COOK COUNTY HEALTH

Standard Job Description

Job Code: 8987
Grade: K-None
HCWR: N

Job Title	**Department**
Physician Advisor	Medical Administration

Job Summary

The Physician Advisor will assure effective and efficient delivery of quality medical care consistent with federal, state, and regulatory standards for physician utilization review management and documentation. This position will work with Cook County Health (CCH) leadership to identify opportunities to improve care and documentation as well as minimize clinical denials by providing the physician perspective on utilization review to achieve physician adoption of best practices and documentation requirements. The Physician Advisor will serve as a liaison between the departments engaged in revenue cycle/reimbursement, e.g. Utilization Management (UM), Health Information Management, Patient Accounts, Managed Care/County Care, as well as, Quality and Patient Safety, Risk Management, Corporate Compliance, Providers, Insurers and CCH senior leadership. The Physician Advisor will also be responsible for providing guidance and education to providers on utilization review regulatory changes as well as documentation requirements to support coding, reimbursement, quality and outcomes measurement and medical necessity for the services provided. The Physician Advisor will be required to provide direct patient care.

Typical Duties

- Serves as a subject matter expert for physician utilization review management and documentation providing guidance and education to efficiently submit information for timely reimbursement.
- Provides prospective, concurrent, and retrospective review and opinion on cases referred by utilization review, case management, and clinical documentation specialists including cases referred for medical necessity and appropriate level of care.
- Supports staff in activities related to quality, utilization, and resource management.
- Serves as a resource in reviewing cases and interfacing with physicians to obtain responses to coding queries.
- Creates an environment that is data driven to review the utilization of resources and objectively measure the outcomes for inpatient and observation stays. Monitors physician and group patterns and presents the information to physician and hospital committees.
- Reviews cases under dispute with third party payers and presents the hospital's case to third party payer Medical Director or Peer Review Board, to overturn denials and receive payment.
- Identifies barriers to timely discharge and assists with developing solutions to remove those barriers in collaboration with care management and community partners.
- Collaborates with hospital leadership, case management, and business office staff to assist in addressing concurrent and retrospective denials.
- Provides education to medical staff and house staff on new clinical practice guidelines, protocols, research evidence and regulatory requirements including, but not limited to, ICD-10, meaningful use, Centers for Medicare & Medicaid Services (CMS), Joint Commission and compliance.
- Guides physicians to adopt new or revised processes or guidelines for the improvement of

Typical Duties

quality of care, outcomes, and documentation.
- Collaborates with executive and clinical leadership to develop a process for providing ongoing provider performance feedback in the areas of quality, outcomes, documentation quality, and utilization review.
- Provides one-on-one provider education when necessary on a wide array of topics including quality, utilization review, and documentation improvement.
- Collaborates with leadership to implement and monitor clinical initiatives and the development of clinical indicators/diagnostic criteria for diagnoses that prove problematic for reimbursement.
- Collaborates with the Chief Medical Information Officer, Health Information Management, and clinical leaders to develop Electronic Medical Record (EMR) tools that optimize documentation quality and reimbursement.
- Mediates and resolve conflicts with medical staff where quality, documentation, and utilization or case management are at issue.
- Provides leadership for Case Management staff by directing case management teams regarding appropriateness of patient specific plans of care and discharge planning.
- Collaborates with the Director of Inpatient Care Coordination, UM Committee leads and other clinical representatives to improve throughput, length of stay, readmission rates and transitions.
- Facilitates strong working relationship between providers, nursing, clinical documentation specialists, case managers, utilization review staff, coding, and the management team.
- Attends appropriate medical department meetings sharing Information specific to department utilization performance, updating the department on internal or external utilization practices, educating physicians on statistical and other review techniques.
- Participates as a team member on committees or subcommittees.
- Provides supervision and oversight to utilization management professional and support staff, as needed.
- Provides direct patient care as an attending physician in the area of clinical specialty.
- Performs other duties as assigned.

Minimum Qualifications

- Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) degree from an accredited medical school
- Must be licensed as a physician in the State of Illinois or have the ability to obtain Illinois physician licensure prior to starting employment
- Current and valid Illinois Controlled substance License or have the ability to obtain license prior to starting employment
- Current and valid licensure with the Federal DEA or have the ability to obtain licensure prior to starting employment
- Board certification in clinical area of expertise
- Five (5) years of clinical practice experience in a large health care system or group practice
- Three (3) years of experience using an integrated electronic medical record
- Two (2) years of experience in Utilization Management, i.e. member of a UM committee
- Current Health Care Quality and Management Certification (CHCQM) by the American

Minimum Qualifications

Board of Quality Assurance and Utilization Review Physicians (ABQAURP) or the ability to obtain certification within six months following employment
- Current Physician Advisor Certification by the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP) or the ability to obtain certification within one (1) year following employment

Preferred Qualifications
- Two (2) years of experience using a large scale EMR platform (e.g. Cemer, EPIC)
- Three (3) years of experience working in a multispecialty group practice

Knowledge, Skills, Abilities and Other Characteristics
- Knowledge of current health care regulation, accreditation and licensure requirements for physicians and facilities.
- program structure.
- Knowledge of Quality Management, Utilization Management, documentation processes and
- Knowledge of utilization, case management, clinical documentation, and quality guidelines.
- Knowledge of applicable Federal, State, and local laws and regulations, Corporate Integrity Program, Code of Ethics, as well as other policies and procedures to ensure adherence in a manner that reflects honest, ethical, and professional behavior.
- Excellent interpersonal skills with ability to build collaborative working relationships with medical staff, clinical staff, finance, and compliance.
- Excellent written and oral communication skills; ability to write clearly and succinctly in a variety of communication settings and styles.
- Ability to demonstrate a comprehensive knowledge of a broad range of medical/surgical diagnoses, treatment modalities, therapeutic services, and intervention techniques.
- Ability and willingness to effectively approach physicians on issues related to quality, documentation and utilization as needed.
- Ability to make sound decisions based on criteria of Medicare/Medicaid, other payers and/or other utilization/reimbursement agencies regarding medical necessity and the quality, appropriateness, and efficacy of patient care.
- Achieves excellence by being action oriented, decisive and follows through and aligns resources to accomplish objectives.
- Demonstrated how to use effective strategies to facilitate change initiatives and overcome resistance to change.
- Skill to builds cooperative relationships and alliances throughout the organization and relates to all levels and classifications of employees.
- Ability to understand, incorporate, and demonstrate the mission, vision, and values of CCH in leadership behaviors, practices, and decisions.
- Ability to understand complex issues and develops solutions that effectively address problems.
- Ability to understands the role of emerging technology and its impact on operational effectiveness and organizational change.

Physical and Environmental Demands

This position is functioning within a healthcare environment. The incumbent is responsible for adherence to all hospital and department specific safety requirements. This includes but is not limited to the following policies and procedures: complying with Personal Protective Equipment requirements, hand washing and sanitizing practices, complying with department specific engineering and work practice controls and any other work area safety precautions as specified by hospital wide policy and departmental procedures.

The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not intended to be construed as an exhaustive list of all responsibilities, duties and skills required of the personnel so classified.

For purposes of the American with Disabilities Act, “Typical Duties” are essential job functions.