Physician Advisors and PA Programs

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Importance

- Severe sepsis, septic shock are responsible for significant morbidity, mortality and cost to patients
- Six leading principal diagnosis for admissions
- 4.2% of hospitalized patients
- 751,000 cases per year
- More than half treated in ICU
- Medicare patients account for about 60% of patients with septicemia cared for in U.S. hospitals
- Mortality rate is 30%
- Average cost per case ~$22,000

Sepsis Management
What is a Physician Advisor?

• There is no single definition
• “Operationalists“
• A Physician Advisor (PA) provides advice and support to processes related to the medical necessity of medical services as part of care management and utilization review activities.
  • Key elements include advising, consulting, teaching, analyzing and serving as a liaison
  • Cross organizational layers and functional silos
What Kind of PA Program?

- Too many programs just “happen”
  - Little or no planning or rationale
  - Lack of executive support/understanding
- Physician(s) who are most supportive of case management discover one day that they are a physician advisor
- There has been little opportunity for education or networking of new PA’s
- Program development should be based on physician resources and organizational willingness to invest in the program
The Change Model
Managing Complex Change
PA Program Services

• Secondary physician review for medical necessity (status determination prior to October 2013)
• Audit denials and appeals
• Concurrent commercial denial management
• Clinical documentation improvement education (ICD-10 conversion)
• Utilization management
  • Length of stay
  • Resource use
  • Internal patient flow (level of care transfers)
Program Services (cont.)

- Case management support
  - Manage care team rounds
  - Discharge planning
  - Family/patient conferences
- Support to quality improvement and patient safety efforts
  - Readmissions, process improvement efforts
- Support to patient satisfaction improvement efforts
- General physician and administration liaison and education efforts
Program Drivers?

• Where does the impetus for the program come from?
  • Case management
  • Medical staff
  • Administration/finance

• How well are drivers/problems understood?
  • Prioritization of needs
  • Develop process maps to understand the resources needed, especially time
  • Avoid scope creep
  • Magical thinking
Development Constraints

- Executive support and understanding
  - Critical element to long-term program success
  - Rarely understand how clinical care translates into the final bill
  - No end-arounds
- Physician resources
  - Willingness to participate/time commitment
  - Skills
- Program leadership
- Financial
  - Avoid magical thinking
  - Cost vs. FTE philosophy
Development Constraints

• Silos and politics
  • Medical staff perceptions/understanding

• Physician secondary review for medical necessity determination
  • Commonest driver and most expensive
  • 24/7 multi-portal coverage is often desired
  • May require greater numbers of physicians to provide coverage
  • Physician training required
  • Medicare Conditions of Participation and the new Two Midnight Rule
Justifying the PA Program

• Financial and quality benefits
  • Proper medical necessity and status determinations
  • Reduced concurrent inpatient commercial denials
  • Reduced pre-payment, RAC and other recovery audit denials
  • Reduced avoidable days (delay days)
  • Reduced length of stay
  • Improved resource utilization
  • Improved HCAHPS/Value based purchasing metrics
  • Improved physician behavior/support
Physician Advisor Selection

• Although the life of a PA is glamorous and exciting, attracting candidates for the work can be surprisingly difficult
• PA’s require a unique set of skills, thus this is not a job for just anybody
• Defining the program scope is important in defining the physician needs
  • Full time vs. part time
  • Generalized vs. specialized PA’s
• Hiring right is a key to success
Defining the Ideal PA

• There is no one size fits all model
• Needs to “believe” in the role
• Minimum of five years of clinical practice
  • Currently practicing vs. retired physicians
  • Team player
• Specialty vs. primary care physicians
• Internal vs. external candidates
  • Respect of and for peers
  • Leadership capability
Defining the Ideal PA

- Excellent verbal/written communication skills
  - Physician-to-physician
  - Physician to lay audience (families, non-clinical staff, administrative law judges, etc.)
  - Enjoys education
- Critical thinker, comfortable with “gray zone” issues
  - Medical necessity issues
  - Willing to learn on an ongoing basis (criteria, coding and documentation rules, regulations)
Defining the Ideal PA

• Politically astute and self-secure
  • A relationship manager that must not be conflict-averse and is willing to be persistent
  • Good negotiation skills
  • Physical presence is critical
  • Flexible and approachable

• Ability to multi-task and react to the changing demands of daily workflow

• Generally positive outlook to avoid burnout
Program Leadership

• The case for the Physician Advisor
  • Clinical knowledge and “complex medical judgment”
  • Understanding of how clinical documentation translates into coding
  • Can more effectively turn audit and denial lessons into physician and staff education as well identify process improvement to improve patient care and prevent future audit denials
  • Integrate coding, documentation improvement, case management and CPOE
Program Options

• The ideas discussed so far will guide the choices of how to build a program
  • Case management/UR Committee (the almost no program approach)
  • Internal
  • External (outsourced)
  • Hybrid

• Programs come in almost infinite variety as there are almost infinite situations
Case Management/UR Committee

• Pros
  • Traditional model that is rapidly disappearing
  • Cheap and easy to implement

• Cons
  • Limited availability and relies on local physicians for support
  • Limited local expertise or regulatory knowledge
  • Large missed opportunity cost and potential compliance issues
  • Difficult to demonstrate commitment to compliance should OIG audit
Internal Pros

• Maximum flexibility to design program to fit needs
• Familiarity with local medical staff, processes, customs and politics
  • Credibility and relationships with physicians and staff
  • Direct chart/patient access facilitates exercising “judgment”
• Can focus on physician education to improve compliance, documentation and quality
• Incentive is to reduce denials
• Internal PA in a better position to judge medical necessity
• Cost effective for larger programs and keeps $ local
• Internal PA can support internal process improvement
Internal Cons

- Lack of internal physician resources
  - Insufficient coverage schedule
- Lack of knowledge and difficulty in maintaining ongoing training
  - Difficult to keep up with legal/regulatory changes
- PA turnover
- Quality control and inter-PA variation
- For PA’s with clinical practice – negative impact on their practice
External Pros

- Primary focus on secondary physician review
- Minimal lead time to launch program
  - Little or no internal PA support needed
  - Extensive reporting capabilities
- Better quality control with reduced variability
- A variety of services may be available
- Extensive expertise in audit appeals
  - Up to date legal and compliance knowledge
- Predictable cost/case
  - Can be more cost effective for smaller facilities
  - Can provide more hours of coverage
External Cons

- Limited scope of services
- Lack of local physician relationships and knowledge of local practices
- Communication by phone and e-mail
- No physician education
  - Does not enhance local expertise
- Difficult adapting to the Two Midnight Rule
- Need to demonstrate compliance education
- Can be extremely expensive
- Requires internal oversight
Hybrid Pros

- May combine the advantages of internal and outsource programs
- Allows internal PA’s to focus on education and improvement while external PA’s focus on physician secondary review
- Most practical solution for most organizations as fewer physician resources are required internally
- Can be a transitional model to a full in-house program
- Strong internal leadership required to maximize the value of the program
Hybrid Cons

- Tendency for internal and external PA programs to operate in silos limiting education opportunities for internal PA’s and medical staff
- Difficulty in coordinating work and may lead to inconsistencies in approach
- Many of the cons of outsourcing persist
- Cost of external component may limit dollars for internal PA program
Education Resources

- ACMA – American Case Management Association
- ACDIS – Association for Clinical Documentation Specialists
- AHIMA – American Health Information Management Association
- ACPE – American College of Physician Executives
- Commercial resources – Report on Medicare Compliance, Accretive PAS Update, AppealMasters, Day Egusquiza’s Info Line
- RAC Relief
Questions?

For additional information or to be added to the RAC Relief Listserv, please direct requests to:

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