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Outpatient Spinal Fusion Is Added to PEPPER; Three Areas Are Dropped

By Nina Youngstrom

The spinal fusion target area in the Program for Evaluating Payment Patterns Electronic Report (PEPPER) now includes outpatient claims as well as inpatient claims, a nod to the fact that far more of the procedures are performed on outpatients now that they're off the inpatient-only list.

That's one of the changes in the latest quarterly release of PEPPER for short-term, acute-care hospitals, said Karen Sabharwal, a senior data analyst with TMF. It also lost some target areas: emergency department (ED) evaluation and management (E/M) services and admissions for chronic obstructive pulmonary disease (COPD) and excisional debridement.

PEPPER, which is generated for CMS by RELI Group Inc., is a free comparative report on billing rates in certain medical necessity and coding target areas. The purpose of PEPPER is to help hospitals point their compliance monitoring in more productive directions. The data is specific to each hospital, comparing the hospital's billing statistics for target areas to other hospitals in the nation, Medicare administrative contractor jurisdiction and state. It's a red flag when a hospital's billing in a target area is at or above the 80th national percentile, which means it bills a higher percentage for that target area than 80% of all hospitals nationally. There may not be a compliance problem, but it's up to the hospitals to sort that out.

Spinal fusion inpatient claims were first added to PEPPER in 2012 when the procedure was on the inpatient-only list, Sabharwal said. The driving force was a 2010 article in the Journal of the American Medical Association by researchers from the Oregon Health and Science University.[1] They reported a sharp increase in the frequency of complex fusions for spinal stenosis, which was associated with greater risk of major complications and 30-day mortality compared to decompression.

"They were trying to caution surgeons to weigh fusions cautiously," Sabharwal said. "That's why we created the fusion target area."

Outpatient spinal fusions also require prior authorization from Medicare when performed by hospital outpatient departments. "The fact that cervical spine fusion was added to the prior authorization list indicated concern for overutilization," Sabharwal said. "That gave us more evidence we needed to consider adding outpatient claims to the targeted area."

The PEPPER reports on the ratio of spine fusions compared to all spine surgeries, said Ronald Hirsch, M.D., vice president of R 1 RCM. Until now, surgeons could avoid scrutiny by scheduling their spinal fusions as outpatient surgery, Hirsch said. "It would never appear as an outlier," he noted. "Now that loophole has been eliminated." If a hospital has a high percentile of spinal fusion cases, it should have someone review the documentation to ensure the fusion was medically necessary.

A spinal fusion might pay $30,000 to $50,000 compared to a laminectomy, for example, that reimburses $15,000, Hirsch noted. "The message to hospitals is if you have a high number of spinal fusions, you want to

review your physician's documentation to ensure it clearly explains why a fusion is necessary as opposed to a 'lesser' surgery."

According to the PEPPER user's guide, "medical record documentation of 1) previous non-surgical treatment, 2) physical examination clearly documenting the progression of neurological deficits, extremity strength, activity modification, and pain levels, 3) diagnostic test results and interpretation, and 4) adequate history of the presenting illness, may help substantiate the necessity of the procedure."[2]

Hospitals Audit Based on Data Trends

Hospitals use PEPPER longitudinally because data points from a single quarter may not reveal much about their billing compliance. An outlier "could just be episodic—the luck of the draw for that particular quarter," said the compliance auditor for a health system, who prefers not to be identified. That's why the health system looks at whether target areas are "trending up" at any of its hospitals using the graphs in its PEPPER. If a target area is above the 80th percentile two quarters in a row, "it automatically goes on the work plan," he said. There are exceptions. For example, PEPPER only includes hospitals in a target area if they have a minimum of 11 claims. But if one of its hospitals had 12 claims that quarter, "we aren't going to devote resources to it" because the population of claims was still so low. Also, the health system doesn't necessarily worry when sepsis is an outlier on PEPPER because it uses different diagnosis criteria than Medicare, a common and controversial situation. "We did an audit previously and found we are consistent with our criteria," he said. "We keep an eye out for it" but sepsis won't go on the work plan. Stroke and intracranial hemorrhage, however, which was up two quarters in a row, landed on the work plan and an audit is in progress.

The compliance auditor isn't losing any sleep over the addition of outpatient spinal fusion claims to PEPPER because the documentation requirements are the same as when spinal fusion was on the inpatient-only list. The health system "did some internal reviews on medical necessity in the past and those looked pretty good," added the compliance officer. The reviews also looked at inpatient versus observation and they were favorable as well. "Case Management is pretty good in this area when something comes off the inpatient only list, like total knee replacement," the compliance officer said.

The health system has developed a grid for more of a bird's eye view of the status of target areas in its hospitals.[3]

At Lifespan, an academic health system in Rhode Island, collaboration drives the PEPPER response, said Donna Schneider, vice president of compliance and internal audit. "We started an interdisciplinary team" with compliance as the facilitator. The team includes the clinical compliance auditor, patient financial services, the director of utilization review, a revenue compliance team member, case management and the director of clinical appeals. The team wouldn't dig into a target area until it's above the 80th percentile in two quarters. But sometimes outliers are just a function of low volumes, Schneider noted. "That's why I always like to have everybody at the table with expertise to look at it," she said. "It's really about collaboration."

COPD, ED E/Ms Dropped; Data Has Less Value

In other PEPPER developments, TMF dropped three target areas from the latest release. TMF received feedback last year that there were too many of them and decided to scale back, Sabharwal said. ED E/M services made the hit list for a few reasons: there are no CMS-approved national standards for assigning ED facility E/M levels of service; people are confused by E/M levels for hospital resource use because physicians also assign E/M levels for their services in the ED; and it's a low-dollar service "so we thought it would have less value for a hospital than" data on readmissions or malnutrition, for example.

TMF also cut COPD from PEPPER "because its error rate has gotten very low," said Annie Barnaby, outreach and education specialist at RELI Group. "My assumption is there's more information out there about COPD and doctors are learning more about it and maybe there are simplified treatments that can be used by patients instead of coming" to the hospital. The third target area eliminated is excisional debridement. Sabharwal attributed that to the fact it's largely an outpatient procedure now and no longer relevant in terms of admission PEPPER data.

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1 Richard A. Deyo, Sohail K. Mirza, Brook I. Martin, William Kreuter, David C. Goodman, and Jeffrey G. Jarvik, "Trends, Major Medical Complications, and Charges Associated With Surgery for Lumbar Spinal Stenosis in Older Adults," *Journal of the American Medical Association* 303, no. 13 (April 7, 2010), http://bit.ly/3m1JSlw.
2 PEPPER, *User's Guide: Thirty-Second Edition*, effective with the Q4FY20 release, last accessed March 30, 2023, https://bit.ly/40r4L8J.
3 Nina Youngstrom, "Grid for Monitoring Program for Evaluating Payment Patterns Electronic Report (PEPPER) Target Areas," *Report on Medicare Compliance* 32, no. 13 (April 3, 2023).