

How Best Practice Organizations Are Structuring Their Physician Advisor Programs

Executive summary

Many revenue cycle offices have long employed physician advisors to help appeal denials, but at top-performing organizations, these advisors are doing more than ever before.

Keep reading to see:

- What characteristics make a strong physician advisor
 - How best practice organizations are structuring their physician advisor programs
-

The Role of the Physician Advisor

Optimal Performance Extends Scope to Mitigate Denials Through Cycle

Denials Mitigation Opportunities Extending Beyond Business Office



Patient access



1

Utilization review / admission decisions, pre-auth education



Mid-cycle



2

Peer-to-peer requests



Business office



3

Clinical appeals

Key Physician Advisor Roles Bridge Clinical-Financial Gap



Identify governmental audit risks (MACs, RACs) via OIG



Remove revenue cycle burdens from hospitalists to-do lists



Understand specific clinical requirements for delivering care under different contracts



Strengthen communication with payer's clinical decision makers



Act as physician champion for revenue cycle team

What Makes For a Strong Physician Advisor?

Key Characteristics to Look For

Profile of a Physician Advisor



- MD/DO
 - Background/interest in payer relations, or specialty cognizant of utilization
- Licensed at system facilities
- ~5 years of clinical experience
- Examples of good fits:
 - Hospitalist with broad based clinical knowledge
 - Physicians with clinical leadership experience
 - Specialists cognizant of utilization, such as pediatric hospitalists

Skills and Characteristics



Clinical understanding of multiple specialties



Good relationship with physicians and staff



Strong communication skills



Comfortable with IT



Knowledge of regulations (and changes to regulation), appeals process, contract terms

Proactively Spearheading Clinical-Financial Initiatives

Playing a Broader Role than the “Traditional” Physician Advisor



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 documentation¹. 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



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

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

Key to Stronger Payer Relationships

Physician Advisors Can Appeal Directly to Payer Medical Directors

Health Systems with Developed Physician Advisor Programs Seeing the Benefits

“Our team of physician advisors are building a relationship with medical staff at payers, and they are integral in the clinical conversations. The impact they have on medical necessity write offs is huge.

Director of Business, St. Elizabeth Health

“The physician advisors have specific skills in negotiation, gamesmanship, and working with payers. They learn which arguments will hold up with the medical director, and can judge which cases are worth fighting for.

Senior Director of RCS Utilization, Novant Health

Physician Advisors Uniquely Positioned to Work with Payers



Develop in-depth knowledge of payers' preferred clinical care guidelines



Gain familiarity with past rulings on appeals



Build close relationship with payers' medical directors



Maintain objectivity on cases, as they remain more removed than the attending hospitalists

Physician Advisor Program Models

Detailing Roles and Responsibilities at Leading Organizations

<i>Organization</i>	<i>Model</i>	<i>Physician Advisor Responsibilities</i>	
 5 hospital, 892 bed system	In-house; 1 FTE, 2 part-time; internal hires, experience with medical group and payers	<ul style="list-style-type: none"> Clinical appeals CDI HIM 	<ul style="list-style-type: none"> Utilization review Peer-to-peer requests
 1 hospital, 322 bed system	In-house; 1 FTE, hired from medical group	<ul style="list-style-type: none"> Clinical appeals Utilization review Peer-to-peer request 	<ul style="list-style-type: none"> ACO oversight Physician education Clinical documentation improvement
 13-hospital, 2,500+ bed system	In-house; 4 FTEs and 4 part-time employees ¹ , hired from medical group and from external search	<ul style="list-style-type: none"> Clinical appeals Utilization review and chair UR committees Peer-to-peer requests 	<ul style="list-style-type: none"> Physician education Denials research Medical care evaluation studies
 7-hospital, 2,000+ bed system	In-house; 1 FTE at system level, 1 FTE at each facility	<ul style="list-style-type: none"> System Level (1FTE): <ul style="list-style-type: none"> Clinical appeals Denials management 	<ul style="list-style-type: none"> Facility CMOs <ul style="list-style-type: none"> Denial trends High level appeals Champion revenue cycle
 2-hospital, 320 bed system	In-house and vendor-sourced; 1 FTE at system level, with advising from vendor for clinical appeals	<ul style="list-style-type: none"> Utilization review CDI and coding Denials management 	<ul style="list-style-type: none"> Physician education Case manager, office staff, and nurse education

Build, Buy or Both?

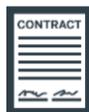
Organizations Deploy Physician Advisors Through Multiple Models

	Outsourced	Combination	In-House
<i>Expected Benefits</i>	<ul style="list-style-type: none"> • Faster program launch • Access to large bank of know ledge 	<ul style="list-style-type: none"> • Access to large bank of know ledge • Non-clinical appeals responsibilities still handled • Allow s for initial, on the ground review s 	<ul style="list-style-type: none"> • Control over appeals decisions • Strong organization-payer relationships
<i>Capabilities needed</i>	<ul style="list-style-type: none"> • Streamlined appeals process 	<ul style="list-style-type: none"> • Strong physician candidates w ith payer experience/know ledge • Streamlined appeals process 	<ul style="list-style-type: none"> • Strong physician candidates w ith payer experience/know ledge • Streamlined appeals process
<i>Caveats for consideration</i>	<ul style="list-style-type: none"> • Less opportunity to build relationships between organization and payer • Non-clinical appeals responsibilities of physician advisors not covered 	<ul style="list-style-type: none"> • Potentially disjointed w orkflow s • Have to manage a vendor and an internal department 	<ul style="list-style-type: none"> • Requires established internal know ledge • HR burden; physician advisors may be a flight risk

The Right Answer for Each Organization is Different...

...And Can Change Over Time

St. Elizabeth Healthcare Brings Physician Advisory Services In-House



Service Outsourced

Engaged physician advisory vendor to help handle RAC audits, payer scrutiny

Shifting Priorities:

- RACs diminished
- Payer relationships hurt by vendors' approach to appeals
- Physician employees willing to take on physician advisory roles



In-House Program Developed

Developed physician advisory program. 1 FTE is focused on denials, while 2 part-time employees work on CDI, utilization, and peer reviews

12% → 7%

Initial denials before and after bringing service in-house¹

.9% → .5%

Denial write-offs as a % of NPR before and after bringing service in-house¹



Case in Brief: St. Elizabeth

- 5-hospital not for profit health system based in northern Kentucky.
- Brought all denials services in-house, including Physician Advisory services previously performed by a third-party vendor

¹) Results impacted by other denials mitigation initiatives, including the in-sourcing of other denials management services.

Percent decrease was measured across a 2.5 year time period. Source: Revenue Cycle Advancement Center interviews and analysis.

Evaluate Dollars at Risk

Possible Incremental Savings Opportunity for Organizations

Key Cost and Potential Savings to Consider



Costs

of FTEs needed (~1/200-250 beds)

X

Base salary

+

Benefits

+

Education and training



Potential Savings

Example Metrics:

- Reduced dollars at risk from Medicare FFS, Medicare Advantage, and commercial denials
- Reduced labor costs in appeals
- Reduced dollars at risk from audits (MACs, commercial auditors)
- Improved CDI
- Improved UR (reduction of hours in obsvs, improvement of obsvs to inpatient transitions, reduction of inappropriate clinical use)



This is an Advisory Board publication, one of the many resources available to members.

For over 35 years, Advisory Board has helped executives work smarter and faster by providing clarity on health care's most pressing issues and strategies for addressing these issues. Our team of 350 health care experts harnesses a network of 4,400+ member health care organizations to discover and share the industry's most successful and progressive ideas.

As of November 17, 2017, Advisory Board research division has a new home within OptumInsight. While this marks an exciting new beginning, our commitment to objective research and member confidentiality remains the same. [Learn how we can help you:](#)

- Develop **market-leading strategy** with proven guidance to ensure your organization is taking the right strategic direction
- Accelerate **performance improvement** with personalized access to right answer, including how-to guidance for translating that strategy into action for all stakeholders
- Enhance **team effectiveness** with ready-made resources and on-call experts to enable leaders to do more with less

Preview resources available with membership

Advisory Board members have access to national meetings featuring new research and networking forums, research reports exploring industry trends and proven strategies, on-call expert consultations, forecasting and benchmarking tools, live webconference presentations and an on-demand webconference archive, expert-led presentations on the ground at your organization, and expert blogs on current health care topics.

Preview some of the other resources we've designed to support revenue cycle leaders and their teams.



Research report: [Nine Revenue Cycle Integration Lessons from Progressive Health Systems](#)

This report presents insights from Revenue Cycle Advancement Center research with health systems that are integrating different elements of their revenue cycles system-wide.



Meeting Series: [2019 Revenue Cycle Advancement Center National Meeting](#)

Our 2019 Revenue Cycle Advancement Center National Meeting is designed to help Revenue Cycle Executives (CFOs, VPs of Revenue Cycle, and VPs of Finance) understand and address challenges such as ensuring revenue integrity, deploying an engaged revenue cycle workforce, and understanding the opportunities within ambulatory revenue cycles.



Benchmarking Tool: [The Hospital Revenue Cycle Benchmarking Initiative](#)

The Hospital Revenue Cycle Benchmarking Initiative provides a powerful combination of meaningful, actionable benchmarks, easy-to-access analytics, and insight from research experts.

Contact us at programinquiries@advisory.com or visit advisory.com/research/about-research to learn more.



LEGAL CAVEAT

Advisory Board has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and Advisory Board cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, Advisory Board is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member's situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither Advisory Board nor its officers, directors, trustees, employees, and agents shall be liable for any claims, liabilities, or expenses relating to (a) any errors or omissions in this report, whether caused by Advisory Board or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by Advisory Board, or (c) failure of member and its employees and agents to abide by the terms set forth herein.

Advisory Board and the "A" logo are registered trademarks of The Advisory Board Company in the United States and other countries. Members are not permitted to use these trademarks, or any other trademark, product name, service name, trade name, and logo of Advisory Board without prior written consent of Advisory Board. All other trademarks, product names, service names, trade names, and logos used within these pages are the property of their respective holders. Use of other company trademarks, product names, service names, trade names, and logos or images of the same does not necessarily constitute (a) an endorsement by such company of Advisory Board and its products and services, or (b) an endorsement of the company or its products or services by Advisory Board. Advisory Board is not affiliated with any such company.

IMPORTANT: Please read the following.

Advisory Board has prepared this report for the exclusive use of its members. Each member acknowledges and agrees that this report and the information contained herein (collectively, the "Report") are confidential and proprietary to Advisory Board. By accepting delivery of this Report, each member agrees to abide by the terms as stated herein, including the following:

1. Advisory Board owns all right, title, and interest in and to this Report. Except as stated herein, no right, license, permission, or interest of any kind in this Report is intended to be given, transferred to, or acquired by a member. Each member is authorized to use this Report only to the extent expressly authorized herein.
2. Each member shall not sell, license, republish, or post online or otherwise this Report, in part or in whole. Each member shall not disseminate or permit the use of, and shall take reasonable precautions to prevent such dissemination or use of, this Report by (a) any of its employees and agents (except as stated below), or (b) any third party.
3. Each member may make this Report available solely to those of its employees and agents who (a) are registered for the workshop or membership program of which this Report is a part, (b) require access to this Report in order to learn from the information described herein, and (c) agree not to disclose this Report to other employees or agents or any third party. Each member shall use, and shall ensure that its employees and agents use, this Report for its internal use only. Each member may make a limited number of copies, solely as adequate for use by its employees and agents in accordance with the terms herein.
4. Each member shall not remove from this Report any confidential markings, copyright notices, and/or other similar indicia herein.
5. Each member is responsible for any breach of its obligations as stated herein by any of its employees or agents.
6. If a member is unwilling to abide by any of the foregoing obligations, then such member shall promptly return this Report and all copies thereof to Advisory Board.



2445 M Street NW, Washington DC 20037
1-202-266-5600 | [advisory.com](https://www.advisory.com)