimum Education and Experience Requirements

Master's degree in behavioral health from an accredited university Minimum qualifications as defined in the current DSHS Mental Health Community Services Standards and has at least 5 years clinically appropriate experience in treatment of persons with mental illness and chemical dependency. Experience in a commercial setting in a UMUR role is required. One of the following RN, RN-APN, PA, PhD psychologist, LCSW (LMSW-ACP), LMFT LPC or LMSW-ACP.

Experience with trauma-informed services; cognitive behavioral therapies, including DBT; and motivational therapies including the use of incentives, preferred.

Required Knowledge and Abilities

Knowledge of trauma-informed theories, principals, and practices (includes multi-faceted understanding of concepts such as community trauma, intergenerational and historical trauma, parallel processes, and universal precautions), preferred.

Physical Demands

Performs sedentary work that involves walking or standing some of the time and involves exerting up to 10 pounds of force on a regular and recurring basis or sustained keyboard operations.

Unavoidable Hazards (Work Environment)

- None

Special Certifications and Licenses

- Must possess and maintain a valid state Driver's License with an acceptable driving record.
- Must be able to pass a TB, criminal background and drug screen.
- Possess and maintain recognized current certification, or complete specialized training to ensure up-to-date knowledge of job related skills and technology.

Americans with Disabilities Act Compliance

Emergence Health Network is an Equal Opportunity Employer. ADA requires Emergence Health Network to provide reasonable accommodations to qualified persons with disabilities. Prospective and current employees are encouraged to discuss ADA accommodations with management.

Other Job Characteristics

- Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.
- Credentialed, certified, and licensed professionals with adequate training in person-centered, family centered, trauma informed, culturally-competent and recovery-oriented care.

Note: This Class Description does not constitute an employment agreement between the Emergence Health Network and an employee and is subject to change by the Emergence Health Network as its needs change.