2019 Compass for Physician Advisors

Course	Module Description	Learning Objectives
101-19:Core Concepts of Physician Advising	**Basic Principles of Physician Advising** *Several elements form the fundamental characteristics of a successful physician advisory role. The first key to a successful physician advising is a collaborative approach – among physician advisors, case management professionals, medical staff members, and other hospital leadership. Second, in a liaison role, the physician advisor actively bridges the differences in scope among bedside clinicians, administrative staff, and other case management professionals. A third element is a structured physician advising program with deliberate goals and process as well as an appropriate management structure. Fourth, skilled leadership is required to implement and manage a successful program over multiple areas with multiple physician advisors. Lastly, physician advising when embedded within the existing clinical enterprise, allows escalation and leverage through medical staff and facility leadership.*	• List key characteristics of a successful physician advisor. • Explain potential advantages of an effective Physician Advisor program. • Examine possible instances when physician advisor input is necessary and beneficial through the use of case reviews.
	Basic and Advanced Strategies of Physician Advising *Partnership between physician advisors and the healthcare team is essential for the successful resolution of difficult cases and improvements in the areas of cost, compliance, and other initiatives. The physician advisor can serve an important bridge between retrospective review findings, evolving clinical practice, and concurrent improvement efforts. To support this function, a variety of metrics are used to measure performance, communication, team behaviors, and intervention/escalation rates.*	• Recognize advanced principles through case-based reviews. • Describe the relationship between physician advising and peer review. • List outcomes from a broad and balanced approach to utilization management. • Describe physician advisor advocacy activities spanning the continuum of care.
	Physician Advising with a Systems-Based Approach *Physician advisors must be familiar with major conceptual frameworks within transforming health systems. Core concepts include systems-based practice, patient safety, and quality improvement, and performance improvement. As healthcare continues to move away from a fragmented delivery system and toward a patient-centered process, a systems approach can provide an understanding of elements that influence health outcomes and lead to policy or process improvement that provide better coordinated care. Improvement of healthcare outcomes needs to be based on an appreciation of the whole system that contributes to those*	• Describe and define system-based practice. • Determine the role that patient safety, quality and utilization improvement play in the physician advisor's work. • Identify the organizations that provide qualitative and quantitative oversight and the common toolsets applied in the modern exercise of utilization and case management.

	outcomes, and physician a should seek deeper understanding of the concepts and commonly applied frameworks.	
	Health Insurance and Care Model Fundamentals *Physician advisors must be familiar with common health plan designs and care models, along with their impact on consumers, providers and care communities. Understanding the basic tenets of the Affordable Care Act, accountable care, transitions of care, the patient-centered medical home, health plan design, value-based purchasing, and chronic disease management models are critical to the core fundamentals of physician advising.*	• Evaluate health insurance plan fundamentals and payment methodologies. • Identify critical elements of the Affordable Care Act and their impact on patient access to care. • Recognize the common models of Accountable Care Organizations. • Explain the measurement domains of value-based purchasing arrangements. • Summarize the key benefits of the Patient-Centered Medical Home (PCMH) and Chronic Care Model (CCM).
	Advocacy, Professionalism and Areas of Focus *Physician advisors are involved in many areas, including patient quality and safety, billing status determinations, clinical documentation, patient length of stay, utilization management, and appeals. The physician advisor is not only a help to physicians, but also nurses, case managers, and other medical personnel – serving as the intermediary between clinical staff members and administrators. This scope and accountability require the application of both advocacy and professionalism, in addition to clinical perspective.*	• Determine the role that patient advocacy plays in the physician advisor's work. • Describe the core types of communications and level of professional required of a physician advisor. • Identify the recommended areas of basic clinical knowledge for effective physician advising.
	General Approach to Reviews *In an era of declining reimbursement, new Medicare regulations, and ICD-10 implementation, physician advisors are critical to addressing administrative concerns. Physician advisors should bring a broad base of clinical experiences to act as liaison between the administration, clinical staff, and support personnel to ensure compliance with regulatory issues and medical necessity, and to help the leadership team reach overall organizational goals related to the efficient utilization of healthcare services. Medical necessity and compliance reviews are an important aspect of this role. Physician advisors conduct second-level medical necessity reviews for patient cases that do not meet first-level screening criteria or do not have a documented expectation of length of stay. They also provide recommendations on inpatient admissions, outpatient and*	• Present the review process structure and work flow and apply its structure to effective case review. • Identify policies and regulations required for patient care and appropriate utilization. • Recognize the necessary documentation needed in the medical record for both denial management and appeals.

	observation services, or cases not deemed appropriate for hospital-level services.	
201-19: Communication in Theory and Practice	**General Communication in Theory and Practice** *Effective communication is key to the role of the physician advisor, and there are many stakeholders with whom the physician advisor will communicate with on a regular basis. Understanding communication theory, methods of communication, and enhancers or roadblocks to successful communication is a valuable part of developing this skill as is defining and understanding the value of collaboration in achieving desired results.*	• Describe communication theory and methods of successful communication. • Determine what enhances, and what creates, roadblocks to successful communication. • Identify with whom the physician advisor will communicate on a regular basis and describe the value of collaboration to achieve desired outcomes.
	The Tools and Responsibilities of Utilization Management *Physician advisors require a command and understanding of the utilization management process, including the role and tasks of the Utilization Review (or UR) Committee. It is, therefore, crucial for individuals in this role to be fluent in the CMS Conditions of Participation that govern the UR plan, understand the required, and most effective, composition of the UR committee, demonstrate strong knowledge of the electronic health record (or EHR), and carry over knowledge to clinical review processes and secondary reviews.*	• Restate the CMS Conditions of Participation governing the Utilization Review (UR) Plan. • Explain the Electronic Health Record (EHR) and its uses in the physician advising role. • Summarize the clinical case review process and describe the physician advisor's role in patient documentation and secondary review.
	Physician Advisors as Teachers *The experienced physician advisor becomes a teacher for case management staff and other stakeholders within the organization. To be an effective communicator while in the teaching role, it is important to understand the audience and to define the "who, what when, where, and why" of the education to be provided. Successful teachers will understand Adult Learning Theory and be able to appropriately tailor education materials to achieve maximum comprehension, recall and impact. They will also be able to recognize when their role as teacher should transition to coach and how to tailor their approach to the learning style and personality of their audience as well as situation.*	• Describe the physician advisor's role as teacher and recognize the stakeholders and audience for teaching efforts. • Outline how to identify education content, setting. and tools and apply Adult Learning Theory when tailoring education for maximum comprehension, recall and impact. • Describe when and how to transition from teacher to coach and identify ways to tailor education to learning style and personality of the audience as well as situation.
	Change Management *Change is necessary, and in the fluid healthcare environment, change is frequent. Managing change is about handling the complexity of the process. It is about evaluating, planning, and implementing operations, tactics, and strategies to ensure change is worthwhile and relevant. It is*	• Identify and recognize impediments to change. • Describe what change management is and how it works. • Present the steps involved in change management to maximize effectiveness.

	important to recognize impediments to change, understand what change management is, and identify the steps involved to be effective.	
	Conflict Management *However well the planning and implementation of change management is accomplished, there will likely be conflict. Physician advisors are, to some extent, responsible for changing the behavior of physicians and leaders, a highly-educated and methodical group of professionals. This type of audience requires a different approach to conflict management and resolution, and it is a key component of the physician advisor's role.*	• Identify early signs of conflict, particularly as it arises in the change management process. • Outline the multi-step conflict resolution process. • Determine when and how to escalate unresolved conflicts.
301-19: Medical and Legal Topics	**Understanding Medicare Program Oversight** *Addressing improper payments in the Medicare fee-for-service program is a top priority for CMS. Preventing improper payments actively involves every division of CMS as well as effective coordination with their partners, Medicare and Medicaid contractors, and providers. Understanding the roles and missions of the various contractors and their effect on healthcare practice provides a foundation for physician advisors as they effectively support the monitoring of patient status errors and appeals.*	• Define the roles of the RA, MAC and other regulatory auditing entities. • Explain the impact that regulatory auditor activity has on healthcare organizations. • Discuss proactive strategies that case management can deploy to minimize risk or prepare for a successful appeal. • Define the five levels of Medicare appeals.
	EMTALA and the Medical Screening Exam (MSE) *All hospitals with a dedicated emergency department that participate in Medicare must meet the statutory requirements of EMTALA. EMTALA requires hospitals to provide a medical screening examination and treatment and transfer, if appropriate, to individuals with an emergency medical condition or women who are in labor. The provisions apply to all individuals who present to the hospital for emergency care, not only Medicare beneficiaries. It is important for physician advisors to understand these regulations, their implications for patients, and the potential liabilities for organizations found in non-compliance.*	• Define EMTALA and associated terminology. • Describe the requirements of a medical screening exam. • Identify the EMTALA requirements of a dedicated emergency department. • Explain EMTALA regulations governing the transfer of patients. • Discuss when EMTALA investigations occur and what is involved.
	Patient Privacy *Patients retain certain rights to privacy, which must be respected without regard to the patient's economic status or source of payment for his or her care. Understanding these rights as they relate to the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Health Care Act (ACA) is key to avoiding non-compliance or medical malpractice. Patient confidentiality is one of the most important pillars of medicine. Protecting the private details of a patient is not just a matter of moral respect, it is essential in retaining the important bond of trust between the provider and the patient.*	• Explain the purpose and application of patient privacy. • Define and discuss HIPAA, its intent, and the promulgated Privacy Rule. • Examine the costly effects of privacy violations.

	Patient Rights and Conflicts of Interest *Per the Joint Commission, patients have a "fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial and spiritual values." The goal of patient rights is to improve patient outcomes by respecting each patient's rights and beliefs, as well as conducting business relationships with patients and the public in an ethical manner. Ensuring that all parties are well cared for and are protected, both clinically and legally, is a daily challenge of case management departments and is an oversight role of the physician advisor.*	• Recognize the implications of the ACA on patient rights and know the premise of the "Patient Bill of Rights." • Explain the various types of conflicts of interest, their appropriate reporting, and potential legal implications. • Examine cases of real-world conflicts of interest and their impact on organizations.
401-19: Patient Classifications	**Patient Status and Level of Care** *Patients undergoing treatment at a hospital tend to be classified in a variety of ways based on how they were admitted or the type of services they need. Patient classification should be determined using best practice guidelines and federal rules. Understanding the clinical criteria for classification is key to managing patient cost, hospital reimbursement and quality care.*	• Define patient status. • Differentiate between patient status and levels of care. • Describe the application of clinical criteria in determining patient status and level of care.
	Outpatient with Observation Services *Observation services are hospital outpatient services that a physician orders to allow for testing and medical evaluation of a patient's condition. While under observation care. Although a patient's room may be located anywhere in the hospital, the quality of care is the same regardless if the patient is an observation patient or inpatient admission. Patient status affects patient cost, payer reimbursement, and coverage for post-acute facility stays. It is critical for case management staff and physician advisors to understand appropriate assignment, the patient management involved, as well as implications for reimbursement.*	• Define and describe requirements for managing patients receiving observation services. • Describe implications of the Balanced Budget Act of 1997 on the use of observation services. • Define the rules applied to observation services associated with reimbursement.
	Inpatient Admission and Observation Services in Action *Patients classifications are largely determined using federal guidelines and best practices as a mechanism for quality care delivery and financial stewardship. Being able to apply these guidelines to real-world scenarios helps physician advisors have better oversight of patient expenses, hospital reimbursement and overall quality of care.*	• Analyze patient presentation, setting and needs. • Classify patients as best suited for inpatient admission or outpatient with observation services. • Recognize the common triggers that determine appropriate patient assignment.
	Two Midnight Rule *Hospitals can provide care to patients on either an inpatient or outpatient basis. Reimbursements from Medicare are paid separately based on patient status and represent different payment amounts for patients receiving similar services, along with differing cost-sharing*	• Describe the key tenets of CMS 1599-F. • Discuss the "Two-Midnight Rule" and its implications for physician advisor practice. • Restate the necessary requirements for a 20-day certification statement.

	obligations. Shifting of services between inpatient and outpatient has significant implications for Medicare and its beneficiaries. CMS' "Two Midnight Rule" defines specific requirements for patient assignment and is intended to add discord around Observation versus Inpatient hospital stays. Physician advisors must understand the provisions of the rule and its implications to the patient and provider.	• Explain the qualifying nights for a skilled nursing facility transfer. • Define the use of provider liable.
	Medicare Patient Notifications *Physician advisors should be aware of the Medicare Conditions of Participation requirements for patient notification and be familiar with the tools and forms needed for compliance. It is important to understand the triggers requiring an Advance Beneficiary Notice of Non-coverage as well as the Hospital Issued Notice of Non-coverage and Medicare Outpatient Observation Notice. It is additionally important to be familiar with the form and delivery of the Important Message from Medicare outlining a patient's right to appeal a discharge. Recognition of the requirements, appropriate forms, and timing for issuance can be burdensome for case management departments, but it is necessary to be vigilant, provide staff education, and implement structure to ensure the Conditions of Participation requirements are met.*	• Identify the tools and forms available to comply with Medicare Conditions of Participation. • Describe how and when to utilize various forms for proper patient notification. • Explain the regulatory requirements that govern the 'Important Message' from Medicare regarding discharge.
501-19: Utilization Management	**General Review Principles** *Utilization Management entails evaluation of the appropriateness, medical necessity, and efficiency of healthcare services, procedures and facilities according to established criteria, clinical guidelines or provisions of an applicable health benefits plan. Proactive procedures including discharge planning, concurrent planning, pre-certification and clinical case appeals are an important component and area of oversight for physician advisors as they are implemented in conjunction with ongoing utilization reviews and compliance.*	• Establish and identify the general principles of Utilization Management (or UM). • Describe the types of UM reviews. • Define and discuss medical necessity and its measurement.
	UM Committee and Related Functions *UM committees provide recommendations on utilization programs, processes and guidelines and are responsible for internal monitoring and reporting on cost and efficiency, promoting care coordination and cost reduction. It is frequently the case that the physician advisor would serve on such a committee. It is key for physician advisors to understand both the CMS Conditions of Participation and requirements for the committee, so they can serve effectively and compliantly within their capacity.*	• Describe the UM committee structure and functions. • Discuss the CMS Conditions of Participation and the requirements of a Utilization Review (UR) Plan. • Identify the appropriate criteria for using Condition Code 44 in changing patient status.
	Interpretive Guidelines and Escalation	• Identify where escalation may be necessary outside of the UM Committee.

	Hospitals 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. Understanding the interpretive guidelines in §482.30 and escalation process will ensure physician advisors are knowledgeable about utilization case reviews, referrals and escalation processes.	• Apply appropriate judgment when determining scope and function of UM committee. • Review interpretive guidelines for UR/UM plans in the CMS Conditions of Participation.
	Coverage and Clinical Appropriateness *Effective utilization management requires an understanding of the distinction between coverage and clinical appropriateness as well as the role that documentation and other criteria have in the coverage determination process. Coverage and clinical practice discrepancies require careful attention with respect to reimbursement, clinical appropriateness, and patient-centered care. Physician advisors should perform reviews proactively and in a timely manner, as well as utilize tools to minimize discrepancies and subsequent denials and appeals.*	• Explain the distinction between coverage and clinical appropriateness. • Assess and identify the role of documentation and other criteria in coverage determinations. • Identify proactive tools and processes to help in denial management and appeals. • Describe the role of consumer-driven healthcare in utilization of services.
	Metrics, Feedback and Peer-to-Peer Discussions *Recognizing and employing appropriate systems for data mining and identifying the appropriate paths for providing feedback or escalation is essential to solve utilization issues and prevent liability, delays, denials and even conflict. Having effective tools and systems in place helps with the effective utilization management and internal and external coordination efforts. Understanding the roles physician advisors play in these areas provides organizations with the means to implement effective physician advising programs and/or identify the best uses of physician advisors in achieving optimal outcomes.*	• Identify useful metrics for tracking variances, provider liable cases, waits and delays and apply the use of metrics to effective utilization management. • Identify useful feedback and recommendations to attending physicians to minimize variances and recognize appropriate strategies for peer-to-peer discussions. • Highlight the roles, functions and advantages of Physician Advisors in overall utilization management.
	Utilization and Resource Management for Pediatric Care *Pediatric case management is responsible for guiding families through the complexities of health benefits by working with payers, providers, and regulatory bodies and utilizing resources for under- or uninsured patients. To maximize efficiency, pediatric case management programs should be evaluated based on key performance indicators. It is critical for physician advisors to understand the key differences to utilization management when dealing with the pediatric population.*	• Explain why screening criteria is utilized to ensure pediatric patients receive appropriate care at the correct level of care. • Discuss different coverage options and resources for low-income families. • Evaluate pediatric case management programs for effectiveness and process improvement.
601-19: Resource Management	**High Value Care and High Cost Outliers**	• Demonstrate the stewardship role the PA has in resource management.

	Providers are given an incentive to keep healthcare costs down because they experience a positive bottom line only if their costs are less than the amount reimbursed to the provider by the diagnosis related group (DRG) category. Understanding the key measures impacting resource management and the role the physician advisor plays in managing these resources is necessary to maximize reimbursement and assure quality care is delivered in a cost-effective and appropriate manner.	• Identify key influencers on resource management and the measures of cost of care, cost reduction interventions, and common high cost outliers. • Discuss alternatives to outlier treatments when appropriate and strategies to minimize impact on net reimbursement when alternatives are not appropriate.
	Readmissions *Hospital readmissions are costly to all parties involved and are disruptive to the patient and family. Many payer reimbursement models also recognize the significant negative impact of readmissions and financially incentivize or penalize organizations to encourage better management of such occurrences. For these reasons, physician advisors should make every effort in the care, discharge, and transition process to prevent avoidable readmissions.*	• Explain the impact and cost to hospitals of readmissions. • Determine methods for conducting root cause analysis and identify tools to support readmission reductions. • Recognize effective readmission management strategies by stage of care.
	Transition Management *Resource management is directly affected by the length of stay and successful transition of the patient post-discharge. Understanding the tools needed to support an effective care plan will aid in successful care transitions. Physician advisors should be aware of these tools and understand regulations that affect these functions of case management so that they can positively influence staff and care processes as well as support care decisions that directly impact the resources of the organization.*	• Interpret the discharge planning mandate in the CMS Conditions of Participation. • Apply EMTALA regulations to transition management practice. • Identify the function of bundled payments and post-acute venders in relation to total episode of care.
	Post-Acute Care and Barriers to Care *Physician advisors should be knowledgeable regarding the appropriate post-acute setting for meeting patient needs by becoming aware of specific criteria, characteristics, services, and coverage for utilization of post-acute levels of care. Additionally, physician advisors should recognize potential barriers to care and the steps or resources that could be used to overcome these obstacles.*	• Recognize and define the post-acute levels of care. • Identify some of the most common barriers to care. • Develop strategies to address common barriers to care.
701-19: Clinical Documentation and Coding	**Overview of Clinical Documentation** *Clinical documentation is the primary communication venue to share information about a patient. Though the clinical documentation process involves multiple key players and departments, the physician advisor maintains an important role in the accuracy and improvement of clinical*	• Explain the purpose and goals of having accurate and detailed clinical documentation. • Identify the key contributors and stakeholders for clinical documentation. • Identify historical misrepresentations of clinical documentation and provide a rationale for the

	documentation to ensure effective patient care and seamless communication to healthcare payers.	importance of clinical documentation improvement efforts. • Recognize the consequences of improper or poor clinical documentation.
	Impact of Documentation and Coding *As liaisons and educators, physician advisors must be cognizant of how documentation and coding impacts reimbursement and physician quality outcome performance data. Complete, precise, and accurate physician documentation leads to clear communication, high quality data, appropriate reimbursement, and better outcomes. Physician advisors work to support the activities of clinical documentation improvement teams in many ways, but the first step to expand their knowledge and incorporate this within their clinical documentation is to serve as a role model for others.*	• Discuss the role of the physician advisor in clinical documentation improvement efforts and reimbursement practices. • Analyze and apply DRG, APR-DRG and high volume and high risk DRGs. • Describe MDC and MS-DRG. • Identify the reimbursement implications of various coding options.
	Documentation Best Practices *Working with providers to produce accurate documentation is critical to ensure validity and fairness in quality assessment and reimbursements. It is equally critical for providers to understand how the quality of their documentation impacts perceptions about the care provided. Once providers have been engaged, utilizing documentation best practices outlined can help improve the validity of their documentation, so they more accurately represent the patient to downstream consumers.*	• Examine the role of the physician advisor in CDI efforts. • Apply best practices to ensure accurate and valid documentation. • Determine methods for preventing poor or confusing clinical documentation.
	High Frequency Diagnoses *High frequency diagnoses are often mischaracterized by providers. Educating providers on these diagnoses will not only improve the accuracy and validity of documentation, but will also help standardize language and criteria used in clinical care.*	• Analyze frequently mischaracterized diagnoses and apply best practices to their documentation. • Review definitions, scoring metrics, and defining characteristics of high frequency diagnoses. • Discuss complications and consequences of poor documentation of several high frequency diagnoses.
801-19: Reimbursement	**Payment Types, Implications and Risk Models** *Physician advisors, as financial stewards, must understand the various healthcare delivery systems in order to balance patients' needs with insurance health plan requirements and available resources. Balancing the financial and clinical outcomes can only occur successfully when the physician advisor maintains current knowledge of healthcare trends and reimbursement methodologies that apply to daily practice. Shifting reimbursement models can present a challenge, and while current trends show a shift from fee-for-service to value-based reimbursement,*	• Explain the different payment models. • Describe cost containment strategies and their impact on care providers. • Describe Population Health and Accountable Care Organizations.

	physician advisors should have a robust knowledge of all models, their implications and risk.	
	Medicare Overview *An important part of understanding reimbursement payment models, implications and risk is the understanding of Medicare, how it's structured and its requirements for reporting and reimbursement. Physician advisors, as financial stewards to their organizations and liaisons to their interdisciplinary teams and patients, must have an understanding of the Medicare (and Medicaid) programs so they can appropriately serve their patient populations and assure appropriate reimbursement of services.*	• Identify the individuals covered under Medicare. • Describe Medicare Part A, B, C and D. • Describe Medicare reimbursement policies. • Identify the key coverage criteria for Medicaid.
	DRGs, MS-DRGs and Calculating Reimbursement *DRGs are a patient classification system used to identify resources expended for hospital services without considering the therapeutic approaches employed. In the DRG system, patient records are categorized into homogeneous groups according to diagnosis and healthcare expenses involved. Medicare and most payers focus explicitly on documentation to accurately reflect each patient's severity of illness, complexity, and quality of care provided to justify the length of stay or service duration. As care costs are reimbursed based on the accuracy and specificity of such documentation and coding, it is important for physician advisors to understand the system and be capable of effectively evaluating reimbursement practices.*	• Describe the role of the physician advisor in reimbursement practices. • Identify DRG, APR-DRG and high volume and high risk DRGs and describe MDC and MS-DRG. • Discuss the appropriate use of Condition Code 42 and 43. • Describe how case mix index can be used as a predictor of the financial health of an organization.