

AGATE HEALTHCARE

POSITION DESCRIPTION

POSITION TITLE: Exceptional Needs Care Coordinator (ENCC) (Nurse Level III)

POSITION SUMMARY: Responsible for coordination of medical case management services for Lane OHP (LOHP) primary members. Follows Health Plan and other regulatory requirements while promoting quality, cost-effective care outcomes, ensuring appropriate implementation of quality assurance principles and Medical Management policies. Responsible for advocating and facilitating medical care access for OHP members with special needs, challenging or disruptive behaviors, mental and physical disabilities, alcohol/chemical dependencies and others who may be vulnerable, fragile, or at-risk.

PRIMARY RESPONSIBILITIES & DUTIES

1. Prepare, negotiate and implement case management interventions which are appropriate for member's medical status and contract benefits, and which are coordinated with the care activities of the PCP and other providers.
 - Identify case management needs from multiple areas, including providers, patients or support members, outside agencies, or from prospective, concurrent, or retrospective review of authorization or claims data. Establish contact with patients requesting ENCC services within one business day of request.
 - Gather and assess all available data to identify individual needs, and develop a comprehensive case management plan. Interview patients, review medical records, and research medical texts and guidelines. Assess home environment, physical, financial and psychological factors affecting recovery of functional abilities, support systems, and communication, transportation and other service needs.
 - Determines specific objectives, goals and actions designed to meet the client's needs as identified through the assessment process.
 - Implement the case management plan, including utilization and coordination of all available resources, in- and out-of-area and across a continuum of care (e.g. treating physicians, ancillary, home health and medical equipment providers, pharmaceuticals, wellness programs, hospital and rehab teams, behavioral health and chemical dependency providers, social service agencies, safety net clinics, and the member's family.)
 - Perform ongoing assessment/evaluation and appropriate and timely revisions of individual care plan in order to determine medical necessity and to assure appropriate utilization and cost-effective care. Utilize case management tools and software, ER reports, delivery data, pharmacy profiles, and input from caregivers, hospital discharge planners and social workers.
 - Evaluate outcomes by comparing treatments (length and cost) and medical improvement feedback. Determines case management plans effectiveness in reaching outcomes and goals.
 - Maintain documentation of all case management and special needs services provided and communication with appropriate parties.

2. Review denials of medical, surgical and DME services for LOHP Phase II members. Provide information as indicated that would impact the denial decision. Interface with the member and provider to coordinate alternative solutions as appropriate.

3. Coordinate activities and services for dual-eligible members with the Trillium Care Coordinator

4. Evaluate appropriate utilization of funds, including monitoring of patient's insurance benefits (limitations and exclusions), preparing cost/benefit analysis on prospective, concurrent and retrospective basis, and negotiation of the number and intensity of visits or services.
5. Interact with, report to and maintain compliance with insurers, third party administrators, and regulatory bodies such as Medicare, OMAP, CMS and other certification bodies.
6. Attend and participate in internal and external meetings for coordination of service delivery to members with special needs.
7. Provide back up for Case Manager during absences.
8. Perform other duties as assigned.

Reports To: Director of Medical Management

JOB REQUIREMENTS

Education:

Graduate of accredited school of nursing (RN) and hold current Oregon State Board of Nursing License. Certification in Case Management preferred.

Experience:

- Five years nursing experience with varied medical exposure
- Two years Case Management experience.
- Prior experience with managed care contracts preferred.
- Knowledge of diagnosis and appropriate care modalities. ICD9 & CPT codes, health insurance benefits and exclusions and state and federal mandates.
- Experience with word processing, healthcare guidelines, technology assessment tools and online information search techniques.
- Must be able to evaluate a situation and make appropriate care management decisions and work to control costs through monitoring all aspects of the patient's plan of care and disposition.
- Excellent oral and written communication skills are required.
- Must have cooperative working skills, leadership skills, and interpersonal skills.
- Must be able to demonstrate a courteous, caring and understanding attitude toward patients, families, co-workers, physicians and staff of other facilities and agencies.