The Program for Evaluating Payment Patterns Electronic Report, or PEPPER, is a free comparative data report made available to health care providers to support their efforts to identify and prevent improper Medicare payments. PEPPER, produced by TMF® Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), summarizes Medicare claims data statistics for areas that have been identified as prone to improper Medicare payments, referred to as “target areas” in the PEPPER.

PEPPERs are available for these providers: short-term acute care hospitals, long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, hospices, skilled nursing facilities, home health agencies, and partial hospitalization programs. Each type of PEPPER is customized and includes statistics for areas at risk for each individual provider type. This article will focus on the PEPPER available for short-term acute care hospitals.

About PEPPER
The short-term (ST) acute care hospital PEPPER summarizes Medicare claims statistics for one hospital over twelve federal fiscal quarters. The PEPPER only includes traditional fee-for-service Medicare claims statistics; Medicare Advantage and other payers are not included. Statistics for each of the target areas (refer to Table 1: ST PEPPER Target Areas) in PEPPER are determined using a defined numerator and denominator, which then lead to the calculation of the hospital’s target area percent.

For example, the “Simple Pneumonia” target area is defined in the table below.

The PEPPER displays the numerator and denominator counts as well as the hospital’s percent over the past twelve quarters in tabular and graphic formats, as shown in Figure 1.

Accompanying each data table is a graph (shown in Figures 2, 3 and 4), which can help hospitals identify changes over time and visualize how their statistics compare to the 20th and 80th percentiles for the three comparison groups: national, state, and Medicare Administrative Contractor (MAC) jurisdiction. These comparisons are one of the most valuable attributes of the PEPPER. While most hospitals can calculate their own claims data statistics using internal data, most don’t have the ability to determine how their billing patterns compare to those of other hospitals. These comparisons provide context to help hospitals understand whether their statistics look different from the majority of other hospitals.

In the PEPPER, hospitals are identified as a “high” outlier if their target area percent is at/above the national 80th percentile, and as a “low” outlier if at/below the national 20th percentile; low outliers being applicable to coding-focused target areas only. Interpretive guidance and suggested interventions for high and low outlier status is included in the PEPPER as well as in the PEPPER user’s guide.

Using PEPPER to Support Coding and Documentation Improvement
The PEPPER can help identify concerns related to diagnosis-related group (DRG) coding errors and opportunities to improve documentation. In general, high outlier status may be an indication of overcoding, while low outlier status
may be an indication of undercoding. The graphs can help identify significant changes in statistics over time (e.g., increase or decrease). Some questions to ask in this instance could include:

- Have there been any changes in coding or billing staff?
- Have there been changes in medical staff?
- Has the hospital implemented a documentation improvement program or undertaken any quality projects that could impact the target area statistics?
- 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?
- Did the change occur with the transition to ICD-10? For example, in Figure 2, the hospital's statistics decreased significantly when ICD-10 was implemented, even though the 80th and 20th percentiles do not change much.

Keep in mind there can be regional differences in patient population. For example, one hospital located in an area of the country with high prevalence of pulmonary disease identified undercoding issues using their PEPPER.

Consider reviewing coding-focused target areas (see Table 1) that could be related, for example, “Simple Pneumonia” and “Respiratory Infections.” If the target area percent for “Simple Pneumonia” discharges is low, but the percent for “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 the coding professional staff, 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 patients who are at a higher severity level, so the ALOS for the numerator discharges may be expected to be somewhat longer than that of the denominator discharges.

Additionally, review the “Medical DRGs with Complication or Comorbidity/ Major Complication or Comorbidity (CC/MCC)” and the “Surgical DRGs with CC/MCC” target areas. If a hospital’s target area percent for one target area is low, as is for the “Medical DRGs with CC/MCC” example (see Figure 3), but the other target area is high (see Figure 4), some questions should be asked. Is the patient population with medical issues higher-functioning, with fewer complications/comorbidities, while the surgical patients are more complex? Could this represent an opportunity for documentation improvement for the medical staff (i.e., those who treat medical patients versus surgical patients)?

**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. Outside of HIM and coding, share your hospital’s PEPPER with utilization review, case management, quality improvement, compliance, finance, physician leadership, and others who would be interested in the report and who could help brainstorm factors that may impact the hospital’s statistics.

It’s important to keep in mind that the PEPPER cannot identify improper Medicare payments or compliance issues. A hospital’s statistics may be expected to look different (i.e., be higher or lower than most hospitals’) for a variety of reasons, including the hospital’s patient population, referral sources or any specialty programs. In addition, there may be regional differences in disease or illness. If, when reviewing the hospital’s PEPPER statistics, they do not seem to align with what is expected internally, consider developing an audit plan to review a sample of medical and billing records.

Submit corrected claims to the MAC for any identified improper payments. Based on the findings from the review, determine if a larger scope audit is

<table>
<thead>
<tr>
<th>Coding-focused Target Areas</th>
<th>Admission Necessity-focused Target Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke Intracranial Hemorrhage</td>
<td>Transient Ischemic Attack</td>
</tr>
<tr>
<td>Respiratory Infections</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>Simple Pneumonia</td>
<td>Percutaneous Cardiovascular Procedures</td>
</tr>
<tr>
<td>Septicemia</td>
<td>Syncope</td>
</tr>
<tr>
<td>Unrelated OR Procedure</td>
<td>Other Circulatory System Diagnoses</td>
</tr>
<tr>
<td>Medical DRGs with CC or MCC</td>
<td>Other Digestive System Diagnoses</td>
</tr>
<tr>
<td>Surgical DRGs with CC or MCC</td>
<td>Medical Back Problems</td>
</tr>
<tr>
<td>Single CC or MCC</td>
<td>Spinal Fusion</td>
</tr>
<tr>
<td>Excisional Debridement</td>
<td>3-day Skilled Nursing Facility-qualifying Admissions</td>
</tr>
<tr>
<td>Ventilator Support</td>
<td>30-day Readmissions to Same Hospital or Elsewhere</td>
</tr>
</tbody>
</table>

Table 1: Focused Target Areas
necessary. If potentially fraudulent issues are identified through the review, consider self-disclosing that to the Office of the Inspector General (OIG). Discuss this option carefully with legal counsel to determine a course of action. To learn more about the OIG’s self-disclosure protocol, visit oig.hhs.gov/compliance/self-disclosure-info/protocol.asp.

Once root causes of errors have been identified, 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, conduct a follow-up 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. Also review the PEPPER to see if changes in target area statistics can be identified.

Where to Learn More?
TMF Health Quality Institute has developed several resources to assist providers with using PEPPER. Visit PEPPERresources.org for recorded training sessions, PEPPER user’s guides, sample PEPPERS, national and state-level comparative data, peer group bar charts, and other resources. For questions about the PEPPER report, submit them through the “Help Desk” on the website at PepperResources.org.

Kimberly Hrehor, MHA, RHIA, CHC, PMP; Director, TMF Health Quality Institute