

White Paper: Overutilization, Abuse and Fraud within Cardiac Departments

For Hospital Groups, ASCs and Specialty Medical Facilities

Executive Summary

Overutilization, abuse, and fraud within cardiac departments have been receiving a great deal of media attention lately, since the federal government continues to demand that physicians and hospitals demonstrate that the invasive and expensive care they provide results in improved outcomes for patients.

Recently, a number of high-profile cases have shed light on the widespread extent of questionable physician and hospital practices, thereby underlying the importance of transparency and unbiased peer review in order to ensure that the quality of care meets professionally recognized standards.

Hospitals are now being forced to demonstrate that cardiology procedures meet strict medical necessity criteria and guidelines. The penalties for inappropriate reimbursement are steep, with some physicians facing suspension or jail time and some hospitals facing millions of dollars in fines in addition to ruined reputations.

External peer review has been shown to overcome the issues with transparency and conflict of interest that traditional internal peer review has been unable to overcome. Utilizing external peer review for monitoring both ongoing and sentinel events allows hospitals to ensure that procedures fall under the medical necessity category and helps to identify issues with overutilization and possible abuse or fraud before they get out of control.

Introduction

Although the United States spends substantially more per person on healthcare than any other country, health outcomes in the United States are the same as or worse than those in other countries. The most important contributor to the high cost of healthcare is overutilization, which results from more office visits, hospitalizations, tests, and procedures, or from more costly specialists, tests, procedures, and prescriptions than are appropriate.

A panel of experts convened during the recent American College of Cardiology (ACC) 2011 Scientific Sessions to discuss what constitutes appropriateness, how it is measured, and how it should be enforced. The panelists agreed that appropriateness is based on benchmarking physicians to their peer group, taking into account the different mix of cases for each physician and looking at the clinical cohorts to make sure that each physician is appropriately treating patients.

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While acknowledging that determining what is appropriate can be challenging, the panelists agreed that interventional cardiologists should practice according to evidence-based guidelines, such as the 2009 Appropriateness Criteria for Coronary Revascularization developed by the American College of Cardiology Foundation along with key specialty and subspecialty societies.

The panel of experts also discussed the recent scrutiny on hospitals and physicians allegedly overutilizing treatments,

and mentioned the importance of looking at the underutilization of procedures as well. Although the issue may seem to be relevant only for high-volume centers, the panelists cited that low-volume centers tend to have similar distributions of over- and underutilization cases.

Overutilization, Fraud, and Abuse: A Widespread and Ongoing Issue

The Centers for Medicare and Medicaid Services (CMS) has identified nearly \$1.03 billion in improper Medicare payments since it began its Recovery Audit Contractor (RAC) program in 2005. More than 95% of the improper payments identified by the RACs were overpayments to healthcare providers.

Penalties under the False Claims Act for performing inappropriate procedures are steep: a court may assess three times the amount of damages for each claim, plus significant civil and possible criminal penalties. These investigations also result in negative publicity for physicians and facilities, thereby causing damage to reputations and impacting revenues, as you will see in the examples that follow.

Hospitals in Alabama, California, Florida, Louisiana, Maryland, Mississippi, North Carolina, Pennsylvania, South Carolina, and Texas have been subject of audits.

Louisiana Cardiologist Sentenced to 10 Years in Federal Prison

In 2006, a hospital in Louisiana paid \$3.8 million to settle a Department of Justice false-claims lawsuit and also paid 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 sentenced to 10 years in federal prison for implanting stents in patients who did not need them. He was convicted on 51 counts of billing private and government health insurers for unnecessary medical procedures and received the maximum sentence. Testimony during the trial revealed that the doctor had falsified patients' symptoms in medical records, including chest pain when patients never complained of such pain, and had falsified findings on medical tests. From 1999 to 2003, he billed Medicare and private insurance companies more than \$3 million, which made him the top cardiology biller in the state and allowed him to personally pocket more than \$500,000.

Maryland Hospital Pays \$22 Million to Settle False Claims Allegations

Last year, a Maryland hospital agreed to pay a \$22 million fine to settle charges that it paid illegal kickbacks to a cardiologist's practice in exchange for patient referrals. Reports indicate that the cardiologist may have implanted more than 500 stents that were medically unnecessary, with Medicare paying \$3.8 million of the \$6.6 million charge for those procedures. According to a hospital statement, "The medical center reached the agreement without admitting any liability in order to avoid the expense and uncertainty of litigation and to allow the medical center to move forward."

Maryland Cardiologist Indicted on Fraud Charges

Another cardiologist in Maryland was accused last year of placing hundreds of medically unnecessary stents and of carrying out unnecessary diagnostic procedures worth millions in combined Medicare payments. He surrendered practice privileges at his Maryland hospital in 2007 following an internal investigation about unnecessary stenting procedures. The doctor was charged with one count of fraud and six counts of making false statements to insurers and patients, whose records he allegedly falsified. If convicted on all counts, he could face 40 years in prison.

Government Audit Programs: Expanding and Becoming More Aggressive

In an effort to promote evidence-based healthcare, protect patients, to improve the quality of care, and to reduce fraud and overbilling issues so as to contain costs, a CMS has been expanding its use of RACs to recover inappropriate payments for Medicare services. Medicaid Integrity Contractor (MIC) auditors and federal regulators are also actively audit-

ing hospitals to make sure that they are complying with new the rules and regulations. Although target audit issues vary among hospitals, the most lucrative procedures, such as interventional cardiology procedures, are under a high level of scrutiny.

Audits are widespread in the United States; hospitals in numerous states have undergone investigation. Hospitals in Alabama, California, Florida, Louisiana, Maryland, Mississippi, North Carolina, Pennsylvania, South Carolina, and Texas have been subject of audits.

Fraud and Abuse

CMS Definitions

CMS defines fraud as “making false statements or representations of material fact in order to obtain some benefit or payment for which no entitlement would otherwise exist.” “These acts may be committed either for the person’s own benefit or for the benefit of some other party.” Fraud involves unlawfully obtaining something of value, through willful misrepresentation, false statements, kickbacks, or collusion. To prove fraud, prosecutors must that a provider has engaged in intentional deception or misrepresentation in order to gain some unauthorized benefit for him/herself or some other person.

Abuse refers to violations of agency regulations; these violations impair the effective and efficient administration of government healthcare programs. CMS describes abuse as “practices that, either directly or indirectly, result in unnecessary costs” to Medicare and other federal healthcare programs. Abuse may include:

- ▶ Providing services that are medically unnecessary or inconsistent with the professionally recognized standards
- ▶ Submitting a bill for noncovered services for which there is no 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

According to CMS, what distinguishes abuse from fraud is the inability to “establish that abusive acts were committed knowingly, willfully, and intentionally.” Practices considered routine “overpayment” matters one day can become “abuse” the next and can even become “fraud.”

A Major Issue for Cardiac Procedures

According to the Department of Health and Human Services Office of Inspector General (HHS OIG), the most common Medicare reimbursement violation is the failure to comply with medical necessity requirements, especially for certain costly diagnoses involving interventional cardiology procedures such as angioplasties and pacemaker implantations. The average length of stay for these procedures has gradually decreased, leading auditors to believe that they can be routinely performed in an outpatient setting. Hospitals that admit patients with these diagnoses can expect thorough reviews by a variety of parties, including RACs and Medicare quality improvement organizations.

Government Audit Programs: Expanding and Becoming More Aggressive

Ongoing internal peer review should include concurrent and retrospective reviews by peer specialist reviewers of a physician’s performance through formally adopted written procedures. Performance evaluation can take several forms:

- ▶ Data review of aggregate performance data, including comparisons against industry/regional benchmarks and established standards, in order to recognize opportunities for improvement and to identify trends in

professional practice

- ▶ Case review of patients' records identification through data reviewed and by a group of peers in order to evaluate issues that have been deemed important by the group overseeing the process

Timeliness is a critical component of the peer review process. Each of the steps in an established process must be completed within reasonable time-frames to ensure that any issues are promptly addressed. In-house physicians often have the disadvantage in performing this critical function simply because of time limitations or the lack of the experience and expertise that are needed for peer review activities.

While hospitals perform internal peer review so as to ensure that their physicians are properly credentialed, competent, and adequately trained to safely treat patients, internal peer review carries the potential for conflicts of interest and the lack of transparency and accountability, especially if there are social or professional relationships or too few physicians in a specialty.

Internal Peer Review Fails at California Hospital

Between 1992 and 2002, cardiologists and cardiac surgeons at a hospital in California performed unnecessary procedures and operations on more than 600 patients, with the encouragement of hospital leadership. Documents indicate that quality assurance entities repeatedly certified or accredited the institution throughout this period, despite records that showed that peer review was not performed. Only after discovery by the FBI in 2002, were the physicians and hospital officials stopped. They eventually paid about \$500 million in combined negligence awards and the hospital was sold. The valuation and reputation of the corporation that owned the hospital was damaged and has never recovered.

Why External Peer Review?

When properly executed, external peer reviews, which supplement but do not replace, hospitals' internal peer review processes, can reduce medical errors through objective evaluations performed in a no punitive educational context that supports a healthy culture of continual improvement. Increased transparency and accountability result from physicians knowing that their work will be objectively evaluated at regular intervals by board-certified specialists with the same credentials in similar practice settings, thereby leading to improved quality of care and patient safety. Ongoing evaluation of physicians can also uncover problematic practice patterns, as well as physician- and hospital-level issues that need to be addressed.

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Unlike internal peer review, which only looks at sentinel events, external peer review can help hospitals to discover, highlight, and deal with physician performance issues quickly and efficiently before patients' complaints, legal actions, or audits. In addition, external peer review avoids conflicts of interest that can arise from economic, professional, or social ties among physicians within a single institution. It may also be an effective solution for hospitals that lack adequate physician resources to conduct timely performance analyses.

CardioAudit: A Proactive Approach

CardioAudit is an external peer review program that helps hospital administrators identify and correct any potential problems before they occur. This review process is the first of its kind to systematically evaluate specific cardiac procedures (please see Table 1) to determine medical necessity in accordance with

CardioAudit

the guidelines set forth by professional medical societies and with Medicare National Coverage Determinations (NCDs), as well as necessity outside of NCD language. CardioAudit reviews utilize a scoring system that allows for benchmarking and business intelligence data gathering that can be reviewed and compared with similar procedures and physicians in other areas and hospitals.

Table 1. 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 and radiofrequency ablations

The ongoing monitoring and identification of potential overutilization in advance of outside auditing processes allows hospitals to take remedial action, including tightening of clinical criteria, providing additional training to physicians, and taking other corrective measures to protect all parties.

As an ongoing external peer review program, CardioAudit is a cost-effective solution that improves quality of patient care while overcoming potential barriers to effective peer review, including conflicts of interest, uncompensated time limitations, sham reviews, and economic profiling. With CardioAudit, hospitals can prepare for audits by identifying issues before they spiral out of control, reducing the risk of False Claims Act liability, demonstrating a commitment to patient safety, and improving compliance with evidence-based guidelines.

PeerScore FPPE: The Role of External Peer Review in Audits

One of the key components of developing an audit response strategy is preparation. In-depth focused reviews are required for audited hospitals. This serves to overcome issues regarding conflict of interest and lack of accountability. PeerScore FPPE reviews are different from CardioAudit because they are in-depth narrative reviews that focus on breaking down a situation that has already happened.

PeerScore FPPE^(sm)
Focused Narrative Review

The PeerScore FPPE review process identifies an appropriate sampling size that is statistically valid based on the number of physicians and procedures that are performed at the hospital. All PeerScore FPPE cases are reviewed by leading board-certified cardiologists who are in active practice, thereby ensuring that cardiovascular procedures are medically indicated according to the latest clinical criteria. Reviews conducted by physicians outside of the influence of the hospital allow for unbiased and medically defensible evaluations. If necessary, AllMed's medical team can provide expert witness services.

Conclusion

The United States Government and CMS have been taking aggressive measures to promote evidence-based healthcare. The use of RACs to recover inappropriate payments for Medicare Services has been expected. Medicaid Integrity Contractor auditors and federal regulators are also actively auditing hospitals to make sure they are complying with new rules and regulations. Although target audit issues vary among hospitals, the most lucrative procedures, such as interventional cardiology procedures, are under a high level of scrutiny.

AllMed's CardioAudit and PeerScore FPPE programs are designed to help hospitals meet the challenges of Medicare and Medicaid audits and to either prevent potential investigations by the Department of Justice or prepare for them. As an ongoing external peer review program, CardioAudit offers a proactive approach to ensure that cardiac procedures are medically indicated.

Ongoing review with CardioAudit facilitates the regular assessment of high-risk procedures, and lessons risk through prevention. Rather than taking a reactive approach, CardioAudit focuses on promoting a proactive culture of investing in loss prevention. It is a simple and straightforward process that utilizes a proprietary system of unbiased external peer review to help administrators and medical executive committees at hospitals identify and correct any potential problems before they occur.

PeerScore FPPE allows hospitals to have a reactive solution to governmental audits. The in-depth narrative reviews from PeerScore FPPE are defensible and ensures hospitals that the cardiovascular procedures being reviewed are medically necessary based on the latest clinical criteria.

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