The Role of the Physician Advisor

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LEARNING OBJECTIVES:
At the conclusion of this presentation, the participant should be able to:

1. What is the Physician Advisor
2. The current milieu that hospitals and physicians face with insurers.
3. Working Relationship between Physician Advisors & clinical providers.
The Role of the Physician Advisor

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Learning Objectives

• The current milieu that hospitals and physicians face with insurance
• The peer to peer encounter with insurance companies
• Working relationship between Physician Advisor and Clinical Providers
Responsibilities of The Physician Advisor

• Champion for your Case Management program, supporting review functions
• Work with hospital administration and clinical committees to develop processes and guidelines to improve quality of care.
• Educator and negotiator with the medical staff
• Provide perspective on UM program from the Physician point of view.
• Liaison between Managed Care companies and the providers.
• Member of the Utilization Review Committee
Desirable Characteristics for a Physician Advisor

- 5+ years medical staff experience
- Strong communication skills
- Appropriate knowledge base (medical necessity criteria)
- Respect of peers
- Flexibility/Availability
- Credibility
Desirable Characteristics for a Physician Advisor (Cont’d)

• Not afraid to take an unpopular stand
• Willing to educate peers
• Willing to assist in counseling peers
• Willing to keep abreast of new criteria
• Willing to advise peers
• Acceptance of medical staff
• Leadership capability
Benefits Realized with a Physician Advisor

- Reduced length of stay due to early intervention with barriers to discharge.
- Education resource for Case Management team.
- Appeal of concurrent and retrospective denials.
- Direct communication with attending physicians.
Benefits Realized with a Physician Advisor (Cont’d)

• Decreased avoidable days
• Decreased denials
• Decreased cost
• Improved documentation
• Improved use of resources
The P.A. role includes

- Advisory Role
- Administrative Role
- Educational Role
Advisory Role

- Available to the Case Management team on site, by phone, or electronically.
- Support Case Managers via review of case information to assist with the best plan of action for the patient.
- Direct interaction with the Medical Staff to resolve issues that affect utilization management or quality.
Advisory Role (Cont’d)

- Provides clinical support with issues regarding documentation.
- Provides support when lack of response by physician to query.
- Assists the case managers in medical necessity issues.
- Contact physicians when not responding to case managers.
- Assists in phone calls and/or meetings with medical directors of managed care of insurance companies regarding denied payments.
Administrative Role

• Review referred cases for medical necessity and appropriate level of care.

• Review of difficult cases referred by Case Managers to improve Case Manager/Physician interaction.

• Assist Case Management in situation when a Physician’s involvement is necessary (i.e. meetings with physician’s to address quality or UM issues).
Educational Role

• Attending rounds or length of stay meetings regularly to provide education and insight for effective management of cases.

• Review physician practice/behaviors and provide education as needed per your hospital protocol.

• Educate the medical staff to increase their collaboration and cooperation.

• Advise Administration on complex cases.
Educational Role

• General medical staff and board of trustees presentations.
• Communicate PRN with payer medical directors.
• Co-Chair of UR Committee (varies by hospital).
• 1:1 and department presentations regarding:
  – Inappropriate utilization
  – LOS issues
  – Avoidable issues
  – Inappropriate status (obs/inpt)
  – Potential denials
Key Elements Of P.A. Job Description

• Role Description and Reporting
• Experience
• Accountability Targets (“Deliverables”)
• Availability
• Minimum Requirements (per facility job description)
• Duties
• Specialized Skills
Advantages of Physician Advisor

- Decreased Length of stay
- Decrease hospital costs
- Decreased Avoidable days
- Improved documentation
- Decreased denials
- Improved use of hospital resources
Organization Management

- Utilization Review (UR) is a process used to assess the medical necessity, use, delivery, cost effectiveness, appropriateness, and efficacy of healthcare services provided by medical professionals on a prospective, concurrent, or retrospective basis. The UR process compares requests for medical services with treatment guidelines and criteria, with the case managers from both the payer and providers arenas making recommendations based on that comparison.
Utilization management (UM) is a case management (CM) program to assess efficiency and quality of patient care based on criteria established in conjunction with the medical staff and should be tightly linked to the revenue cycle of the hospital or health system. UM encompasses expanded UR functions, including processes that improve patient outcomes as well as resource utilization. UM also includes proactive procedures, concurrent planning, precertification, and clinical case appeal. As precertification and concurrent review of cases grew, UM was spun out of UR. Although not synonymous, health care professionals tend to use the terms interchangeably.
Organization Management Continued

- Historically, in the inpatient setting data collection occurred after the patient was discharged. After discharge, HM professionals checked the record for discrepancies that could hinder code assignment. HM professionals would then query the provider for clarification. (For purposes of this practice brief, the term “query” will be used to identify my physician communication tool.)
Organization Management Continued

- However, with the implementation of the prospective payment system, coded data took on greater significance and became a mechanism for reimbursement, quality measure reporting, and profiling. The increased need for interpreting coded data for meaningful comparison and quality reporting has led to the expansion of the HM professional’s role in clinical documentation improvement (CDI).
The focus of most CDI programs is on improving the quality of clinical documentation regardless of its impact on revenue. Arguably, the most vital role of a CDI program is facilitating an accurate representation of healthcare services through complete and accurate reporting of diagnoses and procedures.
Organization Management Continued

• A successful CDI program can have an impact on Centers for Medicare and Medicaid Services quality measures, present on admission, pay-for-performance, value-based purchasing data used for decision making in healthcare reform, and other national reporting initiatives that require the specificity of clinical documentation.

• Improving the accuracy of clinical documentation can reduce compliance risks, minimize a healthcare facility’s vulnerability during external audits, and provide insight into legal quality of care issues.
SO, I’M LIKE

“Your call is very important to us”
Case Study 1

This is a 48 year old female who presented to the hospital with chest pain and weight gain. Her medical history included MI with stent, renal cell carcinoma, and HTN. The blood pressure was 139/93 mmHg, pulse 71 BPM, respirations 16 per minutes, temperature 97.8 degrees and oxygen saturation 99% room air. The physical examination revealed no distress, clear lungs, regular heart rate and rhythm, and no edema. The chest x-ray was negative. The EKG showed NSR, unchanged. The concern of the attending physician is for edema and weight gain. The plan of care includes telemetry, IV NS at 100ml/hr, Coreg 6.25 mg PO bid, Plavix 75 mg PO qd, troponin, magnesium, EKG, CXR, cardiology consult and routine labs.
Case Study 2

- This is a 61 year old gentlemen who presented to the hospital from another hospital with a nosebleed for 2 weeks. The medical history is significant for hypertension and COPD. The BP was 149/97 mmHg, HR was 93 BPM, temperature was 97.5 degrees F. RR was 27 per minute and oxygen saturation was 97% on room air. The physical examination was remarkable for controlled bleeding from the left nare. After discussion with the attending physician, his concern was for epistaxis. The plan of care included Septra twice daily and intravenous D5 ½ normal saline with 20 mEq of potassium chloride at 100 mL/hr.
Case Study 3

- This was a 31 year old patient who presented to Greenville Memorial Hospital on December 9, 2013 for defibrillator pulse generator battery depletion. Prior to presentation to the hospital, the patient reported experiencing a vibrating sensation in her device. The patient’s past medical history is significant for chronic systolic heart failure, ESRD and dilated cardiomyopathy (status post single-chamber defibrillator implantation in 2007). Initial evaluation of the vital signs revealed a blood pressure of 118/65 mmHg, a pulse of 80 BPM and a respiratory rate of 18 per minute. On physical examination there were no abnormalities reported. The patient was treated as an outpatient. A defibrillator pulse generator removal, right ventricular defibrillator lead implantation and defibrillator implantation with testing was performed for defibrillator pulse generator battery depletion. Postoperatively, the patient required intravenous Ancef every 6 hours times 3 doses and one dose of IV Demerol. Subsequently, she was monitored for early complications and her final defibrillator program settings included: single tachycardia zone cutoff at 207 beats per minute and pacing mode VVI at 40 beats per minute. On December 10, 2013, the patient was determined stable for discharge.
Case Study 4

- This is an 89 year old woman who presented to the hospital from his physician’s office with increasing edema, and shortness of breath, associated with dizziness and an abnormal echocardiogram showing severe mitral regurgitation. The medical history is significant for HTN, hyperlipidemia and osteoporosis. The blood pressure was 166/72 mmHg, pulse was 72 BPM, and respiratory rate was 16 per minute. The physical examination was remarkable for a grade 3 out of 6 systolic mumur heard over the apical, and there was one plus bilateral edema. The concern of the attending physician was for severe mitral regurgitation. The plan of care includes telemetry, EKG, transesophageal ECHO, Cardiology consultation and cardiac catheterization.
This is a 78 year old gentleman who presented to the hospital after he awoke with diaphoresis and cramping abdominal pain followed by nausea and vomiting and who reported recent loose stools. The medical history is significant for HTN, the blood pressure was 146/80 mmHg, pulse was 79 BPM, temperature was 97.7 degrees, respiratory rate was 17 per minute, and oxygen saturation was 99% on room air. The physical examination was remarkable for vague right lower quadrant tenderness to deep palpitation, no hepatosplenomegaly, negative fluid wave and positive bowel sounds. Significant laboratory findings include WBC count 9.9m, Hgb 13.6, Na 138, K 4.2, BUN 19, creatinine 1.1 glucose 173, troponin 0.05, 0.06 and 0.11 (0-0.04), CKMB 1.9 (no reference range available) and BNP 126 (no reference range available). Radiographically, his CT scan of the abdomen and pelvis found thickening at the ascending and hepatic flexure of the colon consistent with colitis and the EKG showed a RBBB and LAFB. The concern of the initial treating physician is for nausea and vomiting with a new diagnosis of colitis. The plan of care include IV Cipro every 12 hours, IV Flagyl every 8 hours, IV fluids at 75 mL/hour, a Gastroenterology consultation, and echocardiogram, repeat cardiac enzymes and further orders pending the clinical course.
Case Study 6

- This is a delayed review of a 41 year old male who presented to the hospital for left side chest pain associated with nausea. The medical history is significant for CAD, HTN, MI, seizures, and automatic ICD. His blood pressure was 132/86 mmHg, pulse was 79 BPM, respiration rate was 18 per minute, and oxygen saturation was 99% on room air. The physical examination was remarkable for regular heart sounds. The stress test was abnormal with findings consistent with multivessel coronary disease and ischemic cardiomyopathy, inferoposterior scar with minimal peri-infarct ischemia, moderate area of anterolateral ischemia, and severe left ventricular systolic dysfunction. The chest x-ray showed no active disease. Laboratory findings included troponin 0.00. The initial concern on presentation is for chest PAIN, non-specific and severe ischemic cardiomyopathy. The plan of care includes telemetry, aspirin, PO Plavix, serial troponin levels, PO Toprol, PO Imdur, PO Ranexa and myocardial perfusion stress test.
This is a 77 year old woman who presented to the hospital after she was found with possible anasarca and bilateral pleural effusions in need of treatment with an urgent thoracentesis to be completed. The blood pressure was 150/63 mmHg, pulse 96 BPM, RR 16 per-minute, temperature 97.3 degrees, and oxygen saturation 91% decreased to 89% on RA. The physical examination was remarkable for her to be with difficult breathing during ambulation with evidence of desaturation to 89%. Significant laboratory findings included Hgb 9.6, Hct 28.8, Na 131, K 2.6, chloride 91, glucose 119, BUN 21, creatinine 3.1, albumin 3.2 and alkaline phosphatase 133. The concern of the attending physician is for a pleural effusion and anasarca. The plan of care includes oxygen therapy, IV potassium repletion, aspirin PO daily, IV fluid administration, a thoracentesis, and further intervention.
Case Study 8

This is a 56 year old gentleman who presented to the hospital with back pain, loss of consciousness, and falling backwards. The medical history is significant for HTN, OA, and heart disease. The blood pressure was 124/80mmHg, pulse was 101-106 BPM, respiratory rates was 17 per minute, and oxygen saturation was 98% on room air. The physical examination was remarkable for PERRLA, clear lungs, a regular heart rate and rhythm, a soft nontender abdomen with bowel sounds, leg laceration, upper thoracic spine tenderness, and intact sensation and strength. Significant laboratory findings included WBC count of 8.9, hemoglobin of 10.7, and INR of 5.1. Radiographically, his left shoulder x-ray found no acute abnormality and the head CT scan found cerebral atrophy and a dermoid. The initial concern of the attending physician was for concussion, leg laceration, supra-therapeutic INR, T2 compression fracture, and possible transient ischemic attack. The plan of care included Orthopedic Surgery consultation, Cardiology consultation, IV fluid, laceration repair, echocardiogram, CT scan of the abdomen and pelvis, and additional management as indicated.
Case Study 9

- This is a 51 year old gentleman presented to the hospital with myalgias, arthralgias, rhinorrhea, a nonproductive cough, a sore throat, fatigue and decreased oral intake times 1 week. The medical history is significant for ESRD on HD, Wegener’s granulomatosis, leukocytoclastic vasculitis, COPD, HTN and TIA/CVA. The blood pressure was 170/52 mmHg, pulse was 85 BPM, temperature was 97.8 degrees F, respiratory rate was 20 per minute and oxygen saturation was 97%. The physical examination was remarkable for moist oral mucosa, RRR, substernal chest pain, clear lungs, with SOB and no peripheral edema. Significant laboratory findings included WBC count 8.6, hemoglobin 8.7, sodium 140, potassium 4, BUN 34, creatinine 8.34, glucose 88 and Troponin 1 0.12 (range 0.04). Radiographically, the CXR showed some cephalization of the vessels indicating possible congestion with no infiltrates, focal consolidation or effusions and the EKG was reported as within normal limits. The concern of the physician was for viral illness with chest pain and shortness of breath. The plan of care included normal saline at 75 mL/hr, vital signs every 8 hours, clonidine, Norvasc and aspirin.
Case Study Results

• 1. Observation
• 2. Observation
• 3. Outpatient
• 4. Observation
• 5. Inpatient
• 6. Observation
• 7. Inpatient
• 8. Inpatient
• 9. Inpatient
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