Utilization Management Physician Advisor Return on Investment, Part One

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Gabrial Carter, MSF
Contents

1. THE SIT DOWN
A prospective physician advisor meets with their CFO

2. MAKING THE CASE
Brief of how the physician advisor impacts ROI in UM

3. BASELINE DATA
Defining data used in ROI calculations

4. FUNCTIONAL CATEGORIES, REACTIVE AND PROACTIVE APPROACHES
Two different ways to approach the role of physician advisor

5. DETERMINING RETURN ON INVESTMENT
General instructions on how to determine ROI

6. SCENARIO ONE FOR ROI, REACTIVE, APPEALS AND DENIAL
Case based look at how to measure the ROI of the PA’s reactive approach

7. SCENARIO TWO FOR ROI, PROACTIVE, AUDITS
Case based look at how to measure the ROI of the PA’s proactive approach

8. TURNING THE TABLES
How simply tracking your activities in a table can help increase ROI

9. THE SIT DOWN, PART TWO
The physician advisor has a follow up meeting with their CFO

10. FINAL LESSONS
1. The Sit-Down, or the Challenge

You’re sitting across from your Chief Financial Officer (CFO). You have a good relationship that’s been developed over time out of mutual professional respect. She’s heard good things about you from the physician leadership, as well as the administrators you work with on various hospital committees.

This meeting is about you being hired as the new physician advisor for the hospital. The current position is one-third of a full-time employee (FTE), held by a family practitioner with deep roots in the hospital who was transitioning out of his medical practice. He is getting ready to retire. In keeping with current trends, the CFO believes that the value of a physician advisor might be enough to justify more than 1/3 FTE.

The outgoing physician advisor focused primarily on care management. After attending various educational events and talking with her colleagues, the CFO believes it would be of great value to have a physician advisor assist the Utilization Management (UM) department.

So, here you are. There’s a tremendous career opportunity right in front of you. But, being a numbers-driven person, your CFO needs to make the case for Return on Investment (ROI). Surprisingly, she asks you to help make that case. And making that case might be harder than you think, but that is the challenge that you are faced with.
2. Making the Case

Physician advisors provide value to Utilization Management partly because they are involved in so many different aspects of UM every day, including departments that indirectly impact UM. Clinical documentation and care management can have a tremendous impact on UM, yet are not strictly within the UM department. The degree of coordination and cooperation between these departments can increase dramatically with good leadership from the physician advisor. Precisely because their role is so varied, ROI is that much harder to measure. For the purposes of this paper, we are assuming that the physician advisor role in UM encompasses medical necessity and appeals and denials.

An additional consideration is how to evaluate the relative effect of the physician advisor. For example, how do you prove that your input is actually what led to an overturned payer denial? In cases where you act as the subject matter expert, it is difficult to say definitively, because it can depend on how competent the Appeals program handles that role on their own. Even in cases where you call the medical director for a peer-to-peer discussion and they end up overturning the denial, could the staff have merely convinced another physician involved with the case to do the same thing?
Utilization Management is a prominent part of the physician advisor’s role for a reason – there is clearly a return on investment for involvement in this area. However, this ROI is difficult to measure, and providing the tools to measure the degree of that effect, and quantifying it, is the purpose of this paper.

3. Baseline Data

Every calculation requires reliable data. In some cases, that data is readily available. In other cases, it is more difficult to obtain, and proximate measures can be used to provide a reliable estimate. In the most challenging instances, obtaining the data requires understanding and measuring complex phenomena such as human behavior.

Many inputs into an ROI calculation are hard to quantify. Assumptions can be made for these variables based on the combined knowledge of other experienced physician advisors, values from comparable scenarios, and other approaches. Generally speaking, these estimates will use a conservative number or value that minimizes the impact of the physician advisor on a particular variable. In reality, the effect you have could be much higher than our estimate (or lower if you don’t do your job properly). Taking this approach makes the conclusions, and thus your case for value, more robust.

Known Independent Variables

<table>
<thead>
<tr>
<th>Known Independent Variables</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Advisor Time</td>
<td>$100 – $200 per hour</td>
</tr>
<tr>
<td>Utilization Review Time</td>
<td>$34-$48 per hr</td>
</tr>
<tr>
<td>Appeals and Denials Review Time</td>
<td>$40-$55 per hr</td>
</tr>
<tr>
<td>Medicare average reimbursement per hospitalization, 2012 date</td>
<td>$12,200</td>
</tr>
<tr>
<td>Medicaid average reimbursement per hospitalization, 2012 date</td>
<td>$8,100</td>
</tr>
<tr>
<td>Private Payer average reimbursement per hospitalization, 2012 date</td>
<td>$9,700</td>
</tr>
<tr>
<td>Rate of audit, Rate of appeal, Rate of denial</td>
<td>(variable per facility)</td>
</tr>
</tbody>
</table>

[Example rates for a private payer: Rate of Audit 30%, Rate of Denial 50% of Audits (15% of Total Claims), Rate of Appeal 30%]

Estimated Independent Variables

The following inputs require more complicated calculation and present a wider range of possible values. Some will be available within an organization, and others need to be compiled from the input of knowledgeable professionals. In some cases, they require translating an intangible benefit, such as increased interdepartmental cooperation, into a numeric value. We have consulted our team of physician advisors and business professionals to obtain conservative consensus values where appropriate.
• “Physician advisor effect on rate of appeal (10-25% increase in number of appeals that your facility elects to pursue against denials). Average time committed is generally independent of the total number of denials, 20 hours of physician advisor time is a good measure.
• Physician advisor effect on rate of denial as a subject matter expert (30-60% success rate). Usually a 30-60 minute time commitment for a physician advisor per appeal supported.
• Physician advisor effect on rate of denial as peer-to-peer resource (40-80% success rate). Usually a 60-minute time commitment for a physician advisor per appeal supported. Note that not all appeals are appropriate for peer-to-peer support, and that this value is only valid for private payers – not Medicare or Medicaid.
• Physician advisor effect on rate of audits by private payers (10-20% success rate). This is a proactive approach that reduces the number of audits and denials.
• Insurance effect on prevention of loss of “high value” cases (covered in Part Two).
• Effect of physician advisor on correct designation of medical necessity (covered in Part Two).
• Effect of physician advisor on interdepartmental cooperation in assisting utilization management (particularly from care management, clinical documentation, nursing – covered in Part Two).

Dependent Variables

This category involves high-impact, hard variables. They are notoriously difficult to affect in a significant and predictable manner. These metrics also involve multiple different duties of the physician advisor, of which UM is one part. Because of their importance, we have mentioned them here. In the future, we will focus on the many false attributions and claims made regarding these metrics, which can distract from what is actually happening. Because they are not strictly UM, they will not be included as part of the final calculation for ROI as part of a strictly UM role for the physician advisor, but shall be part of a future ROI analysis.

• Length of Stay
• Readmission Rate
• Case Mix Index
• Severity of Illness Index
4. Functional Categories, Reactive and Proactive Approaches

We can further subdivide how you impact return on investment by way of how you function in your duties. Broadly, there are two functional categories that utilize fundamentally different mechanisms.

Reactive functions of the physician advisor are duties in which you are reacting to an event that has already happened. You are fixing a problem ex post facto. Examples of reactive functions include acting as a subject matter expert after a denial has already happened, performing a peer-to-peer appeal with a medical director, or assisting in getting an incorrect Level of Care order changed. In all of these cases, you are reacting to something that has already occurred. Reactive functions have the benefit of being easier to measure for ROI.

Proactive functions are actions in which you take the initiative before possible events happen. Your goal is to prevent bad outcomes, or to increase good outcomes. An example of a proactive function would be to permanently modify a physician’s workflow so that they consistently place the correct Level of Care order as opposed to previously failing to do so. Another example is developing a reputation for your hospital as being more difficult to deny payment on. Insurance payers will target your hospital less if you systematically make it more difficult to deny payment by virtue of a robust and targeted effort in your Appeals and Denials process.

Proactive functions have the potential for exponentially higher Return on Investment than reactive functions. However, they are much more difficult to measure, and once you have permanently affected one of these variables, it is probable that your organization will take for granted the effect you have had. For this reason, it is critical that you already have a basic understanding of what constitutes ROI between yourself and administration.

Let’s return to the sit-down at the beginning of the paper, when your CFO asked you to help her define the Return on Investment of your position in the Utilization Management Department. Here are two potential scenarios, one involving a Reactive function and the second a Proactive one.
5. Determining Return On Investment

Return on Investment (ROI) is determined by comparing the financial benefits of a program or initiative with the costs invested. These invested costs can include equipment or software, but in UM initiatives these costs are usually the salary or wages of the professionals. ROI is measured as the difference between two cases, one where the process is not changed and one where the initiative is successfully implemented. To determine the ROI for a physician advisor-led program, these two cases are compared mathematically.

The benefits of a program implementation include reduction in denial costs and reduction in time costs of professionals as a result of the initiative. The costs of a new program generally are just the additional costs of professional time, always including the physician advisor, required to implement the program. This does consider other professionals’ time (such as a UM reviewer) if their time commitment increases as a result of the program.

<table>
<thead>
<tr>
<th>Scenario One</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Determining Benefits</strong></td>
</tr>
<tr>
<td><strong>Without Program</strong></td>
</tr>
<tr>
<td>(+) Medicare Denials (45 x $12,200)</td>
</tr>
<tr>
<td>(+) Private Payer Denials (48 x $59,700)</td>
</tr>
<tr>
<td><strong>Total without Program</strong></td>
</tr>
<tr>
<td><strong>New Program</strong></td>
</tr>
<tr>
<td>(+) Medicare Denials (45 x $12,200)</td>
</tr>
<tr>
<td>(-) Reduction due to PA effect as subject matter expert (-30% x $549,000)</td>
</tr>
<tr>
<td>(+) Private Payer Denials (48 x $59,700)</td>
</tr>
<tr>
<td>(-) Reduction due to PA effect as peer-to-peer resource (-40% x $465,600)</td>
</tr>
<tr>
<td><strong>Total with New Program</strong></td>
</tr>
<tr>
<td><strong>Total Benefits of New Program (Total w/out Program - Total w/ New Program):</strong></td>
</tr>
</tbody>
</table>

| **Determining Costs** |
| **Without Program** |
| No additional costs | **$0** |
| **New Program** |
| (+) PA time as subject matter expert (1hr x 45 denials x $150) | $6,750 |
| (+) PA time as peer-to-peer resource (1hr x 48 denials x $150) | $7,200 |
| **Total with New Program** | **$13,950** |
| **Total Additional Costs of New Program (Total w/ New Program - Total w/out New Program):** | **$13,950** |
| **Net Benefit of New Program (Total Benefits of New Program - Total Additional Costs):** | **$336,990** |
| **Total Additional PA Hours Estimated for New Program** | **98** |

**Return on Investment (ROI) of New Program**

- Benefit / Cost Ratio = **x24.2**
- Total Net Benefit per PA hour = **$3,439**
The general version of the ROI calculation is below. Benefits of the new program are found by
adding together the relevant costs and cost reductions for the “Without Program” case and the
“New Program” case. The difference between the two is the Total Benefits of New Program.
To determine the costs of the new program, the relevant costs are added for the “Without
Program” and “New Program” cases as before. The total additional costs of the program are the
difference between these two cases.

The Net Benefit of New Program is the direct dollar impact of the initiative, and is the Total
Benefits of New Program minus Total Additional Costs of New Program.

To determine ROI, it is also necessary to indicate the estimated number of physician advisor
hours needed for the program implementation.

**Two ways of showing ROI for a physician advisor-lead program**

Both ways of presenting ROI are useful for looking at the financial impact of the initiative in
different ways and depending on audience. These metrics are the Benefit / Cost Ratio and
the Total Net Benefit per Physician Advisor Hour. The Benefit / Cost Ratio is the total financial
benefit of a program (Net Benefit of New Program) divided by the cost (Total Additional Costs of
Program), presented as a ratio multiplier. This provides a simple way to view how impactful the
initiative was in terms of dollars generated (or saved) per dollar invested. Looking at this with
example numbers:

- Net Benefit of New Program: $100,000
- Total Additional Costs of Program: $10,000
- Benefit / Cost Ratio: x10.0

The Total Net Benefit per PA Hour is an efficiency metric for the physician advisor, and is a
way to look at how many dollars are generated (or saved) per hour of PA time involved. This
considers the Net Benefit of New Program and the Total Additional PA Hours for New Program.
Looking at this with example:

- Net Benefit of New Program: $100,000
- Total Additional PA Hours for New Program: 20
- Total Net Benefit per PA Hour: $5,000

Let us take a look at how this calculation can be used for two scenarios that could be seen in a
hospital organization to find the ROI and make the case for a physician advisor led initiative.
6. Scenario One For ROI – Reactive Function, Appeals and Denials

After working with your Utilization Management department, you find that there were 45 Medicare denials last year where they could have used your support as a subject matter expert. There were also 48 private payer denials that could have escalated to a peer-to-peer level, but no physician was willing to call to support those appeals. You tell the CFO that having a physician advisor to support this process could reasonably result in a minimum of 30% increase in overturned denials against the Medicare cases and 40% increase in overturned denials against the private payers as a peer-to-peer resource. These values are based on input from other experienced physician advisor colleagues and mentors.

Calculating ROI is a three-step process. First, the financial benefits of a new program need to be determined. Second, the additional costs of an initiative need to be determined. Here this will be additional time commitments from physician advisors but could also be additional requirements from other professionals, equipment, software, etc. Lastly, the Net Benefit of New Program and Total Additional PA Hours Estimated for New Program are used to calculate ROI.

Determining the benefits:

- The “Without Program” case considers the 45 Medicare denials and 48 Private Payer denials, totaling $1,014,600
- The “New Program” case also notes these denials, but reduces the Medicare denials by 30% to account for the PA effect due to acting as a subject matter expert and a 40% reduction in Private Payer denials to account for the PA effect of acting as a peer-to-peer resource.
- As a result, the costs associated with the Total with New Program are $663,660.
- This gives Total Benefits of New Program (the difference between the two totals) of $350,940.

Determining the costs:

- To implement the program, the physician advisor will need to take action on all 45 Medicare denials and 48 Private Payer denials. At 1 hour per denial and $150 per hour, this totals to $13,950. As this is the only additional cost item for the new program, this is also the Total Additional Costs of New Program.

Determining ROI:

- The Net Benefit of New Program is the difference between the benefits and costs, or $336,990.
- The Benefit / Cost Ratio is found by taking this $336,990 and dividing by the Total Additional Costs of New Program ($13,950), resulting in x24.2.
- The Total Net Benefit per PA hour is found by taking the same $336,990 and dividing by the Total Additional PA Hours Estimated for New program (98), resulting in $3,439.
Which is more valuable? After reading the above two scenarios, it should be obvious that Proactive functions have the potential for a lot more value for the time invested. It may shock you, but the amount of effort you will invest to make Scenario Two work for you is actually less than Scenario One. Actually, you should be doing both at the same time, all the time. Proactive functions require more planning, organization, and strategy, but not that much more effort.
7. Scenario Two For ROI – Proactive Function, Audits

After running a report on audit and denial data, your Utilization Management department concludes that there were a total of one hundred seventy five private payer denials (375 were successfully appealed, 500 were lost). They estimate that 1.5 hours per appeal is required from support staff. Experience with the UM Manager has taught you that she considers her department to be understaffed and that the extra time spent on the case reviews is eroding morale, and you convey this to the CFO.

You plan to implement a comprehensive proactive plan in concert with your UM department to aggressively support their appeals program and to have discussions with the private payers to reduce the redundant case reviews they are pursuing which benefit no one. You tell the CFO that it is reasonable to expect a decrease of 10% in all audits conservatively, which includes potential denials, as well as improvement of the morale of the UM department and potentially saving an FTE. In addition, by also reducing the total audit frequency and addressing the problem of the unreasonable case reviews, you save the UM department a significant number hours in that year – as well as a more happy and engaged UM department.

Determining the benefits:

- The “Without Program” case considers the 875 Private Payer denials, totaling $8,487,500. The 42.9% successful appeal rate (resulting in a savings of $3,641,138) is also considered here. This is important because this savings rate changes between the “Without Program” and “New Program” cases.
- The time associated with the Appeals and Denials Reviewer is considered here as well, since this cost changes between the cases. At 1.5 hours per 875 denials, and at $35.50 per hour, this totals to $45,938.
- The “New Program” case also notes the Private Payer denials, but reduces the denials by 10% to account for the PA effect on Private Payer denials. This reduction totals to $848,750.
- As a result of the PA effect on Private Payer denials, only 788 denials make it to the Appeals and Denials reviewer.
- The 42.9% successful appeal rate and Appeals and Denials Reviewer time are calculated here off of 788 cases instead of 875. The appeals result in a savings of $3,277,024 and the Appeals and Denials Reviewer time is $41,961.
- Total with New Program is the sum of Denials after PA Effect ($7,638,750) and Appeals after PA Effect (-$3,235,063), or $4,403,687.
- This gives Total Benefits of New Program of $488,613.

Determining the costs:

- To implement the program, the physician advisor will need to take implement a process and training program totaling 20 hours.
Determining ROI:

- The Net Benefit of New Program is the difference between the benefits and costs, or $485,613.
- The Benefit / Cost Ratio is found by taking this $485,613 and dividing by the Total Additional Costs of New Program ($3,000), resulting in x161.9.
- The Total Net Benefit per PA hour is found by taking the same $485,613 and dividing by the Total Additional PA Hours Estimated for New program (20), resulting in $24,281.

![General ROI Calculation](image)

Which is more valuable? After reading the above two scenarios, it should be obvious that Proactive functions have the potential for a lot more value for the time invested. It may shock you, but the amount of effort you will invest to make Scenario Two work for you is actually less than Scenario One. Actually, you should be doing both at the same time, all the time. Proactive functions require more planning, organization, and strategy, but not that much more effort.
8. Turning the Tables

The table below helps transform your Reactive function of supporting the UM department for Level of Care, into a quantified Proactive one:

This table shows a hypothetical situation regarding Level of Care orders that is based on patterns observed in one of our hospitals. It demonstrates an effort by a physician advisor to track and quantify their activities, regarding how many Level of Care orders were missed by the worst offenders at their hospital, and what kind of interventions the physician advisor implemented. As can be seen from the table above, these three physicians were responsible for over 50% of missed Levels of Care. This pattern should be recognizable to most of us, as in most hospitals, a small number of physicians have a disproportionately high number of missed Level of Care orders.

<table>
<thead>
<tr>
<th>Physician</th>
<th>Level of Care orders missed in FY 2013</th>
<th>Interventions by Physician Advisor</th>
<th>Level of Care orders missed FY 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Winnner</td>
<td>8</td>
<td>Discussion, meeting</td>
<td>2</td>
</tr>
<tr>
<td>Dr. Funnguy</td>
<td>7</td>
<td>None</td>
<td>6</td>
</tr>
<tr>
<td>Dr. Evil</td>
<td>11</td>
<td>Discussion, meeting, escalation to CMO</td>
<td>3</td>
</tr>
<tr>
<td>All physicians</td>
<td>47</td>
<td>N / A</td>
<td>25</td>
</tr>
</tbody>
</table>

Here, the physician advisor’s efforts have prevented additional problems from developing. While Dr. Funnyguy did miss fewer orders than the prior year, it is only a marginal difference, because there was no significant intervention by the physician advisor. Dr. Winnner and Dr. Evil each had interventions by the physician advisor, and each of them went on to miss far fewer Level of Care orders than Dr. Funnyguy, who did not have an intervention. Keep in mind that missing a Level of Care order on a Medicare patient can lose a hospital, on average, over $12,000.

The key here is reading between the lines. The physician advisor has obviously said and done the right things in the meetings with the above physicians, because it has made a lasting difference. Those meetings are going to happen either way (at least they will if you are doing your job). But rather than just reminding them to sign the Level of Care order, there has been a concerted effort to fix the problem from happening again. This is the essence of Proactive function, and also why it is so important to carefully track data in order to make your argument for Return on Investment.
Now that you have your data and analysis in hand, you come back to sit down with your CFO, who is eager to hear your case for Return on Investment. The CFO has already heard from the UM department that you have taken an active interest in supporting their department, and she lets you know that she appreciates your involvement. She reviews the numbers you’ve presented, and wants to know the basis for your projections, especially on the potential benefits from your involvement. You explain that these are conservative estimates for your success based on consensus data obtained through your research into how the physician advisor can support Utilization Management and Appeals and Denials. The CFO agrees to allot 0.5 FTEs to support your role in UM, and wants you to continue to track your involvement so that the two of you can review the data in six months to make sure things are on track. Congratulations. You’re now the physician advisor. Be prepared to back up all of these projections with some hard work. You’ll need to continually make the case for ROI as you move forward, but you’re confident that you’ll be able to do just that.
10. Final Lessons

This concludes our first paper on Return on Investment for the Utilization Management function of physician advisors. We hope that this discussion has expressed the importance of tracking your activities, and the benefits of having a well-organized plan behind your UM involvement. Most importantly, it is our wish that this paper helps you begin to make your case for the tremendous value that we know a physician advisor brings to the table.
11. Glossary

Not all of these terms are utilized in this paper. Discussion of these definitions will be expanded in future papers as they become more relevant.

**Physician advisor time:** The above numbers account for the most common range of physician advisor compensation, which includes a standard benefits package.

**Average reimbursement per hospitalization:** This information is publicly available at the Agency for Healthcare Research and Quality. The numbers above are aggregates that include medical and surgical patients; on average, surgical patients are significantly more costly. Also, the relative percentage of whether patients are surgical or medical depends on payer.

**Rate of audit:** You have no control over this, and the value varies dramatically. This is empirical information readily available from your UM Department. Remember to request it for different payer categories (Medicare, Medicaid, Private). Certain private payers are approaching audit rates of 100% in some hospitals.

**Rate of first denial:** Audits result in a certain amount of denials. Many of these are procedural and easily overturned if your UM department is vigilant. This number will include ALL initial denials. There are some general trends – for example, it is currently estimated that private payers deny up to 15% of gross charges.

**Rate of appeal:** The numerator is the number of appeals, and the denominator is number of first denials.

**Rate of final denial:** How many denials are upheld despite appeal? Obtain a baseline rate where you are not involved if possible. Numbers vary dramatically.

**Physician advisor effect on rate of appeal:** It is not always good to increase the rate of appeal, as it does depend on the opportunity cost of having your UM department pursue these appeals at the expense of doing something else. However, assuming they do have the capacity, you should generally seek to increase the number of appeals as part of a coordinated strategy to decrease audits from targeted private payers.

**Physician advisor effect on rate of denial as subject matter expert:** In most hospitals, it is quite rare for staff physicians to support the appeals process by providing additional documentation. You should confirm that this is the case, or if your predecessor provided this service, measure the effect in terms of successful appeals. If you are diligent as a subject matter expert and select cases appropriately, it is reasonable to assume a 30-60% boost in overturning appeals using this method.

**Physician advisor effect on rate of denial as peer-to-peer expert:** At most hospitals, the UM department will have instances where they were able to convince a physician to make a peer-to-peer phone call to help overturn a denial. If possible, you should obtain two data points from their archives: How frequently a request for peer-to-peer appeal was answered, and how successful those efforts were as a percentage of the total. It is easy to measure your effect in terms of number of peer-to-peer requests answered, but the total benefit could be more difficult. It is reasonable to assume that 40-80% of peer-to-peer discussions should result in an overturned appeal.
**Physician advisor effect on rate of audits by private payers:** This datum represents a tremendous unrealized source of opportunity at most hospitals. The reason is that most UM departments are quite adept at determining which cases to successfully appeal, but decidedly worse at understanding the big picture of a robust appeals program. By aggressively appealing cases with a particular payer and providing assertive support as a physician advisor, you can actually modify the behavior of that payer. This results in a decrease of the total number of audits from that payer, which can have significant downstream effects. There is no way to reliably predict this effect; you should empirically determine what effect you have on a particular payer in a targeted manner.

**Effect of physician advisor on medical necessity (Reactive):** When most people think of, “UM” and “physician advisor,” they think of medical necessity. After all, that is the central function of a UM department – determining medical necessity. You can have a tremendous impact in this area, and only partly by chasing down unsigned or inappropriate Level of Care orders. This variable is the expected result using your Reactive functions as physician advisor. These include the following:

- Correcting incorrect Observation orders into Inpatient orders, resulting in increased revenue per case. Request a list of the physicians who most frequently miss this order and are difficult to contact or work with from UM, and try to get specifics about how many orders were missed. The revenue difference for Medicare patients is tremendous, as an OBS payment is currently just over $2000 (and set to decrease in 2016), while an Inpatient payment is thousands more.
- Correcting incorrect Inpatient orders into Observation orders, resulting in fewer denials. Because these cases can often still be re-billed for the original Observation charge, the cost to the hospital is more a reflection on extra work for the UM department, especially since it requires a Code 44 for Medicare or Medicaid patients.
- Obtaining signatures from physicians on unsigned Level of Care orders. Failure to obtain a signature in the specified time results in loss of all revenue for Medicare and Medicaid, and some private payers are following suit.

**Effect of physician advisor on interdepartmental cooperation in assisting utilization management:** There are two types of interdepartmental cooperation that the physician advisor can impact to help affect UM.

- Passive cooperation means that a different department, such as Clinical Documentation, can assist in UM goals by performing their duties at an optimal level.
- Active cooperation requires ongoing communication between another department, such as Care Management, and UM to either fill a UM role.
In order to obtain a solid basis for measuring the value the PA brings to the table, we need to break down the different functions that other departments may contribute into these two categories:

<table>
<thead>
<tr>
<th>PASSIVE COOPERATIVE FUNCTION</th>
<th>DEPARTMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved documentation leads to higher percentage of Inpatients.</td>
<td>Documentation</td>
</tr>
<tr>
<td>Improved documentation resulting in fewer denials.</td>
<td>Documentation</td>
</tr>
<tr>
<td>Improved documentation for short-stay Inpatients.</td>
<td>Documentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIVE COOPERATIVE FUNCTION</th>
<th>DEPARTMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicating clinical info to UM that can impact medical necessity.</td>
<td>Care Management</td>
</tr>
<tr>
<td>Performing UM functions such as medical necessity.</td>
<td>Care Management</td>
</tr>
<tr>
<td>Contacting physicians to change level of care after UM hours.</td>
<td>Nursing</td>
</tr>
</tbody>
</table>

**Effect of physician advisor on correcting physician behavior as it relates to medical necessity (Proactive):** The much greater value as we discussed earlier, is in modifying the behavior of physicians so that orders are correctly placed to begin with. Receiving credit for a Proactive function is often easier once the Reactive benefits have already been implemented and measured. This is because the physicians who continue to exhibit non-aligned behavior will usually be relatively recalcitrant compared to their peers after a period of time where Reactive functions have already been established. It is then much easier to show that the physician advisor’s direct intervention was required to make a difference.