**FLSA: COVERED**
**EEO: 2**
**FEBRUARY 2023**

# UTILIZATION & QUALITY MANAGEMENT COORDINATOR I/II

## DEFINITION

Under direction of the Department Director or Department Leadership, plans, coordinates, and performs the utilization and quality management functions in the County-operated outpatient, crisis intervention, and case management services; and, in contracted facilities. This includes utilization review, quality assurance, performance improvement, and related training activities. The Coordinator audits medical records to determine eligibility for services, medical necessity, and Medi-Cal compliance; ensures optimal reimbursement from Medicare, Medi-Cal, and other payors of these services; conducts quality improvement studies; provides narrative and statistical analyses of audits; orients and trains clinical staff on documentation requirements and/or arranges for appropriate instruction; and, performs related duties as assigned.

## DISTINGUISHING CHARACTERISTICS

The incumbent reports to the Director, Behavioral Health Department, and works in partnership with the Clinical Program Manager, SUD Program Manager, Clinical Services, the Medical Director, and the Compliance Officer in auditing clinical activities. This position can provide clinical services and is responsible for objectively auditing the clinical work done in the Department and reporting the results of the audits to the Director. The incumbent is also responsible for the quality management activities, which encompasses all functions in the Department's operations.

## REPORTS TO

Compliance Officer and/or Behavioral Health Director.

## CLASSIFICATIONS SUPERVISED

May exercise lead technical and clinical supervision over staff.

## EXAMPLES OF DUTIES

*The following are the duties performed by employees in this classification. However, employees may perform other related duties at an equivalent level. Each individual in the classification does not necessarily perform all the duties listed.*

- Conducts quality reviews in certain Department operations on an on-going basis; documents findings in written reports to department director and managers; follows-up to ensure all recommendations from audits are addressed; provides or arranges technical assistance to staff as needed to ensure corrections.
- Reviews assessments, treatment plans, medication profiles, discharge charts, and daily visit notes on a daily basis to verify eligibility for services, medical necessity, and appropriateness of level of care; coordinates determination of level of care changes with Program Manager of Clinical Services, the attending psychiatrist, BHC nurse or Medical Assistant, and/or Utilization Review Committee.
- Orients all new clinical staff on documentation requirements for all payors and programs; monitors initial documentation skills of new clinical staff; provides related assistance and guidance as required. Provides specific training to ensure that all staff record clinical, financial, and administrative information in accordance with state and Federal regulations, and program guidelines.
- Ensures that clinical staff is completing all admission paperwork and recertification paperwork according to guidelines; initiates corrective action for discrepancies in documentation.
- Reviews all Treatment Authorization Requests (TAR) for appropriateness of level of care and plans for lengths of stay. Issues appropriate letters of denial of admission or continued stay after consultation with attending physician and/or Utilization Review Committee chairperson.
- Facilitates and leads the Utilization Review Committee and the Quality Assurance Committee process by organizing the meetings, preparing the agenda, submitting audit reports, and recording the minutes of the meetings.
- Acts as liaison to regulatory agencies and payors on clarification of procedures and application of regulations; prepares medical justification documents to submit reimbursement claims for services provided to patients.
- Performs Continuous Quality Improvement (CQI) studies; identifies and investigates problem areas; selects, initiates, and monitors follow-up actions for problem resolution; analyzes related statistical information and prepares required reports.
- Develops and implements necessary policy and procedures to conform to current criteria from regulatory agencies and accrediting bodies.
- Monitors new standards and regulations affecting hospital and home health care; determines need for new or modified policies and procedures.
- Collaborates with the appropriate Behavioral Health staff to ensure the maintenance of an accurate data collection system.
- Participates in and coordinates committee work as directed or appropriate.
- Manages or assists with special projects and programs as directed.

- Maintains professional certifications and attends training, workshops, seminars, etc., as appropriate or directed.
- Performs related work as required, including preparing reports and correspondence, entering computer data, copying and filing documents, attending meetings, answering the telephone, ordering supplies, etc.
- ***LEVEL II*** – Provides clinical supervision, both group and individual to unlicensed staff as directed.
- ***LEVEL II*** – Provides and/or oversees training for new direct service staff.

## ESSENTIAL QUALIFICATIONS

### Knowledge of:

- Psychiatric and medical terminology, hospital and residential care programming, psychiatric diagnosis, and fee structuring standards.
- Federal and State regulations for Medicare, Medi-Cal, and private insurance requirements.
- Principles and techniques for obtaining optimal reimbursement.
- Assessment, treatment planning, and level of care standards.
- Principles, procedures, issues, and trends in mental health and alcohol and drug treatment.
- The laws, rules, and regulations related to the provision of alcohol and drug and mental health services.
- Application of quality assurance measurement.
- Governmental and voluntary standards, requirements and guidelines for quality assurance and utilization review.
- Data collection and basic statistical methods.
- Performance improvement methodology, including criteria development and data analysis techniques.
- Methods of medical case recording and report preparation.
- English usage, spelling, grammar and punctuation; basic mathematics.
- Modern office procedures, practices, and technology.

### Ability to:

- Interpret, apply, and explain Federal and State laws, rules, and regulations governing behavioral health programs and services.
- Reviewing and analyzing complex regulatory information and reaching sound conclusions.
- Assessing medical necessity of services provided.
- Monitor patient care plans and treatment documentation for congruency of orders and appropriateness of care.
- Maintain the confidentiality of administrative, personnel, and clinical information.

- Deal tactfully, respectfully, and courteously with the public and other County staff.
- Identify, research, analyze and recommend solutions to a variety of hospital and out- patient care administrative problems related to quality assurance/utilization review.
- Ensure accurate and complete documentation of all patient care and treatment.
- Establish and maintain cooperative working relationships.
- Exercise sound, independent judgment.
- Effectively communicate verbally and in writing.
- Effectively represent Amador County Behavioral Health Department services with the public and community organizations.

## TYPICAL PHYSICAL REQUIREMENTS

Ability to sit for extended periods; frequently stand and walk; normal manual dexterity and eye-hand coordination; lift and move object weighing up to 25 pounds; corrected hearing and vision to normal range; verbal communication; use of office equipment including computers, telephones, calculators, copiers, and FAX.

## TYPICAL WORKING CONDITIONS

Work is usually performed in an office environment; continuous contact with staff and the public.

## TRAINING AND EXPERIENCE

*Any combination of training which would likely provide the required knowledge and experience is qualifying. A typical way to obtain the required knowledge and abilities would be:*

### *Utilization & Quality Management Coordinator I:*

### Education

Graduation form an accredited college or university with a minimum of a Bachelor's degree in nursing, psychology, social work, marriage and family-counseling, or other behavioral science field;

**AND**

**Experience**

Three (3) years of professional experience in your field of practice with at least one (1) year at a journeyman level in utilization review and/or quality assurance work.

**Licenses:**

Preferred Registered or Licensed in California in your field of practice.

***Utilization & Quality Management Coordinator II:***

**Education**

Graduation from an accredited college or university with a minimum of a Master's degree in nursing, psychology, social work, or marriage and family counseling;

**AND**

**Experience**

Three (3) years of professional experience in your field of practice with at least one (1) year at a journeyman level in utilization review and/or quality assurance work.

**Licenses:**

Registered or Licensed in California in your field of practice and be a Licensed Clinical Social Worker for a minimum of two (2) years.

**SPECIAL REQUIREMENTS**

Possession of a valid California Driver's License issued by the State of California Department of Motor Vehicles.