

Selecting the Ideal CDI Physician Advisor

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Physicians are increasingly being utilized as advisors in various aspects of healthcare delivery. These include utilization review, quality resource management, and clinical documentation improvement. An effective strategy must be used to develop a physician advisor program in the area of clinical documentation, since accurate information has risen in importance due to increased record audits, quality measures, and use of data analysis to improve care. The success of the physician advisor program hinges upon the definition of the advisor's role(s), the selection of the proper individuals, and the training process.

Effective Physician Advisors Hold Influence

Central to this infrastructure, the physician advisor serves as a liaison between the clinical documentation improvement (CDI) team, which includes hospital coders, clinical documentation specialists (CDS), and the medical staff. The advisor is pivotal in leveraging his or her clinical position to exemplify the marriage of care delivery with specificity in documentation. This is done through effective communication and education of the respective parties. The advisor will enhance other physicians' clinical understanding regarding such issues as pneumonia types, sepsis, and respiratory failure. The advisor will provide his or her expert opinion in relation to clinical validity assessments, and, furthermore, the development of clinically robust and appropriate queries.

In cases where the attending physician fails to respond or questions the need for the query, the physician advisor can provide peer to peer communication to affect the appropriate response. Finally, the physician advisor can provide education to the physician(s) regarding the impact of good documentation on their reimbursement, profiling, and patient care. The key to success in education is concise, pertinent, and frequent dialogue. The advisor can achieve this through developing newsletters, posters, and—most importantly—short discussions integrated into clinical practice.

In defining the role of the physician advisor, the area(s) of impact should also be illustrated. Complete and accurate documentation and coding will impact outcome analysis in terms of quality and reimbursement. The facility needs to decide how to prioritize the use of their time and expertise.

Once the physicians are adequately trained they can have an influence in one or more of the following areas:

- DRG validation
- Risk adjustors for 30-day mortality, 30-day readmission
- APR-DRG risk of mortality and severity of illness
- DRG adjustments by outside reviewers (i.e., RACs)
- ICD-10 clinical validations and medical staff education

Selecting the Ideal Advisor

The selection of the physician(s) is the most important step in establishing an effective CDI physician advisor program. The four main attributes a physician advisor must have are:

1. Broad clinical knowledge base
2. Respect from the medical staff
3. Ability to effectively communicate with physicians and non-physicians
4. Availability

The selection process should have significant involvement by the CDI staff and not be left solely up to senior management. It is suggested that the CDI team screen applicants and submit a list of preferred candidates to senior management.

Physician advisors need to have a broad knowledge base of clinical medicine across all specialties. The overwhelming majority of the inpatient documentation issues involve specification of medical diagnoses. Hospital-based physicians, such as hospitalists and pulmonary/critical care physicians, represent an ideal group of physicians from whom to select a physician advisor(s). These physicians often work with many different specialties and are comfortable conversing with many different medical and surgical specialties.

With the increasing emphasis on outcome measurements, quality of care issues, and the coming implementation of ICD-10-CM/PCS, many facilities are beginning to create a second tier of physician advisors that are specialty-specific. These physicians are often termed “line of service leaders.” The service line physician leaders work as a coordinated team with physician advisors on documentation issues along with other departments such as quality resource management to assist in educating the attending physicians regarding a variety of issues within their specialty areas. Additionally, many have found that communication is easier if the specialists talk peer to peer with their group of physicians.

CDI Case Study: University of North Carolina Hospitals

As an example, the nationally recognized University of North Carolina Hospitals (UNCH), under the direction of Joni Perry, RHIA, director of health information management (HIM) and Melissa Rajappan, RHIA, associate director of HIM, have demonstrated how the investment and development of a physician infrastructure impacts a CDI program. With the growth of their physician advisor program, the coding quality, compliance, case mix index, and severity adjustments have exceeded national standards, illustrating the success and importance of such an integration.

At UNCH, the physician advisors are utilized for various purposes and not all have the same primary function. The hospitalists are used primarily for chart reviews. This function fits their schedule and broad knowledge base that crosses specialty lines. These charts can be reviewed concurrently or after discharge, but are reviewed pre-bill. According to Perry, the focus is on areas that are problematic from the vantage point of medical complexity with the opportunity to improve severity and case mix, as well as any issues that are highlighted by national or state audits. All deaths are reviewed for risk of mortality (ROM) and severity of illness (SOI) to ensure the patient complexity is represented to the highest degree.

Furthermore at UNCH, the service line leaders focus more on the quality issues and education of their specialties as to how physician documentation is influencing the data being generated. This knowledge, coupled with chart reviews, allows an extensive customized educational program. All public data including the University Healthcare Consortium, US News and World Report, and other physician profiling sources are analyzed and incorporated into the instructional seminars.

In addition to providing data analysis and clinical integration, the physician advisors should command the respect of the medical staff. This is why UNCH encourages that the advisors be selected from members of the active medical staff who have held positions of leadership. This will usually ensure they have the ability to communicate with other physicians. Finally, they must have the willingness to dedicate time to this work. A minimum of four to six hours per week is needed to fulfill their tasks. It is best that they commit to working the same time each week. It is of no use to select and train the right physicians and, in the end, find they are not available to fulfill their role. It is recommended that the physician advisors be paid a stipend that is commensurate with their value and experience in order to help maintain their interest and dedication to the CDI team.

Advisor Training Should Be Required

Once the physicians are selected, their training is crucial. This level of intensive training will allow them to be a meaningful contributor to the CDI team from a chart review perspective. Additionally, they need to know how to communicate with non-physicians and physicians regarding coding and documentation issues. For example, the advisors would provide the coders the clinical indicators other than an Echocardiogram which suggests diastolic heart failure. Additionally, the physician advisor would address with the physician the distinction between diastolic heart failure and volume overload. This distinction is important because it impacts correct payment and the 30-day readmission statistics for the facility.

Through years of experimentation with the development of physician advisors, Huff DRG Review found that the most efficient and successful way to train physician advisors is to begin with an initial intensive classroom training followed by a regular

review of their work coupled with weekly or monthly mentoring sessions. Physician advisor programs developed in this manner are more immediately effective, compliant, and sustainable as compared to one to two day courses that do not provide any structured follow-up monitoring or mentoring. Once they reach a level of accuracy and comfort, the advisor can work without supervision. It is very important that the physician advisor training occur in collaboration with other members of the CDI team. It is helpful in order to promote the CDI team concept to include the coding supervisor and concurrent documentation specialists that they may be working with on a regular basis during the initial classroom training.

The initial classroom training, which typically takes 40 to 50 hours, should include:

- Understanding the DRG system and the operative definitions, such as principal diagnosis, principal procedure, levels of co-morbidities, etc.
- Basic coding guidelines regarding the selection of principal diagnosis and reporting additional diagnoses and procedures
- Concepts of risk adjustment, severity of illness, risk of mortality, case mix index, prospective payment, hospital acquired conditions, value-based purchasing, etc.
- How coding and documentation affect payment, profiling, and patient care for hospitals and individual physicians
- Thorough review of all the common clinical documentation issues at their facility
- Applying principles learned during actual sample chart reviews
- Issues that should be covered with the various medical and surgical specialties and other departments
- How to function as a physician advisor and work with the medical staff, coders, and concurrent documentation specialists

A similar but less intense training program can be used for the service line leaders. Since their issues are confined to a single body system, the program can be shortened to four to eight hours.

Following the initial training, advisors and service line leaders should be involved in weekly chart reviews under the guidance of coders and clinical documentation specialists. At first, the physician advisor or service line leader will need some assistance in directing their review efforts. This chart review process will allow the advisor to become more keenly aware of the disconnect between the clinical documentation for patient care and that needed for the most accurate coding. Armed with this knowledge, he or she can become increasingly involved with the education of the medical staff on an individual basis or at the departmental level. Integration of all the members into a regular reconciliation process promotes the team approach to achieving complete and accurate chart documentation. Regular meetings are encouraged that include the advisors, service line leaders, coders, and concurrent documentation specialists, as well as other interested parties.

Tips for Monitoring Performance

The performance of physician advisors and service line leaders should be monitored. This assessment is objective and subjective. The three areas of impact that should be monitored and have significant overlap are value, efficiency, and education.

Value impact is the easiest to monitor and most conducive to objective assessment. When assessing the value, the CDI team must measure impact on the specific area(s) in which the advisors are being utilized. For example, overall case mix is not a good parameter if the physicians are concentrating on a specific financial class, such as Medicare fee-for-service. Additionally, the impact should be broken down by service line or specific Major Diagnostic Category (MDCs) or diagnoses in order to measure the impact. Finally, do not hold advisors accountable for outcomes they have not been actively pursuing. If the emphasis is on case mix accuracy, then they cannot be held accountable for APR-DRG risk of mortality, 30-day readmission/mortality, PSI, etc.

Efficiency is best measured by physician query response rates and the length of time needed for such response. Physician advisors can play a vital role in assisting with response times by direct intervention with the physicians, changing the content of the queries, and through education of the medical staff. Physician advisors play a valuable role in a hospital's escalation policy in reducing Recovery Audit Contractor (RAC) program DRG denials by helping resolve documentation issues with those physicians who provide insufficient indicators.

Assessing the impact of education is the parameter least amenable to precise measurement. This is where trending is important. CDI programs should analyze:

- What are the trends in the case mix index of our main medical and surgical services?
- Are we having to do less queries?
- What is the trend in our risk adjustments PSI audits, etc.?

It is also recommended that all presentations to the medical staff be accompanied by an evaluation regarding style, information, and usefulness. It is essential that physician advisors provide regular educational sessions that focus on how inadequate documentation impacts the practicing physician—and not just the hospital.

Advisors Must ‘Practice What They Preach’

The aforementioned areas of positive impact are compounded by a truly integrated CDI team. One of the most influential outcomes of an effective physician advisor program is the propagation of a longitudinal bidirectional relationship among coding staff, documentation specialists, and practicing clinicians. An advisor that is carefully selected, comprehensively trained, and appropriately monitored will successfully engage and foster physician involvement. The longevity of this physician interaction is the toughest challenge that the advisor will face. However, this peer interaction makes the work of the CDI team personal to physicians, and an effective physician advisor will lead by example by “practicing what you preach.”

The physician advisor can awaken practicing clinicians to the realized impact of quality documentation upon performance, reimbursement, and patient care. This coupled with the CDI team’s ability to integrate evidence-based guidelines into the query process escalates the level of communication with the provider, allowing for an expedited favorable outcome. In addition to the impact on complete and accurate documentation and coding, the physician advisor directly supports the growth and the day-to-day activities of the CDI program as well as serving as a physician representative on the CDI Steering Committee and other hospital committees.

As demonstrated at UNCH, according to Perry, the physician advisors are truly an extension of the CDI program and are integral to the success of CDI efforts. Successes have been demonstrated through improved overall coding quality and compliance with regulatory and coding requirements, and increased case mix index, CC/MCC capture rates, and reimbursement.

With accurate and timely physician involvement a successful CDI program will become recognized as a valuable, irreplaceable asset within the hospital on many levels. In addition to establishing an effective CDI team, the physician advisor program will enhance a CDI program’s proficiency and escalate it to a new level.

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