PHYSICIANS DATATRUST

Job Title: Clinical Services Liaison	Department: Clinical Services	Effective Date: March 28, 2024
Reports to: Clinical Services Manager	**Direct Reports:** None	**FLSA:** Non-Exempt
Working Conditions: Normal, no adverse or hazardous conditions.		

Primary Purpose:
The primary function is the responsibility to manage all aspects of the patient referral flow to ensure quality and professional service to our referring physicians and members.

Principal Duties and Responsibilities (* = essential functions):
- To verify eligibility & benefits for each submitted physician referral by contacting the Health Plans for pertinent information. *
- To process and complete authorization request forms into the company's in-house system in a consistently accurate and timely manner, as well as referring the authorization request forms to the appropriate staff members for processing. *
- To input referrals at or above the benchmark processing daily quota. *
- To communicate promptly, the authorization request form is disposed of back to the appropriate staff, physicians, and facilities per NCQA and Health Plan guidelines. *
- Organize & act upon pending, denial files/cases promptly to maintain designated turnaround times and physician communication. *
- To answer telephone calls coming into the UM Department in a timely, courteous & professional manner.
- To collaborate with the CM to ensure all members are assisted with the coordination of care.
- Integrate behavioral health in collaboration with the PCP and CM when indicated
- Identify and refer members to ACM when indicated
- Ensure all specialty notes are shared with the CM and the PCP
- Help to coordinate transportation for members
- Refer members to community-based resources when appropriate
- Assist the CM in all aspects of ACM within the scope of job responsibilities
- To maintain the transition log for special needs plan (SNP) members
- To assist the case manager in preparing for SNP audits
- To maintain a tracking system for health risk assessment (HRA) and care plan (ICP) completion dates
- To submit the requested SNP reports promptly to the health plans
- To work with contracting personnel to ensure the utilization of appropriate providers.
- To provide requested referral and network information to providers/staff promptly. *
- To provide information to licensed nursing staff regarding referrals that are "not a covered benefit" and facilitate denial letters.
- To organize, manage, and prioritize workload effectively to process authorization request forms within the established time frame. *
- To refer appropriate authorization request forms to the IPA case manager based on established criteria.
- To educate and inform physicians and their office staff of any changes to the referral process, network changes, or other information about the referral process.
- To maintain daily, weekly, or monthly reports as requested by the IPA Administrator.
- To assist the case manager and IPA Administrator in preparation of UM and QI meetings.

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- Retrieval of medical records for HP audits.
- To maintain a courteous and professional demeanor in all interactions, with all persons both inside and outside the office.
- To perform other duties as assigned.

Job Specifications (KSAs):

- The ability to read, write and speak English and perform other basic educational skills as is generally obtained by successfully completing High school or a GED equivalent.
- Clear and accurate knowledge of medical terminology; managed care experience and knowledge preferred.
- Working knowledge & expertise of ICD-10 & CPT-4 codes.
- Demonstrated computer literacy. **Excel experience helpful**.
- Excellent communication skills in both oral and written modes, as well as superior telephone etiquette.
- Excellent Customer Services experience and proficiency required.

Position Performance Criteria:

1. Maintains or exceeds quantitative productivity standards and accuracy standards for cases/authorization request forms input on a daily basis.
2. Maintains professional behaviors, demeanor and work habits consistent with both departmental & company policies and procedures.
3. Maintains good customer relationships with both provider office staff and providers as well as effective and courteous communication with internal staff.
4. Effectively manages and prioritizes workflow of daily provider authorization request forms to accomplish a timely turn-around of authorization request forms.
5. Positively contributes to the utilization management team via effective communication and problem solving within framework established by the department.
6. Communicates clearly, professionally and respectfully to peers, superiors, subordinates and clients.
7. Uses sound judgment with regard to time management and prioritization of work to balance multiple tasks and meet required timeframes for all administrative activities as required.
8. Demonstrates high reliability through consistent punctuality and attendance.

Pay Range $18.50 - $20.50 hourly DOE