The Evolving Role of Physicians and the Impact on your Hospital’s Viability

Ralph Wuebker, MD, MBA, Chief Medical Officer
Learning Objectives

At the completion of this educational activity, the learner will be able to:

– List the duties of a physician advisor
– Describe the components of a Medicare physician advisor compliance program
– Gauge physician advisor staffing needs
Why Use a Physician Advisor?

• 10 years ago the position really did not exist
• There was no operational role for a physician in the hospital – other than delivering clinical care
• Managed care has been capitalizing on this fact for many years
  – They have an entire staff of doctors and nurses who are in charge of ensuring that the medical loss ratio is protected
• Medicare followed
  – RACs and other CMS programs
How Do Hospitals Work?

BOARD OF GOVERNORS
- Limited clinical knowledge
- Known in community
- Average tenure: 5 years

MEDICAL STAFF
- Physicians
- Limited understanding of hospital finance
- Average tenure: 25 years

CORPORATE
- Corporate governance
- Variable involvement
- Consistency is high priority
- Usually “administrators”

HOSPITAL ADMINISTRATION
- Limited clinical knowledge
- Essentially “responsible for everybody”
- Average tenure: 3–4 years

CEO, CFO, CMO

Chief of staff
Misaligned Incentives

- Frequently, physicians are billing independent of the hospitals and thus have limited interest
  - However, even employed physicians can be challenging to work with
- Today, hospital payment is at much higher risk for audit and denial than physician payment (this is evolving)
  - Worse, most commercial insurance plans pay the physician and deny the hospital for days in question
- For the auditors, the amount paid to hospitals is usually much more
  - Example: Kyphoplasty
    - After Medtronic settlement, the DOJ didn’t go after physicians for doing unnecessary bone biopsies or ordering unnecessary overnight stays
    - Hospitals are being audited back to 1999 and repaying 50% of their kyphoplasty revenue plus penalties
The UM Plan Basics
The Basis

- Based in the *Conditions of Participation*
- Specific standard for utilization review is found at §482.30
- Six elements in the standard (A–F)
- Need to have a **plan** to review utilization, a committee to review utilization, and processes to address utilization (both under and over)
**CoP – The Six Elements**

**Background** – The Conditions of Participation (CoP) at §482.30 outline the requirements for a utilization review plan. There are six elements (A–F):

A. **Applicability**
   1. Services of the institution and the medical staff
   2. Medicare/Medicaid patients
   3. State superiority in the event the standard is higher than Medicare

B. **Composition**
   1. Two practitioner members (practitioner as defined by Medicare)
   2. Conflict of interest prohibition – involved in care, financial interest < 5%

C. **Scope and frequency of reviews**
   1. Admission
   2. Duration of stay
   3. Sampling
   4. Professional services – drugs and biologicals
   5. Outliers – assume based on length of stay and extraordinarily high cost
**CoP – The Six Elements**

**D. Determinations** – process for determination of medical necessity
   1. Made by **one member** of committee
   2. **Attending** opportunity to present view
   3. If UM and attending don’t agree – **second member** of committee
   4. Final determination – **two in agreement**
   5. If not medically necessary – must **inform** patient, physician, hospital (HINN)
   6. Time frame for notification – **two days**

**E. Extended stay**
   1. **Outliers (all)** – that exceed outlier threshold
   2. No later than **seven days** after the day required in the plan

**F. Professional services** – including **drugs and biologicals**
What the UM Committee Is Not

- **Not just case review**
  - Concurrent review is used to decrease the amount of time spent in the hospital; therefore, the first concurrent review often determines a discharge plan
  - Goal to ensure that the patient is getting the right care in a timely and cost-effective way

- **Not peer review**

- **Not for punitive action**
  - Physicians frequently see it as such due to peer-to-peer review, but this should be an opportunity to help your physicians improve their practices/documentation through education
  - UM committee is for evaluation and improvement
    - Of services, patient care, revenue integrity, efficiency ...

- **Not a credentialing committee**
  - Although credentialing folks may be sitting on the UM committee

- **Not a new concept**
  - UM management did not just spring up due to recent government scrutiny. Hospitals have been doing this for a long time.

- **Not a committee of administrators**
  - Physicians are required to participate
  - **Standard: Composition of utilization review committee.** A UR committee consisting of two or more practitioners must carry out the UR function. **At least two of the members of the committee must be doctors of medicine or osteopathy.** The other members may be any of the other types of practitioners specified in 482.12(c)(1).

- **Must be a functional committee**
- **NOT OPTIONAL!**
The Role of the Committee
Committee Members

• Voting members:
  – Must be a medical provider as defined in 482.12 c(1)
    • Medical doctor
    • Doctor of osteopathic medicine
    • DDS or DMD
    • DPM (podiatrist)
    • OD (doctor of optometry)
    • DC (doctor of chiropractic)
    • Clinical psychologists (PhD or PsyD)
Committee Members

- Nonphysician medical professionals
  - Case management
  - Quality
  - Social work
  - Ad hoc – ancillary (radiology, diagnostic, therapies, nutrition services, pharmacy)
- Non–medical advisors
  - Finance, data analyst
  - Health information management
  - Patient financial services/denials management
  - Compliance
Role of the Committee

- Improvements
  - Decreasing costs (cost/case)
    - Increasing revenue (decreasing denials)
    - Improved patient outcomes (lower readmission rates, appropriate length of stay)
  - Better patient experience (decreased redundancies, decreased delays, improved communication)
Committee Responsibilities

- Concurrent case review
- Outliers/types and causes
- PA reports – good and poor performers and a call to action when appropriate
- Utilization of high cost/at risk services: Labs, PET, etc.
- ABN, HINN, any kinds of notices
- Discharge dispositions — % to levels of care so that we were appropriately providing care
- Readmission rates per high-level DRG – should refine this to “unplanned”
- LOS by CMI
- PEPPER review
- Sample of RAC charts pulled and opportunities identified as hospital appeals charts
- Dollar amount returned back to RAC
- Readmissions issues with trend analysis
- Inpatient conversion rate
- Observation cases with LOS greater than 48 hours: Trends, opportunities, and action plan
Committee Responsibilities

Avoidable days by service, physician
• Denials overturned concurrently and post-discharge
• Number of cases discharged before expected LOS
• Review and revise UR plan at least once a year update
• Peer review cases appropriate for UR committee – referral between committees
• Condition code 44 and how to minimize its use

• Internal audits done (high-risk areas)
  – Medicare patients discharged to SNF after 3 inpatient days
  – Observation patients – see if there was opportunity to convert to inpatient
  – One-day Medicare inpatient cases
  – CM assessment done in timely manner as per the hospital policy

• Commercial denied days by payer source and opportunities for improvement
  – Pre-certification
  – Peer-to-peer discuss
Role of Physician Advisor
Duties of a Physician Advisor

**Medicare**
- Compliance, rules, regulations, guidelines, etc.
- RAC, MAC, ZPIC denials appeals
- Core measures
- Never events
- Pay for performance, PQRI
- Present on admission
- DOJ, OIG investigations
- Readmissions

**Hospital UM/UR**
- Medical staff education
- Length of stay
- “Coaching” problem physicians
- Present on admission
- Billing concordance (hospital and physician)
- Screening criteria (InterQual)
- Clinical capital projects: Cath lab, CA center, observation unit
- Monitor UM metrics/scorecard
- Quality

**Medicaid**
- Compliance
- MIP and RAC appeals

**Commercial insurance**
- Denial appeals
- Contract negations with insurance companies

**Committee memberships**
- UM
- Credentialing, MEC, quality, others

**HIM**
- Documentation improvement
  - Medical necessity and coding
- ICD-9, ICD-10
Physician Advisor: Part-Time Job?

• Although you may need someone only 20 hours a week, you need them when you need them
• Keep in mind, this is a very specific expertise
  – Training and experience are difficult to come by
• Excellent communication skills are paramount
• Must know how to have a hard conversation
• Metrics for success are currently not standardized
Physician Advisor vs. Attending Physician

Physician advisor

• Must know specific regulations
• Knowledgeable about the appeals process
• Positive and respectable relationships with attending physicians
• Must be a team player

Attending physician

• Does NOT try to teach all of the regulations
• Needs a high-level understanding of why the UR process is important
• Understands that “helping the hospital will help me”
• UR is NOT a quality review
Physician Advisor (PA): Job Description

• Good article in *Case Management Monthly*, June 2012
• Pick select items where you can have the most impact for the hospital (and for yourself):
  – Commercial denials
  – LOS management
  – Medicare reviews
  – Other
• Hire proper staff
  – Or appropriate expectations if part-time
• Prepare a plan to measure success
Job Description Outline: Medical Director UM

- Position summary
- Responsibilities:
  - LOS management
  - CDI
  - ICD-9/10
  - Appeals (commercial?, Medicare?, Medicaid?)
- Education: MD/DO
  - Specialty
- License/staffing
- Reports to CMO, CFO, CEO
- Hours required
- Compensation model
  - Salary vs. hourly
Physician Advisor Traits

• Multi-specialty
• Entrepreneurial, innovator
• Respected by the medical staff
• Clinically up to date
• Focused on relationships
• IT literate
Internal vs. External PA Considerations

Depending on the area of need, there will likely be different answers
• Commercial denials, Medicare reviews, appeals, CPOE, LOS, etc.

Considerations:
• Economies of scale:
  – Clinical and regulatory research/knowledge base
  – Subspecialty representation
  – Experience (ALJ learning curve)
• Consistency and quality assurance (if more than one person)
• Bias (toward cases and by medical staff)
• Cost
• Relationship with medical staff
  – Ability for “face time”
  – Knowledge of the culture
• Multiple roles and responsibilities (quality, UR, documentation, coding, etc.)
• Division of responsibilities is usually the best model
PA Staffing Case: Example for Medicare Concurrent Reviews
Staffing Considerations

- Expected case/work volume
- Hours staffed (vacation/holiday coverage)
- How many physicians are needed?
- Financial impact (prove your worth!)
- Training
  - Internal vs. external
- Documentation requirements
- Communication methods
  - Attending physician
  - CM staff
- CME (UM-specific topics)
What Are the Components of a Medicare Physician Advisor Compliance Program?

Workflow structure:

- Medicare has identified “medical necessity” as a major source of potential overpayment/fraud
- Most Medicare denials are due to “medical necessity”
- Medicare requires a two-part review process for “medical necessity” review according to the *Conditions of Participation*:
  1. **First Level Review**
     - Application of a screening tool (i.e., InterQual® or Milliman) by nonphysicians on every Medicare patient in the hospital
  2. **Second Level Review**
     - Use of a trained physician advisor to weigh clinical risks, treatment options, and regulations for cases that failed first-level review. These are “gray area” cases.

This process has to be performed consistently for every Medicare patient, every day of the week.
## Components of a Physician Advisor Compliance Program

<table>
<thead>
<tr>
<th>Components</th>
<th>Description</th>
</tr>
</thead>
</table>
| **FINANCIAL**                     | • Largest potential cost of a compliance program is the risk of being noncompliant  
• This could result in returning monies, establishing accounting reserves, paying interest, fines, penalties, and potentially signing a corporate integrity agreement |
| **STAFFING**                      | • Required for 7-day-per-week 10–12-hour/day coverage  
• Multiple specialties to cover the clinical diversity                                                                                     |
| **TRAINING**                      | • Recruiting/credentialing of physician team  
• Training/certification of physician team on UR, CMS rules/regs, risk assessment  
• Clinical/regulatory research to keep up with changing regulations  
• Quality assurance to ensure consistency of review  
• Technology/reporting track process, outcomes, ensure documentation                                                                           |
| **QA AND PROCESS IMPROVEMENT**    | • Perform appeals if challenged by RAC/MAC  
• Additional staffing to successfully appeal through all five levels                                                                          |
Potential Cost of Being Noncompliant (Error Rate)

HOSPITAL NAME
(Based on MedPar data and benchmarks)

ESTIMATE NUMBER OF CASES REQUIRING AN EXPERT PHYSICIAN ADVISOR (PA) REVIEW:

Expected volume is based on annual Medicare admissions and the type of case review services requested. This is based on customer’s MedPar data and an assumed rate of cases not meeting nurse-based inpatient screening criteria.

<table>
<thead>
<tr>
<th>Patients needing PA review:</th>
<th>Annual</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients not meeting IP screen</td>
<td>1,421</td>
<td>118</td>
</tr>
<tr>
<td>OBS/OPs not meeting IP screen</td>
<td>631</td>
<td>53</td>
</tr>
<tr>
<td>Ttl est cases needing PA review</td>
<td>2,052</td>
<td>171</td>
</tr>
</tbody>
</table>

Expected number of cases requiring 2nd-level review

| Ttl est reimbursement outstanding | $19,891,781 | $1,657,648 |

Difference between inpatient & OBS/OP reimbursement

COMPLIANCE & REVENUE INTEGRITY RISK OF NOT RECEIVING PHYSICIAN ADVISOR REVIEWS:

<table>
<thead>
<tr>
<th>If your error rate is X%?</th>
<th>Annual</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0%</td>
<td>$994,589</td>
<td>$82,882</td>
</tr>
<tr>
<td>10.0%</td>
<td>$1,989,178</td>
<td>$165,765</td>
</tr>
<tr>
<td>15.0%</td>
<td>$2,983,767</td>
<td>$248,647</td>
</tr>
<tr>
<td>20.0%</td>
<td>$3,978,356</td>
<td>$331,530</td>
</tr>
<tr>
<td>25.0%</td>
<td>$4,972,945</td>
<td>$414,412</td>
</tr>
<tr>
<td>30.0%</td>
<td>$5,967,534</td>
<td>$497,295</td>
</tr>
<tr>
<td>35.0%</td>
<td>$6,962,123</td>
<td>$580,177</td>
</tr>
<tr>
<td>40.0%</td>
<td>$7,956,712</td>
<td>$663,059</td>
</tr>
</tbody>
</table>

A lack of physician advisor review puts you in violation of the UR Standards of the Conditions of Participation with Medicare...

And, If you incorrectly status a patient as inpatient:
- You may receive revenue not owed
- You may be required to return revenue + interest (+ possible penalties)
- You may be exposed to false claims charges, a CIA, and criminal liability

And, If you incorrectly status a patient as observation/outpatient:
- You may lose revenue that you are entitled to
- You may create inappropriate patient liability
- You may artificially inflate your ALOS
<table>
<thead>
<tr>
<th>Assumptions</th>
<th>Description of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Staffing</strong></td>
<td>• 7 day a week coverage/FTE</td>
</tr>
<tr>
<td></td>
<td>• 1680 hrs/FTE</td>
</tr>
<tr>
<td></td>
<td>• Staffing must be adequate to handle the peaks in review volume as admissions do not occur evenly throughout the day</td>
</tr>
<tr>
<td></td>
<td>• Excess capacity needs to be created to handle holiday and PTO coverage</td>
</tr>
<tr>
<td><strong>2. Base/Bonus Compensation</strong></td>
<td>• $XXX,XXX</td>
</tr>
<tr>
<td><strong>3. Benefit Load</strong></td>
<td>• 30%</td>
</tr>
<tr>
<td><strong>4. Support/Ancillary Cost</strong></td>
<td>• Recruiting/Credentialing 15-20% of first year compensation</td>
</tr>
<tr>
<td></td>
<td>• Retention assumption (3 yr)</td>
</tr>
<tr>
<td></td>
<td>• Scheduling/Administrative Assistant</td>
</tr>
<tr>
<td></td>
<td>• Program Management/Staffing (0.5 FTE)</td>
</tr>
</tbody>
</table>
Program Infrastructure: Medicare Reviews

• Recruiting
• Credentialing
• Training/certification of physician team
  – UR
  – CMS rules/regulations
  – Risk assessment
• Clinical/regulatory research
  – Regulation updates/clarifications and changes
• Quality assurance
  – Consistency of review
• Technology/reporting
  – Track process, outcomes, ensure documentation
Physician Advisor (PA) Training/Testing

• How does an internal medicine/family practice physician become a cardiologist or pulmonologist?
  – Additional training and experience
• The same is true for a PA
• A practicing physician doesn’t just “know” how to be a PA simply because of the MD/DO
• How do they learn about Medicare and Medicaid regulations, managed care, documentation requirements, RACs, MACs, and MIPs?
• A physician acting as a PA — without training — will simply follow the recommendation of the RN case manager, which defeats the purpose of an independent secondary physician review
A Medicare training/certification program needs to include didactic training and testing on:

1. **Medicare/Medicaid regulations**: Include *Conditions of Participation*, local coverage determinations, and process and documentation requirements.

2. **CMS contractors**: Who will be looking over their shoulders?
   - What will they be looking for, and how will they look for it?
   - What are their limitations?
   - How do they escalate cases to the DOJ and OIG to trigger penalties, false claims accusations, and corporate integrity agreements (or even personal liability)?

3. **CMS appeal process**: What are the five levels of appeal? How do you perform a medical necessity appeal at each level? How do you prepare for denials through your concurrent review process? How do the requirements differ for Medicare and Medicaid (Medicaid includes state-specific requirements)?

4. **Clinical risk assessment**: In assessing status, does CMS require the evaluation of intensity of service/severity of illness? What other factors can be considered?
PA Training and Testing (cont.)

5. **CMS “inpatient-only” list:** Need to ensure proper staffing for day-to-day compliance:
   a. What about procedures that are not on the “IP-only” list?
   b. What about differences between this and InterQual (IQ)?
   c. What if the post-procedure clinical data differs from what is known pre-procedure?
   d. What clinical risk evaluation models can be used to assess patient-specific risk of in-hospital mortality for a pacemaker insertion/replacement, or kyphoplasty? (Most physicians only refer to 1 or 2 models for assessing risk in the types of patients regularly seen in their specialty area; a true program should have a library of > 5 models per clinical scenario.)

6. **Interface of admission review and coding:** Does a patient receiving a procedure need to have inpatient charges to be considered for inpatient status?

In addition to classroom training and testing, PA training should also include hands-on case reviews and mentoring, as with any residency or fellowship program.
Knowledge Maintenance: Ongoing Regulatory Research

- Who is going to provide updates to local coverage determinations, CMS *Conditions of Participation*, CMS’ inpatient-only list, changes/updates in MAC guidance, and other changes in federal and state regulations?
- How do you ensure that the most relevant regulatory information is being used in each determination?
  - Subscribe to a research service. Someone still needs to interpret the regulations and determine the implications for admission review workflow and documentation decisions.
Knowledge Maintenance: Ongoing Clinical Research (cont.)

- Who is going to provide clinical risk models and updates for new research across all of the medical/surgical subspecialties?
  - For example, will the PA know the probability of in-hospital mortality of a catheterized patient based on demographics, background, test results, and how their data compares to the average catheterized patient?
  - At what point is the risk high enough, relative to the average, to be considered an inpatient?
    - Ex: CABG vs. AICD
- Clinical research and references are the backbone of your appeal process.
- The comment “we always do them as inpatient” is not sufficient and has led to poor outcomes at the ALJ level.
Quality Assurance Program

- How do you ensure that each physician is following a consistent documentation process and applying the same clinical/regulatory content when completing the reviews?
- How do you ensure that the review is defensible and supportable and that another physician would come to the same conclusion?
- Also requires analysis to ensure that physician reviewers don't have biases in determinations by diagnosis or situation.
The true test of an effective Medicare compliance program is reflected in how well it stands up to scrutiny by MACs, RACs, Medicaid RACs, the CERT, or the OIG/DOJ.

A facility should plan that most denied cases will require an appeal to the ALJ.

Have the physician work alone, with a nurse, or bring in someone with regulatory/legal expertise as needed.
• Difficult to predict staffing required for all 5 levels of Medicare appeals (not counting discussion stage)

• Approaches:
  – Physician that reviewed the case handles the appeal
    • Good for consistency
    • Can be staffing problem if there is physician turnover
  – Two departments: Concurrent reviews and appeals
    • Can leverage up expertise
    • Can require additional staffing
  – First available physician
    • Not recommended
    • Poor quality and consistency
    • Blunts learning effect without good documentation
Anticipated Appeals Defense Volume

Recovery Auditors:
• Number of charts pulled
  – Based on hospital volume data
  – 20% of Medicare claims up to 400 charts/45 days
  – Minimum of 35 charts/45 days
• Likely denial rate: 35%
  – Based on demonstration project, but would expect an increase

MAC, OIG, DOJ
• Less parameters and as a result more variability (thus intermittent volume spikes)

Medicaid RACs
• Requirements differ from state to state; know your state rules

Also remember to consider use of extrapolation
Predicting Concurrent Medicare Case Volume: Two Approaches

1. Actual claims data:
   • 92 “high-risk” cases (OBS and inpatient)/month = (485 + 614)/12
   • 888 high-risk MED DRGs*
     – (From RA approved medical necessity list)
   • 485 1- and 2-day stay (highest audit risk)
   • 614 med obs (revenue loss)
   • 12 months of data

   *High Risk DRGs: 56 57 69 182 190 191
   192 249 253 254 291 292 293 302 308 312
   313 314 315 316 393 551 552 640 682 683
   684 689 811

2. Hospital census:
   • Total Medicare fee-for-service (FFS) “inpatients” per year
     – Typical “inpatient” first-level screening failure rate 15%–25%
   • Total Medicare FFS “observation” (OBS) patients
     – Typical “OBS” screen failure rate is 70%–90%
   • Repeat calculation for FFS Medicaid
Physician Advisor Staffing Needs

Expectations of one FTE: 226 typical days worked/year – PA FTE for staffing purposes

• 261 total FTE days/year
  – Maximum work in a year is 5 days/week, 52 weeks/year

• Less vacation days – 25
  – Multiply five weeks of vacation/sick time by 5 days/week

• Less CME days – 3
  – Paid time off for continuing medical education

• Less holidays – 7
  – Paid holidays range from 7 to 10 days
How Many Case Reviews per Physician FTE?

1,354 hours/FTE/year (113 hours/FTE/month) available to perform reviews

• (226 days per year * 8 hours per day) * 75%
• 25% non-productive time during shift
  – Typical staffing standards assume 20% to 30% non-productive time
  – Meetings, lunch
• Average time per case review: 0.5 to 2 hours
  – A case review can vary depending on complexity, the need to talk with the attending physician, concurrent vs. appeal case, and the need to access clinical/regulatory guidance and documentation.
  – Staff the department 8? 16? 24? hours per day.
  – Remember: cases don't come in smoothly during a normal shift. Therefore, may require staffing overlap (Example: Peak times in ER).
  – More coverage = less errors; less coverage = more errors.
Key Takeaways

• Think about where you can make the largest impact given your resources
• When making the decision, remember to consider ALL costs and potential revenues
• You will be able to make a big impact, you just need to decide where
THANK YOU.
Questions?

rwuebker@ehrdocs.com