

RISING STARS: PHYSICIAN ADVISORS ARE TACKLING BIG PROBLEMS IN HEALTHCARE

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Physician advisors continue to establish themselves as key players within healthcare organizations. As healthcare grows more complex, the physician advisor's role has become more pronounced, with responsibilities stretching across utilization review (UR), utilization management (UM), denials and appeals, and CDI. Their role, however, is not without challenges, particularly in managing denials, educating physicians, and balancing the demands of physician advisor duties with clinical roles.

In 2023, the Association of Clinical Documentation Integrity Specialists (ACDIS), in collaboration with 3M Health Information Systems, brought together its Physician Advisor mastermind members for four sessions to discuss the evolving roles, focus areas, and success strategies within this field. These sessions were supported by insights from the nationwide ACDIS survey "Understanding the Physician Advisor Role," which included feedback from 106 physician advisors. The survey revealed that while the physician advisor's role is expanding, only a portion can devote a significant part of their time to these roles.

The sessions offered insights into how physician advisors actively collaborate with CDI, optimize quality measures, and focus on return on investment (ROI)—priorities that are becoming more critical to healthcare leadership. The following is a summary of the key findings from both the survey and these thought-provoking discussions.

The dynamic spectrum of physician advisor roles and commitments

Physician advisors are integral to the world of documentation integrity, assuming a wide range of responsibilities. Responses from a recent survey reveal a wide variation in how much time physician advisors dedicate to their roles: 27% pour all their working hours into it, while close to a quarter limit their advisory work to less than 25% of their time. Meanwhile, 19% distribute their time equally between physician advisor and other professional responsibilities.

ACDIS 2023 Physician Advisor Mastermind Members

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Over a quarter of healthcare organizations have a team of more than five full-time physician advisors. Smaller teams of three to five full-time equivalent (FTE) physician advisors exist in 20% of the surveyed groups. Most commonly, 35% of physician advisors serve at a single location, but a notable 25% are responsible for physician advisory responsibilities across three to five hospitals.

The discussions among the mastermind panel mirrored these survey results, illustrating the adaptability and wide-ranging influence of physician advisors within healthcare systems and the necessity of adapting roles and time allocation to maximize impact.

Andrew Maigur, MD, CHCQM-PHYADV, CMPC, system director of the physician advisor program at Premier Health in Dayton Ohio, uniquely serves as the sole full-time physician advisor in his organization, supported by 13 others who combine part-time physician advisor work (between 25% and 50% of their time) with clinical roles. Maigur maintains there is value in physician advisors continuing their clinical work and says, “Those physician advisors are considered very much relevant to the medical staff because they still practice clinically.”

Conversely, **Vaughn Matacale, MD, CCDS**, medical director, clinical documentation advisor group at ECU Health in Greenville, North Carolina, reflects on the challenges when physician advisors work in two worlds, stating, “We had failures with split time or doing it as an alternate responsibility because a lot of the work that we do is experience-dependent—the more you do, the better you get.” He adds, “When we went full-time, we experienced program growth and developed expertise pretty quickly.” He notes that ECU Health has eight physician advisors.

The reporting structures for physician advisors are shifting, with a growing number reporting directly to the chief medical officer—up to 32% from last year’s 25%. This is in contrast with a decrease in those reporting to the revenue cycle or finance-CFO departments, now at 28% compared to the previous year’s 35%. Additionally, 14% of this year’s respondents report to multiple departments, highlighting the interdisciplinary nature of their work.

In their array of duties, physician advisors are focusing more on UR, UM, and denials management as principal responsibilities. Currently, 41% of physician advisors spend a significant part of their time—ranging from 26% to 75%—on UR and UM tasks, an increase from 34% last year. Denials management has also

become a more substantial part of the role for 39% of physician advisors, up from 30% previously, while CDI is now a principal responsibility for 35%, a significant hike from 22% last year. Yet, it’s noteworthy that the majority of physician advisors only allocate a quarter or less of their time to their primary tasks.

The mastermind group reflects similar trends, reporting often to both clinical and financial leaders while also taking on key responsibilities in denials, UR/UM, and CDI.

David Balt, DO, physician advisor at Avera Health in Sioux Falls, South Dakota, leads seven physician advisors and stresses the importance of reporting to both the CMO and CFO. “Everything we do gets reported to them,” he notes. In addition to CDI and UR duties, half of his work revolves around denials management. Balt notes that UR is an important function due in part to its significant revenue generation. “Our queries alone increase our revenue by about a million dollars every month,” he explains.

Meanwhile, **Nancy Williams, MD**, physician advisor for BJC Medical Group, St. Louis, Missouri, focuses exclusively on CDI, overseeing physician champions across 14 hospitals.

“I don’t do much UR work, which is unusual, but I focus on quality, including projects to improve our morality.”

Matacale from ECU Health indicates physician advisor roles have shifted, now encompassing both CDI and UR, the latter of which focuses on medical necessity. In addition, physician advisors also assist with clinical validation, quality, and most recently, appeals. “Our DRG or CDI budget goes to corporate finance, and UR goes through its own budgeting process,” he says, revealing that the physician advisor group recently transitioned from finance to the corporate director of HIM.

In Orlando, Florida, **Doug Brown, MD, MBA, FACS**, Executive Medical Director-Physician Advisory Services at Advent Health, balances his clinical practice in surgical oncology with his physician advisor responsibilities. He says he initiated a pivotal change in reporting structures, moving from the revenue cycle to a direct line to the CMO. “It didn’t make any sense for doctors to report to non-medical people when dealing with length of stay, meeting

standards of care, and things to do with CDI,” asserts Brown, whose duties primarily involve UR and CDI. He adds that physician advisors are now loosely affiliated with revenue cycle.

In contrast, **Malek Adawi, MD, CCS, CDIP, CCDS**, physician advisor at Community Health Systems in Franklin, Tennessee, embraces the CFO reporting structure, finding value in sharing critical performance metrics, such as non-response rates and expected financial impact, which engage financial leaders in the CDI process.

Figure 1. 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.)	9.4%	50.9%	24.5%	10.4%	4.7%
Utilization review/utilization management support	24.1%	25.9%	25.0%	15.7%	9.3%
Denials management	21.5%	36.5%	23.4%	15.9%	2.8%
New resident/clinical partner training/onboarding	39.4%	47.1%	11.5%	1.9%	0%
Physician burnout prevention initiatives	85.0%	13.0%	2.0%	0%	0%
Physician/provider education, 1:1 or larger groups	14.3%	57.1%	17.1%	8.6%	2.9%
Presenting financial, quality, or other data to organizational leadership	30.5%	58.1%	8.6%	1.9%	1.0%
Researching CDI opportunities for growth, new tools/technologies, etc.	47.6%	44.7%	6.8%	0%	1.0%
Technology evaluation and physician adoption	49.0%	43.3%	4.8%	1%	1.9%

Figure 2. Approximately how much of your time is currently dedicated to your physician advisor role/responsibilities? (Please select the option that most closely matches your time, even if it is not exact)

	Responses
Less than 25%	23.6%
25%	16.5%
50%	19.3%
75%	13.8%
100%	26.6%

Proving value: ROI insights

Physician advisors and CDI teams closely monitor each area’s core set of ROI indicators. Case mix index and UM outcomes are at the forefront at 40% and 39%, respectively—an increase from 32% for case mix index compared to the previous year. Additionally, complication or comorbidity (CC)/major complication or comorbidity (MCC) capture and diagnosis-related group (DRG) denial improvement are key focus areas, accounting for 25% and 20% of ROI measurement, respectively. While these metrics provide valuable financial insights, panelists also acknowledge the challenges associated with quantifying ROI.

During the discussions, panelists shared their ROI tracking strategies and obstacles. Williams from BJC Medical Group stressed the intangible nature of achieving certain outcomes: “Our O/E [observed to expected] ratio went way down from 1.16 to 0.5, and our Vizient ranking went from the seventies to four. However, I can’t assign a dollar amount to prove that we need to continue the program.” Matacale highlighted the need for manual data tracking to justify the work, saying, “It’s cumbersome, but when we’re trying to do program growth or prove FTE needs, it’s a requirement.”

To address these hurdles, the group agreed that one key strategy is to link physician-targeted educational programs to improved performance metrics, such as O/E ratios and quality scores, which can have a ripple effect on areas like payer contracting and risk adjustment in ACO settings.

At Advent Health, Brown emphasizes the significance of denial overturn rates when reporting to the CFO. He notes their importance in the hospital’s financial ecosystem, with a success rate of 70%. Similarly, Maigur says Premier Health achieves a 75%

success rate in overturning inpatient stay denials, adding, “We’ve been able to turn the needle by collaborating with our peers and doing batched peer-to-peers.”

Strategies that are transforming physician education

Physician advisors lead multifaceted efforts to address critical areas and leverage the latest learning methods when educating physicians on CDI topics. Notably, technology is a crucial factor in improving documentation accuracy and quality, along with query responsiveness and denial rates.

A significant 83% of organizations surveyed prioritize educating new physicians on documentation integrity. Notably, 38% of this education is led by physician advisors and 32% by CDI staff, with CDI educators contributing 15%. Education primarily takes the form of one-on-one interactions (73%), followed by tip cards (66%) and in-service sessions (62%). The emphasis on regular documentation training is evident, with most organizations offering formal education monthly (42%).

The survey also reveals that provider organizations assist physicians in more efficient documentation by utilizing

smart phrases and other CDI-related modifications in the EHR (80%), templates (61%), and tools for both query automation and workflow/collaboration between CDI and physicians (each at 38%). The mastermind panelists share a strong commitment to ongoing physician education, targeting residents, specialists, hospitalists, and both employed and non-employed physicians.

During the mastermind sessions, panelists discussed innovative methods for developing impactful learning programs. Maigur, from Premier Health, prioritizes a team approach that involves CDI directors and managers. “They have valuable insights about who’s responding to queries, who’s not, and who has a high rate of unable to determine,” he says. Education is aimed at both group settings and one-on-one sessions. He stresses that it is critical to continuously engage new physicians and address individual barriers such as slow query responses or resistance to working with CDI. “When onboarding new physicians, we try to have a touch point with those providers no matter their specialty,” he says.

Maigur says education is customized to different teams and schedules, with hospitalists receiving frequent training. “They admit up to 90% of the patients at our facilities, and they are system-employed, so they have a lot more buy-in,” says Maigur. Furthermore, he adds that hospitalists are motivated to learn, as their scorecards include quality metrics linked to CDI. Looking ahead, Maigur plans to introduce a comprehensive elective for residents on UR, CDI, coding, patient billing, professional billing, and quality compliance.

Williams from BJC Medical Group plays an active role in physician education across the organization, meeting quarterly with physician champions over each individual hospital. She also conducts quarterly educational sessions with individual specialties, including nurse practitioners who write notes for the surgical specialties.

Like Maigur, Williams uses personalized one-on-one sessions to address high query rates and help physicians understand why they’re receiving denials. She says, “I also talk to them if they’re using ‘unable to determine’ a lot or they’re delayed in answering their queries.” She also uses hospital newsletters, handouts, tip cards and videos, and medical staff meetings as opportunities to educate physicians.

Leveraging technology and analytics for enhanced learning

Survey respondents emphasize the importance of technology in physician documentation, pointing to its role in improving

documentation quality and meeting financial and quality metrics (83%), driving efficiency and time savings for physicians (83%), and achieving standardization and compliance (66%). Furthermore, over half of respondents (55%) say reporting and analytics are “very important” in engaging physicians to use technology that helps them document, while 27% say those tools are “somewhat important.”

Maigur states that Premier Health uses technology to enhance the documentation process within the EHR. This approach includes real-time query viewing and access to smart phrases for common query diagnoses. He is also considering systemwide note templates in the EHR to prompt providers in relevant areas, and the CDI department has experimented with AI tools that assisted with querying.

In gaining physician buy-in, Maigur notes the importance of integrating quality metrics into physician scorecards, including mortality, length of stay, and cost O/E data. Quality data on scorecards indirectly encourages physician engagement with CDI and drives quality clinical documentation. Other incentives, including tying CDI education to citizenship scores

which affect bonus eligibility, further promote active participation in educational efforts.

Diana Nims, MD, MA, FAAFP, CPE, CHCQM-PHYADV, CCDS, medical director of case management at Sarasota Memorial Health Care System in Sarasota, Florida, also recognizes the benefits of connecting good citizenship scores to CDI educational programs. “One of our hospitalist goals is that they attend the monthly meeting as part of good citizenship,” she says.

Sheilah Snyder, MD, FAAP, CDI physician advisor at Children’s Nebraska in Omaha, Nebraska, notes that her pediatric hospitalist group participates in voting for a portion of the organization’s quality domain for their professional performance incentive. “This coming year, I am going to suggest something CDI related—their vote for the metric will drive some buy-in reaching that goal,” she says.

Williams uses technology to offer systemwide documentation support to physicians. This includes a tailored documentation app, which provides clinical guidelines. Williams also employs analytics to shape education strategies, offering a team website for physician champions to access query-related data. “We’ve got all the analytics in there, so they can just push a button to see who in their hospital has the most queries, who delays answering queries, and see the most queried diagnoses.”

Like Maigur, Williams has also rolled out smart phrases in the EHR to simplify the documentation, especially for specific conditions. Reflecting on the effectiveness of these educational interventions, Williams cites improvements in hospital ratings. She notes, “We

moved from a three-star to a five-star hospital, mostly based on our mortality statistics improving,” she states.

“One of the things that we implemented this year was the query response time metric, as we struggled to meet the national average, which is less than 48 hours,” says Adawi. “They have the capability to reach this goal because they receive notification in their phones. We have seen a lot of improvement since introducing this metric, especially among the young physicians who are very interested in technology.”

Denial management strategy

Physician advisors also play a significant role in the denials and appeals process. According to survey data, 47% of respondents state that physician advisors engage in peer-to-peer conversations with payers, 37% participate in the appeals process on an as-needed basis, and 26% write coding/clinical validation appeals.

When Balt started at Avera Health, denials management involved writing appeals letters across a geographically dispersed health system that was hemorrhaging significant losses from denials. Today, he oversees a centralized CDI program supported by

Figure 3. What are the goals or benefits you seek to achieve by implementing technology to help physicians document? (Check all that apply)

	Responses
Standardization/compliance	66.0%
Efficiency/time savings for physicians	82.6%
Efficiency/time savings for CDI	56.9%
Expand documentation improvement reach to more cases	55.1%
Improve documentation quality/financial and quality metrics	83.5%
N/A	1.8%
Other	0.9%

additional physician advisors. He is actively involved in writing appeal letters and conducting peer-to-peer calls, primarily for clinical validation cases. This approach has proven effective, with a 75% success rate for peer-to-peer calls and a 50% success rate for CDI appeals. “When physicians are involved in writing these letters, our overturn rate is much higher,” he notes.

Matacale from ECU Health says the denials process is still in its early stages. “Both our CDI and UR denials processes are rudimentary when it comes to integrating physicians to help draft [appeals] language,” he says. Communication and partnership with the central billing office have been challenging, as this office decides which cases get appealed. “It has been difficult to work with providers and on documentation without knowing the patterns on the back end,” he adds. “However, we’re digging into how we work together on denials because financially it’s extremely important,” he says. Matacale adds that ECU Health also has a coding appeals auditor who drafts the first-level appeals. Subsequent coding denials are escalated to a physician advisor.

Nims with Sarasota Memorial Health Care System is actively involved in CDI education and preventing denials at the front-end. While a skilled RN in CDI handles initial levels of appeals, Nims takes on complex cases, such as heart surgeries. The hospital emphasizes denial prevention with its medical staff culture and has a robust data infrastructure. “We share denials information with physicians each month and why they are receiving education,” adds Nims, noting providers receive a UR data review package that includes length of stay, readmission rates, and denial rates.

Mastermind members generally concurred on implementing systemwide clinical definitions to prevent denials, with varying progress in their creation. Balt and Adawi noted their preference for an educational approach over imposing specific definitions on physicians. Adawi explained, “For conditions like severe malnutrition, we educate everyone involved, from nutritionists to physicians, regarding ASPEN criteria.”

Snyder from Children’s Nebraska in Omaha says it has been challenging to establish clinical definitions within pediatrics, where specific definitions for certain diagnoses are lacking. “Pediatrics lacks specific definitions for certain diagnoses,” she says. “As a national group, we’ve met at ACDIS several times to try and create national definitions.”

Front-end prevention

Organizations extensively employ upstream prevention strategies to mitigate denials. According to survey data, these prevention measures include targeted education (68%), clinical validation reviews (59%), provider education on vulnerable conditions (59%), and systemwide definitions/clinical criteria (50%).

Balt agrees that targeted education is key. He utilizes various methods such as emails, blogs, and videos to educate physicians on frequently denied diagnoses like sepsis and respiratory failure. “I anticipated some resistance, but I have only had positive comments from these physicians,” he says.

Adawi also recognizes the value of focused education and regularly collaborates with the denial management team to analyze denial trends, sharing this information with physicians. He believes in the persuasive power of data, stating, “Data around denial management never lies. If you show it to your physicians, you’ll see them working like never before,” he adds. For instance, when payers began denying acute and chronic heart failure cases regardless of Framingham criteria, Adawi initiated systemwide documentation tips to address the issue promptly.

Managing denials in problematic areas

Despite ongoing efforts, healthcare organizations continue to grapple with a high rate of denials. According to survey respondents, sepsis tops the list as the most commonly denied condition (83%), followed by respiratory failure (61%), malnutrition (35%), and acute kidney injury (AKI; 33%). Sepsis-2 criteria (53%) is the most widely used criteria, followed by a combination of Sepsis-2 and Sepsis-3 (16%) and systemic inflammatory response syndrome (SIRS; 12%).

Mastermind members concur that these are the prevailing denied conditions in their practice. Matacale, for instance, currently focuses on clinical validation denials and frequently denied diagnoses, such as sepsis, respiratory failure, AKI, and hyponatremia, examining payer language. He says ECU Health follows Sepsis-2 criteria and still faces denials in this area. “When we get those denials, we just deal with them on the back end because we’ve agreed within coding and CDI that our job is to support the provider’s definitions.”

Tracy Bercu, MD, FACP, FHM, physician advisor with Torrance Memorial Medical Center in Torrance, California, says her organization experienced an increase in sepsis denials when payers switched from Sepsis-2 to Sepsis-3 criteria. “They’re trying to say it doesn’t meet Sepsis-3 criteria, even though [that criteria] is not in any contract.” She adds that the solution has been to use Sepsis-2 and get it into the payer contract. “We’re just in the beginning stages of fighting it,” she says.

Nims emphasizes the difficulty of winning sepsis denial cases and frequently engages in peer-to-peer discussions over sepsis-related

denials. “The last time I won for sepsis, I discussed both Sepsis-2 and Sepsis-3 in painting the clinical picture of the bedside patient,” she says. Nims and the other mastermind members agree that in such cases, persistence is key, including exhausting all appeals processes. “Payers bully health systems that don’t stand up to them. At Sarasota, we fight every single thing.”

Evolution in 2023

Physician advisors are witnessing significant changes in their roles as the evolving healthcare landscape compels them to further prioritize documentation integrity, quality measures, and ROI. With expanding responsibilities, physician advisors are taking on leadership for critical areas such as UR/UM, denials, and physician education. Organizations increasingly value physician advisors’ roles, allocating more time and resources to drive systemwide change. Advancing technologies that support physician documentation, query processes, data analytics, and performance metrics are helping drive this success. As physician advisors look to 2024, they are well-positioned to overcome challenges and continue expanding the role. ■

Figure 4. Do you/physician advisors participate in the denials appeals process at your organization? (Check all that apply)

	Responses
Yes, I write medical necessity appeals	22.0%
Yes, I write coding/clinical validation appeals	25.7%
Yes, I engage in peer-to-peer conversations with the payer(s)	46.8%
Yes, I supervise the appeals process	15.6%
I participate on an ad-hoc, as needed basis	36.7%
I do not participate in any part of the denials process	13.8%
I perform a different appeals-related activity	6.4%