Short-Term Acute Care Hospital PEPPER Review Webinar Questions and Answers

Sept. 10, 2020

Q: Is QualityNet being phased out?

A: QualityNet will be operational through November 2020.

Q: When the Program for Evaluating Payment Patterns Electronic Report (PEPPER) distribution method changes, how can I be sure that I am able to receive PEPPERs moving forward?

A: Join the email list at PEPPER.CBRPEPPER.org to receive email notifications related to changes in PEPPER distribution.

Q: Please define the NPPES and PECOS acronyms.

A: At this time, the new method for distributing the PEPPERs has not been confirmed. If the PEPPER distribution is moved to the PEPPER Portal, the PEPPER Team may email the validation code necessary to access the PEPPER to the provider contact listed in the National Plan and Provider Enumeration System (NPPES) or in the Provider Enrollment, Chain, and Ownership System (PECOS).

Q: In the PEPPER, how is a hospital compared to its peers? Are all acute care hospitals lumped together, or is there filtering based on size, whether a hospital is a teaching facility or a non-teaching facility, etc.?

A: In the PEPPER, the national, jurisdiction, and state comparison groups include all hospitals. There is no filtering based on size, teaching status, or any other characteristic. The PEPPER Team produces peer group bar charts that allow hospitals to compare their PEPPER statistics to those of their peers. For each of the target areas, the peer group bar charts identify the 20th, 50th, and 80th national percentile for hospitals in four categories:

- Location (i.e., urban or rural)
- Ownership type (i.e., for profit/physician owned, nonprofit/church, or government)
- Teaching status (i.e., major teaching, other teaching, or non-teaching)
- Surgical focus (i.e., surgical or other)

The peer group bar charts are updated annually; they are available on the "Data" page on the tab for short-term acute care hospitals at PEPPER.CBRPEPPER.org.

Q: How can I access the peer group bar charts?

A: The peer group bar charts are available on the "Data" page, on the tab for short-term acute care hospitals at PEPPER.CBRPEPPER.org. The bar charts are updated annually.

Q: If a hospital has one quarter of high outlier status, would you recommend an audit? Should the hospital audit if there are three of four quarters that are "high," and what about if there are two of four quarters, four of four quarters, etc.?

A: There are a number of factors to think about when considering whether to conduct an audit. When there are increases or decreases in the target area percent over time, consider factors that could contribute to these changes, including the following:

- Changes in the provision of specialized services/treatments
- Changes to the medical staff composition
- Changes in coding or billing staff
- Implementation of a clinical documentation improvement program
- Changes in diagnosis-related groups (DRG) assignment related to the final Inpatient Prospective Payment System (IPPS) final rule, which are implemented in the first federal quarter of each fiscal year
- Changes to Medicare payment policy (e.g., two-midnight rule)
- Referral sources
- Changes in the external health care environment (e.g., opening/closing of hospitals or other health care providers)

Hospitals that are high or low outliers in target areas are encouraged to collaborate internally and share the PEPPER with others to explore pertinent factors that may explain their statistics. Outlier status is not an indication that the hospital is doing anything wrong/improper. However, if the PEPPER statistics do not reflect what the hospital expects to see or if there is a potential concern related to coding/billing accuracy or admission necessity, an audit of medical records and submitted claims may be recommended.

Q: If our jurisdiction percentile is 100 for a target area, does that mean we have the highest target area percent of all hospitals in the jurisdiction?

A: Yes. If a hospital has a percentile of 100 on the Compare Targets Report, it means that the hospital has the highest target area percent when compared to all hospitals in the comparison group (i.e., nation, jurisdiction, or state)

Q: How does PEPPER impact Maryland waiver hospitals? For the comparison groups, are Maryland waiver hospitals compared to other Maryland waiver hospitals for the state, Medicare Administrative Contractor (MAC) jurisdiction, and national comparison groups?

A: There are no special provisions for Maryland waiver hospitals considered in the PEPPER. Based on the "Jurisdictions" spreadsheet — which identifies the total number of hospitals in each MAC jurisdiction in total and by state — for the Q2FY20 release, all 47 Maryland hospitals are in the JL Novitas MAC jurisdiction, along with 229 hospitals from other states. If you are a waiver hospital, the state comparison group may be more applicable for you.

Q: Is there a threshold we should consider for the sum of payments when trying to determine whether we should audit a target area for which we are identified as a high outlier in the PEPPER?

A: There is no threshold related to the sum of payments when considering when to audit a target area for which a hospital is a high outlier. In general, consider your hospital's percentile (the greater the percentile, the greater the potential concern) and the total amount of Medicare reimbursement when prioritizing areas for further review.

Q: How should we audit target areas for admission/medical necessity and maintain compliance with disclosure to Centers for Medicare & Medicaid Services (CMS) when we identify that an admission is not medically necessary?

A: During a focused review conducted after discharge, if an admission is determined to not be medically necessary, the prudent next step would be to submit an adjusted claim that identifies the hospital as liable for the claim (i.e., "provider-liable"). Services that are eligible for Medicare Part B reimbursement may be submitted. This guidance can be found in *Medicare Learning Network (MLN) Matters® Number MM11181* and "Chapter 4, Section 240" of CMS' *Medicare Claims Processing Manual (Pub. 100-04)*. Hospitals are encouraged to coordinate internally — with their compliance and/or legal departments, for example — to determine whether self-disclosure may be indicated.

Q: Can you provide patient-specific data for a particular target area?

A: The PEPPER Team is not able to provide patient-specific data.

Q: Why is there data for nation, jurisdiction, and state on the graph worksheet for the *Percutaneous Cardiovascular Procedures* target area when our hospital does not perform these procedures?

A: If a hospital does not have sufficient data for the PEPPER to display statistics for a target area — the term "reportable data" means that the numerator or denominator count is at least 11 for a target area and time period — the data table will have blank cells and the graph will not display the blue bars that represent the hospital's target area percent. The graphs will display the 80th percentile

values for the nation, jurisdiction, and state regardless of whether the hospital has reportable data. The 80th percentile values for the comparison groups are the red trend lines displayed on the graph.

Q: Regarding the last 12 quarters of statistics, is this referring to the National High Outlier Ranking Report and the target area worksheets?

A: Each release of PEPPER summarizes Medicare claims data for the most recent 12 federal fiscal quarters. For example, the Q2FY20 release summarizes the most recent 12 federal fiscal quarters, which ranges from the third quarter of federal fiscal year 2017 through the second quarter of federal fiscal year 2020. The federal fiscal year begins on Oct. 1 and ends on Sept. 30 of the following year.

Q: The *Spinal Fusion* target area is not admission-related; rather, it is related to the medical necessity for the spinal fusion regardless of admission status, is it not?

A: The *Spinal Fusion* target area is classified in the PEPPER as an admission necessity target area. The focus of the target area is whether the spinal fusion procedure was medically necessary. If the patient was admitted for the spinal fusion procedure only and the spinal fusion procedure was found to not be medically necessary, then the admission would also be found to not be medically necessary.

Q: The Medicare Spending per Beneficiary by Claim Type Report is from 2018. Is this report updated and, if so, how frequently?

A: The Medicare Spending per Beneficiary by Claim Type Report is updated on an annual basis for the most recent year available, which is calendar year 2018 currently. Please see the *Short-Term (ST) Acute Care PEPPER User's Guide* for additional information.

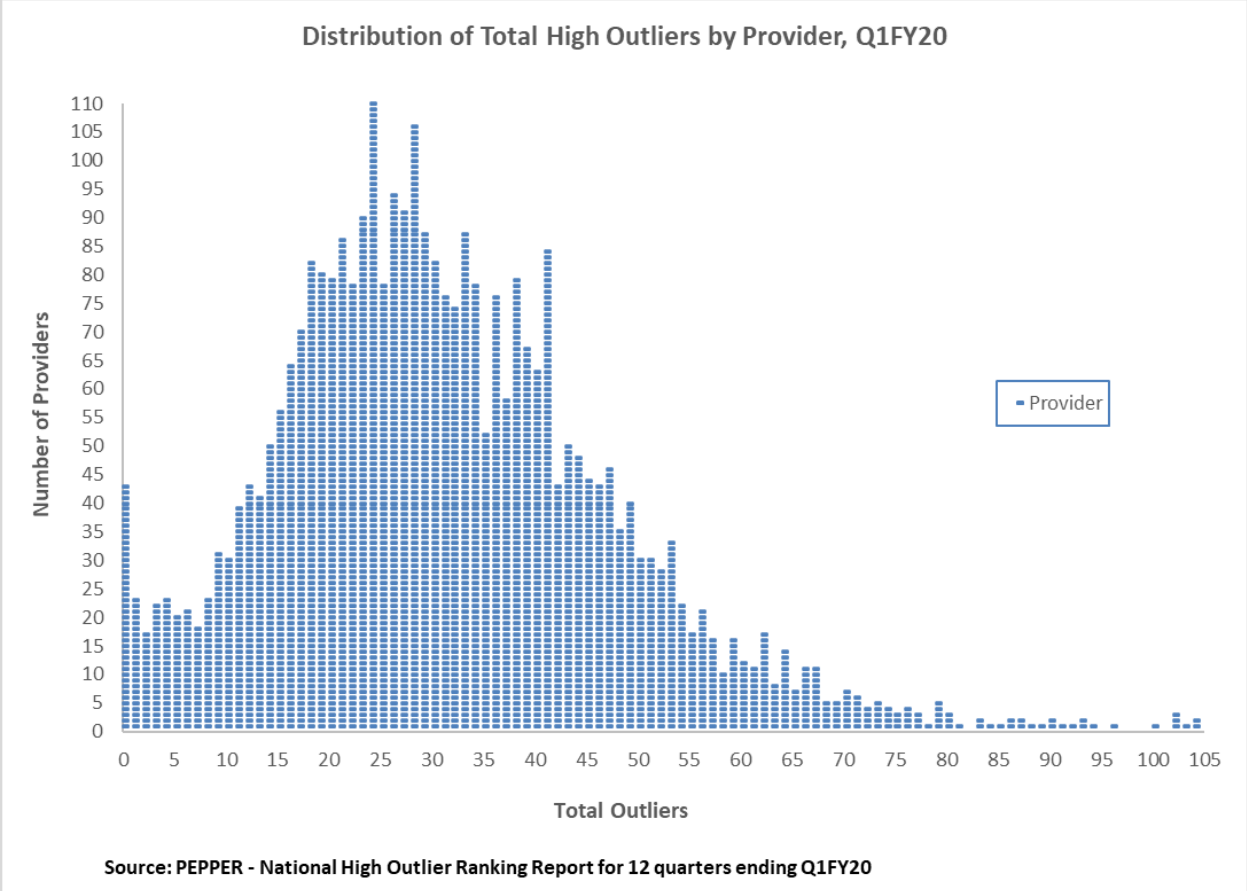
Q: Regarding the *Single CC or MCC* target area, why do I see changes in our numerator and our denominator counts following the revision?

A: An audit of target area statistical programs identified an issue with the programming logic for the *Single CC or MCC* target area. This issue was corrected and made effective with the Q4FY19 *ST PEPPER* release. Most providers observed an increase in their target discharges and a decrease in the denominator discharges. The previous logic evaluated the count of complications or comorbidities (CCs) and major complications or comorbidities (MCCs) for DRGs, whether the DRG was assigned on the basis of a CC, an MCC, or either CC or MCC. The revised logic evaluates three distinct scenarios: 1) the count of CCs for DRGs assigned on the basis of a CC; 2) the count of MCCs for DRGs assigned on the basis of an MCC; and 3) the count of CCs and MCCs for DRGs assigned on the basis of a CC or MCC. The claims most likely to be missed in previous reports for the target discharges were those for DRGs assigned on the basis of an MCC. The claims most likely to be

incorrectly included in the denominator were those for a DRG where the description contained "w/o CC" or "w/o MCC" and there was an otherwise valid CC or MCC.

Q: The National High Outlier Ranking Graph display hospitals' total number of high outliers, as well as the frequency (i.e., number of hospitals) that have a specific number of total high outliers. Why does the graph list the total outliers more than once? For example, 102 is listed twice with different frequencies.

A: The Distribution of Total High Outliers by Provider, Q1FY20 graph shared during the webinar shows that there are 43 hospitals that have no high outliers for any of the target areas for the most recent 12 quarters, and there are two hospitals that have 105 high outliers. There is one hospital with 104 high outliers, three hospitals with 103 high outliers, etc. The graph is intended to give hospitals further context regarding the number of other hospitals that might have the same number of total high outliers, as well as the overall distribution of hospitals' total high outliers.



Source: PEPPER - National High Outlier Ranking Report for 12 quarters ending Q1FY20

Q: Will there be updates to PEPPER related to the CY2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule change that eliminates the inpatient only list starting with the musculoskeletal services?

A: The target areas in the PEPPER are evaluated annually for continued relevance, as well as to determine whether changes/revisions may be indicated. New target areas may be considered based on changes related to Medicare payment policy.

CMS has approved the addition of a new target area related to inpatient total knee arthroplasty (TKA). Effective on Jan. 1, 2018, TKA procedures were removed from CMS' inpatient only list, allowing TKA procedures to be performed on an inpatient or outpatient basis. While the decision to admit a patient as an inpatient is a complex medical decision — based on the physician's clinical expectation of how long hospital care is anticipated to be necessary and the individual beneficiary's unique clinical circumstances — there is a financial incentive to admit beneficiaries receiving TKA procedures as inpatients. This new target area will help hospitals monitor the delivery of TKA procedures. The PEPPER Team anticipates this new target area will be implemented in the Q3FY20 PEPPER.