Spinal fusion procedures are attracting attention from CMS, and the focus is on their medical necessity. The next round of the Program for Evaluating Payment Patterns Electronic Report (PEPPER) will flag the short-term acute care hospitals that may be performing more than their fair share of spinal fusion procedures. But it will require a different kind of scrutiny than other PEPPER coding and admission necessity targets. Because most spinal-fusion procedures are performed on an inpatient basis to qualify for Medicare reimbursement, hospitals have to evaluate whether patients needed them at all.

“This target area is different from most other admission target areas because we are not just asking hospitals to question whether the patient needed to be admitted. It’s deeper — it’s whether the patient needed the procedure, and if the patient didn’t need the procedure, the admission most likely is not medically necessary,” says Kim Hrehor, project director for TMF Health Quality Institute, which generates PEPPERS for CMS.

Medicare requires physicians to document more conservative treatments, such as physical therapy, before ordering spinal fusion, an expensive surgery that may have serious repercussions. “It’s not to say these surgeries are not necessary. But with anything — knee replacement, hip replacement — you would hope physicians would try the conservative route first without jumping into surgery,” she says.

PEPPERS are free comparative electronic reports on billing rates in certain risk areas that are provided quarterly to all short-term acute-care hospitals and other types of facilities. The purpose of PEPPERS is to help hospitals focus their compliance monitoring on outliers unique to their facilities. Targets are based partly on RAC findings.

The decision to make spinal-fusion procedures a PEPPER target in the next release, which is slated for Feb 24, is the culmination of recent revelations about the procedures. For one thing, the Journal of the American Medical Assn. on April 7, 2010, published a study citing a 15-fold increase in complex fusion procedures performed on Medicare beneficiaries between 2002 and 2007. It also noted that “in 2007, compared with decompression, simple fusion and complex fusion were associated with increased risk of major complications, 30-day mortality, and resource use.” An earlier study by the Dartmouth Atlas of Health Care reported that “fusion rates more than doubled, from 0.2 per 1,000 Medicare enrollees in 1992 to 0.5 in 2003” — while the rates of non-lumbar spine procedures stayed flat.

CMS and PEPPER officials realized the potential for hospitals to use PEPPERS to determine whether their spinal fusion rates are out of line, and if so, whether there are underlying problems with their procedures. Traiblazer Health Enterprises, a Medicare administrative contractor, has already audited both hospital and physician claims for a spinal fusion MS-DRG 460 (see box, below). Medicare pays hospitals about $31,000 for spinal fusions and surgeons about $12,000.

With the addition of spinal fusion, there will be 30 PEPPER targets for short-term acute care hospitals, including risk areas for admission-necessity (e.g., syncope, one-day stays for chest pain), and coding (e.g., excisional debridement and septicemia). PEPPER alerts hospitals that are outliers in any of the targets.

An outlier hospital is at or above the 80th percentile, which means it bills Medicare more often for that target than 80% of all hospitals in its MAC jurisdiction. PEPPERS, which also compare hospital billing to other hospitals in the state and nation, make no value judgments; it’s up to the hospital to review medical records and determine whether outliers indicate the hospital has a compliance problem or there’s a reasonable explanation for the billing rate.

PEPPER percentiles are based on a fairly straightforward calculation, Hrehor says (RMC 5/9/11, p. 5). The numerator is the total number of claims your hospital submitted the previous quarter for a particular risk area (e.g., MS-DRGs for medical back problems). The denominator is based on the same claims during the same period, but TMF uses a bigger piece of the hospital billing pie (e.g., all medical MS-DRGs in major diagnostic category 8, which is musculoskeletal and connective tissue).

To come up with percentiles for hospital spinal-fusion procedures, TMF couldn’t use all relevant MS-DRGs because some encompass other kinds of spine and back surgeries. And spinal fusion is just a horse of a different color. Most PEPPER targets are based on an MS-DRG cluster or the medical necessity of an admission versus outpatient surgery/observation. This time, the site of service is sec-
Spinal fusion is one of those risk areas that activates more coordination between compliance, quality improvement and the medical staff, Hambleton says. “From a compliance perspective, we may be able to confirm that documentation supports the fact we billed it, but that is a different question from whether the patient needed the procedure. That requires a higher level of clinical expertise,” she says.

For their part, however, compliance officers will focus on safeguarding peer review, credentialing and quality improvement procedures, Hambleton says, as well as tracking quality trends, education and disciplinary actions. For example, “if I am getting medical necessity rejections or there are complaints through the hotline about surgeons doing medically unnecessary procedures or the number of services provided [has increased], then I need to work with quality improvement and medical staff people to find out why. We have to rely on the expertise of those we have charged with evaluating physician practices and quality of care. Have we established parameters to make them effective and ensure they are monitoring, with the overlay that compliance will continue to monitor documentation?” she says.

Spinal fusion is also a target of proposed prepayment audits by Medicare administrative contractors, says physician Paul Weygandt, vice president of physician services for J.A. Thomas & Associates. There’s an expectation that conservative approaches to treatment have been exhausted before physicians take the procedural route, and that documentation will demonstrate appropriate medical necessity, he notes. Documentation should “tell a good story that anyone can understand substantiating the medical necessity of the procedure for that particular patient,” Weygandt says.

Suppose the physician has treated the patient for two years for back pain and leg problems, but medication and injections aren’t working. “The physician knows why the patient requires surgery and the procedure is legitimate, but the physician may not incorporate the outpatient notes into the inpatient record, so the documentation is thin and the reviewer is left wondering why the patient needed surgery,” Weygandt says.

Spinal fusion MS-DRGs 458 and 460 are on the hit list for the RAC prepayment reviews announced by CMS in November. Although CMS has postponed them for now (RMC 1/8/12, p. 1), the prepayment review demonstration is expected to move forward eventually. “It’s very likely that CMS drew upon the experience of Trailblazer, which independently did post-payment audits for both Part A and physician payment for DRG 460.”

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