The Internal Physician Advisor Role in a Large Hospital

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* I have no relevant financial relationships to disclose in regard to the content of this presentation.
Objectives

1. List 3 major prerequisites for a successful internal physician advisor (PA) in a large academic medical center.

2. Know 5 key roles of the large hospital PA.

3. Understand an approach to educating clinical staff to understand the relationship between clinical documentation and ICD-9-coded/administrative claims data.

4. Learn how to effectively work with the RAC team to identify areas of concern and make proactive improvements.
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<thead>
<tr>
<th>Founded in 1852</th>
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<tbody>
<tr>
<td>1,171</td>
<td>Beds</td>
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<tr>
<td>2,500</td>
<td>Physicians</td>
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<tr>
<td>1,004</td>
<td>Residents and Fellows</td>
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<tr>
<td>1,800</td>
<td>Nurses</td>
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<tr>
<td>58,952</td>
<td>Discharges, including newborns</td>
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<tr>
<td>536,181</td>
<td>Outpatient visits</td>
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<tr>
<td>99,162</td>
<td>Emergency Room Visits</td>
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The Internal Physician Advisor Role

• Prerequisites:
  – Basic knowledge in coding and expertise in clinical documentation.
  – Good understanding of medical necessity denials.
  – Sizable clinical role and internal validity.
  – Full-time availability.
  – Strong relationships with department chairs and clinical program leaders, HIM, compliance, and finance.
The Internal Physician Advisor Role

Key Roles:

- Translate major health care system themes (targeting fraud/abuse, preventable readmissions, ICD-10, patient status, etc.) to clinical staff at all levels, including house staff.
- Focus on quality over finances, and shared incentives.
- Be a readily-available resource for physicians.
- Analyze denials data/trends and select best targets (ie; which ambulatory-sensitive cases) for allocating resources.
The Internal Physician Advisor Role

• Key Roles:
  – Fully understand PEPPER (Program for Evaluating Payment Patterns Electronic Report) reports.
  – Work with clinical leadership on developing evidence-based admission criteria.
  – Ensure senior hospital leadership’s involvement and ongoing support.
  – Create a culture of continued awareness and education.
Introduction When Educating Clinicians

• Health care system is rapidly changing in response to both financial and quality imperatives:

• U.S. spent $2.3 trillion, or $7,681 per person, in 2008 on health care.

• The health care portion of gross domestic product reached 16.2 percent.

  ➢ Payers are shifting from pay for service to:

    o Pay for reporting

    o Pay for performance, not pay for poor quality

    o Value-based insurance design

  ➢ Increasing emphasis on “overpayments” and efforts to recoup: RAC

  ➢ Clinical documentation drives everything
The Case For Good Clinical Documentation

• Improves communication between physicians.

• Enhances the reputation of physicians by accurate data analysis.

• Ensures appropriate reimbursement for the physician and the hospital.

• Helps the medical staff to analyze their patient population.

• Defends the physician in medical liability allegations.

• Informs healthcare data and ratings: profiling, govt/insurance audits.

• Improves the overall quality of care.
Mount Sinai Hospital: Excisional Debridement Form

DEBRIDEMENT PROCEDURE NOTE

Date: 

1) Diagnosis/Indication: 

2) Procedure Date: ____________ Time: ____________ Procedure performed by: ____________

3) Procedure (check only one): □ Non-excisional □ Excisional

**Excisional debridement** is the surgical removal or cutting away of devitalized tissue, necrosis, or slough (AMA Coding Class for ICD-9-CM, 1998, fourth quarter, page 55).

**Non-excisional debridement** includes brushing, irrigating, scrubbing, or washing off devitalized tissue, necrosis, or slough (AMA Coding Class for ICD-9-CM, 1998, fourth quarter, page 55).

4) Tissue removed (check all that apply): □ Devitalized □ Eschar □ Necrotic/Gangrenous

5) Procedure Grid:

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>DIMENSION (cm)</th>
<th>DEEPEST LAYER REMOVED</th>
<th>METHOD (Grasp, dissection, etc.)</th>
<th>FINAL DIMENSION (cm)</th>
<th>ABSCCESS</th>
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6) Specimen Sent to Pathology: □ YES □ NO

7) Post-procedure Follow-up Plan: Follow-up date: ____________
   
   Anticipated Need: Further Debridement: □ YES □ NO
   
   Other: ____________

Physician/ Clinician: Printed Name: ____________ Dictation Code: ____________

Physician/ Clinician Signature: ____________

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“This form is a permanent part of the medical record.”
Sharing CDI Data

• Be clear about rationale for the program.
• Be consistent: eg, q 3-6 months.
• Share with chair and name names (within the dept).
• MD response rates, agreement rates, query rates: compared to others/hospital as a whole and within dept over time.
Denials Data

• Track denials details.

• Break into categories:

  ➢ Denial type: Admission, Amb Surg, Continued Stay.

• Analyze denial rates and reversal rates by payer, department, procedure, diagnosis.

• Carefully share data with physicians.
Proactive Strategy

• Work with clinical service leaders on developing EBM-backed admission criteria for high-risk short-stay procedures and diagnoses (cardiac cath, EP lab, thyroidectomy, prostatectomy, chest pain, nausea/vomiting, dehydration, back pain).

• Document, document, document.

• Educate, educate, educate.

• Milliman and/or Interqual criteria.
Sharing Denials Data

• Share all appeal letters with attending of record, ask for input.

• Feed-back with responses to the appeals to the attendings.

• Share denials data in aggregate and by dept with chairs at least semi-annually. Keep the issue on their radar.
Sample Physician Outreach on Appeal Letter

Date: March 24, 2010

Patient Name: Smith, John
Medical Record #: 1234567
Adm. – D/C Dates: 2/04/10 – 2/07/10

Dear Dr. Joe Best,

Please be advised that the hospital has received a denial of payment from Insurance Co. X for the above named patient who was under your care during this hospitalization.

Dr. Denial has carefully reviewed the medical record for this hospitalization and drafted an appeal (please see attached).

Please let me know of any comments or additional information you may have to strengthen our appeal.

Your participation will increase the likelihood of a successful appeal, ensuring the hospital is appropriately reimbursed.

Your cooperation and assistance in this matter is greatly appreciated.

Sincerely,

Jeff Farber, MD
Director, Appeals Management
March 24, 2010

Dear Chairman Jones,

Just over 5% of all inpatient claims are denied payment by insurers due to a purported lack of medical necessity. The Appeals Management Department responds to these inpatient payment denials from all payers for all departments. The process involves our clinical appeals coordinators reviewing the medical record and writing an appeal to the payer. We are fortunate to have the support of our physicians, whom we routinely notify about the denial, share the drafted appeal, and ask for comments/input. This has helped us to reverse 60% of the denials and recover 65% of the denied reimbursement on finalized cases.

I’m writing to share with you data on your department’s medical necessity denials received in 2009, having included this year details on each case’s DRG, principal diagnosis, and principal procedure, to facilitate your appraisal. With your assistance, we appealed all of the 100 denials received and were able to reverse 40 cases. As you’ll note, over 50% of the denials are for admissions with a 1 day LOS. Payers, as well as regulators and CMS, are increasingly focusing on the medical necessity of these short-stay admissions and I ask that you please focus your department’s attention on good clinical documentation of the reason(s) for admission, highlighting the patient-specific risk of short-term adverse events. Developing evidence-based admission criteria, as we’ve discussed, for these ambulatory-sensitive procedural cases will greatly assist moving forwards.

I thank you and your faculty for your continued support in the appeals process. Please contact me at any time to discuss.

Jeff
PA Role in Outreach/Education

- Monthly didactics by physicians for CDS and coding staff (post-op complications, cardiac cath/reports, CKD and ARF, AIDS).
- CDI column in monthly hospital (compliance, faculty practice, voluntary attending, etc.) newsletters: pathology addendum, anemia, POA/HAC, malnutrition.
- Talk to all incoming housestaff – pocket cards.
- Departmental grand rounds with specific egs.
Tough Questions/Comments

• What’s in it for me? Do I get some of the extra $?
• This has nothing to do with patient care and so I won’t participate.
• We should take all these CDS positions and replace them with floor nurses.
• Why can’t you code from: K 2.9, tx 3 runs IV KCl?
• I’m not adding a record, it’s illegal.
Conclusions

• RAC is one of many increasingly frequent medical necessity denials initiatives.

• Physician awareness, education, and involvement are critical.
  – Clinical documentation drives coding, billing, publicly reported quality data/rankings.
  – Increasing need for specificity, accuracy, and comprehensiveness (ICD-10 in 2012).

• Consistent, compliant, evidence-based criteria – best strategy.

• Internal physician advisor role is a key to success.
Thank you!

Questions?
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