Medical Claims Review Nurse

Only open to candidates residing in California	Opportunity to make a difference in your community	Position not eligible for sponsorship

Position overview

- Review retrospective authorization requests/claims documentation within specified timeframes.
- Review authorization requests/claims for out-of-network inpatient facilities.
- Clinically validate the medical appropriateness and coding accuracy of services rendered in an inpatient setting.
- Accurately document audit determinations within the audit tracking system by creating a rationale narrative.
- As needed, support findings during the appeals process.
- Serve as a clinical resource; provide clinical expertise and clinical guidance to the claims team.
- Work collaboratively with the audit team to identify vulnerabilities and/or cases subject to potential abuse.
- Monitor, track, and report on all work conducted.
- Review targeted claims i.e. high dollar/potential for abuse
- Refer members to care coordination and case management as the need is identified during the review process.
- Maintain collaborative and cooperative relationships with other HPSM departments.
- Utilize appropriate resources to guide review decisions and document decisions clearly and concisely.

Requirements

These are the qualifications typically needed to succeed in this position. However, you don't need to meet every requirement to apply.

Education and experience

- Five (5) years clinical nursing experience.
- Experience with utilization management retrospective review and coding methodologies within a managed care environment is preferred.
- A Bachelor's degree in nursing or a related health services field is a plus.

License and Certification

- A valid California Registered Nurse license

Knowledge of:

- Personal computers and proficiency in Microsoft Office Suite applications, including Outlook, Word, Excel, Access and PowerPoint.
- CPT, ICD-9, and DRG coding principles
- Medicare and Medi-Cal coverage requirements and regulatory guidelines.

Ability to:

- Work cooperatively with others.
- Work as part of a team and support team decisions.
- Communicate effectively, both verbally and in writing.
- Adapt to changes in requirements/priorities for daily and specialized tasks
- Ensure medical appropriateness and effective utilization of health care resources.
- Maintain timely compliance with all UM and Claims regulatory mandates.
- Ensure provider conformance to HPSM UM and Claims guidelines.
- Establish and maintain effective interpersonal relationships with all levels of staff, other programs,

agencies, and the general public.
- Communicate effectively, both verbally and in writing, with individuals from varying cultural and ethnic backgrounds.

Salary and benefits

The starting salary range depends on the candidate's work experience.

Excellent benefits package includes:

- HPSM-paid premiums for employee's medical, dental and vision coverage (employee pays 10% of each dependent's premiums)
- Fully paid life, AD&D and LTD insurance
- Retirement plan (HPSM contributes equivalent of 10% of annual compensation)
- 12 paid holidays a year, 12 paid sick days a year and paid vacation starting at 16 days a year
- Tuition reimbursement plan
- Employee wellness program

To apply, submit a resume to careers@hpsm.org.

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