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The Emerging Importance of the Physician Advisor

Announcer:
You're listening to Conference Coverage on ReachMD, captured on location at the Physician Advisor and Medical Director Summit in Orlando, Florida. Your host is Dr. Prathima Setty, obstetrician, gynecologist, and a fellow of the American College of Obstetrics and Gynecology.

Dr. Setty:
Hello, this is Dr. Prathima Setty, and I'm here at the Physician Advisor and Medical Director Summit in Orlando, Florida. I'm here with Dr. Kalyana Kanaparthy, System Medical Director of the Physician Advisor Program at Rochester Regional Health. Today we're going to talk about setting up and expanding physician advisor programs.

Dr. Kanaparthy, thank you for being with us today.

Dr. Kanaparthy:
Thank you.

Dr. Setty:
So, Dr. Kanaparthy, we're going to first talk about what is a physician advisor, and what is their role?

Dr. Kanaparthy:
My response to people outside of the healthcare industry in regards to what is a physician advisor is usually I say I'm the guy that helps the hospitals represent themselves against the insurance companies in cases of disputes involving medical care. Hospitals increasingly are in need of this kind of a role because of the increasing payer scrutiny as well as increasing volume of denials and resultant financial downside associated with these denials.

Dr. Setty:
So, what is the day-to-day responsibility of a physician advisor? Can you describe that?

Dr. Kanaparthy:
The most important function that we do on a day-to-day is patient status assignment, whether it's observation or inpatient. Other areas that we tend to work with is denials, managing the denials from insurance companies. There are multiple different kinds of denials. Denials could be on status, whether it's observation or inpatient status. There could be disputes related to DRG assignment where the insurance companies are disagreeing with a particular diagnosis, whether it was documented by the physician. And there are several other kinds of denials that occur from the insurance companies, and hospitals have an obligation to effectively manage these. And the third important area where we work with on a day-to-day basis is physician documentation improvement. This is through a combination of CDA program where the CDA staff monitor the charts and look for opportunities where there is scope for better documentation, and also through physician educational efforts, which are directed by the physician advisor.

Dr. Setty:
So, Dr. Kanaparthy, what is the impact to the hospital if a certain hospitalization is labeled as observation versus inpatient? Why is this so important?

Dr. Kanaparthy:
The reason why it is so important is there is revenue impact both to the insurance company as well as the hospital. In general, inpatient hospitalizations are paid by DRG methodology. What that means is, based on the condition that was treated, the hospital gets a fixed amount regardless of the amount of resources or duration of hospitalization, as opposed to observation, which is usually lesser payment to the hospital. Especially for Medicare, the payment is kind of flat, so even if you keep a patient in longer periods of time under observation status and do multiple investigations, and despite the high cost of the hospitalization, the hospital is only going to get paid a flat rate payment. Most commercial insurance payments also kind of follow that methodology, but depending on contracts and how the contracts are structured between the hospital and the healthcare plan, there is significant impact in

terms of the difference in revenue. As a result of this, the status determination has become a significant area where the insurance companies try to cut down on their payments. However, I must also mention that there is certain other important elements that are involved in this from a regulatory perspective. It is important for the hospitals to get the status correct. In regards to Medicare, inpatient hospitalizations are paid through Medicare Part A, and Medicare Part A is a patient right and a benefit, and if we are somehow depriving the patient, despite them having a genuine medically necessary hospitalization in excess of the Two Midnights, and if we are not putting them in the right status, we are actually not adhering to patient rights, and that could be a regulatory concern as well.

Dr. Setty:
So the patient could have implications with this as well, not only financial for the hospital but also for the patient.

Dr. Kanaparthy:
Absolutely.

Dr. Setty:
I know you were integral in setting up the Physician Advisor Program at your health system. Can you talk a little bit about how you accomplished that and what steps you went through?

Dr. Kanaparthy:
Before we set up any program or ask a leadership for approving a new position, we need to do a needs assessment. How we went about it at our hospital was that we looked at multiple areas in the physician advisor and utilization management domains, and there are multiple areas that required physician engagement and physician leadership—like denial management had no physician oversight, and the CDI did not have any physician oversight. Those were the 2 areas where we felt that a small start would make a difference. And one of the things that we paid attention to from the very beginning was to monitor and measure every intervention that we have done. For example, in the denial management world, every denial that you were able to successfully overturn resulted in a revenue impact for the hospital, and that was very easy to measure. And over a period of time, if we count case by case and it all adds up, that would be a good justification for us to show the executive leaders in the hospital to help us expand the program into multiple other domains. As I said, initially in our flagship hospital, we started this with CDI and denial management, but by year 2, in 2015, we were able to expand some oversight into the level of care and medical necessity space, but in 2016 is when we really entered a pilot where I have worked 18 hours a day, 7 days a week, reviewed every hospital chart to kind of look for opportunities in terms of where we can improve our status determination. And one thing that I quickly realized was that this was not a nice 8:00 a.m. to 4:00 p.m. job. Patients come

in throughout the day, and this is a 24-hour process, so we needed to move this utilization management and case management domain, especially that does utilization review, beyond a Monday through Friday and an 8:00 to 4:00 job. And by better staffing the resources and doing total reviews of medical necessity and being consistent with our UR plan helped us expand the program. One thing I always tell is that when you take on a new role, start small, make sure you demonstrate the success of this pilot, whatever you are taking up, and once you have a successful pilot, then you can take it back to hospital leadership and say, "In order to sustain this pilot, that we need X amount of resources, and this is what our plan is." And in our case our leadership was quite engaging and was supportive, and eventually, we grew from a 1-hospital program to a current state of 5-hospital oversight in the entire health system, and the Physician Advisor Program grew from 1.3 FTEs to a total of 10.9 FTEs in a span of 3 years.

Dr. Setty:
So, Dr. Kanaparthy, I know you mentioned this earlier, but you stated that you really started noticing that denials appeal in specific was an area that was lacking. Can you talk a little bit more in detail about the denials and how you got started there?

Dr. Kanaparthy:
There were a large amount of denials that kept increasing over a period of time, which got the attention of our chief medical officer, and at that time he summoned my boss, who was a medical director for the hospitalist program, to see what we can do. And at that time I think my boss had just come up from a conference where he learned about the Henry Ford Physician Advisor Program, and then he also started talking with me in regards to whether I would have any interest. And given that this was an immediate need where we had increasing numbers of denials—there was not enough physician oversight to assist with these appeals as our only resources at that time were 2 nurses, who themselves were in need of help—at that time I was chosen to start this role, and I was asked to help with appeals. And one thing is I absolutely had no prior background in this, but it was only a matter of time where I got acclimatized to the use of integral screening criteria as well as became familiar with the CMS Two Midnight Rule and other regulatory guidelines that go in this workspace. And the beauty of denials management is the end result is measurable and is easily captured, and that helped the hospital administration commit to further resources that were in need or to expand the program.

Dr. Setty:
So, can you talk further about how you dealt with hospital administration and how you helped enlist their help to get resources for the program?

Dr. Kanaparthy:

Every new thing that we started, we started off small with a pilot. The beauty of a pilot is that they can end and you cannot sustain it, and so I like to do pilots. One of the things that we moved on quickly is into the level of care domain, and I did a pilot, and we saw the impact of the pilot in the month of January 2016, which was a significant change to pre-pilot data and historical data where our observation rates were off the charts, quite high. As part of this pilot, I was able to get an understanding on what are some of the problems. One simple example could be when we review a chart in the morning, attending may have plans to discharge a patient, but after 4:00 things happen, and sometimes patient's hospitalization continues beyond Two Midnights, and if we don't have a UR resource reviewing these charts throughout the day and monitoring for these discharges, we will be losing out on potential adjustment of status in a timely manner, so it is very important, and that's one important thing that we recognized. And we also recognized that this UR process needs to be a 7-days-a-week process and not necessarily limited to weekdays, because patients get hospitalized every single day, and if we don't review the charts appropriately on all 7 days of the week, we will have issues with accuracy. As a result, I was able to—based on the pilot data, I was able to show our hospital leadership that this is what we anticipate to be the right state, but this is what we are doing before this, and for us to be able to sustain the performance of the results that we achieved through the pilot, we will need X amount of resources.

Dr. Setty:
Those are all very good points, Dr. Kanaparthy. Do you have any last-minute thoughts, last-minute comments that you want to make on this very important topic?

Dr. Kanaparthy:
Yes, absolutely. It's not just about the financial implications to the hospital and the patient, but as I said, I want to reiterate that it is important for hospitals to get the status accurate as much as possible and keep their accuracy close to 100% of the time because we have an obligation to make sure that we are following the guidelines that are set by Medicare. If we are not adhering to those guidelines and not up-to-date and in sync with those guidelines, that we have a regulatory problem as well.

Dr. Setty:
Well, thank you very much, Dr. Kanaparthy, to enlighten us on this very important topic that we often as physicians don't pay attention to too much. This is all very valuable information. Thank you very much.

Dr. Kanaparthy:
My pleasure, thank you for having me.

Announcer:

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