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Utilization Management

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Utilization Management

A large number of American citizens have signed up on health covers whose organizations use utilization management (UM) programs. UM is a collection of systems utilized to control the costs of healthcare and ensures high levels of standards in place; insurance providers, instead of doctors, often run this process. The purpose of utilization management is to provide a consolidated procedure that ensures all patients are provided with safe and efficient medical support and care. Utilization management also mandates the following; it monitors the provision of care being provided, connects the healthcare fraternity with the patients, evaluates the gaps in the healthcare system and informs the staff about the changes of a patient's condition (Kiechle & Arcena, 2017). The utilization management usually takes place before a patient is admitted, during the admission of a patient and after the admission of a patient. The process of utilization review consists of checking if a patient is under any healthcare plan, verifying and confirming that the service requested is under the medical care plan, gathering of any information that guarantees the basis of the services are met and notifying the provider of the healthcare service about the approval of the directions. Notably, the roles of clinicians in utilization management include maintaining the patients' records, providing updates daily to the utilization manager for reviews, preparing the patient's monthly cost savings records, and following up on the discharging plans of the patient.

Structure of effective utilization management consists of prospective review, retrospective review and concurrent review. Prospective review is the study of a patient's illness and their proposed diagnosis. The purpose of this review is to put an end to duplicate prescriptions. It is only applicable during crucial and procedural referrals and always takes place before the patient's treatment. Contrarily, a retrospective review is usually done after the patient's

treatment, and the purpose of this review is to evaluate that effectiveness and timing of treatments were well delivered during the patient's illness (Smartsheet, 2020). The main objective of this review is to know which medication worked best in the patient's treatment so that it can be prescribed to patients with the same illness. Besides, the review ensures that reimbursements are fair if the procedure was never used. Finally, the concurrent review takes place when the procedure is already underway and often begins from 24 hours to 72 hours after being admitted to a health facility. The review focuses on following up on the patient's progress and the utilization of the resources. It also helps to minimize the rejection of coverage after the completion of the treatment. Notably, utilization management is essential to healthcare because it helps insurance companies and employers to control costs and guarantee that adequate and quality treatment is given to patients at an appropriate time and for the required duration. It also helps to stop treatments that are harmful to a patient.

The utilization management function that I feel I would do well is utilization nurse because I will be able to safeguard that the medical care services are applied in compliance with the rules of the organization.

References

¹ Kiechle, F. L., & Arcenas, R. C. (2017). Utilization Management in a Large Community Hospital. In *Utilization Management in the Clinical Laboratory and Other Ancillary Services* (pp. 151-170). Springer, Cham.

² Smartsheet. (2020). Utilization Management in Healthcare. Retrieved from:
<https://www.smartsheet.com/content/utilization-management>

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