Best Practices From the Field: Different Models for the Physician Advisor

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Disclosures

- No commercial bias
- No financial support or obligations
- Content and opinions are those of presenter and not necessarily those of SRHS

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Objectives

- Describe types of Physician Advisor programs
- Delineate roles for the Physician Advisor
- Share some “pros and cons” to each

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Spartanburg Regional Healthcare System

- **Three hospital system**
  - **SRMC, 540-bed acute care facility, is anchor**
  - **Accredited heart center, first stroke center to be accredited and only Magnet Reaccredited hospital in SC**
  - **Second facility 80 acute care beds and a third rehab facility**
- **~28,000 admissions/year**
- **121,000 ED visits/year**
- **>500 physician medical staff**
  - **240 employed**
- **Six county market area (940,000 people)**

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Needs

- Maximize “correct” inpatient determinations
  - Financial “win” for patient
  - Financial “win” for hospital
  - Financial “win” for the physician
  - Marketing “win” for hospital with less Condition Code 44 procedures
  - Less denials → less appeals
- BUT, many physicians don’t “get it correct”

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How do you advise?

- How you handle this new field of “physician advising”?
  - Internally part or full-time
    - Varied across systems
  - Externally outsourced
    - With or without internal PA Physicians

External Program: Pros

- Available “off the shelf” with minimal lead time
- Advisors already hired and trained
  - subspecialty expertise when needed.
- External PA vendors have a well-defined process
- Predictable cost/case

External Program: Cons

- Lack of relationship with local providers.
- Minimal opportunity or incentive to teach improved documentation to local providers.
- Incentive is to review cases and do appeals, NOT to reduce volume of cases and appeals.
- Fairly expensive, especially for high-volume, low-dollar cases such as syncope or TIA.

Internal Program: Pros

- Most feel more cost effective
- Education at the local level from a colleague and peer better received
- Provider can have input of process and direction – tailor to institution's needs
  - Observation Unit/Clinical Decision Unit
- Internal PA more involved with process and more informed about local problems and global issues (physician, case management, administration)

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Internal Program: Cons

- Lack of baseline knowledge and expertise initially
- Lack of appropriate IT software system in place (rare, but may need modification)
- Lack of external resources to recruit, train, replace, oversee and manage Internal Physician Advisor
- Process development

Hybrid Model Option

- Hybrid of pros and cons
- Coordination of services needs to be well defined
- “Consultant” role (expense)
- External PA vendor used, especially for “high cost” cases (procedural)
- Can be used to develop Internal PAs from local physician pool

Hybrid Model Goal

- Internal Physician Advisors gradually to assume more responsibility
  - More reviews and appeals of medical cases
  - More local education on CDI
- Transition away from external vendor may be difficult

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Physician Advisor Roles

- Sky is the limit…..but first advise
  - Education on IP, OBS, OP Procedure status determination
  - Documentation integrity education
    - CMI, SOI, Clinically Correct Coding
  - Claims denial management
    - Appeals strategy, letter writing
    - Can manage the external vendor for this (or other) role

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Physician Advisor Roles

- Throughput
  - LOS for IP, OBS %, prolonged stay case by case, 1 day stay eval
  - Rapid Treatment Unit (Observation Unit)
  - Care transition facilitation, input
  - Readmission reduction strategies
- Liaison between Physician and CM/UM team

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Physician Advisor Skill Set

- Certified Coder not a must
  - Helps tremendously
- Must understand “big picture” of what new reimbursement models holds for us and where pitfalls are
  - And be willing to help develop and relate to physicians the “rest of the story”
- Respected among peers

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Physician Advisor Skill Set

- Can be retired, but ideally should be an active practicing physician
- Debate skills a plus to think on feet, build strategy to make the medical necessity angle a “win” for your system
  - “Read through the note”

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SRHS: what did we do

- Developed an internal Physician Advisor Team
  - Culture on floor was eroding and extreme pushback from physicians
    - "computer doctors"…that "don't practice medicine"
  - Case Managers/UM Team were growing weary and frustrated
    - "clinical disconnect"

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SRHS: what did we do?

- Full scope advising process to include QIC and ALJ level appeals
- VP of Clinical Operations helped craft the RTU and PAT Hospitalist was assigned to manage it.

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Inter-auditor variability

- Ginger Boyle, MD CCS and Dr. Ulmer oversee audits of PAT
  - Clinical agreement on medical neccesity
  - Content of the PAT note
  - The timeliness of the turn-around
  - Relationship

PAT compensation

- Daily rate and over a minimum, a per chart basis
  - Trade is restricted while on call
  - Maximum number of cases (10), then Medical Director gets rest of cases for day
  - We averaged ~8/day

PAT follow-up ongoing

- Routine meetings
- Case Management feedback (and PA feedback on CM)
- Ongoing education needs at meetings
- Medical Director/Case Manager Team meetings

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