Why Compliance Officers Should Care About Improving Quality of Care Through Peer Review

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Presentation Overview

• The role of compliance officers and how it continues to evolve
• Government measures to address waste, fraud, and abuse in health care
• Why peer review is critical to ensuring high-quality patient care
• The role of compliance officers in the peer review process
• Overcoming barriers to effective peer review
• Components of an effective peer review process
The Role of Healthcare Compliance Officers

- Develop & manage compliance programs
- Audit and monitor compliance with:
  - Regulations
  - Accreditation
  - Billing
  - Privacy
  - Patient safety
  - Quality of care
- Conduct compliance-program effectiveness reviews

The Evolving Role of the Compliance Officer: The Past

- Compliance officer was not necessarily visible to staff
- Not an active participant in hospital’s legal discussions
- Lacked direct lines of communication to hospital CEO and governing body
- Misconduct, noncompliance, or fraudulent activity was not always dealt with promptly
The Evolving Role of the Compliance Officer: The Present

• The role of compliance officers is increasing, as government audits continue to intensify
• Comprehensive compliance programs being developed in hospitals
• Many compliance officers face growing workload and pushback from hospital executives

The Evolving Role of the Compliance Officer: The Future

• Compliance officers need to bridge the gap within the hospital structure so that they are involved in all aspects improving patient safety and quality of care
• Partner with hospital board/executives/anyone involved with performance improvement initiatives
How the Government is Addressing Waste, Fraud, and Abuse in Health Care

Government Audit Programs: Expanding & Becoming More Aggressive

• CMS has expanded its use of Recovery Audit Contractors (RACs) to recover inappropriate payments for Medicare services
• Medicaid Integrity Contractor (MIC) auditors and federal regulators also actively audit hospitals to ensure compliance with new rules and regulations
• Feds are increasingly cracking down; larger enforcement budgets for the U.S. Department of Justice (DOJ)
• Goals: Promote evidence-based health care, protect patients, improve the quality of care, and reduce fraud and overbilling
U.S. Department of Health and Human Services
Office of Inspector General

- Most common Medicare reimbursement violation: failure to comply with medical necessity requirements
- High level of scrutiny for most lucrative procedures
  - Medical necessity of interventional cardiology procedures has recently received national attention

Audits: Widespread & Increasing Throughout the United States

- The CMS RAC Program has now been expanded to include all 50 states
- 2005-2011: RACs examined claims only after payments were made
- Effective January 1, 2012
  - Recovery Audit Prepayment Review demonstration: Medicare RACs review claims before they are paid (targeted states: Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina, and Missouri)
  - Prior Authorization for Certain Medical Equipment (targeted states: California, Florida, Illinois, Michigan, New York, North Carolina, and Texas)
Improper Medicare Payments Identified by the CMS RAC Program

$1.03 Billion in Improper Medicare Payments Identified Since 2005

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CMS Compliance Program Guidance Revisions

An effective compliance program must include measures that prevent, detect, and correct:

- Program noncompliance
- Fraud, waste, and abuse

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Examples of Waste, Fraud, and Abuse

- Providing services that are medically unnecessary or inconsistent with the professional recognized standards
- Submitting a bill for non-covered services for which there is not legal entitlement to payment, but without knowingly or intentionally misrepresenting facts to obtain payment
- Submitting bills to Medicare or Medicaid that are the responsibility of other insurers
- Billing Medicare or Medicaid patients at a substantially higher rate than non-Medicare or non-Medicaid patients

Overutilization, Abuse, & Fraud Within Cardiology Departments: Widespread Scrutiny Continues

- A number of recent high-profile cases have shed light on the widespread extent of questionable physician and hospital practices
  - The U.S. attorney’s office in Miami is investigating allegations that patients underwent unnecessary cardiac catheterizations and stent implantations at facilities owned by the largest for-profit hospital chain in the United States
- The most important contributor to the high cost of healthcare is overutilization, which results from:
  - More office visits, tests, and procedures
  - More costly specialists, tests, and procedures, and prescriptions than are appropriate

Louisiana Cardiologist Sentenced to 10 Years in Federal Prison

- In 2006, a Louisiana hospital paid:
  - $3.8 million to settle a U.S. Department of Justice false-claims lawsuit
  - An additional $7.4 million to settle a class-action lawsuit brought by former patients of one of its interventional cardiologists
- In 2009, the cardiologist was convicted on 51 counts of billing private and government health insurers for unnecessary medical procedures
  - Between 1999 and 2003, he billed Medicare and private insurance companies >$3 million, allowing him to personally pocket >$500,000

Maryland Hospital Pays $22 Million to Settle False Claims Allegations

- Hospital charged of paying illegal kickbacks to a cardiologist’s practice in exchange for patient referrals
- Reports indicate that the cardiologist implanted more than 500 stents that were medically unnecessary
  - Medicare paid $3.8 million of the $6.6 million charge for these procedures
- Although it did not admit any liability, the hospital reached an agreement in order to avoid the expense and uncertainty of litigation
Peer Review: Critical to Ensuring High-Quality Patient Care

Early Detection and Resolution of Errors Reduces Negative Consequences for Physicians & Hospitals

- Minimizes harm to patients
- Minimizes liability exposure of hospitals & practitioners
- Minimizes hospital’s financial losses
A Strong Framework for Effective Peer Review

- Effective leadership and a supportive culture
- Efficient operations
- Effective evaluations
- Compliance with accreditation standards
- Ongoing program assessment leading to continuous improvement

The Role of Peer Review in Compliance

- Compliance with patient safety and quality of care standards
- Compliance with CMS regulations
- Compliance with accreditation standards
  - TJC: FPPE & OPPE
Peer Review Issues Facing Compliance Officers

Only Conducting Reactive Peer Review

- Compromises effectiveness of peer review
- Creates a punitive culture
- Does not provide timely opportunities for education, re-proctoring, or re-training
- Leaves medical errors and poor practice patterns undiscovered until a negative outcome occurs, if they are discovered at all
Unwritten Rules of the Organization

- Unwritten rules of the organization often pervade the peer review process
  - Conflicts of interest (COI) and fear of retaliation lead to covering up and not reporting poor performance
- In some cases, the MEC does not review all cases and/or protects certain parties
- The process becomes slow, cumbersome, and ineffective when leadership does not fully support the peer review process and/or views it negatively
  - There is hesitation to follow the program except in the most difficult cases

Overcoming Barriers to Effective Peer Review
Overcoming Barriers

• Barrier
  – Sensitive cases and/or known issues not being acted upon in a timely fashion due to COI

• Solution
  – Regular auditing and monitoring of the peer review program to ensure elimination of COI
  – External peer review: facilitates fair, objective, nonpunitive consistent review; reduces the potential for expensive lawsuits or sanctions; and lessens internal organizational conflict

Overcoming Barriers

• Barrier
  – Lack of integration of other data into peer review system (e.g., medical staff leadership might not have ready access to negative conduct reports and malpractice claims data)

• Solutions
  – Cross functional integration of data from Compliance, Quality & Risk Management Depts.
  – Undo data silos
  – Improve data collection systems
  – All information is needed to determine areas to focus activity
Overcoming Barriers

- **Barrier**
  - Insufficient resources/budget to meet stated goals

- **Solution**
  - Develop budget for ongoing peer review
  - Develop budget for auditing and monitoring peer review program
  - Pay practitioners to serve on PRC

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Overcoming Barriers

- **Barriers**
  - Lack of systems/processes/staff for reporting and medical error follow-up
  - MEC protects a party even though evidence pointing to fault exists

- **Solutions**
  - Empower employees to report not only incidents, but also near-misses
  - Implement an anonymous system for reporting errors
    - Virginia Mason instituted a patient safety alert system, which requires all staff to stop/report activity that may cause harm—problem is assessed, reported, investigated…
  - Create a culture in which people feel safe to share with colleagues
  - Hold leadership accountable; ensure that they’re abiding by rules; identify COI

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Kenney C. *Transforming Health Care: Virginia Mason Medical Center’s Pursuit of the Perfect Patient Experience*. 2011.

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Components of An Effective Peer Review Process

Vertical Alignment
Backbone of an optimal peer review culture...
Best Practices

• Hospital leadership should support the development of a strong peer review program that is proactive in nature
• Structure the peer review system as a joint venture between the medical staff and administration
• Ongoing educational peer review that provides objective evaluations in a non-punitive context
• Clearly defined performance expectations and objective processes
• Regular reporting, monitoring & auditing of peer review program performance
• Continuous improvement programs

Peer Review Oversight: Best Practices

• Develop well-written bylaws, policies and procedures
• Provide peer review committee members with proper training
• Streamline the peer review process by limiting the number of committees & setting turnaround time requirements
• Establish a strong multidisciplinary peer review committee that is accountable to the MEC
Turnaround Times: Best Practices

- Complete all peer reviews within 30 days of initiation; ideally, within 1 week
- Hospitals should have a standard process & vendor for external peer review, which it can invoke when it lacks adequate physician resources to conduct timely peer review internally

Performance Expectations: Best Practices

- Hospital and medical staff jointly define what is meant by:
  - Quality of care and patient safety
  - Appropriate resource use
  - Professionalism
  - Accountability for active participation as a team member in the care system
- Setting expectations ensures that practitioners are treated uniformly and held to the same standards
- Ongoing monitoring helps to promote practitioner compliance with these expectations
Performance Expectations: Best Practices

Identify automatic triggers for focused evaluations and apply consistently
- Re-credentialing
- Adding new privileges
- Unexpected patient death
- Complication
- Readmission
- Delay in diagnosis or treatment
- Disruptive practitioner behavior
- Inadequate hand-off among practitioners
- Missed or wrong diagnosis
- Serious patient complaint

Evaluation of Practitioner Performance: Best Practices

- Understand the web of economic, competitive, and social or personal relationships that raise COI concerns
- Develop a written policy and procedure for identifying and handling real or apparent COI
- Educate physicians conducting reviews about all potential COI issues
Accreditation Standards

- Joint Commission standards for:
  - Monitoring performance
  - Intervening when safety and quality-of-care concerns are identified
- Hospitals of all sizes must demonstrate that objective peer review is in place for credentialing, privileging, and physician performance evaluations
- Two types of reviews are required to ensure physician competence
  - Ongoing professional practice evaluation (OPPE)
  - Focused professional practice evaluation (FPPE)

Traditional Peer Review vs. Systematic

- Traditional peer review
  - Reactive
  - Isolated review of sentinel events
- Systematic peer review
  - Proactive; regularly assesses highest risk specialties
  - Measures and monitors medical necessity, appropriateness, and physician performance
Systematic External Peer Review As a Risk Reduction Strategy

- Prevents fraud, overutilization, and inappropriate care
- Reduces medical errors, adverse events, and malpractice costs over time
- Provides consistent, objective feedback
- Identifies process improvement opportunities
- Ensures transparency and accountability
- Promotes culture of continuous improvement

External Peer Review: Establishing a Program to Complement and Strengthen Internal Peer Review

- Eliminates COI in evaluating appropriateness of care
- Helps hospitals achieve consistent transparency & accountability across all departments
- Investing in systematic external peer review:
  - Provides a financial payback by reducing and avoiding audits/investigations, as well as malpractice claims
  - Protects/improves hospital financial performance and reputation
When to Turn to External Peer Review

- Cases which involve real or apparent COI
- High volume and few willing or qualified reviewers
  - Can outsource all cases in a particular specialty, or a certain number of cases at regular intervals, quarterly, semi-annually, or annually
- Cases in which internal reviewers cannot reach a conclusion or a consensus
- Unresolved quality issues related to a particular department, procedure, or practitioner
- Cases in which physician behavior or demeanor may have impacted clinical outcomes
  - Could benefit from objective outside review by a peer with no prior personal knowledge of the physician

Ensuring Effective Peer Review by Expanding the Role of Compliance Officers

- Empower compliance officers to partner with other leaders to proactively identify, evaluate, and manage risks to enable hospital success
- Exercise leadership not only in compliance, but also across complex interrelationships within the hospital (e.g., quality, performance improvement, risk management)
- Advise key players in risk mitigation
Thank You

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