Auditing and Monitoring Hospitals’ High-Risk Practice Areas Through External Peer Review

Andrew G. Rowe, CEO
AllMed Healthcare Management, Inc.

Presentation Overview

• How Centers for Medicare & Medicaid Services (CMS) actions are prompting hospitals to increase auditing/monitoring efforts
• What should auditing and monitoring be used for?
• High-risk specialty areas for auditing and monitoring
• The role of peer review in auditing and monitoring
• Reactive vs. proactive peer review
• The role of external peer review in auditing and monitoring
• How to build an ongoing external peer review program
• A case study of ongoing external peer review
The High Cost of U.S. Health Care

• The United States spends substantially more per person on health care than any other country
  – But ranks 37th in overall healthcare quality
• Overutilization is estimated at 30% of total care costs
  – More office visits, hospitalizations, tests, and procedures
  – More costly specialists, tests, procedures, and prescriptions than are appropriate

Emanuel et al. JAMA. 2008;299:2789-2791.

Government Audit Programs: Expanding and Becoming More Aggressive

• The 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
Improper Medicare Payments Identified by the CMS RAC Program

- Overpayments to Healthcare Providers
- Underpayments Repaid to Healthcare Providers

$1.03 Billion in Improper Medicare Payments Identified Since 2005


Penalties Under the False Claims Act

- A court may assess three times the amount of damages for each claim, plus significant civil and possible criminal penalties
- Investigations result in negative publicity for physicians and facilities
  - Damages reputations
  - Impacts revenues
CMS Definitions of Fraud and Abuse

• Fraud
  – Involves obtaining something of value unlawfully, through willful misrepresentation, false statements, kickbacks, or collusion

• Abuse
  – Refers to violations of agency regulations that impair the effective and efficient administration of government healthcare programs; practices that, either directly or indirectly, result in unnecessary costs to Medicare and other federal healthcare programs

Examples of 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
Example: 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

Example: 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
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 and 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)
What Should Auditing & Monitoring Be Used For?

- Fraud
- Abuse
- Quality of care
- Physician performance
- Peer review program

Quality of Care & Physician Performance Needs Auditing and Monitoring Too

- Initial credentialing and privileging are not enough
- Malpractice insurance costs increasing at 5.5% per year
- Traditional peer review is not a guaranteed method
- Conflict of interest (COI) can compromise medical staff operations
- Accreditations standards (e.g., The Joint Commission) are not strong enough or enforced

Highest Risk Specialties for Auditing and Monitoring

- Interventional cardiology
- Neurosurgery
- OB/GYN
- Orthopedic surgery
- ER
- Cardiovascular surgery
- General surgery
- Radiology
- Anesthesiology

How Ongoing Peer Review Can Prevent or Reduce Risks
Traditional Peer Review vs. Systematic Peer Review

- 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 hospital facilities
- 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

The Role of External Peer Review in Auditing and Monitoring

- Overcomes potential COI, which block transparency
- Provides objective, evidence-based evaluations
- Supplements internal peer review processes
- Allows hospitals to conduct auditing and monitoring projects with minimal impact on medical staff resources
  - Provides physician resources and expertise necessary to conduct timely performance analysis
CardioAudit: A Proactive Solution

- An external peer review program that systematically evaluates specific cardiac procedures to determine:
  - Medical necessity in accordance with guidelines set forth by professional and medical societies
  - Compliance with Medicare National Coverage Determinations (NCDs)
  - Necessity outside of NCD language
- Helps hospital administrators identify and correct any potential problems before they occur
- Utilizes a scoring system that allows for benchmarking and data gathering for similar procedures and physicians in other areas/hospitals

Procedures for CardioAudit Review

- Percutaneous coronary interventions (PCI)
- Peripheral vascular interventions
- Carotid artery interventions
- Coronary artery bypass graft (CABG) and valve surgery
- Electrophysiology procedures: implantable cardioverter defibrillators (ICDs), biventricular pacemakers, single and dual chamber pacemakers, radiofrequency ablations
Steps for Building An Ongoing External Peer Review Program

1. Perform departmental risk assessments
2. Rank specialties by risk
3. Rank surgical procedures for review
4. Develop a sample size and interval for case reviews
5. Develop a schedule and budget
6. Calculate the projected return on investment (ROI) of the program
7. Gain management agreement through budget cycle

Case Study: Building An Ongoing External Review Program
Based on 2009 Data From a Full-Service 300-Bed Hospital
Step 1
Perform Departmental Risk Assessments

- Oncology
- Cardiothoracic Services
- Stroke Center
- Emergency
- Pediatric Emergency
- Radiology
- Obstetrics/Gynecology
- Neonatal ICU
- Pediatric Inpatient

Step 2
Rank Specialties by Risk*

1. Cardiothoracic services/interventional cardiology
2. Obstetrics/gynecology
3. Neurosurgery
4. Oncology

*These rankings are based on the number of malpractice claims, industry data, and data from AllMed’s external peer review caseload.

Decision: Focused external review program on cardiology
Step 3
Rank Surgical Procedures for Review

• Cardiothoracic surgery procedures (N = 638) for review:
  – Isolated coronary artery bypass graft (CABG) (n = 251)
  – Valve procedures (n = 56)
  – Thoracic (n = 251)
  – Other (pacemakers, Maze & CABG and/or valve procedures) (n = 80)

Step 4
Develop a Sample Size & Interval for Case Reviews

• Total no. of cardiothoracic surgeries: 638
• Range of the minimum number of cases to be reviewed to obtain a 90% to 95% confidence level*: 191 to 241

*The confidence level refers to the level of uncertainty you can tolerate. In this case, it refers to the degree of likelihood that external peer review will be able to indentify any trends or patterns of concern.
Step 5
Develop a Schedule and Budget

- 3 to 4 reviews per month per interventional cardiologist
- Case materials for each review: 100 to 150 pages
- Average cost per review: $350

<table>
<thead>
<tr>
<th>Intervventional</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Nov</th>
<th>Dec</th>
<th>Annual Total</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology MD1</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>42</td>
<td>$14,700</td>
</tr>
<tr>
<td>Cardiology MD2</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>42</td>
<td>$14,700</td>
</tr>
<tr>
<td>Cardiology MD3</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>42</td>
<td>$14,700</td>
</tr>
<tr>
<td>Cardiology MD4</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>42</td>
<td>$14,700</td>
</tr>
<tr>
<td>Cardiology MD5</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>42</td>
<td>$14,700</td>
</tr>
<tr>
<td><strong>Total Reviews</strong></td>
<td><strong>17</strong></td>
<td><strong>18</strong></td>
<td><strong>17</strong></td>
<td><strong>18</strong></td>
<td><strong>17</strong></td>
<td><strong>18</strong></td>
<td><strong>17</strong></td>
<td><strong>18</strong></td>
<td><strong>17</strong></td>
<td><strong>18</strong></td>
<td><strong>210</strong></td>
<td><strong>$73,500</strong></td>
</tr>
</tbody>
</table>

Step 6
Calculate the Projected ROI of the Program

© AllMed Healthcare Management, Inc.
ASHRM Model and Definition of Terms

- Based on surveys of 119 hospital systems and more than 1,800 facilities nationwide.
- Calculates average benchmark loss cost per “occupied bed equivalent”
  - Other utilization statistics (e.g., ED visits, births) converted to “acute care bed equivalents” based on actual risk factors.
- Physician staff FTEs converted to hospital bed equivalents based on relative risk factors for each specialty.
- Adjustments made for geographic differentials
- The model can also be adjusted for different levels of coverage and reinsurance.


### Hospital Acute Care Bed Equivalent Calculation

<table>
<thead>
<tr>
<th>Hospital Acute Care Bed Equivalent Calculation</th>
<th>Number</th>
<th>Estimated Conversion Factor</th>
<th>Acute Care Bed Equivalents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Beds (staffed)</td>
<td>300</td>
<td>X 1.000</td>
<td>300</td>
</tr>
<tr>
<td>ED Visits</td>
<td>58,000</td>
<td>X 0.0023</td>
<td>133</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>7,224</td>
<td>X 0.0240</td>
<td>173</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>16,250</td>
<td>X 0.0013</td>
<td>21</td>
</tr>
<tr>
<td>Births</td>
<td>722</td>
<td>X 0.0610</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total Acute Care Bed Equivalents</strong></td>
<td></td>
<td></td>
<td><strong>671</strong></td>
</tr>
</tbody>
</table>

### Hospital Employed Physician Equivalent Calculation

<table>
<thead>
<tr>
<th>Hospital Employed Physician Equivalent Calculation</th>
<th>Number</th>
<th>PR</th>
<th>Physician Equivalents (PE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic Surgery</td>
<td>5</td>
<td>X 4.000</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total (PE)</strong></td>
<td>5</td>
<td></td>
<td><strong>20</strong></td>
</tr>
<tr>
<td><strong>Average Conversion Factor</strong></td>
<td></td>
<td></td>
<td><strong>4.000</strong></td>
</tr>
</tbody>
</table>
# Hospital Professional Liability + Physician Liability Losses

## Summary of Hospital Professional Liability

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>ASHRM Risk Conversion Factor</th>
<th>Occupied Bed Equivalents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Bed Equivalents</td>
<td></td>
<td></td>
<td>671</td>
</tr>
<tr>
<td>Physician Equivalents</td>
<td>20</td>
<td>2.7500</td>
<td>55</td>
</tr>
<tr>
<td>Total Occupied Bed Equivalents (OBE)</td>
<td></td>
<td></td>
<td>726</td>
</tr>
<tr>
<td>2010 Benchmark Loss Cost per OBE</td>
<td></td>
<td></td>
<td>$3,280</td>
</tr>
<tr>
<td>State/County Adjustment Factor</td>
<td></td>
<td></td>
<td>1.1</td>
</tr>
<tr>
<td>2010 Benchmark Est. Loss</td>
<td></td>
<td></td>
<td>$2,619,408</td>
</tr>
</tbody>
</table>

## Est. % Reduction in Adverse Events (A)

<table>
<thead>
<tr>
<th>Est. % Reduction in Adverse Events (A)</th>
<th>RAND Coefficient</th>
<th>Est. % Reduction in Malpractice Claims (M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>X 0.37</td>
<td>7.40%</td>
</tr>
</tbody>
</table>

## Est. % Reduction in Malpractice Claims (M)

<table>
<thead>
<tr>
<th>Est. % Reduction in Malpractice Claims (M)</th>
<th>Annual HPL+PL Loss (L)</th>
<th>Potential Total Savings from Reduced Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.40%</td>
<td>$2,619,408</td>
<td>$193,836</td>
</tr>
</tbody>
</table>
Net Total Savings & Payback Ratio (ROI)

<table>
<thead>
<tr>
<th>Potential Total Savings</th>
<th>Cost of Ongoing External Peer Review</th>
<th>Payback Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>$193,836</td>
<td>/</td>
<td>$73,500</td>
</tr>
<tr>
<td>-$73,500</td>
<td>$73,500</td>
<td></td>
</tr>
<tr>
<td>$120,336</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assumptions & Caveats

- This case study uses a conservative assumption about adverse event reductions due to EPR program
- Timely/effective follow-up on areas of concern
  - Focused review
  - Retraining/proctoring
  - Other corrective actions
- Time delay on claims requires a long-term investment philosophy
- Each hospital’s risk profile is different, and must be analyzed individually
Step 7
Management Agreement Through Budget Cycle

- Develop program plan, budget & ROI model
- Present to management
- Discuss/adjust assumptions
- Gain buy-in to invest
- Perform pilot program
- Measure success
- Make adjustments
- Deploy more widely across other specialties

Questions and Answers
Thank You

AllMed Healthcare Management, Inc.
(800) 400-9916
www.allmedmd.com