Going to the dark side…… What is a Physician Advisor?

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Lead Physician Advisor

Medical Director Utilization Management/ Case Management

Munson Healthcare

Disclosures

Objectives

- Identify key activities a PA role would encompass
- Identify key goals of Utilization Management a PA should monitor
- Describe examples of Case Management/ PA collaboration
- Describe how a PA can assist CDI professionals

Overview

- What is a Physician advisor?
- Scope of work for a Physician Advisor
  - Utilization Management
  - Case Management
  - Clinical Documentation
- Hospital Financing

What is a Physician Advisor?

The physician advisor is a key member of the healthcare organization's leadership team and is charged with meeting the organization's goals and objectives for assuring the effective efficient utilization of health care services. The Physician Advisor is a physician servicing the hospital through teaching, consulting and advising the care management and utilization review department and the hospital leadership.

Scope of service

- Educate front line providers
- Coach on documentation
- Track resource utilizations
  - Identify trends, variances
  - Share results of efforts -ROI
- Collaborate for equitable use
  - among colleagues on medical necessity
  - with administrators – provider perspective on culture
- Critical thinking
  - Admission status/ Level of care decisions
  - Regulatory compliance
  - Denial management
- Strong functional relationship with case management

Physician Advisor roles

- Utilization Management
- Case management
- Clinical Documentation Integrity
- Compliance
- Revenue cycle
- Quality management
- Operations
- Administration
- Education

Utilization Management

- Appropriate patient status- identify opportunity for upgrades
- Inpatient / Outpatient
  - Observation services
  - 2 MN rule 2012
  - IPO surgery list
- Medical necessity- IQ/ MCG
- Peer to peer conversations with payer medical directors
- Educate providers for documentation of medical necessity
- Educate utilization review staff identifying medical necessity
- UM committee- Conditions of Participation

Utilization management Patient Status

- **Inpatient**

  Patient who is formally admitted subsequent to an order for admission from qualified practitioner with admitting privileges

- **Outpatient**

Patient registered to receive services who has not been admitted as inpatient

Observation services

> …. *A well-defined set of specific, clinically appropriate services ,which include ongoing short-term treatment, assessment and reassessment that are furnished while a decision is being made regarding whether patient will require further treatment as hospital inpatient s or if they are able to be discharged from the hospital.*

Utilization Management 2 Midnight Rule - CMS

- Does patient require hospital care?

  If not, no inpatient admission

- How long is total hospital time needed starting with symptom-related care?

  Under two MN –Outpatient +/-observation

  Over two MN –Inpatient

- Inpatient only surgery, unexpected ventilation, documented case-by-case exemption or high-risk patient = Inpatient

Inpatient Only list

- Surgical procedures CMS has determined to be
  - Too risky
  - Too complex
  - Too resource intensive
- Will only be paid for if done as an IP

Medical Necessity

- CMS definition
- NCD/ LCD
- Proprietary Criteria
  - Inter Qual
  - MCG- Milliman Care Guidelines

Utilization Management

- Peer to peer conversations with payer medical directors
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Case Management

- Throughput - resolve issues related to progression of care
- Patient Care conferences
- Post Acute Care placement
  - Home with HC/ DME- Home Care / Durable Medical Equipment
  - SNF /SAR – Skilled Nursing Facility/ Subacute Rehabilitation
  - IPR – Inpatient Rehabilitation
  - LTACH- Long Term Acute Care Hospital
- Peer to Peer conversations

Clinical Documentation Integrity

- … *Process of promoting consistent, complete, precise, reliable, nonconflicting, and legible provider documentation integral to the compliant submission of code sets*

Clinical Documentation Integrity

- DRG down grades
- Clinical validation denials
- Educate staff for appropriate documentation and how it affects quality- and yes payment
- Queries- encourage physician compliance and assure queries are compliant

Clinical Documentation Integrity

- Principal diagnosis/ Secondary diagnosis

  the conditions established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care (CMS, 2020)

- CC/ MCC- comorbidity or major co morbidity

- DRG / APC Diagnosis related groups/ ambulatory payment classification

Coding

- Coding is conversion of clinical documentation into numeric or alphanumeric codes
- HCPCS - Healthcare Common Procedure Coding System
  - Level 1 HCPCS = CPT - Current Procedural Terminology

    primarily professional services
  - Level II HCPCS

    products supplies and services

    DME, Ambulance, prosthetics

CPT

- 5-character uniform coding system with descriptive code to identify medical services and procedures
- ICD – 10 – CM = Diagnosis codes

International Classification of Disease, 10th revision- Clinical Modification

- ICD – 10 – PCS = Procedure codes

International Classification of Disease, 10th revision- Procedure Coding system

Compliance

- Audit to assure regulatory compliance
  - Quality/ PSI indicators
  - Mortality reviews
  - Documentation / readmission triggers
  - 2 MN rule compliance
  - Self audits for overpayment
  - 0-1 night Medicare inpatient stays

Compliance

- BFCC- QIO Beneficiary and Family Centered Care Quality Improvement Organization
- MAC Medicare Area Contractor
- CERT – Comprehensive Error Rate Testing
- RAC- Recovery Audit Contractor
- ZPIC- Zone Program Integrity Contractor
- OIG- Office of inspector General

Revenue Cycle

- Determining patient identity and eligibility
- Obtaining accurate demographics
- Collecting patient's copays
- Certifying appropriateness for acute care
- Ensuring documentation specificity
- Coding claims correctly
- Tracking and monitoring claims
- Collecting payments
- Reporting denials
- Appealing denied claims

Revenue Cycle

- Denials/ appeals management
- Contracting
- Joint operating committee meetings
- Represent organization at juridical hearings appealing payment decisions

Additional Duties as Assigned

- Evidence based guidelines
- Interprofessional team meetings and education with CDI , coders, hospitalists, teaching services and UM staff
- Population Health, engagement/ alignment
- Leadership meetings
- Keeping current with local, state and federal guidelines and regulations

How hospitals are paid

- Inpatient care –Diagnosis Related Grouping (DRG)

  average cost of caring for the average patient based on the average resources used

- -Primary diagnosis determines group
- -Secondary diagnoses determine which DRG in group

How hospitals are paid

- •Outpatient care –Ambulatory Payment Classification (APC)
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Typical qualifications

- 5 years clinical experience
- Recent acute care experience
- Practicing or retired from clinical care
- Specialty vs Primary Care
- Part time/ Full time
- Internal vs External

Characteristics of a Physician Advisor

- Team player with leadership qualities
- Excellent written and verbal communication skills
- Enjoy education
- Critical thinker
- Good negotiation skills
- Comfortable with change management
- Ability to multitask
- Generally positive outlook

A Day in the Life

- Run lists
- MDRs
- Secondary Reviews
- Peer to Peers
- Committee meetings
- Patient Care Conferences
- Write appeal letters
- Strategize

Organizations

AMERICAN COLLEGE OF PHYSICIAN ADVISORS

APLCM™
Association of Physician Leadership in Care Management

ABQAURP
American Board of Quality Assurance and Utilization Review Physicians®
Promoting Health Care Quality and Patient Safety Through Education and Certification

Current state 2021

- 42 states
- 40% full time, 55% 5 years or less
- 25 % remote
- Lead Physician Advisor, Chief Medical Officer
- 75% $250,000 + range

Resources

- Educational resources online
- Conferences
- Texts
  - The Hospital Guide to UR
  - The Physician Advisors Guide to Clinical Documentation Integrity- ACDIS
  - The Core Functions of Revenue Integrity- NAHRI