IMPACT OF THE PEER REVIEW PROGRAM ON HOSPITALS AND PHYSICIANS

Mohammad N. Akhter, M.D., M.P.H.

DOI: http://dx.doi.org/10.5915/18-1-11731

ABSTRACT

Prospective Payment System DRGs are designed to limit the amount of payment to a hospital for any particular diagnosis, and the Peer Review Organizations are to police hospital activities. In every state, there is a PRO having a contract with the Health Care Financing Administration to perform the following functions:

(1) Review of reasonableness, necessity, and appropriateness of hospital admissions.

(2) Validation of diagnosis for determination of Medicare reimbursement.

(3) Review of completeness and quality of care provided.

(4) Review of completeness and appropriateness of outlier cases.

Getting a patient admitted to the hospital isn't as easy as it used to be, and it is going to become increasingly difficult. For a physician, it all adds up to another level of interference with which we haven't had to deal before.

The overall PRO program, including preadmission certification and the retrospective review process, is discussed in this article. The focus is on recommendations for physicians of "How to survive under the Prospective Payment System and the PRO program."

Introduction

Many studies have shown tremendous variation in medical care from one region to another and from one city to another. Residents of some cities are up to 20 times more likely to be hospitalized for certain medical problems than residents of other cities in the same state. This variation in medical practice suggests to the Health Care Financing Administration (HCFA) officials and Congress that there are unnecessary admissions to hospitals and probably, in some instances, unnecessary treatment being provided to patients. Unnecessary treatment is treatment which has no reasonable probability of improving the patient's condition. HCFA believes that in areas of high utilization, a very substantial amount of care could be shifted out of the hospitals. The best way to accomplish this, they believe, is by penalizing those who admit patients to the hospital either for unnecessary treatment or for conditions which could be taken care of safely and effectively on an outpatient basis.

The federal government is clearly committed to minimizing differences in medical care as much as possible to assure inpatient admissions only for those patients who really need to be in the hospital for the management of their illness. For example, according to federal estimates, over the next two years 65,000 Missourians will be treated in doctors' offices or in outpatient clinics for medical problems that until now would have meant admission to acute-care hospitals.

Medicare, the federal health insurance program for the elderly and disabled, pays nearly 40 percent of the nation's medical bills. There are new federally financed agencies call Peer Review Organizations (PROs) in every state whose jobs are to review the care given to Medicare patients. These agencies, staffed by doctors, nurses, and medical records technicians exist to assure that federal money is spent properly and that the patients get quality care. Each state PRO has recently signed a contract with the federal government in which they agree to reduce hospital admissions for Medicare patients by a specific percentage over the next two years. They will do this by instituting preadmission certification and retrospective review programs.

Preadmission Certification Programs

In all states PROs are required to perform preadmission certification on certain elective hospital admissions. We have reviewed the preadmission certification programs in several states. The mechanism for most of these programs is the same, but specifics vary greatly. Generally, the requests for admission are received and are reviewed by a nurse. Based on the established criteria, a decision is made either to approve the admission or to refer that particular case to the physician advisor, who in turn makes a decision whether the admission is necessary. In some states, decisions to approve are made by non-physicians (RNs). However, in all states, denial decisions are to be made by physicians.

From: Missouri Patient Care Review Foundation, Jefferson City, MO 65101

Address all correspondence to Mohammad N. Akhter, M.D., M.P.H., Executive Vice President, Missouri Patient Care Review Foundation, 1026C Northeast Drive, Jefferson City, MO 65101

Following is the procedure for preadmission certification:

- Initial requests for approval are customarily made by phone to the PRO area office by the physician or the office staff. The requests are received by a review coordinator who is available at the PRO office between the hours of 9:00 a.m. and 4:00 p.m. each working day.
- If the patient meets the screening criteria, the admission is certified. If not, the case is referred to a physician consultant.
- The physician consultant may approve the admission based on the information provided by the coordinator, or he may contact the attending physician for further information if deemed necessary. Every effort is made by a PRO physician to contact the attending physician prior to making a denial decision.
- Generally, the decision is communicated by telephone to both the physician and the hospital within 24 hours of receipt of the request.
- In the case of a positive decision, written confirmation is provided to the hospital, with a copy sent to the attending physician. When the decision is a denial, written confirmation is mailed to the hospital, with copies sent to the attending physician and the patient.
- The attending physician may ask for a reconsideration of a denial decision. In all such cases, the PRO provides review by another physician advisor.
- All cases which were denied but where an admison took place are subject to a full chart review for admission, quality, and DRG validation. If justification can still not be established, the denial is made and the hospital is not reimbursed for that admission.

Table 1 shows the results of the preadmission certification program. According to the Health Care Financing Administration, the overall denial rate for preadmission certification is 1.14 percent.

Retrospective Review

After a Medicare patient has been treated at a hospital and discharged and the attending physician has attested to the principal and other diagnoses and procedures, the hospital can submit the bill to Blue Cross, which acts as the fiscal intermediary (FI) for Medicare. Unless it is one of the relatively few conditions where prepayment review by the PRO is required, the bill is paid by the FI once it is processed. A tape of paid Medicare claims is prepared by the FI and forwarded to the PRO on a regular basis. It is from such tapes of paid claims that PROs draw their monthly samples of cases, by hospital, for review in the next month.

After monthly samples of the cases are selected for review, worksheets are generated for each case. (The sample may equal 100 percent of Medicare cases for that month if the hospital has lost its favorable waiver and is under intensified review.*) The PRO office notifies each hospital in its area of the records to be pulled for review and schedules an on-site visit. The only exception to scheduling an on-site visit is where the hospital has fewer than ten cases to be reviewed for that month, in which case the hospital is required to mail copies of the records to the PRO office. PRO review coordinators, generally comprised of nurses and medical records technicians, perform the reviews of those selected cases.

Using criteria approved by the PRO Board, the review coordinators review the charts for medical necessity, DRG validation, potential quality concerns, and determination of which, if any, cases should be referred to a local physician for medical review. Most PROs either develop their own criteria or use ISD-A criteria developed by InterQual which are based on severity of illness and intensity of service.

Those cases referred by a review coordinator are forwarded for review to a physician who makes an initial determination based upon his/her own medical expertise and on what is in the medical record. If the reviewing physician (called a physician advisor) determines that the patient could have been treated as an outpatient, a letter (known as a pending denial) is sent to the attending physician informing him/her of the review findings and providing the attending physician an opportunity to submit additional information justifying the need for inpatient services for the case in question. The attending physician has fifteen calendar days to respond with additional information. If there is no additional information submitted, the pending denial becomes a final denial at the end of the fifteen days, and a letter to that effect is sent to the patient, the hospital, the attending physician, and the FI. Depending on the hospital's waiver status, it is possible the hospital will not be paid the DRG for that patient.

If additional information is submitted by the attending physician, the case will again be reviewed by the physician advisor to determine if the original decision is still justified. If the pending denial decision is reversed, the attending and hospital are notified, and the case is certified for payment. If the physician advisor upholds the pending denial, a final denial is issued as discussed in the previous paragraph. (Figure 2)

After a denial has been made, a physician, patient, or the hospital may ask for reconsideration of the determination. When a reconsideration is sought, the medical record, along with any additional information submitted by the attending physician, is forwarded to another physician not involved in the initial

determination. Based on the decision of that physician or physicians, a final decision is made either to overturn the denial or to uphold the initial denial. Table 2 shows the result of retrospective review. Although wide variations exist in the denial rate, the overall denial rate nationwide is 2.48 percent.

Since the PRO has very little flexibility in this entire process, there are certain troublesome spots of which physicians need to be aware:

(1) By the time you get a pending denial letter, the case may already be five or six months old, and you may not remember all the details relating to diagnosis and treatment.

(2) The PRO reviews only the records of the patient after discharge from the hospital and has the benefit of 100 percent hindsight.

(3) There are differences in the practice of medicine among physicians within the same area and certainly within different geographical areas. Some physicians admit most of their patients; others attempt to treat their patients with similar problems as outpatients.

(4) Some procedures, we all agree, can be done in an outpatient setting; but there are others that are much less clear. To what degree should we expose our patient to a risk of poor outcome for budgetary restraints, and how much risk should a physician take in making that decision? This is a challenge.

(5) In the past three years while the increase in the gross national product has been 12.3, 4.0, and 7.7 percent, the national health expenditures have increased at 15.1, 12.5, 12.4 percent. HCFA is serious about reducing health care costs, and we believe the review program is going to be with us for a number of years.

With these thoughts in mind, what must physicians do to avoid unnecessary denials?

(1) **Understand the System** — This is perhaps the most critical point — "What you don't know can hurt you." Physicians must understand the process, as well as the criteria, and participate in the review process as a reviewer if you have not done so in the past.

(2) **Fully Document Each Case** — Poor documentation is a major cause of referrals and denials. You have probably heard the axiom, "If it is not in the record, it didn't happen." From a review coordinator's or reviewing physician's perspective, that is in fact the case. To avoid an adverse decision, the reasons for admission to an acute care facility should be adequately and appropriately documented.

(3) **Know the Criteria** — The criteria developed by your PRO and the ISD-A criteria published by InterQual are guidelines for review coordinators to perform screening of the charts. Most Medicare patients admitted to hospitals meet these criteria; however, documentation is not always adequate. Charts meeting the criteria will generally not be referred by review coordinators, and there will be no need for a physician advisor to review, and possibly deny, the case. Therefore, it is important to be intimately familiar with the criteria and to make sure that you document the appropriate elements of that criteria on the medical records.

(4) **Document Reason for Admission** — If your admission does not meet PRO-established criteria, document the specific medical reasons for admission of the patient to the hospital to enable review by the physician advisor in the event of a referral.

(5) **Participate in the Development of the Criteria** — If you have problems with the criteria or think they are inappropriate, please contact the PRO Director with your proposed changes so that he/she can refer them to the appropriate committee (the Quality Assurance/Criteria Committee of the PRO) for appropriate adjustment.

If you do get a denial, the following is recommended:

(1) Have your chart reviewed by the hospital Utilization Review Committee to determine whether there is reason to believe the case should be reconsidered by the PRO. If so, let the committee, either on your behalf or on behalf of the hospital, write a letter to the PRO for the denial reconsideration with their reasons for the request.

(2) If you have information in your office that is not a part of the original medical record that will justify the admission, provide that information with the record.

(3) You have sixty days from the date of the denial letter to ask for a reconsideration. Ask promptly for reconsideration while the PRO still has the chart at hand and the case is fresh in everybody's mind. Requests for reconsideration received after sixty days are not honored.

(4) If you feel you have been treated unfairly or that your local physicians are too strict in denying your cases, you can ask for reconsideration outside your area by writing to the PRO Medical Director.

(5) Do not take a denial lightly. The implications of a denial are far-reaching for the institution where you practice and for you. Physicians who continuously receive denials are subject to 100 percent review of all Medicare cases. If unnecessary admissions continue to be a problem, then preadmission certification beyond

what is presently required of all physicians might be invoked to address the situation with both the physician and the hospital involved. This would mean that prior to admission of a Medicare patient, the physician would need to get approval from the PRO office. If the problem still continues unabated, then HCFA may impose sanctions such as excluding that particular practitioner from participation in Medicare.

We are very concerned about the extraordinary powers and authority granted to the Health Care Financing Administration to impose punitive actions on physicians. Some hospitals where the denial rate has gone as high as 20 percent have been losing money. Under current economic conditions, not being paid for services provided for Medicare patients creates an extensive burden on the hospital and puts the future of that hospital in jeopardy. During the past ten months, there has been a considerable decline in the number of Medicare cases admitted to hospitals. Denial of payment for even a small number of cases could put a small hospital out of business.

It is important, therefore, that the physician and hospital cooperate in making sure that only those patients needing inpatient care are admitted to the hospital.

**Denial of at least three cases with 2.5% of total cases reviewed in the previous calendar quarter leads to intensified review and loss of waiver.*

FIGURE 1

PREADMISSION CERTIFICATION PROCESS

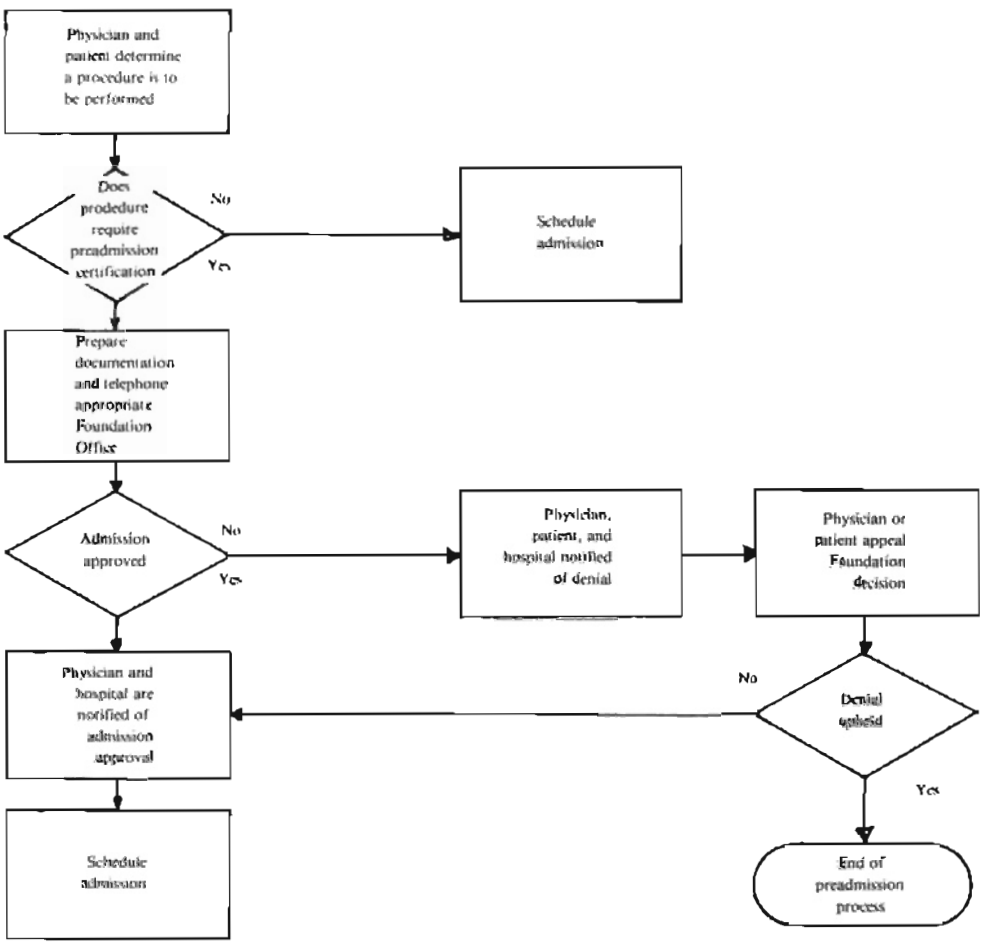

FIGURE 2

REVIEW PROCESS

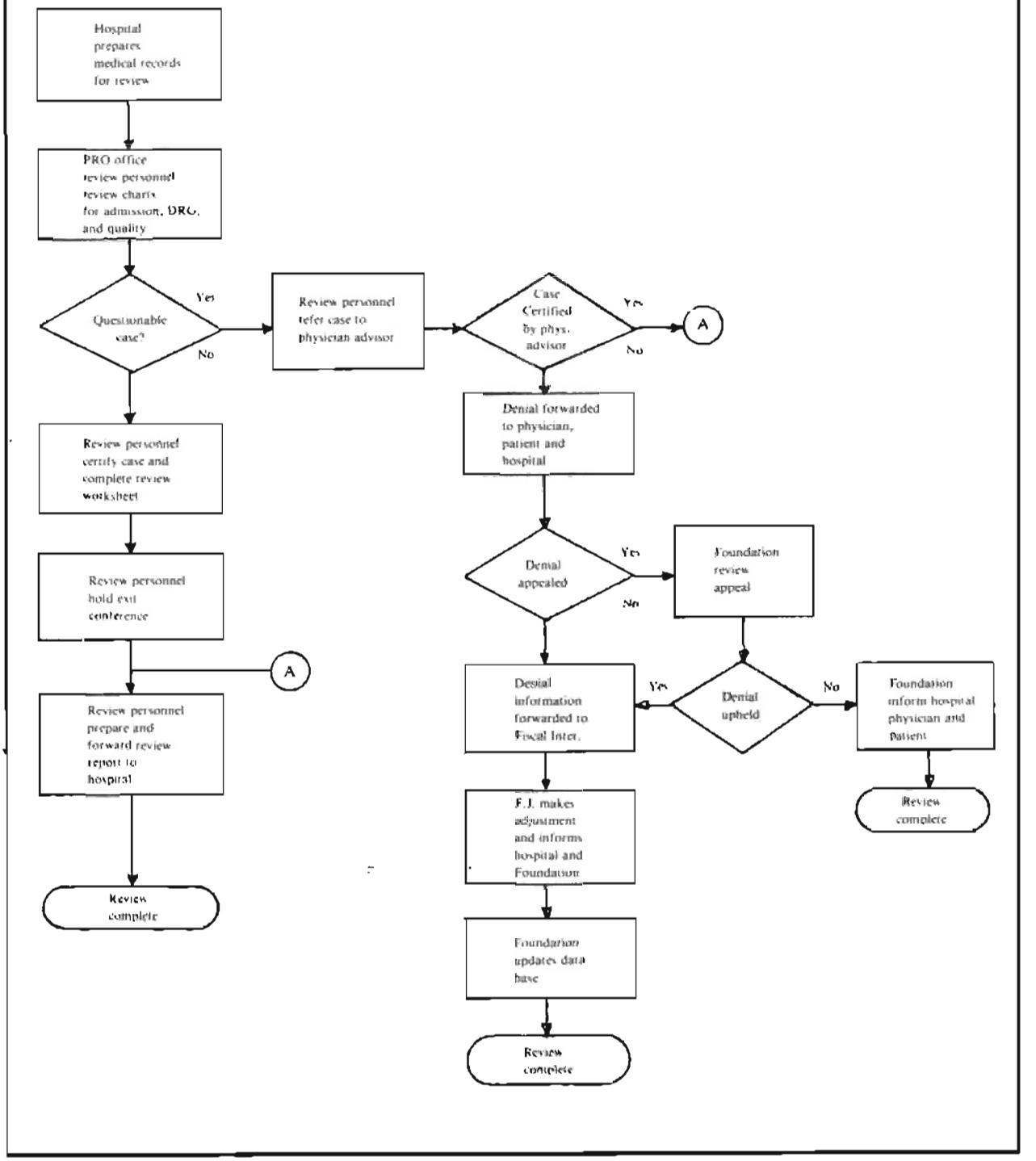

TABLE 1

PREADMISSION REVIEW SUMMARY
START-UP THROUGH APRIL 1985

PRO	PROID	EST DISCH	TOTAL REVIEW COMPLETED	PRE-ADM REVIEWS COMP	% EST PRE-ADM REVIEWS	PRE-ADM REVIEW DENIALS	% PRE-ADM REVIEW DENIALS
AK	0AK00	2463	342	35	1.42	5	14.28
ID	0ID00	19608	4785	8	0.04	0	0.00
OR	0OR00	93895	29462	7301	7.77	42	0.57
WA	0WA00	103343	37641	1007	0.97	35	3.47
CT	1CT00	63357	12539	2959	4.67	17	0.57
ME	1ME00	30856	4340	74	0.23	4	5.40
NH	1NH00	34665	13024	1532	4.41	3	0.19
RI	1RI00	35284	10213	779	2.20	33	4.23
VT	1VT00	12520	3805	570	4.55	1	0.17
DC	3DC00	16077	1534	587	3.65	1	0.17
DE	3DE00	18749	16693	392	2.09	22	5.61
PA	3PA00	398823	53452	3786	0.94	201	5.30
VA	3VA00	134145	30546	3707	2.76	2	0.05
WV	3WV00	108385	20884	2686	2.47	9	0.33
AL	4AL00	200159	210258	83902	41.91	598	0.71
FL	4FL00	550184	50548	5361	0.97	18	0.33
GA	4GA00	207191	102332	5146	2.48	197	3.82
KY	4KY00	174726	162796	84894	48.58	71	0.08
MS	4MS00	119337	29564	1372	1.14	3	0.21
NC	4NC00	207760	38300	5628	2.70	441	7.83
SC	4SC00	107121	45334	2635	5.39	1	0.08
TN	4TN00	255210	64611	50707	19.86	727	1.43
IL	5IL00	280020	63934	1639	0.58	47	2.86
IN	5IN00	195111	46557	9084	4.65	540	5.94
MI	5MI00	247083	22973	5741	2.32	162	2.82
MN	5MN00	165163	140172	82817	50.74	106	0.12
OH	5OH00	307678	92266	12803	4.16	332	2.59
WI	5WI00	199814	73925	42487	21.26	1059	2.49
AR	6AR00	143716	26327	2051	1.42	25	1.21
LA	6LA00	155652	17313	45	0.02	1	2.22
NM	6MN00	35388	8745	2879	8.13	16	0.55
OK	6OK00	101696	45088	7956	7.82	15	0.18
TX	6TX00	412841	100171	12254	2.96	0	0.00
IA	7IA00	145339	63247	5155	3.54	158	3.06
KS	7KS00	121118	35763	7326	6.04	23	0.31
MO	7MO00	236655	61026	1311	0.55	39	2.97
NE	7NE00	61456	12169	4092	6.65	3	0.07
CO	8CO00	87294	19029	83	0.09	1	1.20
MT	8MT00	33575	10376	1653	4.92	0	0.00
ND	8ND00	37558	13926	2905	7.73	29	0.99
SD	8SD00	28897	8034	1369	4.73	0	0.00
UT	8UT00	41705	15757	41	0.09	1	2.43
WY	8WY00	13358	2382	315	2.35	0	0.00
AZ	9AZ00	94948	14729	5297	5.57	249	4.70
CA	9CA00	542694	105036	38610	7.11	532	1.37
HI	9HI00	12438	447	271	2.17	57	21.03
NV	9NV00	28521	5267	2276	7.97	76	3.33
** TOTAL **		6623797	1907643	517526	7.81	5904	1.14
		EXPECTED			5.90		

Source: Health Care Financing Administration

TABLE 2

ADMISSION REVIEW SUMMARY
START-UP THROUGH APRIL 1985

PRO	EST DISCH	TOTAL REVIEWS COM-PLETED	, EST REVIEWS	TOTAL REVIEW DENIALS	, REVIEW DENIALS
AK	2463	342	13.88	12	3.50
ID	19608	4785	24.40	176	3.67
OR	93895	29462	31.37	518	1.75
WA	103543	37641	36.35	816	2.16
CT	63357	12539	19.79	441	3.51
ME	30856	4340	14.06	160	3.68
NH	34665	13024	37.57	394	3.02
RI	35284	10213	28.94	513	5.02
VT	12520	3805	30.38	76	1.99
DC	16077	1534	9.54	1	0.06
DE	18749	16693	89.03	151	0.90
PA	398823	53452	13.40	1966	3.67
VA	134145	30546	22.77	159	0.52
WV	108383	20884	19.26	1291	6.18
AL	200159	210258	105.04	1545	0.73
FL	550184	50548	9.18	1985	3.92
GA	207191	102332	49.39	4779	4.67
KY	174726	162796	93.17	99	0.06
MS	119337	29564	24.77	484	1.63
NC	207760	38300	18.43	1959	5.11
SC	107121	45334	42.32	398	0.87
TN	255210	64611	25.31	946	1.46
IL	280020	63934	22.83	1768	2.76
IN	195111	46557	23.86	2010	4.31
MI	247083	22973	9.29	530	2.30
MN	165163	140172	84.86	1266	0.90
OH	307678	52266	16.98	9.35	1.78
WI	199814	73925	36.99	545	0.73
AR	143716	26327	18.31	1470	5.58
LA	155652	17313	11.12	774	4.47
NM	35388	8745	24.71	121	1.38
OK	101698	45088	44.33	637	1.41
TX	412841	100177	24.26	9602	9.58
IA	145339	63247	43.51	772	1.22
KS	121118	35763	29.52	846	2.36
MO	236655	61026	25.78	1833	3.00
NE	61456	12169	19.80	244	2.00
CO	87294	19029	21.79	1099	5.77
MT	33575	10376	30.90	54	0.52
ND	37558	13926	37.07	249	1.78
SD	28897	8034	27.80	113	1.40
UT	41705	15757	37.78	24	0.15
WY	13358	2382	17.83	2	0.08
AZ	94948	14729	15.51	612	4.15
CA	542894	105036	19.35	2537	2.46
HI	12438	447	3.59	63	14.09
NV	28521	5247	18.39	216	4.11
** TOTAL **	6623797	1907642	28.80	47243	2.48
	EXPECTED —			(W/O Quality Objectives and	
APM)			27.70		

Source: Health Care Financing Administration