PHYSICIAN ADVISERS ADD UP FOR SOME HOSPITALS

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In this article ...

A team of health care experts crunches the numbers and reaches the conclusion that creating — or expanding — a physician adviser program is a good return on investment for any organization that's considering it.

PHYSICIAN ADVISERS ARE UNIQUE HEALTH care professionals who combine an understanding of the clinical and administrative processes associated with safe and cost-effective patient care. They are well-versed in such topics as utilization management, regulatory compliance and clinical core competencies. They help guide the proper use of resources and review the medical necessity of hospitalizations, the duration of stays and discussions about case evaluations and payments. Often, they help manage such issues as bedding levels, complex-case review, provider outreach, and clinical and regulatory education.

Physician advisers lead change within an organization and among medical staff members, with the aim of achieving better patient outcomes while managing costs. Given the increasing scrutiny of medical decisions, expanding regulation, frequently changing rules and the growing use of data-driven models, there's a rising demand for hospitals to have a better handle on their resources. Physician advisers can be a bridge between frontline physicians and hospital administrators as they work toward the same goal.

They monitor outcome data, help case management professionals analyze use of resources, educate physicians about rules and criteria for effective case management, and provide alternative approaches where possible while consistently reinforcing use of best practices and evidence-based care. Sometimes, they work with IT departments to evaluate automation and technology opportunities, thanks to their understanding of the metrics that drive good outcomes for patients and physicians alike. Frequently, their work involves appealing denials from payers or recovery audit contractors and preparing documentation for compliance audits.

Indeed, physician advisers remain increasingly adaptable in the face of change throughout health care. Yet despite the breadth of the role, many hospitals struggle to justify adding a physician adviser program. Often, they say they can't determine a value and the return on investment.

So we studied the daily duties of physician advisers at 15 hospitals and reviewed relevant information from the *Physician Advisor Handbook* (2016, American College of Physician Advisors). We determined the areas that would be affected by direct input from a hospital physician adviser, in an effort to find disease-specific cost savings and dollars at risk.

We created an equation *(see Table 1)* that summarizes the factors that would affect the number of cases with some degree of audit risk, based on previous audits for the health care facility. The result is an educated estimate of cases based on concepts that can predict the number of cases at audit risk and help with forecasting the financial efforts needed to help prevent future audits.

The result also demonstrates ROI for establishing and/or expanding an effective physician adviser program.

DOING THE MATH

We tested our equation on a diagnosis of chronic obstructive pulmonary disease at a specific 250-bed hospital and entered best estimates of the variables using data from the hospital's dashboard, the Centers for Medicare and Medicaid Services' public databank, and national benchmarking. (*See Table 2.*)

Physician advisers are highly adaptable — and useful — in the face of change within health care. Despite the breadth of their role, some hospitals struggle to determine the return on investment. But there might be a mathematical case to be made for organizations to add physician advisers to their staffs.

TABLE 1
THE PAHUJA EQUATION

Here's the mathematical formula the authors use to determine a hospital's risk of audit.

N = ƒB * ƒA * ƒPH * ƒEM * R * L * D

N = Number of active audit risk cases

This product indicates to a hospital the level of financial effort needed to audit, review and appeal processes.

ƒB = Fraction of occupied beds to total number of hospital beds

The number of occupied beds determines the volume of cases per diagnosis-related group. It is important, based on occupancy rates that a hospital can monitor on a daily basis. The higher the occupancy rate, the more exposure of the hospital to errors (and potential audits).

ƒA = Fraction of cases with issues identified in internal audits to total number of cases in internal audit sample

All hospitals have internal audits on medicine and surgical cases with findings based on admission orders, legibility, DRG validation, adequacy of documentation and discharge orders.

ƒPh = Fraction of audited cases per physician/group to total number cases assigned to physician/group

This is based on internal hospital data regarding physician and group audits, regarding documentation lapses and recoupment data on surgical cases and medical cases on high-risk DRGs, and readmission data for hospitalist groups.

ƒEM = Fraction of cases identified in the EM-DRG audits to total number of cases reviewed

Audit data is available for all cases, based on billing data and evaluation/management codes with downcode and upcode historical data validated by recoupment amounts

R = Readmission rate of total hospital or DRG

Readmission rates are available from CMS for Medicare inpatients and hospital administration dashboards for commercial insurers. A readmission is a subsequent hospital admission in the same or a different hospital within 30 days of an original admission (or index stay).

L = Average length of stay for all cases or DRG

Average length of stay for specific DRGs can be used in the equation; the modifier would affect the number of discharges and readmissions for the particular DRG

D = Number of annual discharges

Billed by the provider for inpatient hospital services.

TABLE 2
BY THE NUMBERS

Looking at the discharges and payments for chronic obstructive pulmonary disease for a 250-bed hospital.

DRG	TOTAL DISCHARGES	AVERAGE PAYMENT	TOTAL PAYMENT
190: COPD with major complication or comorbidity	98	$6,712	$657,747
191: COPD with complication or comorbidity	148	$5,626	$832,636
192: COPD without CC or MCC	82	$4,340	$355,852
TOTALS	328	-	$1,846,235

Source: CMS, 2016. DRG Summary for Medicare Inpatient Prospective Payment Hospitals

TABLE 3
WITHOUT A PHYSICIAN ADVISER

The audit/financial risk for a 250-bed hospital for DRG of COPD, using the authors' formula.

FACTOR	DATA	DESCRIPTION
ƒB	0.8	80% bed occupancy rate for calculated year
ƒA	0.8	80% cases with >1 internal audit findings
ƒPh	0.4	40% issues with physician/group billing errors per year
ƒEM	0.68	68% findings in internal EM audit
R	0.14	Readmission rate
L	2.5	Length of stay
D	328	Total discharges

Using the authors' formula, **20 cases** would have a high potential for audit with risk of significant financial loss **(N=ƒB*ƒA*ƒPh*ƒEM*R*L*D=20)**. The estimated annual financial burden of the audits is **$112,575**. That's calculated by multiplying N (20) by total payments ($1,846,235), divided by total discharges (328).

TABLE 4
WITH A PHYSICIAN ADVISER

The reduced audit/financial risk for a 250-bed hospital for DRG of COPD, using the authors' formula.

FACTOR	DATA	DESCRIPTION
ƒB	0.8	80% bed occupancy rate for calculated year
ƒA	0.3	*30% cases with >1 internal audit findings*
ƒPh	0.2	*20% issues with physician/group billing errors per year*
ƒEM	0.25	*68% findings in internal EM audit*
R	0.14	Readmission rate
L	2.5	Length of stay
D	328	Total discharges

Italicized information reflects areas of change. Using the authors' formula, **1.4 cases** would have a high potential for audit with risk of significant financial loss **(N=ƒB*ƒA*ƒPh*ƒEM*R*L*D=1.4)**. The estimated annual financial burden of the audits is **$7,880** — or a reduction of $104,695 over a system without a physician adviser. That's calculated by multiplying N (1.4) by total payments ($1,846,235), divided by total discharges (328).

The equation was studied by three other physician advisers from similarly sized hospitals with identical variables needed to estimate the number of audit-prone cases.

The results *(see Table 3)* were validated with data shared by the hospital. Our findings suggested the hospital had a minimum of $112,575 at risk in audit reimbursement for COPD cases, and ultimately intensified the facility's efforts to educate its clinical staff on adequate documentation, readmission reduction and proper discharge planning with the help of a physician adviser and others for all COPD cases.

The hospital invested in a hybrid physician adviser program, which emphasizes educational activities to improve documentation, communication and collaboration with the case management and utilization review departments. These

interventions resulted in fewer cases with multiple internal audit findings, decreased billing errors through complete documentation, and reduced evaluation/management coding and diagnosis-related group validation errors — and an annual savings of almost $105,000. *(See Table 4.)*

That result, for one DRG, represents a substantial savings in itself. But further analysis of the 250-bed hospital's top 10 DRGs by discharge volume showed a physician adviser would represent savings of more than $1 million.

Compared to the average annual cost for a full-time physician adviser program — $275,000, according to the ACPA 2015 compensation survey — the return on investment is obvious.

Similar savings were noted by co-author Umesh Sharma, MD, MBA, FACP, in his work at Mayo Clinic Health System. He reports organizations such as his have invested in physician advisers to coordinate documentation improvement and resource-use efforts, by leveraging value analytics to reduce risk of reimbursement loss.

By collaborating with a physician adviser during the past two years, Sharma's hospitalist group has increased its total case mix by 20 percent, improved the observed-to-expected mortality ratio to 0.85, and achieved an overall cost savings exceeding $2 million. Senior leaders consider this an adequate ROI. Documentation improvement and utilization management continues to be one of the organization's top initiatives.

LEADING CHANGE

Most hospitalist programs owned and managed by health care organizations are working to improve clinical documentation — a vital function to accurately portray the clinical complexity of patients from onset to discharge. Many regulators, advisers, payers, hospitals and patient advocacy groups have become savvy consumers of health care data to decide where and how to spend their health care dollars. But there's an awareness gap between the desire of frontline health care providers to provide patient care and the realities of current health care economics.

Frontline providers also might not completely understand the ever-evolving rules and guidelines that surround patient care, such as observation/admission status and documenting medical conditions in a way that best recognizes the severity of illness and intensity of service.

Physician advisers help drive improvements by playing multiple roles — educating frontline providers about the constantly evolving rules surrounding patient care, coaching them on improved documentation, and sharing the results of their efforts. Another evolution of this role includes tracking resource utilization, and identifying trends, variances and reasons, and then collaborating with providers to achieve equitable use.

Hospitals also find value in having utilization review-trained physicians who can apply critical thinking to admission status

designation and regulatory compliance efforts, and there's often a savings by having these functions handled in-house rather than outsourcing them to physician adviser companies. Likewise, they find there's more collaboration among colleagues about medical necessity and patient throughput with an on-site adviser. Also, as they collaborate with administrators, the advisers bring insights from the provider perspective that can be applied to the organization's culture.

Additionally, internal physician advisers can oversee commercial denial management, coordinate a recovery audit contractor program, and review readmissions, lengths of stay and clinical documentation integrity. When these services are kept in-house, it's possible for providers to get more meaningful feedback to optimize documentation and conscientious utilization decisions. This ultimately allows a facility to meet hurdles in auditing and reimbursement as they evolve. The ROI shows up in the increased collections and overturned denials, and the reduction of outsourced review.

A strong functional relationship with a physician adviser can be critical to the success of a case management program. Because of time constraints and costs, many case management departments interact with physician advisers via telephone or video conference. This distance inhibits shared learning, efficiency and internal process improvement. Ideally, a physician adviser would be a consistent, physical part of the team with dedicated office space and rounding times. In this way, facility quality and efficiency issues are discussed daily with a physician who champions improved outcomes.

SIGNIFICANT IMPACT

After decades of research, Eliyahu M. Goldratt, PhD, the creator of critical chain project management and the Theory of Constraints, concluded there are two key measurements that govern the success of every business: reliability and effectiveness, as they relate to throughput. Throughput is the profitable output of any process or system. Reliability is the measure of whether you did or did not do what should have been done to positively affect throughput. Effectiveness is the measure of whether you did things that had a positive effect on throughput.

What is "throughput" for a hospital? While physicians deliver care, hospitals deliver tools and space for physicians to do their work. Therefore, a huge part of a hospital's throughput is keeping enough profit from what it charges to at least keep its lights on (and/or deliver dividends to investors, where applicable). A physician adviser measures and reports on reliability (delivering care and documentation of that care with limited risk of audit and denial) and effectiveness (reducing denials as well as the time required for appeals and adjudication). While physician advisers typically cannot affect such measures on their own, they are in a unique position to have a significant impact.

The business of health care delivery is rapidly evolving under CMS rules. Just as a fighter pilot protects an aircraft carrier, its crew and the lives of those in country it serves, a physician adviser can protect a hospital, its employees and the lives of those in the community it serves. Same concept, different execution.

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