UCONN HEALTH

PHYSICIAN ADVISOR

UNCLASSIFIED
Class Code: 4173
FLSA: Exempt

Salary Group:
Managerial
Effective Date: 7/23/2025.

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PURPOSE OF CLASS:

The Physician Advisor (PA) collaborates with care management staff and other team members to address the appropriateness of hospitalization and conduct clinical reviews regarding quality of patient care, hospitalization stay, care progression, denial management, federal and state resource utilization, clinical documentation and integrity, and compliance with regulatory requirements. Facilitates training and guidance for clinical, financial, documentation, education, and regulatory requirements and outcomes.

Reporting relationship:

Reports to the Chief Medical Officer (CMO) or designee.

SUPERVISION EXERCISED:

Responsibilities of the Physician Advisor

Supervises, coordinates, and collaborates with the CEO, Chief Medical Officer, Director of Case Management, and Director of Clinical Documentation Integrity, multidisciplinary members of the hospital care team and outside stakeholders.

EXAMPLES OF DUTIES:

- Conducts clinical review on cases referred by case management staff and/or other healthcare professionals in accordance with the hospital's objectives for ensuring quality patient care and effective, efficient utilization of healthcare services, and to meet regulatory requirements.
- Provides guidance to physicians, case managers and clinical documentation specialists regarding the correct level of care, length of stay, unnecessary testing, avoidable days, non-covered days, and reimbursement.
- Performs or delegates appeals with third-party payers, including peer-to-peer reviews.
- Reviews cases that indicate a need for issuance of a hospital notice of non-coverage/Important Message from Medicare. Discusses the case with the attending physician and if additional clinical information is not available, discusses the process for issuance and appeal to the physician.
- Provides education to physicians and other clinicians related to payer requirements, regulatory and statutory requirements, appropriate utilization, alternative levels of care, community resources, and end-of-life care. Works with physicians to facilitate referrals to the continuum of care.

- Educates individual hospital staff physicians about appropriate level of care, ICD coding guidelines (e.g., co-morbid conditions, outpatient vs. inpatient) and clinical terminology to improve their understanding of severity of illness, acuity, risk of mortality, and DRG assignments on their individual patient records.
- Participates in the review of prolonged stay patients, in conjunction with Case Management and other members of the multidisciplinary team to facilitate the use of the most appropriate level of care.
- Works collaboratively with the Chief Medical Information Officer, Chief Quality Officer, and Chief Medical Officer to assist Information Technology with clinical decisions for the EHR.
- Performs related duties as required.

MINIMUM QUALIFICATIONS REQUIRED:

KNOWLEDGE, SKILL AND ABILITY: -

- Understands and uses InterQual and Milliman and other appropriate criteria.
- Considerable knowledge of utilization management, care management and progression, denial management
- Considerable Knowledge of Coding Documentation Integrity.
- Considerable knowledge of state and federal regulations and payor contracts.
- Ability to work with medical staff and hospital leadership.
- Strong organizational, interpersonal and leadership skills.

EXPERIENCE AND TRAINING:

GENERAL EXPERIENCE:

- MD or DO
- Board eligible or Board certified in a medical or surgical specialty.
- Five (5) years of direct inpatient hospital patient care management

Licensure / Certifications:

- Active Medical State license

PREFERRED:

- Care Management Physician Certification (CMPC) preferred.
- Continuing Medical Education credits in utilization management