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Navigate the Compliance Universe

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Adding some spice to your compliance program

by Ronald Hirsch MD, FACP, CHCQM, CHRI

Every quarter, each acute care hospital that is paid under the Inpatient Prospective Payment System has access to an Excel workbook that contains valuable information about your hospital's compliance with myriad Medicare rules and regulations commonly known as the "PEPPER" (formally known as the Program for Payment Patterns Electronic Report). Other healthcare facilities—including critical access hospitals, inpatient rehabilitation facilities, skilled nursing facilities (SNFs), and more—receive a PEPPER every year. This report contains comparative data on discharges and services vulnerable to improper payments. Before I discuss the usage of this report, I am obligated to point out the most common error in the use of this report is calling it the PEPPER "report." As you can see, the "R" in PEPPER stands for report, so calling it the PEPPER report is redundant.

Not only does the report provide improper payment risks, but it also provides information about where the provider is potentially leaving compliant revenue on the table due to undercoding. Despite the clear value such data could provide, a significant proportion of providers never retrieve their PEPPER.[1] Imagine having access to such information and not using it. Why does this happen? It is likely multifactorial.

First, the PEPPER must be retrieved and is not automatically distributed to providers. Then once the report is obtained, the report itself can be intimidating. The Excel workbook has 56 tabs, each with 30 to 50 lines of information. Because it can be so overwhelming to interpret, I often refer to the PEPPER as data-rich and information poor. So, allow me to provide some guidelines to help one make the best use of the PEPPER.

First, ignore the tab labeled "outlier rank." It provides no information that is not present on other tabs. In addition, it only indicates areas where the hospital is a high outlier and not a low outlier.

Use the topic titles with caution

Second, do not trust the "target area" titles, as many can be misleading. For example, the target area entitled "respiratory infections" is actually measuring the number and percentage of patients with complex cases of pneumonia, such as aspiration pneumonia or gram-negative bacterial pneumonia, and "Perc CV Px" measures the percentage of patients who have a cardiac stent placed as inpatient. Referring to the "definitions" tab and the corresponding descriptor of the numerator and denominator is crucial.

On the other hand, it is simple to ascertain that the measure "Med CC MCC" measures the percentage of your medical inpatient admissions that are billed with a CC (complication or comorbidity) or MCC (major complication or comorbidity) on the claim. Similarly, the "3-day SNF" measure is self-evident; it measures the number of patients who were transferred to a SNF after a three-day inpatient hospital stay.

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PEPPER caveats

When reviewing the PEPPER, it is important to keep in mind several caveats. The data only represents Medicare fee-for-service patients. As more Medicare beneficiaries migrate to Medicare Advantage plans, the PEPPER data loses some of its value. The PEPPER data is "old" in that each report is released six months after the end of that quarter. As a result, in winter, you will be looking at data for patients who were hospitalized the previous spring. Knowing this is also crucial if you undertake any performance improvement projects, as the results of those efforts will not show up on the new PEPPERs for a year.

Being an outlier is not an admission of guilt

The PEPPER reports data on the hospital's performance in each measure compared to all other hospitals in your state, your Medicare administrative contractor's jurisdiction, and the nation. In no way does it tell you if you are doing things improperly. A hospital that provides complex specialty services such as transplant, surgical oncology, and interventional cardiology will inherently have more complex patients than a small community hospital without such services and should have a higher percentage of patients with CCs and MCCs. Each measure, therefore, needs to be evaluated based on that hospital's patient population. In addition, the PEPPER uses the outlier range of 20% at the high and low ends. If you ask a statistician what percent should be used for an outlier range, they will likely tell you 2.1%.

As the data is interpreted, instead of asking what the hospital is doing wrong, they should ask if the data accurately represents their patient population.

Know where to look

For the compliance officer with more tasks than time, reviewing all 26 measures and 56 tabs in depth is unlikely, so where should the precious time be spent? Start with the "compare" tab, where every measure is listed with the hospital's total number of discharges in that target area, along with the hospital's percentile ranking. It also conveniently labels high and low outliers with red or green, respectively.

A glance at each "graph" tab can also provide a quick view of the hospital's performance along with presenting three years of past data. If the hospital's performance was always below the outlier limit but one quarter is above, it may warrant less attention than the measure where the hospital is consistently above the 80th percentile.

For each high outlier that warrants review, assess the number of cases and the percentile. If an outlier area has 11 admissions and is at the 82nd percentile, it has a lower priority than an area with 120 admissions at the 94th percentile. Read the definition to understand what is being measured and determine who can assist in performing a review. For instance, an outlier in "DRGs (diagnosis related groups) with CC or MCC" should be referred to the clinical documentation staff to review a random selection of cases to ensure all coded CCs and MCCs are clinically supported, and the "Perc CV Px" should be referred to the cath lab manager to ensure that physicians performing elective cardiac stents are not admitting their patients as inpatient. Many of the measures refer to specific DRGs, so make use of your clinical documentation and coding colleagues liberally to understand the difference, for instance, between DRG 064 (intracranial hemorrhage or cerebral infarction with MCC) and DRG 067 (nonspecific cerebrovascular accident and precerebral occlusion without infarction with MCC).

Enlist the help of your physician advisor

A high percentage of "spinal fusion" should be referred to the physician advisor to review documentation to support the medical necessity of a spinal fusion was present. Spinal fusion is a more complex surgery with a

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higher reimbursement, so ensuring that a spinal fusion was necessary as opposed to a less complicated, lower reimbursed surgery is warranted.

Likewise, a high percentage of one- and two-day inpatient admissions should be referred to the physician advisor to ensure the physician chooses the correct admission status. At first glance, one might question why a two-day inpatient admission is potentially noncompliant, as the Two-Midnight rule specifies that a patient who passes two midnights in the hospital should be admitted as inpatient. But the caveat is that these two midnights must each be medically necessary. A large number of two-day inpatient admissions may suggest that patients who could safely be treated as outpatients with observation services are being admitted as inpatients due to delays in care, convenience issues, or simply the desire of the physician to "stretch out" the care to qualify the patient for inpatient admission. None of these would be compliant.

Physician advisors should also be asked to review "total knee replacement" cases if the percentage performed as inpatient is high. This surgery was removed from the Medicare Inpatient Only list in 2018 and, as a result, can be performed as inpatient only if inpatient admission is clinically justified and well documented. If that justification is not present, processes should be undertaken to improve the status determinations in this surgery.

Valuable readmission data available

While compliance may not be directly involved with readmissions, the data on the PEPPER can provide some valuable insights. The report not only includes the number of readmissions in the quarter, but it also breaks down the readmissions into any hospital and the same hospital. This allows a hospital to determine what percentage of patients who had their index admission at their hospital were readmitted to another hospital or returned to them. However, there are many other explanations; a high percentage of patients whose readmission was at another facility might suggest that they were unhappy with their care during the index admission and chose to go elsewhere when they once again required hospital care.

The PEPPER and measuring quality

Another area that compliance may want to review is "single CC or MCC." This is the percentage of claims that only had one CC or MCC. While some patients will only have one CC or MCC, it would be essential to ensure that coders are not coding charts, capturing one CC or MCC, and then moving on to the next chart. This would potentially leave off diagnosis codes that, while not resulting in additional revenue, would be important for the many quality programs that rely on diagnosis codes for risk stratification. While not a compliance issue, the presence of only one CC or MCC makes the chart a compelling target for auditors who realize that if they can determine that the one CC or MCC is clinically invalid, they can remove it from the claim and save the payer thousands of dollars.

It is worth noting that the issues reported in the PEPPER are reviewed periodically, with additions and removals as warranted. The 2022 Quarter 4 report no longer contains data on "excisional debridement" or "emergency department evaluation and management" coding, and the "spinal fusion" measure was updated to include both inpatient and outpatient procedures now that Medicare has removed several of the spinal fusion codes from the inpatient only list.

The PEPPER is a valuable tool for targeting compliance efforts, yet its complexity often leads to underuse. Taking the time to understand the PEPPER and reviewing it quarterly is crucial for all compliance professionals. While not all areas were covered in this article, understanding these areas will assist you to better understand the others.

Takeaways

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- The PEPPER (formally known as the Program for Payment Patterns Electronic Report) is data-rich but information-poor—until you learn to interpret it.
- Enlist your partners in clinical documentation and coding and your physician advisor to help.
- Being an outlier is often acceptable—no two hospitals have the same patient population.
- Remember, the data is old and won't reflect your process changes for months.
- Short of time? Review the "compare" tab and the graphs for a quick overview.

1 Program for Evaluating Payment Patterns Electronic Report, "ST PEPPER Retrievals – PEPPER Resources Portal," accessed March 21, 2023, https://pepper.cbrpepper.org/Training-Resources/Short-term-Acute-Care-Hospitals/PEPPER-Portal-Retrieval-Map.

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