March 12th, 2019

Optimizing Your Physician Advisory Program

Re-evaluating Your Denials and Revenue Leakage Minimization Infrastructure

Highlights

- **Physician advisory programs are a powerful denials mitigation function:** The observed rise in medical necessity denials in recent years elevates the importance of staff with frontline clinical experience.
- **Examine your current physician advisory model and strategy to maximize impact**. We recommend organizations review their existing physician advisory model to ensure best fit for the organization. While a fully insourced model may work well for some organizations, outsourcing may help offset organizational gaps across a broad range of capabilities, from recruitment and training to performance and performance incentives.
- **Improve your denials defense by involving advisors in upstream mitigation efforts:** Top-notch physician advisors will extend themselves to spearhead initiatives such as risk compliance and physician education that can help transform the organization from a defense-only mentality, to a proactive offense against denials.

Background

As hospital margins face ongoing pressure, the need to minimize revenue leakage via denials and underpayments takes center stage. Physician advisors play a critical function, helping bridge the clinical and financial worlds while defend against revenue erosion attributable to medical necessity denials. Our recent research revealed several common questions associated with the establishment and operation of Physician Advisory programs including whether to insource or outsource the function, what the core expected functions of such an advisor should be and how progressive organizations are utilizing their advisors beyond the traditional core competencies of the role.

Insights

There is no "one-size-fits-all" physician advisory model

Our research revealed organizations use a variety of models from fully insourced to fully outsourced, and a combination of the two. Model choice was driven by a variety of factors, including current capabilities, culture, past experience and future goals. Additionally the scope of the role may differ from facility to facility. While Clinical appeals, CDI, "P2P" reviews and UR are broad commonalities, some organizations may broaden the responsibility set to include physician education, ACO oversight, audit risk, denials trending and medical care evaluations studies.

Thinking of moving to a full "home grown"' model? Be aware of the common failure points

There are several common sticking points preventing success when moving physician advisory programs in house. Hospitals and health systems must be aware of the common recruitment challenges that may emerge, while also ensuring that ongoing training considerations are met. Last, success metrics need to be clearly defined that support organizational priorities and are mutually agreed upon, along with data that is accurate and sufficiently timely to monitor performance

Ensure you're periodically re-evaluating opportunities to utilize Advisors more broadly

Revenue cycle leaders should be cognizant of pinpointing opportunities to include physician advisors more broadly in revenue cycle efforts. Such considerations need to take into account current duties and performance, physician willingness to extend responsibilities and organizational culture.

Appeals, CDI and P2P Common, Other Responsibilities Differ Based on Organizational Priorities

As denials continue to chip away at revenue, hospitals and health systems increasingly draw on physician advisor programs to prevent margin erosion. Serving as a bridge between clinical and financial departments, physician advisors are especially critical in combatting the rising number of medical necessity denials. Top-notch physician advisors possess a unique combination of skills including deep knowledge of regulations, appeals process and contracts, understanding of multiple clinical specialties, and the ability to build relationships with other physicians, and navigate IT comfortably.

While core functions of the physician advisor include peer-to-peer reviews and some utilization review, progressive organizations report physician advisors who see their role more comprehensively: as a clinical expert and leader in the war on denials. In these cases, the role includes proactive reviews of MAC or OIG reports to determine areas of compliance risk, root cause analyses for existing (or emerging) denial trends, building stronger payer relationships, and serving as champions of CDI.

Organization	*Model*	*Physician Advisor Responsibilities*	
St. Elizabeth HEALTHCARE 5 hospital, 892 bed system	In-house; 1 FTE, 2 part-time; internal hires, experience with medical group and payers	• Clinical appeals • CDI • HIM	• Utilization review • Peer-to-peer requests
SELF REGIONAL HEALTHCARE 1 hospital, 322 bed system	In-house; 1 FTE, hired from medical group	• Clinical appeals • Utilization review • Peer-to-peer request	• ACO oversight • Physician education • Clinical documentation improvement
NOVANT HEALTH 13- hospital, 2,500+ bed system	In-house; 4 FTEs and 4 part-time employees[1], hired from medical group and from external search	• Clinical appeals • Utilization review and chair UR committees • Peer-to-peer requests	• Physician education • Denials research • Medical care evaluation studies

SHARP
7- hospital,
2,000+ bed system
	In-house; 1 FTE at system level, 1 FTE at each facility	• System Level (1FTE):
		  • Clinical appeals
		  • Denials management
			• Facility CMOs
			  • Denials trends
			  • High level appeals
			  • Champion revenue cycle

ProHEALTH™ Care 2- hospital, 320 bed system	In-house and vendor-sourced; 1 FTE at system level, with advising from vendor for clinical appeals	• Utilization review • CDI and coding • Denials management	• Physician education • Case manager, office staff, and nurse education

Importantly, Physician Advisors play a critical role in the appeals process, alleviating that burden from hospitalists. Patient-focused hospitalists are often unprepared for payer reviews and avoid or delay experience, further limiting effectiveness. Advisors are well situated to handle these conversations given their experience and familiarity with past rulings.

Buy or Build? No One Size Fits All, but Understand the "Home Grown" Pitfalls

There are three common approaches to physician advisory programs, fully insourced, fully outsourced, or a hybrid model that retain their own physician advisory services but utilize some outsourcing, as summarized in the chart on the next page.

1) Moody's Investors Service, Preliminary Medians, 2013, 2014, 2015, 2016.
2) Preliminary Median.
3)Four-star plan elements include (1) Staying healthy: screenings, tests, and vaccines, (2) Managing chronic (long-term) conditions, (3) Plan responsiveness and care, (4) Member complaints, problems getting services, and choosing to leave the plan, and (5) Health plan customer service.

	Outsourced	Combination	In-House
Expected Benefits	• Faster program launch • Access to large bank of knowledge	• Access to large bank of knowledge • Non-clinical appeals responsibilities still handled • Allows for initial, on the ground reviews	• Control over appeals decisions • Strong organization-payer relationships
Capabilities needed	• Streamlined appeals process	• Strong physician candidates with payer experience/knowledge • Streamlined appeals process	• Strong physician candidates with payer experience/knowledge • Streamlined appeals process
Caveats for consideration	• Less opportunity to build relationships between organization and payer • Non-clinical appeals responsibilities of physician advisors not covered	• Potentially disjointed workflows • Have to manage a vendor and an internal department	• Requires established internal knowledge • HR burden; physician advisors may be a flight risk

There is no one answer, nor will the answer necessarily remain the same over time. For those building a new program, there are several common pitfalls to be aware of:

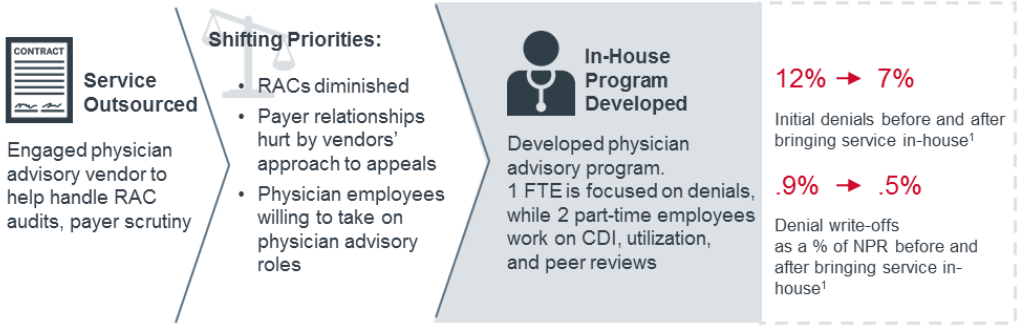
Recruitment Difficulties: It can be challenging to find physicians with sufficient interest in, or experience with being a physician advisor. In addition, increasing competition for talent from both payers and providers may result in headhunting once a new recruit is established, forcing an organization to start over.

Training Considerations: Ongoing education and support is critical for an effective advisory program. All too often, physicians may be tasked to "go do it" being expected to relying upon their own initiative, even in situations where they are new to the role. Training platforms will be required, and finding suitable peers and/or resources to co-learn from must be provided to keep the advisor up to speed with changing payer dynamics.

Failure to Define Success: Defining and codifying performance metrics is critical. Selecting appropriate metrics will depend upon both availability and quality of data, and may need to be altered as the reimbursement landscape changes. Failure to appropriately align metrics with incentives leave physicians in a difficult grey area that may result in disengagement.

If the above challenges seem daunting, outsourcing, either initially or for a longer period of time may be more appropriate. St. Elizabeth Healthcare outsourced to a vendor while building, but eventually transitioned to their own fully "home-grown" physician advisor program.

St. Elizabeth Healthcare Brings Physician Advisory Services In-House



Physician Advisors: Organizational Champions for Denials Prevention

Two examples in our recent research illustrate how a physician advisor can act as a champion to physician peers in order to benefit denials mitigation efforts. At Self Regional Hospital, a physician advisor received notification from the OIG regarding an impending announcement of spinal fusion audits. The advisor proactively reviewed the notification and analyzed a sample of internal cases to test compliance according to the documentation requirements listed in the report. The analysis showed that a significant proportion of cases would ultimately fail such an audit; the advisor then developed and led education sessions for neurosurgeons on appropriate documentation for spinal fusion cases, proactively preventing future denials.

Audits Announced

Physician Advisor alerts health system of OIG's announcement of spinal fusion audits

1 **Self-review**

Physician Advisor pulls 30 most recent spinal fusion charts and audits documentation[1]. Estimated MACs would deny 60% of cases.

2 **Physician Education**

Physician Advisor shares self-review findings with neurosurgeons, leads education session on proper documentation practices

Results

0% Self Regional's spinal fusion denial rate

28% Average spinal fusion denial rate at South Carolina hospitals

1) Self-audit process used CMS standards to evaluate completeness of the documentation from past cases.

Case in Brief: Self Regional Healthcare

- General medical and surgical facility in South Carolina
- In 2016, OIG announced a Fall 2017 work plan that included spinal fusion audits
- Self Regional performs a high volume of spinal fusions; physician advisor lead initiative to prepare for audits

At Prohealthcare, a 2-hospital healthcare system based in Wisconsin, the physician advisor serves as champions physician response rates to documentation queries. Under this program, physicians have a maximum 8-day outer limit in place for CDI response time. At six days, the physician advisor sends a reminder directly to the physician about their with notifications direct from the physician advisor to individual's in receipt of outstanding requests. Query response rates jumped by 17 percentage points, dramatically improving time to coding.

Eight-Day CDI Model

Day 0	Day 2	Day 4	Day 6	Day 8
Query sent	Reminder sent from CDI team	Reminder sent from CDI team	Reminder sent from Physician Advisor	Response due; Reminder sent from Physician Advisor

Query Response Improvement

80%
Query response rate before 8-day model implemented

97%
Query response rate after 8-day model implemented