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Association of **Clinical Documentation Integrity** Specialists

HOW PHYSICIAN ADVISORS HAVE BECOME INDISPENSABLE

ACDIS national survey: Physician advisors play significant role in driving CDI, physician, quality, and financial initiatives

December 2022

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Physician advisors are becoming more autonomous, collaborative, and strategic as their reach expands further inside healthcare systems, touching everything from CDI and utilization management (UM)/utilization review (UR) to quality, denials management, and finance. Although it can be challenging for those physician leaders who continue to straddle the two complex worlds of advisor and clinician, many feel a growing satisfaction as health systems increasingly view their role as a necessary and valued full-time position.

The Association of Clinical Documentation Integrity Specialists (ACDIS) held a series of meetings with its Physician Advisor Mastermind Members in 2022 in partnership with 3M HIS to explore the physician advisor's evolving role. During these sessions, physician advisors discussed the results of the recent nationwide ACDIS survey "Understanding the Physician Advisor Role," sharing key aspects of their changing responsibilities, top concerns, and new ways they are supporting CDI, physicians, and their organizations. Below are the highlights from the survey and discussions.

The physician advisor's advancing role

More than ever, physician advisors are spending a higher percentage of their time on non-clinical work. According to the survey results, more than half (52%) of physician advisors do not hold clinical hours. Of the 47% still in practice, 19% practice less than a quarter of the time, while 12% practice 26%–50% of the time.

"The fact that more than 50% are non-clinical and are getting paid for pure administrative work shows that healthcare institutions recognize the value of their work," says **Deepa Velayadikot, MD, CHCQM-PHYADV,** medical director of care coordination and medical director of hospital medicine for Cooper University Hospital in Camden, New Jersey. Velayadikot, who is a hospitalist, also works 50% of the time in a clinical capacity.

ACDIS 2022 Physician Advisor Mastermind Members

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Several other panelists fall into the 25% or less bracket, including **John Pettine, MD, FACP, CPHQ, CCDS,** vice president of CDI services at Lehigh Valley Health Network in Allentown, Pennsylvania, who says, "I still love clinical, but it is difficult to do and be an expert in everything all the time." T**ravis Bias, DO, MPH, FAAFP** family medicine physician and chief medical officer of the clinician solutions team at 3M, agrees. "It's difficult to maintain being an expert in two areas simultaneously."

Megan H. Cortazzo, MD, medical director of clinical quality capture and health information management at the University of Pittsburgh Medical Center in Pittsburgh, shares these sentiments. "I still see patients a full day each week. I still like seeing patients and don't want to give it up completely, but it can be challenging with juggling patient and administrative needs."

Meanwhile, physician advisor reporting structures are also shifting. Most survey respondents report to revenue cycle/finance (35%) or the chief medical officer (CMO) (25%), while 13% report to two or more areas. The mastermind members show similar reporting trends, with most reporting to finance or clinical areas while a few report to multiple people. Some also say that reporting has changed as their roles have become more complex. Pettine, for example, says that for 12 years running, he reported to the organization's CMO until recently. "Given the various financial initiatives, they moved me under the senior vice president of revenue integrity within the last year," he says, noting that he also has a dotted line to the CMO.

Vaughn Matacale, MD, CCDS, medical director of the clinical documentation advisor group at ECU Health in Greenville, North Carolina, has always reported to the VP of finance. "Many different reporting models can work as long as the person you're reporting to understands the work and the complexities with which you deal," he says.

Kory Anderson, MD, CHCQM-PHYADV, FACP, medical director of physician advisor services, CDI, and quality for Intermountain Healthcare in Ogden, Utah, says he reports to the office of patient experience but has a dotted line to finance. "Every month, we send him a financial scorecard that says here's what our comprehensive group is doing," says Anderson. "Highlighting the financial ROI [return on investment] your group brings is key to advocating for resources."

Muhammad K. Al Mounayer, MD, MBA, CHCQM-PHYADV, CCDS, physician advisor for Atrium Health in Charlotte, North Carolina, says he reports to the CMO of physician advisory services but reported to a revenue cycle manager in a previous organization. "I like this new reporting structure better, but dual reporting is the best because you can touch both worlds," he says.

The survey results also support what we know anecdotally: Healthcare organizations are increasingly formalizing the physician advisor role. Most respondents (43%) say their position is very formal, meaning it is their primary job with well-defined roles and responsibilities. Twenty-eight percent have a somewhat formal role, comprising 25%–50% of their time, while 26% hold an informal position, such as a service line champion who supports CDI initiatives.

Mastermind members say, for the most part, their roles are formal, with some indicating this wasn't always the case in the early days of CDI. "In 2009, it was very informal, and I didn't know if it was going to last," says Pettine, adding that over time he and the department developed credibility and autonomy. "Today, CDI is a full-fledged, multi-faceted department," he says.

Physician advisors also wear many hats and say they are increasingly collaborating across multiple areas, which can be both exciting and overwhelming. "I have gotten a lot more autonomy," says Cortazzo. "We have many things on our roadmap to accomplish, especially with technology." To this point, very few survey respondents spend most of their time in any one area. For example, UR/UM support (11%) and denials management (10%) were the top responsibilities for which physician advisors dedicate 76%–100% of their time.

Most physician advisors dedicate 25% or less of their time to any given role, including physician/provider education (64%); CDI support (59%); new resident/clinical partner training (47%); presenting financial, quality, or other data to organizational leadership (43%); and researching CDI opportunities for growth, new tools/technologies (39%). "Nobody is pure CDI," says Velayadikot. "The fact that roles have multiple functions shows that we touch many different aspects of a healthcare institution."

Figure 1. Do you still practice clinically?

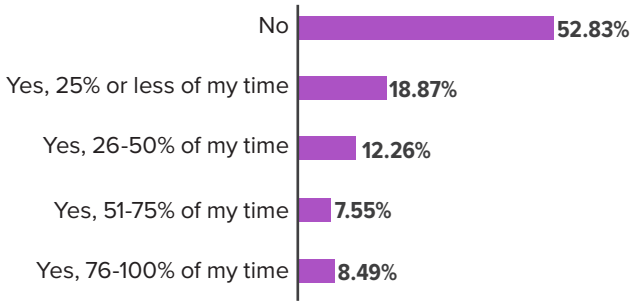
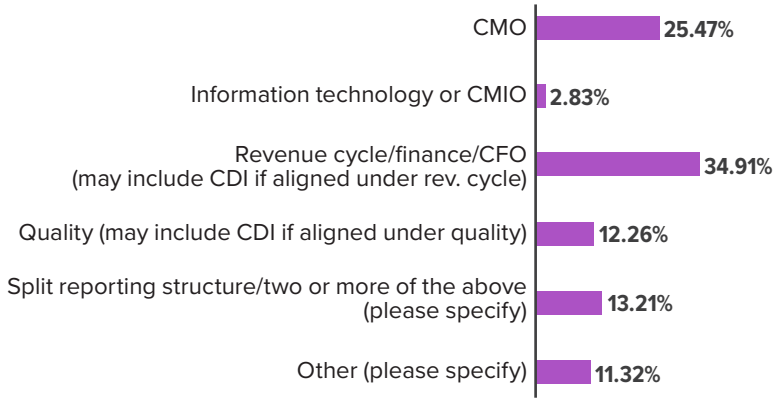


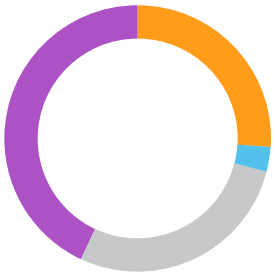
Figure 2. To whom do you and/or your organization's physician advisor(s) report?



Selected other responses:

- CEO
- Corporate CMO
- Division chief
- Chief Financial Officer of the hospital
- CCO
- CDI team

Figure 3. Please describe the formality of your role/your physician advisor(s) roles within your organization



43.40% Very formal (i.e., majority of time dedicated to position, well-defined roles/responsibilities)

28.30% Somewhat formal (25-50% time carved out)

26.42% Informal (i.e., service line champion to support CDI initiatives)

1.89% Other (please specify)

Selected other response:

- We don't have dedicated physician advisor

Figure 4. What are your and/or your organization's physician advisor(s) principal responsibilities? Please list by approximate percentage (check all that apply).

	This is not a principal responsibility of physician advisors at my organization	25% or less of my time	26-50% of my time	51-75% of my time	76-100% of my time
CDI support (CDI staff education, escalation for non-meaningful query responses/ incomplete charts, etc.)	14.40%	55.20%	16.80%	5.60%	8.00%
Utilization review/utilization management support	29.84%	22.58%	19.35%	15.32%	12.90%
Denials management	27.64%	30.08%	18.70%	11.38%	12.20%
New resident/clinical partner training/onboarding	49.18%	45.08%	2.46%	2.46%	0.82%
Physician burnout prevention initiatives	82.79%	14.75%	—	0.82%	1.64%
Physician/provider education, 1:1 or larger groups	13.49%	61.11%	15.08%	5.56%	4.76%
Presenting financial, quality, or other data to organizational leadership	40.32%	41.13%	12.10%	3.23%	3.23%
Researching CDI opportunities for growth, new tools/ technologies, etc.	53.28%	37.70%	5.74%	1.64%	1.64%
Technology evaluation and physician adoption	59.02%	31.97%	4.92%	1.64%	2.46%

Top struggles spark innovation

CDI programs also continue to face the same hurdles, from physician engagement and staffing shortages to denials and tighter budgets. When asked to rank CDI challenges from "significant" to "not a challenge," respondents indicated that changing physicians' perceptions of CDI from finance to quality (64%) was their leading moderate/significant challenge, followed by CDI or coding staff shortages/staff capacity (58%), diagnosis/MS-DRGs denials and downgrades (58%), and physician engagement (55%).

Budget limitations and physician burnout trailed closely behind at 50%. Interestingly, technology limitations (55%), social determinants of health capture (53%), technology adoption by physicians (50%), and identifying cases with the most review opportunity (47%) were mostly viewed as "minor challenges."

Panelists generally agreed with these findings, noting that retroactive denials, DRG downgrades, holding patients in observation vs. inpatient status, and payers' irresolute behavior when asked to define clinical criteria are particularly troubling. They also say these challenges are only intensifying. "Payers are ramping up denials," says Matacale. "We are experiencing more aggression on the concurrent denials and pushing patients to the outpatient space or observation," he says, adding that common themes for retroactive denials are sepsis, acute kidney injury, respiratory failure, and encephalopathy diagnoses.

"The rationales for their denials are getting flimsier," says Matacale, adding that senior leaders at his organization are looking to CDI and the physician advisor team to help solve increasing financial issues. "We have strained margins, so there is much pressure."

Velayadikot says she also sees a lot of retroactive denials. "One of the biggest issues is having full visibility into 2018–2020 denials," she says. "One week, we had 10–15 denials every day. This is probably the heaviest I've seen in the decade I've been a physician advisor."

Mastermind members also point out that they are working more strategically with their

teams, finance, contracting, and other leaders and departments to find creative solutions for engaging payers. "I don't think it's about how we reduce denials, but rather how do we combat the denials through better processes," says Anderson. His physician advisor group of 30 physicians is increasing peer-to-peer payer meetings. "We do a lot of peer-to-peer stuff that we did not do before, including meeting with one payer every Friday for 30 minutes. Our strategy is to focus more upstream in a week rather than wait months down the road to get paid."

Anderson also leans heavily on the organization's payer contracting team for help, especially concerning specific payer tactics. Regarding patient status issues, Velayadikot adds that having a physician advisor and an observation UR nurse on staff 365 days a year has "helped tighten timely conversions. We can talk with one another and document in real-time."

Jessie Roske, MD, physician section director of improvement at CentraCare in St. Cloud, Minnesota, says her work plan calls for attaching a CDI nurse to UR to ensure patients get an appropriate inpatient status. "Right now, CDI doesn't do obs. [observation admission status] reviews; we do inpatient reviews. It would be useful to partner diagnosis validation and medical necessity evaluation." She adds that the organization recently launched pre-bill clinical validation following a big run of denials. The team also continues to do peer-to-peer reviews that come with reducing the denials burden. "I want to feel like we have robust integrity in everything we send," says Roske.

Physician engagement and burnout are also pressing concerns for mastermind members. Physicians can be overwhelmed when they receive multiple requests at the same time, says Matacale. "Communicate one important message at a time to clinical leaders and then monitor progress to build momentum." Anderson agrees, adding that "inundating people with all the data and opportunities you're seeing is overwhelming."

Mastermind members also discussed the importance of recognizing physicians for work well done. "We give kudos in our hospital medicine meetings when somebody has done a good job with documentation," says Velayadikot.

"Our nurses use an Excel sheet to nominate somebody for kudos, and then once a month, I handwrite a kudos card and send candy," says Roske. She adds that it is also essential always to have a "give" when asking a physician for something. For example, Roske says her department is building a standardized clinical indicator library for physicians that will include a smart list of phrases that are top misses during documentation. "Right now, we have 40 of the most common conditions."

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—Kory Anderson, MD, CHCQM-PHYADV, FACP
Medical Director, Physician Advisor Services, CDI & Quality, Intermountain Healthcare

Resources for future success

Survey respondents shared top resources and solutions they need for success, including additional CDI and/or coding staff (54%), better dashboards/metrics (52%), additional physician advisor staff or support (49%), improved payer relationships/transparency

in contracting (48%), and a dedicated data analyst to support reporting (46%).

Mastermind members agree, stressing the importance of having enough staff, better strategies for managing payer relationships, robust education programs, and comprehensive data analytics to drive continuous improvement. The need for better payer data and physician performance metrics was a common theme that also emerged during their sessions. Pettine says his network recently hired a data analytics expert to develop an analytics program that looks at payer behavior. "We used the denial data to compare payers and show them why they are an outlier," he says. Roske says her organization has created a center for analytics that she hopes to tap for future projects. "The first project I sold them is a dashboard on audit denials."

Velayadikot says it's vital to look at the whole story behind payer metrics to prevent future denials and better prepare for appeals. "We look at the percentage of accepted downgrades and how many we appealed, and even the softer appeals that didn't go to written appeal, so we can tell the whole story of our physician advisor, UR, and even CDI." She adds that the appeal and overturn rates are key metrics her team monitors when

Figure 5. Which of the following do you consider to be a current challenge for your CDI program? For all that apply, indicate if significant/moderate/minor, or not a challenge.

	Not a challenge	Minor challenge	Moderate challenge	Significant challenge
Budget limitations	14.85%	34.65%	32.67%	17.82%
CDI or coding staff shortages/staff capacity	12.38%	29.52%	33.33%	24.76%
Changing physicians' perceptions of CDI from finance to quality	7.48%	28.04%	43.93%	20.56%
Effective cross-department collaboration (i.e., between CDI, coding, quality, etc.)	14.02%	42.99%	27.10%	15.89%
Demonstrating return on investment of CDI to hospital leadership	29.25%	40.57%	23.58%	6.60%
Diagnosis/MS-DRGs denials and downgrades (i.e., sepsis, malnutrition, acute hypoxic respiratory failure, etc.)	11.21%	30.84%	38.32%	19.63%
Expansion into new areas with uncertain opportunity or extant model	16.98%	42.45%	22.64%	17.92%
Identifying cases with the most review opportunity	25.47%	47.17%	22.64%	4.72%
Impacting multiple risk adjustment models with unclear adjustors	15.09%	44.34%	33.02%	7.55%
Medical necessity denials/inpatient stay denials	23.81%	33.33%	25.71%	17.14%
Multiple EHRs across organization and/or other interoperability issues	67.62%	15.24%	11.43%	5.71%
Overexpansion/too much work on plate	29.52%	35.24%	25.71%	9.52%
Physician burnout/excessive administrative burden	12.38%	37.14%	38.10%	12.38%
Physician engagement/buy-in to CDI initiatives	4.81%	40.38%	36.54%	18.27%
Social determinants of health capture/other unstructured data reporting	20.95%	53.33%	17.14%	8.57%
Technology limitations	20.19%	54.81%	18.27%	6.73%
Technology adoption by physicians	20.00%	50.48%	24.76%	4.76%

Selected other responses:

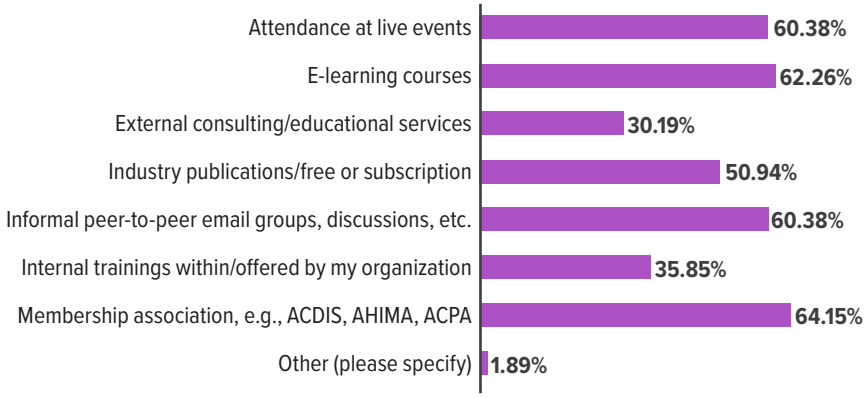
- We are a DRG-exempt organization and getting buy-in on any information regarding the DRG is a challenge. We have just begun to revamp our program, and it is so exciting!
- Medical necessity/inpatient stay denials are an issue, but UM is a separate entity. We do support this with a cosign structure for UM nurse authored notes.

appealing. "I want my physician advisors to be very aggressive in appealing. If they don't win, we send it for a written appeal by a vendor we contract with," she says.

"Our biggest success is front-end education," adds **Aaron "AJ" Hegg, MD,** physician advisor, UM/CDI, and critical care physician at Essentia Health in Duluth, Minnesota. "Two of our CDI nurses are full-time physician educators, and now we meet with 26 sections across the system," he says, noting that the organization supports educators with performance data and specific case examples.

According to the survey results, membership association (64%), E-learning courses (62%), attendance at live events (60%), and informal peer-to-peer email groups and discussions (60%) are most helpful in staying up-to-date and educated on best practices and opportunities. Respondents say leading membership associations are

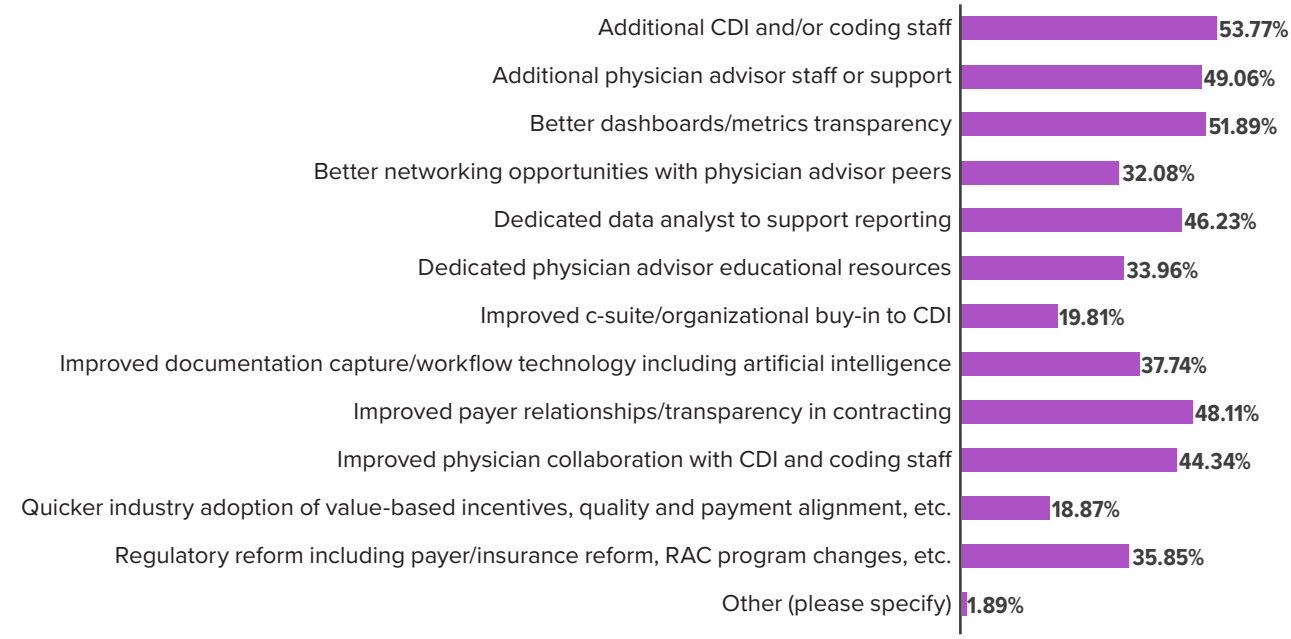
Figure 6. What resources do you find helpful in keeping up to date/educated on best practices, opportunities, etc. in physician advisor and/or CDI work?



Selected other responses:

- SCCM webinars
- Podcast

Figure 7. What resources/solutions do you believe you need to succeed in your role? Select all that apply.



Selected other responses:

- More experienced/ better educated coding staff
- Improved collaboration with IS

ACDIS (45%) and the American College of Physician Advisors (ACPA) (25%), while favorite live events include ACDIS (43%) and the ACPA National Physician Advisor Conference (19%). ACDIS and *ICD-10 Monitor* are top industry publications.

CDI expansion plans

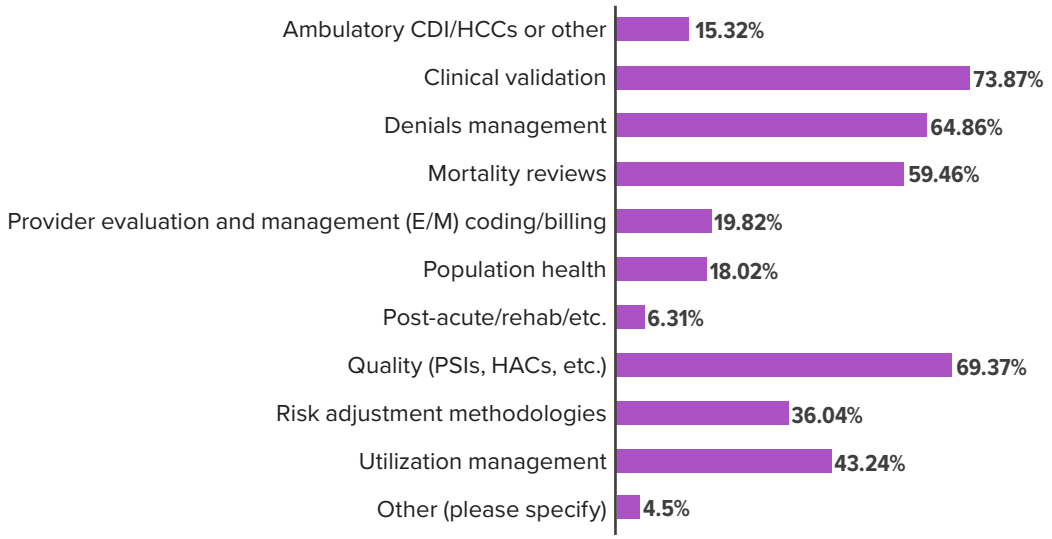
With so much attention on CDI, quality, and finance, it's no surprise that CDI is moving into new areas, including clinical validation (75%), quality (72%), denials management (66%), and mortality reviews (61%), according to the survey results. Looking ahead, respondents say they are considering a move into other critical areas, such as ambulatory CDI/hierarchical condition categories (HCC; 33%), denials management (23%), and risk adjustment methodologies (23%).

Mastermind members have already or plan to make similar expansions into HCCs, clinical validation, denials, and risk adjustment. Al Mounayer says the physician advisors expanded into clinical validation two years ago. "Coders look at the clinical validation denial, and if the case is clearly appealable, they will go ahead and do it. If there is a question, or if it is an upheld appeal, then I review the case. Volume is pretty heavy, but we have about a 65 to 67% overturn rate." He notes that CDI is also heavily involved in risk adjustment methodologies.

Anderson adds that Intermountain Healthcare does HCC reviews in both hospital and ambulatory settings. It also does clinical validation documents or procedures. "Our physician advisors do any denials related to clinical validation, and we're doing pre-bill hold mortality reviews."

Matacale says that while his department is involved in many areas noted on the survey, HCCs have been a persistent challenge. "We've been spinning our wheels on HCCs for about six years. HCCs are necessary, especially when you think about condition categories, index admission exclusions on CMS risk adjustment, and bringing the comorbidity capture message

Figure 8. Please describe the CDI-adjacent areas that you/your CDI department have already expanded into (check all that apply).



to outpatient for shared savings programs," he says. "The main challenge is getting over the hurdle of dealing with a different billing system." Matacale says he is also interested in denials management but must first overcome territorial issues.

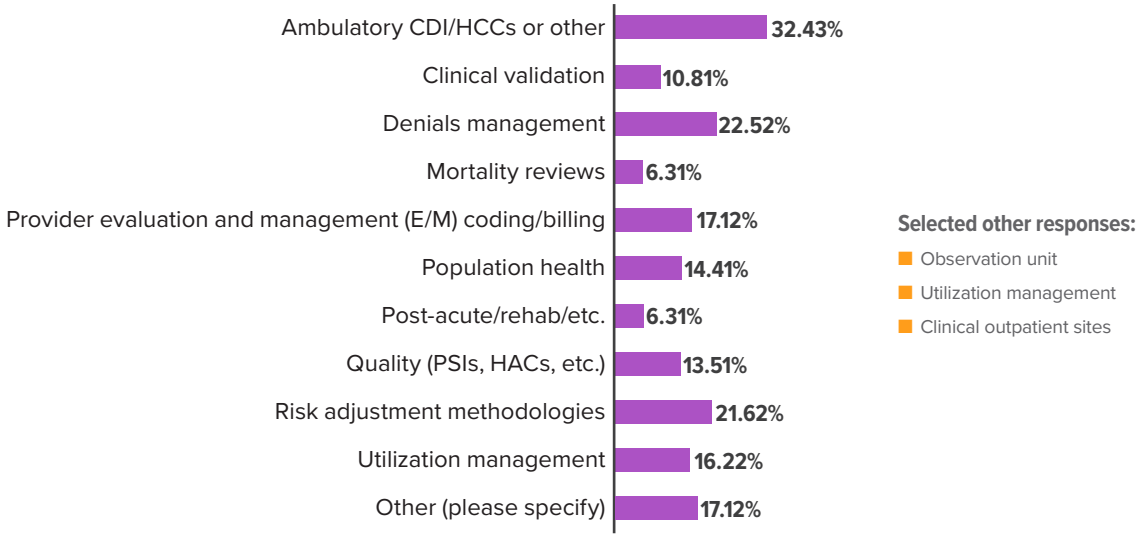
Roske notes that in addition to pre-bill clinical validation, her organization emphasizes HCCs on the ambulatory side. "We also want to put the education and focus on HCC capture on the inpatient side." Denials management is another big challenge, she adds. "We are trying to get everyone on the same page to understand what our internal data tells us about how to strategize going forward." Hegg adds that he is looking for more cross-training between UM and CDI to drive quicker diagnoses in the ER as soon as the decision is made to admit the patient. "Maybe there's an opportunity to get the diagnosis right off the bat and help us justify our status as well as decrease queries down the road," he says.

Key technologies and metrics

Survey respondents use multiple technologies and physician-assistive tools, including CDI-friendly modifications to the EHR (48%), chart prioritization solutions (42%), and computer-assisted coding (38%). Mastermind members use similar tools, and several are also testing AI technologies with mixed reviews, including an ambient voice-enabled solution that automatically documents patient encounters. "It doesn't do CDI-type stuff, such as prompting a diagnosis or more specificity on a diagnosis, which would be the ideal state, so it's not quite there yet," says Roske. Pettine adds that his network has used an AI tool for three years that prompts for HCCs on the ambulatory side.

CDI departments also rely on many metrics to determine ROI and to justify growth and expansion. Survey respondents ranked case mix index improvement (32%) as the most important metric they use to show ROI, followed by APR-DRG improvement (25%) and complication or comorbidity (CC)/major complication or comorbidity (MCC) capture (20%). "We're looking at quality rankings," including HCC

Figure 9. Please describe the CDI-adjacent areas that you/your CDI department are considering expanding into/view as a potential opportunity (check all that apply).



captures, risk adjustment factor (RAF) scores, and mortality risk adjustments, says Roske. “We’ve shown the financial ROI for a long time, and now that leaders are paying attention, this is how we’re positioning ourselves to be ready for more shared risk contracts.”

Anderson adds that Intermountain Healthcare also looks at HCC captures. “We look at the projected dollars attached to the HCCs we bring in through our program. We also use expected and overall mortality and some quality metrics.” He says attributing this data to CDI involves drilling down by DRG and by admitting physician, attending physician, or discharging physician. “We also filter through certain subspecialties rather than generic specialties.”

Mastermind members concluded with a reminder that as metrics and technology tools become more complex, it’s essential to get back to basics and CDI fundamentals to better support physicians in their documentation practices. “Ten years ago, we were looking at CCs and MCCs, and now we have PSIs [patient safety indicators] and HACs [hospital-acquired conditions],” says Anderson. “How do you help people work effectively and efficiently knowing they have to look for many different things under different methodologies?” The answer is education, he says. “Education is still foundational to the work. Workflows and tech are great, but physicians need to understand why this is important.” ■

Figure 10. What technology and physician assistive tools does your CDI department/organization presently use (check all that apply)?

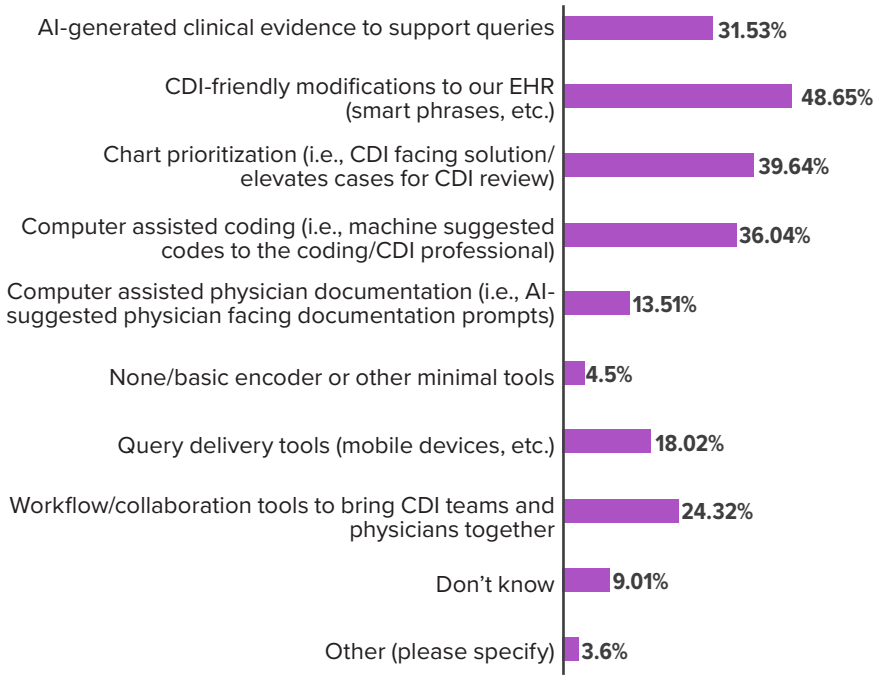


Figure 11. What is the principal metric you use to demonstrate CDI return on investment (ROI) and justify program growth/ expansion? Please rank in order of importance.

1 Case mix index improvement

2 APR-DRG improvement

3 CC/MCC capture

4 DRG denial improvement/overturn

5 UM outcomes (i.e., status reviews, peer-to-peers, backend appeals)

6 Observed/expected length of stay improvement

7 Observed/expected mortality reduction

8 Hospital quality ranking/peer to peer improvement (i.e., U.S. News and World Report, Leapfrog, Vizient, Healthgrades, etc.)

9 HCC capture/RAF scoring

10 PSI rate improvement