# The Physician Advisor Program at Lancaster General Hospital

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## BACKGROUND

Hospitals face ongoing challenges to provide the highest quality and safest patient care that is cost-effective and allows for financial sustainability and growth, while also ensuring patient satisfaction and staff engagement. Effective utilization management and compliance with payer and regulatory requirements are critical competencies. Commercial payers concurrently review hospitalizations for appropriateness and medical necessity, and interface with hospitals about their evaluations and payments; Medicare and Medicaid also review utilization, sometimes with adverse determinations for the hospital. Medicare has created a variety of regulations that hospitals follow to help guide appropriate resource utilization, including conditions of hospital participation (COP). These require that hospitals have a utilization review (UR) plan that provides for the review of services furnished by the hospital and its medical staff to Medicare and Medicaid patients. The COP requires a utilization review committee with at least two physicians to carry out the UR function, which must include review of Medicare and Medicaid patients with respect to the medical necessity of admission, duration of stays, and professional services rendered.

## WHY PHYSICIAN ADVISORS?

To meet the above mentioned needs as well as the need to coordinate patient care, hospitals have developed care management departments which are responsible for hospital compliance with regulatory requirements, utilization review and management, care coordination and management, transitions of care, improvement of clinical documentation, and engagement and education of providers. Some hospitals choose to outsource the physician component of care management to outside UR partners, while others have developed an internal physician competency using Physician Advisors (PAs). These physicians work with, support, and champion Care Management to the medical staff. An increasing number of hospitals are making the strategic decision to insource this service and develop their own PA program. Advantages of this approach include on-site presence, familiarity and credibility with the medical staff, and opportunities to build relationships across the enterprise.

The advisory roles of PAs include supporting case managers in their work regarding plans of care, documentation, determinations of medical necessity of services and provider outreach, review of complex cases, and appeals of commercial payer denials. In their administrative role, PAs review cases for medical necessity and appropriate level of care and support compliance with regulatory requirements. As educators, PAs educate case managers and medical staff on regulatory issues, documentation improvement, utilization, and patient status determination.

## PHYSICIAN ADVISORS AT LGH

Dr. Steve Olin was one of the first Physician Advisors at LGH, hired in 1985 to perform medical necessity reviews and payer appeals. He was joined in 2007 by Dr. John Schantz. Dr. Scott Lauter joined the team in 2012. All three physicians perform this role on a part time basis. As a department chair, Dr. Lauter is uniquely positioned to interact with the broader medical staff on utilization issues.

The PA program was expanded in May 2014 to include Drs. Phil Billoni and Jen DeLutis, two hospitalists job-sharing a full time hospitalist position and a full time Physician Advisor position. The strategic vision for program expansion was to reduce utilization and expense with Executive Health Resources (EHR), LG Health's external UR partner; to expand commercial payer appeals to capture revenue; to expand provider outreach and education to improve documentation of an appropriately increased case mix index (CMI); to increase regulatory compliance and reduce adverse audit risk; and to create or enhance effective working relationships with the LG Health medical staff, payer medical directors, and many LG Health organizational units,

including care management, clinical documentation improvement, coding, compliance, finance, and information technology (IT).

The expanded PA program has been a success in all areas of strategic focus. Projections for FY 2015 based on annualizing 2015 year-to-date results include a reduction in EHR utilization by 54% and expense of $100,000; an increase in revenue from successful payer appeals and reduction in payer denials of $4,500,000, which includes a 51% reduction in HealthAmerica denials driven by relationship building with their medical director; improvement in Medicare CMI from 1.71 FY 2013 to 1.75 FY 2014 to 1.81 for FYTD 2015. Projected FY 2015 revenue and cost savings of $4,600,000 and PA salary expense of $600,000 result in a projected net of $4,000,000 for a ROI of 6.7.

## PHYSICIAN ADVISORS AND MEDICARE RULES

Provider outreach and education has been a critical success factor dealing with Medicare's two midnight rule which went into effect October 1, 2013. Medicare Recovery Audit Contractor (RAC) scrutiny of short inpatient stays led to increased hospital utilization of observation status, sometime extending many days beyond the expected 24- to 48-hour time frame. When Medicare beneficiaries are inpatients they pay a deductible of $1,260, but when they are in observation they pay 20% of allowable charges and medication costs. As observation stays grew longer, and patient out-of-pocket expenses grew beyond the inpatient deductible, Medicare was petitioned by seniors, the AARP, and elected representatives to change its policy. The Office of the Inspector General reported to Medicare an analysis of one-day inpatient and observation stays, revealing that Medicare was paying hospitals three times as much for a one-day inpatient stay than a one-day observation stay. Six of the top ten diagnoses were the same for one-day inpatient and observation stays suggesting that many one-day inpatient stays should have been treated in observation. The mandate for Medicare was clear: eliminate one-day inpatient stays to reduce Medicare expenses and eliminate prolonged observation stays to reduce patient expenses. The two midnight rule that resulted specifies that patients who meet medical necessity and have an expected hospital stay exceeding two midnights from presentation should be admitted as inpatients; if the expected hospital stay is less than two midnights or is uncertain, they should be placed in observation. If a patient with one midnight in observation is expected to remain in the hospital for medically necessary services beyond a second midnight, that patient should be admitted prior to the second midnight, even if they are expected to go home the following day.

LGH performance on Medicare Administrative Contractor audits of compliance with the two-midnight rule improved dramatically from a 76% denial rate in the initial March 2014 audit to a 13% denial rate for the current follow-up audit. This improvement has been driven by PA engagement and education of the medical staff, and partnership with IT to create Epic tools to support provider documentation of medical necessity.

## EXPANSION OF PHYSICIAN ADVISOR ROLES

Expansion of the PA program has also created capacity for the PAs to take on operation improvement projects including observation status utilization management and peer review; auditing of short inpatient stays and prolonged observation stays for provider feedback on opportunities for improvement and celebration of success; improvement of surgeon determination and documentation of appropriate surgical patient status of day surgery vs. inpatient to improve compliance with Medicare inpatient-only surgery requirements; elimination of lost Medicare billing opportunities and improvement of the patient experience; and getting the medical staff onboard with care management, clinical documentation improvement, and the PA program.

Physician Advisors are supported by several national organizations, by regional and national meetings sponsored by these organizations and by UR companies, by several online and print newsletters, and by an active national list-serve.

## WHAT NEXT?

With the retirement of the two senior part-time PAs, the program's strategy is to replace them with two hospitalists in the current job-sharing model, which would add the equivalent of an additional full time PA. Employing hospitalists is preferred, since they reduce expenses compared with medical and surgical subspecialists; provide a broad range of clinical experience and relationships across the medical staff; have facility with medical patient care which is important since the majority of reviews and appeals concern medical patients; provide outreach and learning through direct clinical relationships with hospitalists, who comprise

the largest number of attending physicians; and through their clinical role, hospitalist PAs have clinical experience and credibility. The LGH experience that hospitalists are ideal for the PA role is mirrored at many hospitals and health systems nationally.

Strategic direction for the PA program after successful replacement of retiring PAs (Dr. John Schantz retired in December 2014 and Dr. Steve Olin in June 2015) includes expanding the appeals program to additional commercial players by creating relationships with their medical directors for LGH physician advisor appeals and reconsiderations; expansion of audits of short inpatient and prolonged observation stays to give providers feedback, education, and celebration of success while improving the patient experience and reducing the risk of adverse audits; and completion of the improvement project to ensure determination and documentation by surgeons of appropriate surgical patient status.

Finally, as LG Health takes on gain-sharing contracts with payers, the PA role in utilization review will expand. Since the highest costs are associated with hospitalization, the PAs will play a key role in the success of these contracts, as they work with primary care providers, hospitalists, and specialists to ensure appropriate utilization management across the health system.

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