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The Case Management Utilization Review Officer is responsible for in managing the High cost cases while ensuring that departmental goals, timeline of activities, and compliance measures are met.

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Responsibilities

Performing complete file review of high cost claims with regards to the multidisciplinary notes, TPR charts, physician order's notes, lab reports, radiology reports, drug chart sheets, consultation notes, nursing notes, progress notes, etc.

File Audit to be performed when required (Non- Physical or Physical (Provider Visit)) to capture hospital acquired infections, mismanagement, iatrogenic injuries, etc.

Requesting any medical documentation or finding any missing document which is essential in decision making.

Performing review of DRG Severity of Illness (SOI) in line with revision of CPT codes / ICD codes, which are being up-coded by the provider – if required discussion with the treating doctor and the medical coders.

Performing utilization review for DRG cases and FFS cases with regards to and not limited to final bill review + consumables mark ups + non covered item/services + overutilization of services.

Performing review of claims as per CPT and ICD coding guidelines in line with insurance regulators (DHA,DOH/HAAD,MOH).

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Requirement

Bachelor's of Medicine (MBBS);

3+ years medical practical experience (reputable insurance provider, broker or a TPA experience a plus).

Knowledge of overall insurance industry practices is a plus.

Legally permitted to work in the country of operations.

Physically fit to carry out duties.

Fluency in MS Office (Excel, Word, Outlook, PowerPoint) and general internet navigation and research skills.

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