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Turning to external peer review when internal processes are not enough

The internal peer review processes at hospitals aim to measure and monitor physicians' performance through evaluations by other physicians. Peer reviewers are typically physicians in the same community and specialty as the physician who's being evaluated. However, in certain situations, hospitals may need to turn to external peer reviewers.

Sometimes a hospital may only have a single provider in a specialty or with a given set of privileges, says **Sharon Beckwith,** CEO of MDReview, a third-party peer reviewer located in Centennial, Colorado. With no one else available internally to conduct a thorough peer review, reaching out to an external reviewer may be the only option to ensure cases are adequately reviewed.

This scenario may be more common at smaller hospitals, but larger facilities can experience it too, Beckwith says. "For example, with neurosurgery you may have 10 neurosurgeons on staff, but you may have one that does coiling procedures or has endovascular privileges. So if that procedure needs to be reviewed, the other nine neurosurgeons on staff don't have the expertise to do it."

Reaching out to an external peer reviewer may also be a viable option after a sentinel event occurs at a hospital, Beckwith says. If the case is emotionally charged and no one internally thinks he or she can address it properly, it may be best to have it looked at by an objective external expert.

Sometimes a hospital's peer review committee cannot make a determination regarding a case, having exhausted the internal process, says **Anne Roberts, CPCS, CPMSM,** senior consultant for medical affairs at Children's Medical Center of Dallas. If so, sending the case to an external party may be preferable.

Getting peer reviews done in a timely fashion can also necessitate the use of an external reviewer, says **Andrew Rowe,** CEO of AllMed, a third-party peer reviewer located in Portland, Oregon. Since most peer

review is done on a voluntary basis, it may take time to find a physician in house who is willing and has the time to review another physician. You may also be under a time constraint because you want to get the results of the review to the peer review committee for its next meeting. In the case of a sensitive peer review issue, rather than delaying a determination on a practitioner, the committee may choose to use an external review to help the hospital achieve a quick, evidence-based resolution to the case.

Avoiding conflicts of interest

Using an external reviewer can sidestep allegations of bias in the peer review process. Any internal conflict of interest—whether real or perceived—may prevent an objective review, and if one is present, it provides an excellent reason to send a case outside, says Beckwith. Possible conflicts may arise if the reviewers are competitors or partners, or even if a reviewer attended medical school with the physician being reviewed.

"There are so many different reasons, and it's really important that when you look at an external reviewer to make sure those conflicts are also managed so you find somebody that didn't train with the physician who is under review, or who is geographically not a competitor," she says.

Referral sources can be another source of conflicts of interest, says **Don Lefkowits, MD, FACEP,** medical director at MDReview. If a physician being reviewed is a referral source for the physician doing the reviewing, it can sometimes be hard to maintain an unbiased approach.

Additionally, when physician leadership has to be reviewed, oftentimes the physician staff may be reluctant to weigh in on the care of someone whom they feel can influence their own practice, Lefkowits adds. An external, unbiased review would come in handy in this situation.

The external peer review process can also help a hospital overcome any claims that it is trying to steer a review toward a conclusion, especially when there isn't strong evidence backing up that conclusion, Rowe says. "This is where the transparency of an external peer review organization can really help to overcome any allegations there was any bias in reviewing the performance of a particular practitioner or group of practitioners."

The benefits of using an external peer reviewer

Physicians may have a fear of peer review because it is sometimes used to assess competence, training, knowledge base, and technical skills, or because it's conducted following an unexpected adverse outcome,

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Lefkowits says. The use of an unbiased external reviewer helps provide some reassurance that physicians' care will be judged on the quality of care provided.

External peer review can also help alleviate physicians' fear of retaliation from colleagues, says Rowe. In many states, the peer review protections that have traditionally kept peer review work confidential from fair hearings or legal proceedings are being stripped back. With challenges to maintaining confidentiality surrounding peer review proceedings, many physicians are afraid to call out poor performance, especially by high-profile practitioners.

He adds that an external peer reviewer is also advantageous when a practitioner is being reviewed in a fair hearing or some sort of pre-litigation setting. The hospital may want to use a third party to show that the findings were completely evidence-based and objective by pointing to the accreditation standards and quality processes of the reviewer.

Rowe says that hospitals are increasingly looking beyond the reactive nature of peer review to find ways to integrate peer review into more proactive settings, such as monthly, quarterly, or annual re-credentialing of active practitioners' privileges. They are also examining outlier data from their core measures to identify potential areas of concern.

This sentiment is echoed by Lefkowits, who says external peer review can also be used to look for improve-

Have a policy to determine when to use external peer review

When should a hospital utilize an external peer reviewer? Should there be a medical staff policy in place, or should it be done on a case-by-case basis? **Beth Dyson-Muskopf, MSHA, CPMSM,** director of peer review and medical staff for MDReview, a third-party peer reviewer in Centennial, Colorado, says the answer is both. She recommends that external peer review be addressed in medical staff bylaws, rules and regulations, the hospital's policy, or the medical staff's policy to give some structure and guidance to the process so that it's used consistently in each situation.

"The policy has to be thorough enough that it's applied consistently, yet give you enough room for the unique situations you may encounter so you can have the flexibility to make a decision," says Dyson-Muskopf.

Anne Roberts, CPCS, CPMSM, senior consultant for medical affairs at Children's Medical Center of Dallas, agrees. "There should always be a policy in place, and it should also be a case-by-case decision. The policy should outline what triggers will warrant external review," she says. Triggers could be things like potential conflicts of interest or lack of staff members with the expertise needed to conduct a review.

Roberts suggests that a policy should, at a minimum, contain the following:

- Peer review protections clause
- Composition of the peer review committee, committee duties and responsibilities, and quorum requirements
- Circumstances/triggers for internal peer review
- Circumstances/triggers for external peer review
- Committee referral process—how cases get referred to and accepted for review by the committee
- Committee review and notification process—how is review conducted, what notification goes to the provider under review, what are the provider's rights, when can the provider meet with the committee, etc.
- An outline of the process for handling any cases that are deemed to deviate from the standard of care (i.e., possible referral to the medical executive committee for corrective action)
- How nonclinical process issues that may be identified during the course of the review are addressed and whom they're addressed by (e.g., referred to risk management or other appropriate department for follow-through)
- How cases are handled when they do not rise to the level of formal committee review

Ultimately, the decision to use an external peer reviewer should be made by the peer review committee, Roberts says. If there is disagreement amongst committee members, the matter should be referred to the medical executive committee for consideration.

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ment opportunities by assessing the performance of a group of physicians, rather than a single physician. "It doesn't just have to be a punitive assessment of competency, it can actually be an asset to medical staffs. They might be six months into a new set of procedures and may want to know, 'Are we really doing okay?' or, 'If we're doing just okay, how can we be excellent? How can we be world-class?' "

External peer review can be used by a medical staff to assess several facets, says Lefkowits. How are its processes, performance levels, and physician training? Does it have the right equipment? Is it reaching for the right standards? If not, the reviewer can provide opportunities for improvement.

"Our real goal is to provide opportunities for continuous quality improvement, enhancing processes and procedures, additional training, or whatever it may take to elevate the level of care to the best care that's possible. I think if physicians knew that was the goal, they're much more willing to accept feedback and participate in the process in a way that allows their own practice to improve," he says.

Despite this, some hospitals may be hesitant to utilize an external peer reviewer. One reason for this may be budgetary, Rowe says. "If a hospital has a volunteer internal peer review committee, that means they don't have to pay for peer review. This is seen particularly in hospitals that have employed medical staff and have employees that are assigned duties in this area. Whereas with an external peer review organization, if you're not budgeted for it, it can appear very costly, although it is a very small percentage of a hospital's cost."

Best practices for using an external peer reviewer

Beth Dyson-Muskopf, MSHA, CPMSM, director of peer review and medical staff for MDReview, suggests that hospitals should have a peer review policy connected to their medical staff bylaws that outlines when the external peer review is warranted. For more information about external peer review policies, see the sidebar on p. 3.

Teresa Sappington, FACHE, CJCP, CPHQ, CPMSM, a consultant specializing in medical staff affairs and healthcare regulatory compliance, suggests that a hospital and external peer review vendor need to decide in advance the criteria that the review will be based on—either national benchmarks or a benchmark chosen by the hospital or medical staff.

"In some cases the benchmark criteria that the hospital or the medical staff has decided to use exceeds national benchmarks. So if they have a physician

Address new NPDB reporting challenges

The National Practitioner Data Bank (NPDB) quietly updated its guidelines last spring. In the 90-minute webcast, "FPPE and the Revised NPDB Guidebook," expert **Todd Sagin, MD, JD,** will review the new guidelines, which include expanded definitions of "investigations" that can trigger reports to the NPDB. Attendees will also learn what they should report to the NPDB regarding peer review, credentialing, and malpractice actions, plus what medical staff activities truly constitute a reportable investigation. During this webcast, Sagin will provide an overview of the changes and delve deeper into the new requirements that will affect medical staff professionals, including sample NPDB reporting policies, potential changes facilities should make regarding focused professional practice evaluation (FPPE), and how NPDB reporting is applicable to advanced practice professionals (APP) and nonphysicians.

At the conclusion of this program, participants will be able to:

- Inform medical staff members about the NPDB changes that apply to them
- Implement or revise a policy on reporting to the NPDB
- Report FPPE, and other peer review actions, to the NPDB when necessary
- Notify physicians about an investigation or the closure of an investigation
- Handle disputes over reporting to the NPDB
- Prepare medical staff professionals for what the new Data Bank requirements might cause them to encounter

Join us on **Thursday, November 12, at 1:00 p.m. ET** for the live webcast. To learn more or to register, please visit ***http://hcmarketplace.com/product-type/webcast.***

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they're sending out for external peer review, he or she may be far below the hospital's benchmark but within the standard of care, having reached the national benchmark," Sappington says.

Rowe recommends that hospitals routinely and consistently use their external peer review partners in adjunct with their internal peer review committee to overcome sensitivities and to keep peer reviews flowing in a timely fashtion. "You see a big difference between those hospitals that are hesitant to do it and those who do it all the time. Oftentimes we find that the hospitals that are most focused on improving quality of care view external peer reviewers as an integral part of their performance management and peer review processes. And the ones that don't oftentimes seem to struggle more on the quality front."

Hospitals should always have a contract in place with the external peer reviewer that outlines the qualification and competence requirements of the reviewer—education, training, certification, and experience, says Roberts. The contract should also specifically contain deadlines, compensation, and HIPAA and privacy clauses.

The choice of an external peer review partner needs to be an informed and objective decision, says Sappington. Some hospitals within certain geographic

How to select appropriate external peer reviewers

People select their physicians in two ways: prospectively before they are sick or more urgently when a sudden illness occurs. However, very few individuals select all the specialists they might need in case they get sick. This is typically done by choosing a primary care provider who can then guide them in the selection of the right specialist when they need one.

Selecting an external reviewer is similar to selecting your physician. It is wise to have potential external peer reviewers in mind because the need for them can arise without warning. This is typically done by identifying an organization, either another hospital or an external peer review (EPR) company, that can meet your external review needs for whatever types of cases that arise.

What are the characteristics of a good external review organization? The following list may be helpful:

- **Credibility:** A good track record of EPR experience and use of currently active, board-certified, clinical consultants in all specialties.
- **Objectivity:** The ability to ensure that the physician reviewer has no knowledge of or connection to the physician being reviewed. This is typically achieved by using reviewers from other geographic areas. (Note: External peer reviewers do not need to be privileged by the facilities that use their services.)
- **Professional report:** A description of the review methods, record selection mechanism, case-specific findings, and conclusions or recommendations when requested.
- **Timeliness:** Defined typical turnaround time frames that meet your needs and the ability to expedite reports when needed.
- **Ease of interpretation:** The rating system should differentiate between definitive findings and clinical areas in which appropriate treatment is still being debated, and the language should be as specific as possible. Equivocal language that only implies problems leaves the medical executive committee (MEC) with a dilemma. (Note: Although some hospitals request that the external peer reviewers include recommendations in the report, do so only after consulting your attorney. It may be more appropriate for an MEC to arrive at its own conclusions after the report is completed because it must make the final recommendation anyway.)
- **Support:** Assistance with case selection decisions, willingness to participate in conference calls to clarify the report, and the ability to defend and support findings if a subsequent fair hearing or litigation ensues, including testifying.
- **Confidentiality:** The ability to commit to absolute confidentiality and strict nondisclosure. Provisions pertaining to confidentiality should be discussed in advance and included in the contract language.

Source: Effective Peer Review, Third Edition, *by Robert J. Marder, MD.*

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locations may have well-qualified teaching schools with available specialists who can take on individual cases for peer review. Sometimes these hospitals are comfortable doing that, and other times they'll prefer to use a national peer review organization. "That allows for additional objectivity of selection, but it also allows for multispecialty review," says Sappington. "There are instances when cases sent out will need more than one specialty to review the case, so that allows for that multispecialty review within one peer review organization."

For more information about choosing an external peer reviewer, see the sidebar on p. 5.

Case summary

Texas Supreme Court orders hospital to turn over peer review documents

Citing the Texas "anticompetitive action exception" to the peer review privilege, the Supreme Court of Texas (the "Court") ordered a hospital to produce a number of peer review documents.

Miguel A. Gomez, MD, PA, filed a suit against Memorial Hermann Memorial City Medical Center (the "Hospital") in Houston. Gomez practiced at the Hospital from 1998 until 2012, when he resigned his privileges and sued the Hospital and several of its officers, alleging business disparagement, defamation, tortious interference with prospective business relations, and improper restraint of trade under the Texas Free Enterprise and Antitrust Act of 1983 (TFEAA).

According to his complaint, Gomez pioneered the implementation of off-pump and robotic-assisted heart surgeries at the Hospital. He was also the only surgeon at the Hospital capable of performing robotic heart surgeries, which the Hospital had heavily advertised. The Hospital's administration engaged in a campaign to harm his reputation and to discredit robotic heart surgery procedures after he agreed to practice at another hospital, Methodist West Houston Hospital, opening in the area. The alleged goal of the campaign was to retaliate against Gomez and to minimize any advantage Methodist West would gain from its association with Gomez.

Gomez claimed that the campaign against him included rumors around the Hospital that he was having problems with his mortality rate, an end to all promotion or marketing of his speaking engagements, and dissemination of manipulated data and statements regarding his practice and mortality rates to the medical community. This resulted in a loss of

What does this decision mean for you?

Exceptions to the peer review privilege, such as the Texas "anticompetitive action exception," mean that a lot of peer review may become public if sought under such an exception, thereby potentially undermining the goal of the privilege.

The standard for disclosure is very low; there is no evidentiary hearing, and the court must assume that the allegations in the complaint are true for purposes of determining relevance.

In some states, actions alleging discrimination, or actions by a physician against hospitals or physicians other than those claiming the privilege, also may be exempt from the privilege. (In other words, a physician sues Hospital X and Physicians Y and Z, but claims that peer review materials from Hospitals A, B, and C are relevant. Some courts have held that the peer review privilege does not protect Hospitals A, B, and C.)

It seems highly advisable to either seek a protective order from the court to the effect that the peer review material is to be used only for the litigation at hand and is otherwise confidential. If such protective orders cannot be obtained under state law, hospitals and physicians should seek legislation providing that peer review material subject to the exception is otherwise strictly confidential and may not be disclosed except for purposes of the specific litigation.

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referrals from other physicians and his status as a sought-after surgeon.

Finally, Gomez alleged that in January 2012, the Hospital's CEO Keith Alexander, one of the defendants named in the case, publically ridiculed Gomez at a meeting and let the administrators, physicians, and nurses present know that Gomez was targeted because of his affiliation with Methodist West. These actions supposedly served as a preemptive warning to other physicians considering affiliation with Methodist West.

As a result of these actions, Gomez brought suit against the Hospital and asked that it turn over certain peer review documents, which the Hospital argued were protected from discovery by the state's peer review privilege. The trial court inspected the documents, found that the anticompetitive exception to the peer review privilege applied, and ordered the Hospital to produce the documents. The Hospital appealed to the Texas Supreme Court after the court of appeals declined to revisit the issue.

In its decision, the Court held that although the documents requested fell under the protection of the state peer review privilege, the anticompetitive exception applied to many of them. According to Texas Occupations Code § 160.007(b), "If a judge makes a preliminary finding that a proceeding or record of a medical peer review committee or a communication made to the committee is relevant to an anticompetitive action, or to a civil rights proceeding … the proceeding, record, or communication is not confidential to the extent it is considered relevant."

Because Gomez alleged that the Hospital disseminated manipulated data on his mortality rates in order to cause his referral rates to decline and to serve as a warning to other physicians, a number of documents were found to be relevant to his claims of anticompetitive actions. These documents either contained data on mortality rates of cardiovascular surgeons, discussed obtaining or directing others to obtain mortality rates of cardiovascular surgeons, established plans to review mortality data, or referenced appropriate parameters for calculating mortality data.

The Court also found that any documents that discussed physician volume were also relevant to Gomez's claims that he suffered a loss of referrals by providing a baseline to measure the effects of the Hospital's alleged actions. The information contained in these documents could be relevant to Gomez's allegation that the Hospital violated the TFEAA by showing if referrals increased for the Hospital's other physicians.

Other documents were found to be relevant because they discussed the Hospital's plans to differentiate itself from the cardiovascular surgery departments of other hospitals, which would support Gomez's assertion that his unique services formed the motivation behind the Hospital's actions.

However, the Court held that the trial court abused its discretion in compelling the Hospital to produce certain other documents that lacked relevance to Gomez's claims. These included documents in the sealed record that did not discuss mortality rates, physician volume, or referral pattern, nor plans to disseminate the data. The Court directed the trial court to modify its discovery order with regard to these documents.

Source

In re Mem'l Hermann Hosp. Sys., No. 14-0171 (Tex. May 22, 2015).

Case summary

Illinois district court rules that audit trails are not protected by peer review statute

The United States District Court for the Southern District of Illinois (the "Court") rejected a hospital's argument that the state's peer review statute applied to electronic medical record audit trails.

The plaintiff in a medical malpractice lawsuit against Cardinal Glennon Children's Hospital in St. Louis and two physicians (the "Hospital") alleged that she received two different medical charts for a patient during discovery. Believing the medical records may have been edited, the plaintiff, who is the special administrator of the patient's estate, requested the audit trails, which include "a date, time, the name of the person who accessed the

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What does this decision mean for you?

In that there is no generally accepted state or federal definition of the "medical record," it appears likely that courts will conclude that everything in the medical record is a part of the record and therefore is discoverable in a malpractice case.

In this case, the electronically generated audit trail was held to constitute an integral part of the medical record and therefore was not protected from discovery. It is likely that everything else in the electronic medical record will be treated in the same fashion by most courts.

record, their user ID and the action that was taken and the items in the record viewed (or presumably edited)."

The Hospital argued that information included in an audit trail should be protected by the peer review privilege because it would include the names of any peer review committee members who viewed the record and what they looked at.

The Court found that the peer review privilege did not apply because the audit trail is an integral part of the medical record, and the entire record is discoverable in a malpractice action.

In addition, the court noted that the identities of members of peer review committees are not confidential.

The Court wrote, "[The audit trail] does not contain any information regarding the discussions that were held during the peer review committee meeting and there is no evidence that the peer review committee even looked at the audit trail during their discussions. The audit trail is not interviews or memoranda, or even minutes of any meeting." Furthermore, the audit trail is automatically generated during the ordinary course of the Hospital's business, not specifically for the peer review committee's use.

The Hospital also argued that some information included in the audit trail would be protected by the work product privilege, which, according to the Federal Rules of Civil Procedure, protects "documents and tangible things that are prepared in anticipation of litigation or for trial" from disclosure, such as the activities of its risk management department and of the defendants' representatives after the plaintiff requested the chart.

The Court dismissed this claim, noting that the audit trail was not prepared in anticipation of litigation, but "is a part of the electronic medical record and is automatically generated."

Source

Hall v. Flannery, Case No. 3:13-cv-914-SMY-DGW (S.D. Ill. May 1, 2015).

These case were reviewed by Michael Eisner, Esq. *(meisner@jmeisner.com)* of Eisner & Lugli, of New Haven, Connecticut. Case summaries are prepared for informational purposes only and should not be considered legal advice.

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