Non-Union Exempt Position Summary

		JOB CODE:	2
POSITION TITLE:	Utilization Management Coordinator	**DATE:**	March 2021
DIVISIONS:	Operations		
REPORTS DIRECTLY TO:	Senior Director of Clinical Operations		

ORGANIZATION AND POSITION PURPOSE:

Fulcrum Health is a physical benefit management organization, performing delegated administrative functions for its' clients; including credentialing, utilization management (UM), claims processing, and care coordination in support of delivering high-quality practitioner networks to our customers. These functions are supported by an infrastructure of third-party vendor SaaS applications, an internal Enterprise Data Warehouse, and third-party administrator (TPA) claims services integrated with multiple customers' claims processing and other business systems.

The UM Coordinator:

- Supports the day-to-day utilization management process, telephonic and written communication with providers about the UM process, supports the medical necessity audit process and adheres to UM regulatory and NCQA requirements.
- Participates in business and technology implementations as Fulcrum onboards new customers, expands our provider networks, and enhances our business processes and technology solutions, coordinating cross-functionally with internal teams.
- Identifies improvement opportunities within the UM process, conducts issue remediation and resolution with providers, system and across cross functional teams.
- Engages with other stakeholders and functional areas to facilitate provider communication and understanding of the UM Program.
- Supports application enhancements and system releases, by defining business requirements and conducting testing.
- Develops and maintains procedures for internal staff and network providers.

ACCOUNTABILITIES:

- Ensures compliance to organizational and departmental policies and procedures.
- Ensures UM program development, implementation, and evaluation.
- Follow and support collaboration between internal stakeholders, ie. clinical team, coworkers, and cross functional departments.

- Facilitate transparency and open communication with providers to promote improved prior authorization and outcome submissions and increasing provider satisfaction.
- Manage a roster of utilization review cases.
- Conduct utilization review processing within regulatory requirements and turnaround times.
- Participate in development of procedures that drive operational workflows and systematic tracking.

REQUIRED QUALIFICATIONS: (*Minimum qualifications needed for this position)*

Education*:*

- Bachelor's Degree, or equivalent experience

Experience:

- Two years' experience in utilization management.
- Two (2) years' experience within a health plan strongly preferred.
- Skilled at establishing and maintaining effective interpersonal relationships with all level of leaders, chiropractors and other providers, employees and members/customers.
- Experience in working in a matrix organization with shared service models

PREFERRED QUALIFICATIONS:

- 5 years of experience working in managed care environment
- Two (2) years' experience within a health plan strongly preferred.
- Minimum 5 years of experience managing people, processes, and technology in a health care setting.

OTHER

Tools:

- Proficient in use of Prior Authorization Portals or Utilization Management Systems
- Proficient in using Microsoft office applications, Project, Word, Visio, Excel, PowerPoint, OneNote

Process Skills:

- Process development and process improvement experience

DIRECT/INDIRECT REPORTS:

Number of direct reports and titles: 0
Number of indirect reports: 0