Operationalizing the Onsite Physician Advisor Program



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Initial Steps: Getting Started

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Agenda

- Background of a Physician Advisor
- Job Description
- Basics
- Regulations to be aware of, also see “References”

  This is awareness only. These will be covered in detail in later modules
- Other considerations

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Quick Background

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What is a Physician Advisor

- A physician advisor is hired by the hospital to act as a liaison between the hospital administration, clinical staff, and support personnel in order to ensure regulatory compliance, advise physicians on medical necessity, and assist hospital leadership in meeting overall organizational goals related to the efficient utilization of health care services.
- The term physician advisor was introduced by companies that delivered remote advisory services to support hospital case/utilization management teams. Over the years, it grew into a full-time, in-house and/or remote position that hospitals are beginning to embrace.”

https://www.scp-health.com/providers/blog/what-is-a-physician-advisor

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Qualities of a Physician Advisor

- Knowledge of hospital processes and goals
- Working knowledge of federal regulations and contractual processes
- Ability to teach and collaborate
- Knowledge of appropriate level of care for patients
- Work to improve physician documentation
- Understand quality, resource utilization, and throughput initiatives
- Consultatory role
- Skills in writing, presentations, communication, negotiating

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Job Description Questions

- What are the job expectations?
  - You must be aware of them
- Will you be full-time or part-time?
- Still practicing, is it a requirement?
  - Retired?
- What are the duties?
  - Generalized
  - Specific

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Key Purpose

Must integrate with:

- Case Management/UR
- Physicians
- Executive level

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Required Knowledge Basics

- Regulations
- Inpatient vs. Observation
- Skills
- Processes
- Denials Management
- Quality
- Education

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Schedule Basics

Expectation of time spent on:

- Reviews
- Other duties

Days of coverage

- Should at least match UR coverage times

Meetings and Committees

- UR Committee
- LOS
- Others

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Ideal Physical Setting

Office location
- Onsite or Remote

Engagement
- Employed or Consultant

Ideally located close to UR

EMR access

Computer with 2 monitors
- Computer - hospital or personal

Credentialing – Type and Necessity

Facility access and parking

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How will you been introduced to facility and Medical Staff?

- Blast email
- Newsletter
- Department meetings
- Medical Exec (MEC)
- Medical Staff Meetings
- UR Committee

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Other Considerations to Learn

Hospital culture	Community culture	Expectations of community involvement
Expectations of other hospital involvement	Mandatory	Voluntary

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Regulations

- Most Important to Know

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Regulations – Will Be Lessons or References

- Conditions of Participation
- Condition Code 44
- Condition Code W2
- Medicare Benefit Policy Manual
- Chapter 1 – Inpatient
- Chapter 6 – OP/OBS
- The 2 Midnight Rule
- Billing types

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Conditions of Participation - CoP

- 42 CFR §482

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Knowing and Understanding the Conditions of Participation (CoP) is a MUST

42 CFR §482

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CoP

- 42 CFR §482 contains the health and safety requirements that hospitals must meet to participate in the Medicare and Medicaid programs. **Social Security Act Title XVIII, §1861 Definitions of Services, Institutions, etc.***

*Not a bad idea to be aware of this portion of the SSA and even read it

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Social Security Act Title XVIII, §1861 Definitions of Services, Institutions

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and…

https://www.ssa.gov/OP_Home/ssact/title18/1800.htm#ft1

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Conditions of Participation

- § 482.30 - Condition of participation: Utilization review.
- The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.30

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Conditions of Participation - § 482.30: Reviews

- (c) *Standard: Scope and frequency of review.* (1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of -
- (i) Admissions to the institution;
- (ii) The duration of stays; and
- (iii) Professional services furnished, including drugs and biologicals.
- (2) Review of admissions may be performed before, at, or after hospital admission.

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§ 482.30 - Condition of participation: Utilization review.

- The process of reviewing an episode of care through use of commercial criteria to determine a level of care as inpatient, observation, outpatient, or not appropriate for hospital care.
- Review of admissions may be performed before, at, or after hospital admission.

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Are there any regulations regarding reviewing every patient?

- Must every admission undergo a review?
- No regulations to support this but…
- What about AI?
- All claims must be compliant
- False Claims Act

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Importance of Utilization Review

Must all cases be reviewed?

UM Committee is one of the only committee required by Medicare in the Conditions of Participation

Medicare does not say ALL cases have to be reviewed, but Medicare does say **ALL billing claims have to be accurate**

The best way to ensure claims are accurate is by using a **compliant and consistent UR process** that ensures appropriate review and documentation to support the claim

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False Claims Act — Quick Synopsis

The **False Claims Act (31 U.S.C. §§ 3729–3733)** is the federal government's primary tool to combat **fraud against federal programs**, especially Medicare and Medicaid.

What It Prohibits

The FCA makes it illegal to **knowingly**:

- Submit a **false or fraudulent claim** for payment to the federal government
- Cause someone else to submit a false claim
- Use false records or statements to get a claim paid
- Retain government overpayments without returning them ("reverse false claims")

Key point: "Knowingly" includes **actual knowledge, deliberate ignorance, or reckless disregard** — intent to defraud is *not* required.

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2 Midnight Rule

Will be discussed in greater detail
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Background

- In recent years, through the Recovery Audit program, CMS identified high rates of error for hospital services rendered in a medically-unnecessary setting (i.e., inpatient rather than outpatient).
- CMS also observed a higher frequency of beneficiaries being treated as hospital outpatients and receiving extended “observation” services. Hospitals and other stakeholders expressed concern about this trend, especially since days spent as a hospital outpatient do not count towards the three-day inpatient hospital stay that is required before a beneficiary is eligible for Medicare coverage of skilled nursing facility services.

https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0

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Benchmark vs. Presumption

- “Benchmark of 2 midnights”
- An inpatient admission is generally appropriate when the admitting practitioner **expects** the patient to require hospital care that **spans at least two midnights**, and that expectation is supported by the medical record.
  - The benchmark is based on the **cumulative time** the patient spends in the hospital **receiving medically necessary hospital care**
- *“Presumption of 2 midnights”*
- When an inpatient stay **spans two midnights after the formal inpatient admission order**, CMS medical reviewers generally presume the admission was appropriate for Medicare Part A payment, absent evidence to the contrary.

- The 2 MN rule will be discussed in greater detail in Module 4

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Inpatient Expectation <2 Midnights

- For payment purposes, the following factors, among others, would be relevant to determining whether an inpatient admission where the patient stay is expected to be less than 2 midnights is nonetheless appropriate for Part A payment:
  - The **severity** of the signs and symptoms exhibited by the patient;
  - The medical predictability of something adverse happening to the patient; and,
  - The need for diagnostic studies that appropriately are **outpatient** services (that is, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more).
- 80 FR 70541

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Thank you!

QUESTIONS



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