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Compliance, quality, and the role for unbiased peer review

- » Quality-of-care measurements are becoming key components of compliance.
- » External, unbiased peer review is an effective component of quality assessment.
- » Peer review is confidential, educational, and has the potential to improve risk profiles.
- » The emphasis of prospective regular peer review should be on education and improvement, not punishment.
- » External reviews can avoid department politics, but should not necessarily replace the internal peer review.

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For decades the Office of the Inspector General has focused on stemming fraud and abuse in the realm of reimbursement for medical care. In his 2012 keynote address for the Health Care Compliance Association's Compliance Institute,¹ Inspector General Daniel Levinson alluded to a paradigm shift in health care—one in which there will be an emphasis on value rather than volume.

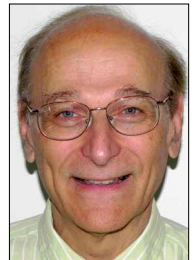
If health care facilities and providers of care focus on quality of care, this should be rewarded. The patient should be helped, the facility and providers edified and rewarded in reputation and financially (by “doing it the right way” the first time), and the health care system rewarded by receiving true value for the health care dollar.

We foresee the next frontier in compliance will entail some regular measurement of quality of medical care. Although there is significant subjectivity involved in assessing quality of care, most physicians in a specialty have a

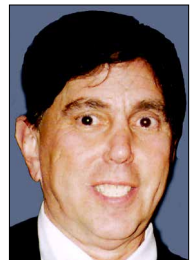
sense of what falls within (and what falls outside) the standard of care.

The Joint Commission has required ongoing assessment of quality in health care since 2009, in the form of the Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE).² Essentially, each facility seeking accreditation must have a method for assessing the competence of their medical staff. At this time, the method of such assessment is to be defined by the institution itself,³ resulting in a wide range of acceptable methods, from perfunctory internal reviews to rigorous periodic external peer review.

In addition to fulfillment of requirements for hospital accreditation, the growing importance of coordinated efforts between compliance officers, risk managers, and quality managers has been in the limelight. D. Scott Jones has pointed out that there has been limited funding for quality assurance and peer review and the “self-policing abilities of peer review...are frequently affected by political and relationship considerations...[resulting] in



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quality programs [that] are usually less effective than quality managers would prefer...⁴

With the changes some foresee, starting now to develop a rigorous method of periodic peer review of practitioners not only will have the potential to improve patient care and quality of outcomes, but will position an institution to be ready (and perhaps model-setting) when objective methods of quality assessment are required, not only for accreditation, but also for reimbursement.

Mr. Jones went on to note that “administrators should be on notice that quality is a...major concern...soon to be considered part of the regulatory compliance program...” And he stressed that it is “easier to be ahead of the curve than behind it” in embracing the integration of quality and compliance.

Recently, Dr. Richard Moses and D. Scott Jones realized that “physicians understand but often dislike peer review...”⁵ The goal should be to change this attitude, because a rigorous unbiased peer review program has the potential to confidentially identify trends that need remediation, lead to avenues of education, and improve risk management profiles. The emphasis of prospective regular peer review should be on education and improvement, not punishment. Such reviews might be most accepted and valued if the specific results were used by department chairs for internal discussion and education.

So, how can one conduct relatively objective peer reviews as part of a quality assurance program to satisfy a compliance investigation?

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One example of periodic peer review comes from diagnostic imaging. The American College of Radiology has a model for ongoing internal review of radiologists’ interpretations of studies (which they term RADPEER), but a similar model could be adopted for external peer review, where the biases of review within a practice or within a hospital would be avoided. The emphasis should be on *prospective* peer review, rather than solely on review of individual

instances where an adverse outcome or trend has already been identified.

The proposed model in Radiology

A small percentage of cases from each radiologist is randomly chosen to reflect the case mix of the practitioner. These are submitted to an external panel of radiologists for “over-reading,” and the original reading is scored for its accuracy in making the objective findings, interpreting the findings within the somewhat more subjective arena of standard of care, and communicating the findings.

Specific results and statistics could be shared internally for discussion between department chairs and practitioners. Maintaining anonymity of physicians/practices and confidentiality of results would allow for

more comfort and honest participation by the physicians, and would avoid the potential of interfering internal or external political agendas. Documentation that the process was done is provided by the department chair or quality assurance person and by the external review panel to satisfy hospital, accreditation, and regulatory requirements. Any adverse trends can be noted within the department and can be a stimulus for education and improvement in the risk profile.

D. Scott Jones went so far as to write, “in today’s health care environment, the failure to include quality in a strategic initiative may expose an organization to risk...”⁶

Other procedure-based practices, such as Pathology and Laboratory, are amenable in a similar manner to peer review; for example, random periodic review of pathology slides by an external peer review panel of pathologists, or periodic submission of blood samples to peer-review laboratories for comparing results with the laboratory being reviewed.

In the clinical realm, the review may be more complex. But one could envision, with proper patient consent (and probably compensation), a small number of patients would be separately evaluated by a clinical team of physician peer-reviewers whose objective findings and ultimate assessments and treatment plans would be compared with those of the treating physician. Evaluation of random hospital charts could be another arm of the project.

The external reviews described would not necessarily replace the retrospective peer review, as exemplified by morbidity and mortality or other quality assurance conferences. There could even be a combination of internal and intermittent external peer review. This alternative model for those who are reluctant to fully commit to external peer review could include external review as a quality control on the department’s primary internal peer review

program. This hybrid model may be more palatable to many physicians.

Perhaps some institutions would consider formal grant-funded studies to compare the value of external peer review with internal review. Is there a significant difference in morbidity and mortality, malpractice claims, patient satisfaction, complications, or re-admission rates between programs that utilize external prospective peer review versus those with only internal peer review?

In a 2010 paper for the American College of Radiology, Dr. Joseph Steele, and his co-authors noted that:

Hospitals have always had the responsibility to ensure the competence of their medical staff members... Unfortunately, hospital administrators are also motivated to keep their high-volume referrers happy and to avoid messy turf battles, so they let individual practitioners or departments ‘work it out.’ The recent Joint Commission mandates, however, require hospitals to take a more active role, because OPPE [Ongoing Professional Practice Evaluation] is now their responsibility.²

Along these lines, as “value” becomes more important than “volume,” as anticipated by the Inspector General, one can foresee Compliance requirements for objective, unbiased measures of quality, which can be to some degree accomplished by a regular program of external peer review. ☐

1. Daniel Levinson keynote address, HCCA Compliance Institute. April 30, 2012, Las Vegas.
2. Steele, JR, et al: “Joint Commission Practice Performance Evaluation: A Primer for Radiologists.” *Journal of American College of Radiology*, June 2010; vol.7, no. 6, pp. 425–430
3. Personal communication with J.Wallin, The Joint Commission on Accreditation of Health Care Organizations, June, 2012
4. Jones, DS: “Combining Disciplines: Making the Connection Between Compliance, Risk, and Quality Management.” *Journal of Health Care Compliance*, May-June 2007; vol. 9, no. 3, pp. 5–12
5. Moses, RE and Jones, DS, “Educating Physicians on Fraud and Abuse Compliance Issues,” *CCH Healthcare Compliance Letter*, June 19, 2012, pp. 3–6
6. Jones, DS: “Quality and Mission: What is Your Strategy?” *Journal of Health Care Compliance*, March/April 2010; vol. 12, no. 2, pp. 53–56.