New PEPPERs Refine Short-Stay Targets; Pneumonia/COPD Change May Affect Data

When hospitals open the new Program for Evaluating Payment Patterns Electronic Report (PEPPER), they will find that the risk areas have been revamped again in the CMS compliance monitoring tool. The number of short hospital-stay targets has been reduced and occurrence span code 72 has been dropped in response to the two-midnight rule. The goal of the changes is to make the data more helpful, according to the project director of the PEPPERs.

The changes appeared in the March 3 release of the PEPPERs, which are free comparative reports on billing rates in certain medical necessity and coding risk areas. “We felt the data would be more useful for hospitals if we combined same-day stays and one-day stays,” says Kim Hrehor, project director for the TMF Health Quality Institute, which generates PEPPERs for CMS. “We found there are smaller numbers of hospitals that have significant numbers of same-day stays so we decided to merge them into the one-day target areas.” Forthcoming PEPPERs for critical access hospitals and inpatient psychiatric hospitals, which also are subject to the two-midnight rule, will have the same changes in the short-stay target areas, Hrehor tells RMC.

Meanwhile, on the coding side of the PEPPERs, an important clarification from Coding Clinic on pneumonia has not shown up yet in the data. It’s something hospitals should keep an eye on, says Amy Gendron, director of clinical and regulatory compliance at Trinity Health in Livonia, Mich.

PEPPERs are provided quarterly to all short-term acute-care hospitals and annually to long-term acute-care hospitals, critical access hospitals, inpatient psychiatric facilities, inpatient rehab facilities, hospices, home health agencies, skilled nursing facilities and partial hospitalization providers. The purpose of PEPPERs is to help hospitals point their compliance monitoring in more productive directions—toward outliers, which could mean overpayments or underpayments depending on the reason billing is outside the norm (RMC 2/6/12, p. 1).

The PEPPER data is unique for each hospital. It compares the hospital’s performance on risk areas to other hospitals in the nation, Medicare administrative contractor (MAC) jurisdiction and state, Hrehor says. It’s a red flag when a hospital’s billing in a target area is at or above the 80th percentile, which means it bills a higher percentage for that target area than 80% of all hospitals nationally. That doesn’t necessarily mean there was an error, but it’s up to the hospitals to determine whether there’s a compliance issue or some reasonable explanation.

PEPPERs were updated in 2014 in the wake of the two-midnight rule’s debut (RMC 5/19/14, p. 1). TMF eliminated the DRG-specific target areas for short-stay admissions, such as two-day stays for heart and renal failure, and replaced them with six target areas: two-day stays for medical MS-DRGs, two-day stays for surgical MS-DRGs, one-day stays for medical MS-DRGs, one-day stays for surgical MS-DRGs, same-day stays for medical MS-DRGs and same-day stays for surgical MS-DRGs.

The March 3 release sticks to this format but the target areas are consolidated, Hrehor says. There are now four target areas for short stays: two-day stays for...
medical DRGs, two-day stays for surgical MS-DRGs, one-day stays (including same-day stays) for medical MS-DRGs and for one-day stays for surgical MS-DRGs. “With only about 1% of hospitals having data for the same-day stays for surgical DRGs and 14% for the same-day stays for medical DRGs, the decision was made to merge same-day stays into the one-day stays,” Hrehor stated. Hospitals are still able to identify their top 20 medical and top 20 surgical MS-DRGs for same- day and one-day stays, which can help them focus on the DRGs driving their one-day stay rate.

Also, for the four short-stay target areas, the PEP- PERs exclude claims with occurrence span code 72 where the “through” date is on the day of or the day before admission. Hospitals report code 72 to inform Medicare about outpatient time (e.g., emergency room, observation) associated with an inpatient admission. The time is incorporated into the two-midnight stay if it’s medically necessary. “This means that discharges that meet the two-midnight rule will not be included in the PEPPER statistics for the one-day target areas,” Hrehor explains. The move should streamline compliance monitoring.

**Keep an Eye on Pneumonia**

On the coding front, Gendron says the March 3 PEPPERs, which have a target area for pneumonia, did not reflect changes to coding guidance for pneumonia and chronic obstructive pulmonary disease (COPD) that affect principal-diagnosis sequencing and MS-DRG assignment. There was a drop in pneumonia MS-DRGs and an increase in COPD MS-DRGs prompted by the third quarter 2016 edition of the American Hospital Association’s Coding Clinic, says Barb Houghtaling, integrity and audit specialist at Trinity Health. In a nutshell, when patients are admitted with COPD and pneumonia, COPD with lower respiratory infection should be sequenced first, according to Coding Clinic. That turned things upside down at hospitals, Houghtaling says. They’re accustomed to Medicare patients coming in with pneumonia and sequencing that as the primary diagnosis—the condition that occasioned the admission—even if they have a history of COPD. It’s not clear that everyone understands the ramifications of this change, which means the patients with pneumonia and COPD will be assigned the MS-DRG for COPD instead of pneumonia, Houghtaling says. It will affect reimbursement, hospital readmission penalties and PEPPERs.

This may skew the PEPPER data, Gendron adds. “Because of coding guidelines, the volumes are shifting,” she says. “You may have the false perception you have an outlier or opportunity, but it is the result of coding guideline changes and the sequencing of your principal diagnosis.”

On the short-stay side of the PEPPER house, Catherine Hicks, director of compliance audit services at University of Colorado Health, has found the data less “actionable” with the medical staff. “If the PEPPER data points to a potential coding issue, we can take that to the coding department of UC Health, which is managed by one person who can provide feedback to her people. But when it’s medical necessity and physician documentation, it’s much harder to get that message across,” she says. Physicians who are not employed may be less receptive to feedback about billing outliers. It will take a “full court press” to improve compliance with the two-midnight rule, an effort that’s under way, Hicks says. Physician advisers will review PEPPERs as part of it.

**Hospice Release Has New Targets**

There also will be changes in the April 17 release of the hospice PEPPERs, Hrehor says. There is one new target area for long general inpatient (GIP) stays and a new report that identifies live discharges by type, Hrehor says.

Long GIP stays are draining Medicare coffers. According to a 2016 HHS Office of Inspector General report, one-third of general inpatient stays billed by hospices were improper, and in 2012, this cost Medicare $268 million (RMC 4/11/16, p. 8). GIP, which is supposed to be short-term, can be provided only in hospitals, hospice inpatient settings and skilled nursing facilities and is available for pain control and acute or chronic symptom management that can’t be handled in other places, such as the patient’s home. The PEPPERs focus on long GIP stays, which means five plus days, a definition pulled from a 2013 OIG study that found one-third of GIP stays lasted longer than five days.

The new “live discharges by type” report in the PEPPERs flags the hospice’s live discharges for various reasons: discharges as “no longer terminally ill,” beneficiary revocations, beneficiary transfers, instances when the beneficiary moved out of the service area and “discharges for cause.” Hospice live discharges have been an ongoing concern of the Medicare Payment Advisory Commission, Hrehor says. “Excessive live discharges may signal that hospice admissions don’t meet the hospice eligibility criteria or that the financial concerns drive hospice elections/discharges/revo- cations,” she notes. “The new report will allow hospices to see at a high level the types of live discharges they have and compare themselves to the MAC jurisdiction and nation.”

Contact Hrehor at Kimberly.Hrehor@area-B.hcqis.org, Gendron at gendrona@trinity-health.org, Hicks at Catherine.hicks@uchealth.org and Houghtaling at houghtab@trinity-health.org.