UTILIZATION REVIEW NURSE I

Definition

Under supervision, to provide and implement a hospital utilization review and discharge planning program; and to do related work as required.

Distinguishing Characteristics

Positions in this classification are assigned to the Utilization Review division of Kern Medical Center. Incumbents perform clinically oriented medical chart reviews and other administrative tasks to meet the requirements of the medical center's utilization review plan, state and federal regulations, insurance company requirements for reimbursement and facility accreditation standards. Utilization Review Nurse I represents the entrance level for administrative tasks concerning Utilization Review and Discharge planning activities. Incumbents are expected to apply knowledge gained in clinical practice to patient care situations which may be affected by regulatory constraints. The Utilization Review Nurse I level is expected to gain full working knowledge of applicable regulations and to develop knowledge of outside agencies and services to develop appropriate discharge plans. Promotion to the fully experienced level of Utilization Review Nurse II is based on recommendation of the Chief Executive Officer and approval of the Director of Personnel.

Essential Functions

• Obtains and evaluates medical records for in-patient admissions to determine if required documentation is present.
• Obtains appropriate records as required by payor agencies and initiates Physician Advisories as necessary for unwarranted admissions.
• Conducts on-going reviews and discusses care changes with attending physicians and others.
• Formulates and documents discharge plans.
• Provides on-going consultation and coordination with multiple services within the hospital to ensure efficient use of hospital resources
• Identifies pay source problems and provides intervention for appropriate referrals
• Coordinates with admitting office to avoid inappropriate admissions.
• Coordinates with clinic areas in scheduling specialized tests with other health care providers, assessing pay source and authorizing payment under Medically Indigent Adult program as necessary.
• Reviews and approves surgery schedule to ensure elective procedures are authorized.
• Coordinates with correctional facilities to determine appropriate use of elective procedures, durable medical goods and other services.
• Answer questions from providers regarding reimbursement, prior authorization and other documentation requirements.
Essential Functions (continued)

- Learns the documentation requirements of payor sources to maximize reimbursement to the hospital
- Keeps informed of patient disease processes and treatment modalities.

Other Functions: Performs other job related duties as required.

Employment Standards

Possession of a valid license as a Registered Nurse in the State of California AND two (2) years of experience or its equivalent as a registered nurse in an acute care hospital, at least one (1) of which was on a medical/surgical ward or unit.

OR

Possession of a valid license as a Registered Nurse in the State of California And two (2) years of experience as a Case Manager in an alternate medical setting such as a clinic or physicians office performing utilization or discharge planning.

Incumbents may be required to possess and maintain specific certificates competency based on unit specific requirements as a condition of employment.

Possession and maintenance of a current American Heart Association Healthcare Provider Basic Life Support (BLS) card. Appointees not possessing the BLS card must successfully complete appropriate training and qualify for the BLS card within 60 days of employment.

Knowledge of payor source documentation requirements and governmental regulations affecting reimbursement; knowledge of acute care nursing principles, methods and commonly used procedures; knowledge of common patient disease processes and the usual methods for treating them; knowledge of medical terminology, hospital routine and commonly used equipment; knowledge of acute hospital organization and the interrelationships of various clinical and diagnostic services; ability to effectively evaluate the medical records of hospital admissions regarding continuing stay necessity, appropriateness of setting, delivered care, use of ancillary services and discharge plans; ability to assess and judge the clinical performance of physicians and other health professionals; ability to communicate documentation needs in an effective and tactful manner that promotes cooperation; ability to gather and analyze data and prepare reports and recommendations based thereon; ability to get along with physicians, other health providers, outside payor sources and the general public.

Revised
October 2006
#2051
JS2051