ACDIS Physician Advisor Virtual Roundtable: Five Big Ideas

Hospital and health system physician advisors and medical directors discuss provider engagement, denials management, and developments associated with the ongoing COVID-19 outbreak.

ACDIS PHYSICIAN ADVISOR VIRTUAL ROUNDTABLE PARTICIPANTS

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The role of a physician advisor is challenging and ever-changing. This is reflected in the diverse job description, which often includes educating on regulatory updates and effective documentation, triaging and managing denials, and motivating providers with both carrot and stick.

ACDIS gathered together more than 20 physician advisors to clinical documentation integrity (CDI) for guided discussion on their day-to-day roles and responsibilities, with an additional emphasis on the current climate of COVID-19 and the continued survival of CDI departments in an economic downturn.

Following are five highlights from the ACDIS Physician Advisor Virtual Roundtable, held September 21. Although it was held virtually, the discussion reinforced that progress in the quest for more accurate, complete, and specific documentation can be accomplished through personalized touch, care, and persistence—even while remote.

PROVIDER ENGAGEMENT

1 LEVERAGE RESOURCES, MAKE IT PERSONAL

Some of the roundtable attendees work in sprawling organizations with thousands of providers, which might seem to make personalized engagement an impossible task. But attendees have experienced success with creative approaches that leverage CDI staff, technology, and relationships. All agreed

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that they are in the relationship business with providers, and those relationships need to be maintained and fostered.

For example, **Vaughn Matacale, MD, CCDS,** physician advisor at Vidant Health in North Carolina, taught his team of internal auditors what makes physicians tick, and turned an ineffective "stick" approach (instilling fear of audits), which physicians ignored, into a "carrot" of partnership and support that resonated. "I had to make sure that the other members of the education team could understand what was going to matter," he said. "I can't do it myself—I need all these other folks, and equip them with those tools."

John Pettine, MD, FACP, CCDS, CPHQ, physician advisor at Lehigh Valley Health Network, uses many formats to engage the system's nearly 3,000 providers, but found success recording a short 12-minute CDI video with help from his department of education on the importance of documentation. On the video he appears as an animated version of himself. After watching the presentation, providers receive a 10-question multiple-choice quiz to reinforce its lessons, with the correct and incorrect answers provided as remediation. Providers who complete the video and quiz as well as additional coding and compliance educational bundles earn a small incentive. The video has proven particularly effective in educating new providers and residents during the COVID-19 outbreak. Lehigh Valley Health Network has a stick as well, via an escalation policy involving the chairs and chiefs of medicine and surgery when necessary.

Barbara Abrams, MD, JD, CHCQM-PHYADV, physician advisor with Orlando Health, discovered through a process of trial and error that 1:1 dialogue still works best for provider engagement, even though it is the most labor-intensive and time-consuming method. "When there is a problem with that particular patient, finding that particular doctor, going on to the wards, sitting down with them, and saying, 'Hey, I want to talk to you about Mrs. Smith in Room 209. You wrote this, but you didn't specify such-and-such, and here's why it's a problem.' "

Less effective among participants were newsletters, which often went unread, and mandatory educational classes, which resentful physicians participated in with poor body language, slumped in chairs with crossed arms.

COVID-19

2 TAKE THE INITIATIVE, BE AN "OPPORTUNIST"

Many CDI departments have taken a hit during the COVID-19

crisis, as hospital administrators respond to decreased patient census with unpaid time off, furloughs, and in some cases layoffs. But CDI departments that analyze the situation and get creative with new ideas, instead of becoming passive or defensive, are faring better.

For example, New Jersey–based Cooper Health, a Level I trauma facility, experienced a surge of patients with acute respiratory failure and other acute conditions, even as the overall census dropped and administration began to question the need for CDI. **Nicole Fox, MD, MPH,** seized the opportunity by educating anesthesia providers rounding in the MICU who had never previously documented in critical care charts. Another opportunity was accurately capturing procedure note documentation for ECMO treatments.

"I think being an opportunist is always good. What service lines are being developed at your hospital? Focus on that," she said. "COVID comes—what's the crisis then? It's critical care and their needs. Focus on that."

3 COMMUNICATE AND BE FLEXIBLE IN TIMES OF CRISIS

Surviving the COVID-19 pandemic requires CDI departments to be flexible with traditional job assignments and double down on communication to hospital administration. Be prepared to have the thickness of your skin tested, roundtable participants said, and resist the urge to become defensive and reactionary.

"In terms of the volume/census issue, what is your CDI team doing when the census is down? I think it's a very legitimate question on the part of administration," Fox said. "I said to my team, 'We have to be honest. If people aren't being utilized correctly, these are hard times, and we may have to make difficult choices in terms of how we manage the team.' So the more honest and transparent we can be with administration, the better off we are. Be proactive with your plan, because if you don't make the plan, someone else will do it for you."

Alvin Gore, MD, a physician advisor with St. Joseph Health System, said that early in the pandemic CDI staff became a shared resource, covering multiple facilities whereas in the past they might be assigned to just one. "They share responsibilities through the region; we have the same EMR, so they can cover cases for all five facilities."

DENIALS

4 WIN THE WAR OF ATTRITION

Starting this year, the coding department at the University of Pittsburgh Medical Center took over inpatient coding denials management (not medical necessity denials) for the organization's 30-odd hospitals. **Megan Cortazzo, MD,** medical director of CDI and HIM for the organization, said its approach is to fight the denials for which fighting is justified. "I feel really strongly that if the condition was treated, we should get paid for it."

Cortazzo backs her team of auditors by providing clinical support and argumentation. Seeing many of the same reasons for denials creep up

again and again, she and her team created standard rebuttal letters to begin the first level of appeal. Since then, she's gotten involved with denials at the Administrative Law Judge (ALJ) level, arguing cases as far back as 2013–2014.

Cortazzo also is able to make good use of denied cases by incorporating select examples into CDI education and presentations. "I now can go back as I'm giving my CDI lectures, to talk to the physicians like, 'Hey, you're answering these queries, you're doing these things, but these are the types of things you really need to think about to make sure that we even get reimbursed for them,' " she said. "That's a nice feedback loop for me."

5 DEFINE THE OBJECTIVE AND FOCUS ON CARE

Howard Rodenberg, MD, MPH, CCDS, physician advisor at Baptist Health in Jacksonville, Florida, helped his organization develop definitions for common or at-risk diagnoses. The project started with sepsis and has since expanded to definitions for conditions such as:

- Acute respiratory failure
- Acute blood loss anemia
- Postop ileus
- Acute kidney injury
- Acute encephalopathy
- Morbid obesity
- CVA/TIA
- Postop respiratory failure

While these documents take work to research and develop, standardized institutional definitions allow CDI and frontline clinicians to speak the same language, and provide additional justification for queries and clinical validation requests.

Baptist Health initially attempted to tailor the definitions to match payer requirements, but after it found that insurance companies were consistently moving the goal posts, Baptist quickly adopted a patient-first approach. "We went down that rabbit hole when we started, but if you start by trying to play with the insurance companies, it's a losing game," Rodenberg said. "We came to the belief that we were going to support what is clinically the best definition for our patient population, given what our specialists prefer. We're going to do what's right for the patient, and if the insurance company doesn't accept it, that's fine. You have to present your arguments consistently, on behalf of the patient, and understand that you may lose in the short run. But in the long game, when someone from the outside like a mediator is looking at disputed claims, they'll see who's more consistent, reasonable, and patient-focused."

ACDIS is the nation's only association dedicated to the unique needs of the clinical documentation integrity (CDI) profession. It conducts roundtables and exchanges like that described above to share ideas, solutions, and insights among CDI professionals. Please visit www.acdis.org to learn more.