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McCombs School of Business
The University of Texas at Austin
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by Kimberly Hrehor, MHA, RHIA, CHC; Marianne Lundgren, RHIA, CCS; and Dan McCullough, RN, CHC

Using comparative data to support compliance efforts

» PEPPER is a free report summarizing Medicare claims data in areas prone to improper Medicare payments.

» A provider’s claims data statistics are compared to other providers in the state, MAC jurisdiction, and nation.

» PEPPER can be used to identify when a provider may be at higher risk for improper Medicare payments.

» Providers should assess their PEPPER and consider internal and external factors that may contribute to higher billing patterns.

» More information on PEPPER is available at www.PEPPERresources.org

Kimberly Hrehor (khrehor@txqio.sdps.org) is Project Director, and
Marianne Lundgren (mlundgren@txqio.sdps.org) and Dan McCullough
dmccullough@txqio.sdps.org) are Program Specialists with TMF Health
Quality Institute in Austin, Texas.

D o you work for any of these provider types?

- Short-term acute care hospital
- Long-term acute care hospital
- Critical access hospital
- Inpatient psychiatric facility
- Inpatient rehabilitation facility
- Hospice
- Partial hospitalization program

If the answer is yes, chances are your facility receives a free report that can help identify areas that may be at risk for improper Medicare payments. It’s called the Program for Evaluating Payment Patterns Electronic Report, or PEPPER.

PEPPER, produced by TMF® Health Quality Institute (TMF), is a report that summarizes Medicare claims data statistics for areas that may be at risk for improper Medicare payments. PEPPERS have been available for short-term acute care hospitals and long-term acute care hospitals for several years; more recently, they have been available for critical access hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, hospices, and partial hospitalization programs. The PEPPER for each type of provider has been customized, as the risk areas vary for different provider types. (See sidebar for target areas for each setting).

PEPPER summarizes the Medicare claims statistics for one provider. You may think: “I can calculate my own claims data statistics.” True, but do you know how your billing patterns compare to those of other providers? Probably not. One of the most valuable aspects of PEPPER is that it shows how a provider’s billing statistics compare to all other providers in the state, jurisdiction, and nation. These comparisons provide context so providers can determine if they are at higher risk for improper payments. If so, they can review medical record documentation, billing, and coding processes to ensure they are complying with payment policies. Although PEPPER cannot identify improper Medicare payments, it can be used to help providers identify when they may be at higher risk for improper Medicare payments. Therefore, they can be proactive in determining whether any issues exist and take any necessary corrective measures.
### Target Areas for Short-term Acute Care Hospitals and Critical Access Hospitals

- Stroke/intracranial hemorrhage
- Respiratory infections
- Simple pneumonia
- Septicemia
- Unrelated operating room procedures*
- CC/MCC for medical DRGs
- CC/MCC for surgical DRGs
- Excisional debridement*
- Ventilator support*
- Transient ischemic attack*
- Chronic obstructive pulmonary disease
- Percutaneous cardiovascular procedure with stent insertion*
- Syncope
- Other circulatory system diagnoses*
- Other digestive system disorders*
- Medical back
- Spinal fusion*
- 3-day stays prior to a SNF admission
- swing-bed transfers (CAHs only)
- 30-day readmissions to the same hospital or elsewhere
- 30-day readmissions to the same hospital
- 2-day stays for other vascular procedures*
- 2-day stays for heart failure and shock
- 2-day stays for cardiac arrhythmia
- 2-day stays for esophagitis/gastroenteritis
- 2-day stays for nutritional/metabolic disorders
- 2-day stays for renal failure*
- 2-day stays for kidney/urinary tract infections
- 1-day stays excluding transfers
- 1-day stays for medical DRGs
- 1-day stays for chest pain/atherosclerosis
*Applicable for Short-term acute care hospitals only

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CMG = Case mix groups  STACH = Short-term acute care hospital  IRF = Inpatient rehabilitation facility
Using PEPPEER to support compliance efforts

How do providers use PEPPEER? According to more than 70 individuals who responded to a PEPPEER feedback form available on the PEPPEERresources.org website, PEPPEER is being used to:

- guide the auditing process to focus on areas of potential vulnerability (61%),
- improve the quality of clinical documentation (53%),
- review their diagnosis and procedure coding process (50%),
- assess case management procedures (44%),
- educate staff regarding coding guidelines (43%),
- educate medical staff (43%), and
- assess previous efforts to change billing patterns (39%).

It’s notable that PEPPEER is most frequently used to guide auditing and help providers focus on areas of potential vulnerability. Several reports in PEPPEER can help with that goal; for example, the Compare worksheet as well as the National High Outlier Ranking Report (available in short-term acute care hospital PEPPEERs only). PEPPEER also includes data tables and graphs displaying the summarized statistics. These reports can help identify changes over time. To see sample PEPPEERs, visit the PEPPEERresources.org website and click on the applicable Training and Resources page.

For example, a short-term acute care hospital may see this graph (figure 1) in their PEPPEER, depicting an increase in the percent of one-day stays for medical diagnosis related groups (DRG) over the past several quarters; the hospital’s percent is now above the national and jurisdiction 80th percentiles, an indication of risk for improper payments. Questions the hospital may wish to explore are:

- Were there any changes in admission processes?
- Are there new physicians with admitting privileges?
- Has the hospital added any new lines of service that may have increased one-day stay admissions?

The critical access hospital PEPPEER graph (figure 2) for simple pneumonia indicates an increase in coding for the higher-weighted simple pneumonia DRGs. Questions to ask could include:

- Have there been any changes in coding staff?
- Has the hospital implemented a documentation improvement program?
- Have there been any changes in the external environment (opening or closing of other health care providers) that may have resulted in a change in the patient population?
In another example, the Inpatient Rehabilitation Facility (IRF) PEPPER graph (figure 3) for miscellaneous case mix groups (CMGs) shows the facility’s percent of all Medicare discharges for the four miscellaneous CMGs (including diagnoses such as debility, generalized weakness, and other miscellaneous conditions) has increased somewhat over time, although it is still below the national and jurisdiction 80th percentile. Is it possible that these patients did not require an IRF level of care, or perhaps there was a more definitive diagnosis that should have been assigned?

Figure 3: Miscellaneous case mix groups for an inpatient rehab facility

![Graph showing miscellaneous case mix groups for an inpatient rehab facility.]

Putting PEPPER to use

It’s a good idea to share and review your PEPPER with others within your organization, so they can be involved in interpreting the statistics and planning next steps. Share the PEPPER with health information management/coding, utilization review, case management, quality improvement, compliance, finance, physician leadership, and any others who could assist with these activities. At this point, consider factors that could result in your facility’s billing patterns that identify you as being at risk for improper payments, such as the type of services offered, patient case mix/population, and external events in your community, such as the opening or closing of other health care providers.

When reviewing your PEPPER, if applicable, consider reviewing target areas that could be related in conjunction with each other. For example, consider simple pneumonia and respiratory infections. If the target area percent of simple pneumonia discharges is low, but the percent of complex pneumonia (respiratory infections) discharges is high, this could be an indication of overcoding. If the opposite is true, it may be possible that the type of pneumonia diagnosed is not being recognized by coders, and physicians are not being queried for further information. Also, review the average length of stay (ALOS) for the numerator and denominator discharges for coding-focused target areas. Theoretically, the numerator discharges would represent higher-severity patients, and the ALOS for the numerator discharges may be expected to be somewhat longer than that for the denominator discharges.

Another example would be to look at all one- and/or two-day stays as a group to see if they are increasing over time. Even though your target area percent may be below the 80th percentile, gradually increasing target area percents could indicate processes should be reviewed. This could give you an early heads-up to practice patterns that should be considered, such as employee education, etc.

Use the information you’ve gleaned to develop an audit plan, tackling those areas with highest priority first (consider percentile level, number of discharges, and sum of reimbursement for each target area). Think about how you will conduct your reviews. Will they be internal or external, using consultants or outside staff? What time period will you select to review? You may wish to review records from the most recent time periods and move backwards in time if you need to expand the review.
The next step is to review a sample of medical records. You can determine if you want to conduct a random record review, or if you want to select some records that may be more prone to unnecessary admission or DRG coding errors, perhaps by principal diagnosis code, length of stay, admission source, or some other factor. Submit corrected claims to your Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI) for any identified improper payments.

Based on the findings from the review, determine if you need to conduct an audit that has a larger scope. If potentially fraudulent issues are identified through the review, you may wish to consider self-disclosing that to the Office of the Inspector General (OIG). You would want to discuss this option carefully with legal counsel to determine a course of action. To learn more about the OIG’s self-disclosure protocol, visit www.oig.hhs.gov.

Work as a team to develop changes to processes, develop and conduct staff education, and put systems in place to prevent future payment errors. Once changes are implemented, remember to conduct another review (a remeasurement review) to determine if the changes were successful or if further interventions are necessary. Periodic monitoring or spot checking is also important to ensure relapses don’t occur. You can also review your PEPPER to see if changes in target area statistics can be identified.

Who else might be looking at my PEPPER?

TMF releases a provider’s PEPPER only to that specific provider. PEPPERS are not available for public release. TMF does not provide PEPPERS to other contractors, although TMF does provide an Access database (the First-look Analysis Tool for Hospital Outlier Monitoring, or FATHOM) to MACs, FIs, and Recovery Auditors. FATHOM can be used to produce a PEPPER. It’s important to keep in mind that federal contractors have access to much more claims data information about providers than are included in PEPPER, and the contractors have access to sophisticated data mining tools. In addition, law enforcement (such as the Department of Justice) may be able to obtain your PEPPER in an effort to support their internal activities. While this may sound alarming to some providers, the benefit of PEPPER is that the providers will have it first and be able to prepare if regulatory or law enforcement agencies come knocking.

Where to learn more?

TMF has developed many resources to assist providers with using PEPPER. Visit www.PEPPERresources.org for recorded training sessions, PEPPER user’s guides, sample reports, national-level comparative data, and other resources. TMF encourages users to submit questions about accessing or using their PEPPER through the Help Desk on the website.