On or around April 20, CMS contractor TMF Health Quality Institute will release the third annual Program for Evaluating Payment Patterns Electronic Report (PEPPER) for SNFs—a resource characterized by both its unrivaled offering of free, comparative billing data and mediocre utilization by nursing home providers.

The SNF PEPPER provides detailed comparisons of a facility’s Medicare claims data in six domains considered at potential risk for abuse or improper payment to that of counterparts in the same state and Medicare Administrative Contractor (MAC) jurisdiction, as well as the country at large. Experts call the report a dynamic tool for helping providers flag potential problems in their billing practices, steel themselves for scrutiny come audit time, and understand their position within the greater SNF landscape.

“There’s not a lot of comparative data out there that’s publicly available that is free of charge, and so the PEPPER is a really great resource for ... all providers in that it does allow them to compare their Medicare claims data statistics with [that of other] providers,” says Kimberly Hrehor, MHA, RHIA, CHC, project director at TMF.

Despite the unique billing insights it offers and its near universal availability to SNFs, PEPPER still seems to be struggling to find a foothold in the setting—only 61% of facilities accessed their 2014 report. Experts say there may be several factors fueling this low statistic.

Because the SNF version of the report is still in its infancy, many providers don’t know what it is, says Kris Mastrangelo, OTR/L, MBA, LNHA, president and CEO of Harmony Healthcare International (HHI), a consulting and talent management firm for postacute care providers in Topsfield, Massachusetts.

“As I cross the country and speak and meet hundreds and hundreds of administrators and directors of nursing, what we’re finding is that they’re not even aware that the report exists,” Mastrangelo explains.

The report can also cut an imposing figure: 13 pages of multimedia data (graphs, tables, and text distributed...
over a variety of spreadsheet tabs) that weigh an individual provider’s billing patterns against aggregated SNF statistics to highlight outlier areas.

“It’s a lot of information to digest,” says Elisa Bovee, MS, OTR/L, vice president of operations at HHl. “As the naked eye looking at it before you dig in to the actual elements and the explanations of PEPPER, it can be an overwhelming report.”

But despite these complexities, Bovee says the report is worth delving into. “Once you sit down and digest what the data, the definitions, and explanations behind the data actually mean, you see the value of the data,” she explains.

**Background**

According to Hrehor, PEPPER was first developed in 2003 for short-term acute care hospitals (STCH) as part of a Quality Improvement Organization—run initiative to reduce improper Medicare payments in hospitals. In 2009, TMF began contracting with CMS to continue producing PEPPERs and broaden the report’s scope to include all acute care hospitals.

Over the years, TMF has also adapted the report for a number of diverse settings along the healthcare continuum, including critical access hospitals (CAH), inpatient rehabilitation facilities, hospices, and SNFs. This year, the contractor will introduce a version for home health.

Each setting’s PEPPER compiles billing data for discharges or episodes of care completed within a reporting period that spans the three previous federal fiscal years (FY)—allowing providers to analyze changes over time, says Hrehor. For example, this year’s reports will aggregate claims data from FY 2012 to FY 2014 (i.e., October 1, 2011, through September 30, 2013).

First available in 2013, the SNF version of the report is one of TMF’s most recent PEPPER developments. This iteration covers six target areas pegged by various sources as potential avenues for abuse or improper payment in the setting. It reveals how many of a facility’s claims fall within each of these domains out of the broader claims category that encompasses it. Table 1.1 outlines the bounds of each target area and its corresponding claims category.
Using the report

TMF chose each target area based on a review of SNF payment methodology, government research (e.g., reports from the Office of Inspector General), and input from subject matter experts at CMS, says Hrehor, adding that because CMS contractors (e.g., MACs and RACs) have been ramping up scrutiny of therapy utilization and ADL scores, insight into billing practices in these domains can help providers identify problems before auditors do.

Mastrangelo echoes this sentiment, explaining that PEPPER is particularly well-suited to aid SNFs’ compliance programs and audit preparation. She says that the report has extra utility for providers with multiple facilities, as they can compare and contrast billing data from within their own organizations to determine overall best practices and risk areas to build new improvement initiatives around.

This multi-pronged utility stems from the report’s identification of not only the percentage of a SNF’s claims in a designated category that fall within the associated target area (outlined in Table 1.1), but also in which national, jurisdiction, and state percentiles this statistic places the facility.

As an example, consider the hypothetical facility whose billing data is aggregated in the sample SNF PEPPER provided by TMF on the “Training & Resources for Skilled Nursing Facilities” page of the report website (PEPPERresources.org). Out of all the days this facility billed for therapy and non-therapy RUGs (the encompassing claims category), 97% were for therapy RUGs (the target area). This percentage places the facility in the 77.6 percentile nationally, the 88.2 percentile within its (unspecified) MAC jurisdiction, and the 92.1 percentile in its (unspecified) state for this specific target area.

The distinction between percentage and percentile is confusing but critical, says Mastrangelo, as the national

<table>
<thead>
<tr>
<th>Target area</th>
<th>Description of target area</th>
<th>Encompassing claims category</th>
</tr>
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<tbody>
<tr>
<td>Therapy RUGs with high activities of daily living (ADL)</td>
<td>Days billed with RUG equal to RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB</td>
<td>Days billed for all therapy RUGs</td>
</tr>
<tr>
<td>Non-therapy RUGs with high ADL</td>
<td>Days billed with either: - <strong>RUG III</strong> equal to SC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 OR - <strong>RUG IV</strong> equal to HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1</td>
<td>Days billed for all non-therapy RUGs</td>
</tr>
<tr>
<td>Change of therapy (COT) assessment</td>
<td>Assessments with assessment indicators (AI) whose second digit is “D”</td>
<td>All assessments</td>
</tr>
<tr>
<td>Ultrahigh therapy RUGs</td>
<td>Days billed with RUG equal to RUX, RUL, RUC, RUB, RUA</td>
<td>Days billed for all therapy RUGs</td>
</tr>
<tr>
<td>Therapy RUGs</td>
<td>Days billed for all therapy RUGs</td>
<td>Days billed for all therapy and non-therapy RUGs</td>
</tr>
<tr>
<td>90+ day episodes of care</td>
<td>Episodes of care with a length of stay of 90+ days</td>
<td>All episodes of care</td>
</tr>
</tbody>
</table>

Source: Adapted from target area descriptions in the SNF PEPPER User’s Guide on PEPPERresources.org.
percentile measurements in the report are used to determine whether a provider’s billing practices in a given target area fall within typical industry bounds. SNFs with high billing patterns (i.e., at or above the 80th percentile nationally) and those on the opposite end of the spectrum (i.e., at or below the 20th percentile nationally) in a particular area are flagged as outliers in that domain, a classification that pegs them as at risk for improper payments and one that could expose them to additional audits, says Mastrangelo.

Hrehor says she doesn’t know if CMS and its contractors use the provider statistics in the reports, but according to the SNF PEPPER User’s Guide prepared by TMF, MACs and RACs have access to a special analysis tool that can be used to produce a PEPPER.

Despite the potential for contractors to refer to this data during enforcement activities, Mastrangelo and Hrehor stress that PEPPER doesn’t identify the presence of improper payments at a facility—only the risk. In turn, depending on its specific characteristics, a provider can be an outlier in a certain area while exercising completely compliant billing practices. For example, Hrehor says that it may be reasonable for a SNF to have steep claim rates for ultrahigh therapy RUGs if its care focus is on intensive therapy.

“SNFs should examine their PEPPER statistics and consider whether they make sense with the patient population and regular operations of their facility,” she explains, adding that facilities can also compare clinical outcomes with the report’s findings to determine whether they align.

If peaks or valleys in PEPPER billing targets don’t mesh with resident populations, care focuses, or other individual facility circumstances, experts suggest digging deeper into outlier areas through internal audits. Mastrangelo’s organization consolidates the statistics from a SNF’s PEPPER into a six-page analysis that summarizes a facility’s comparative billing data from the most recent fiscal year covered by the report and evaluates the facility’s outliers. In a sample PEPPER analysis provided by HHI, the organization suggests conducting focused medical record reviews to ensure all documentation reflects that residents are receiving clinically appropriate care and to establish justification of service delivery in the event of government scrutiny. In addition, the organization underscores the necessity of training for staff—especially those whose work involves a facility’s outlier domains—on the clinical and documentation practices that support compliant billing. HHI also urges providers to ensure these individuals are familiar with Medicare coverage criteria and regulatory requirements.

Finally, providers should make sure billing analyses cover all bases, experts say. Although the SNF PEPPER doesn’t identify low outliers for the COT target area, a low percentage in this domain might indicate that a facility is failing to complete the number of COT assessments required by a resident’s specific circumstances. Infrequent use or nonuse of the COT assessment could result in reviews by MACs and RACs, according to the SNF PEPPER User’s Guide.

Lower percentile rankings could also indicate chronic undercoding of ADLs or the use of practices that jeopardize residents’ access to the benefits for which they’re eligible, according to the HHI sample PEPPER analysis. Table 1.2 provides some target area–specific questions adapted from HHI’s sample report to help providers focus internal investigations into outlier areas.

Limitations

Despite the broad utility of PEPPER, experts also point to a few caveats.

In addition to the report’s inability to pinpoint actual incidents of improper Medicare payment, Hrehor says that production lag times result in statistics that are over a year old—a circumstance that explains why the most recent data contained in this year’s report will be from September 2013 (the end of FY 2014), despite its April 2015 release.

Consequently, Bovee says providers should consider report findings carefully, as the data might not reflect up-to-the-minute practices.

“It’s sort of a retrospective look,” Bovee explains. “You also have to make sure that you know if there have been any changes so that ... you’re not making adjustments based on information that was accumulated in the previous three fiscal years.”

Accessing this year’s report

This year’s PEPPER will be available to most SNFs (i.e., those that are independent from STCHs and CAHs) electronically through the secure portal on the
This retrieval method was introduced last year to replace the snail mail distribution used during the first year of SNF PEPPER production, though both access avenues had some initial pitfalls, according to the experts at HHI.

Mastrangelo explains that because the first SNF report was only sent in hardcopy form through the postal service, some providers mistook the important documents for junk mail and never bothered to open them. Then, when the report was made available electronically the following year, some SNFs were stumped by the new safeguards put in place to verify a provider’s identity before granting access to its report, says Bovee. “It was definitely a hiccup for providers,” she explains. “Once you walk through step by step, it really wasn’t that complicated, but there are a couple pieces of information you need that are specific to your facility.”

To stave off such confusion this year, each SNF’s CEO, president, or administrator—the only members permitted to access PEPPER directly—should be sure to have the following information on hand before attempting to retrieve their 2015 report through the secure portal:

1. **The facility’s six-digit CMS certification number (also called a provider number or PTAN).** TMF notes that this is not the same number as tax or national provider identification numbers.

2. **A patient control number** (found at form locator 03a on the UB04 claim form) OR a medical record number (found at form locator 03b on the UB04 claim form) for a traditional FFS Medicare Part A resident who received services from the facility during September 2014.

SNFs that are part of STCHs (i.e., those whose third PTAN digit is “U”) will receive their PEPPER via QualityNet, as they have in previous years, and can download the report files from their corresponding Secure File Transfer Inbox. SNFs that are part of CAHs won’t receive PEPPERS.

Although this year’s SNF report holds no major content or distribution changes, Hrehor advises providers to:

<table>
<thead>
<tr>
<th>Target area(s)</th>
<th>Guiding questions</th>
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| Therapy RUGs with high ADLs; non-therapy RUGs with high ADLs | 1. Does ADL documentation support MDS coding?  
2. Does ADL documentation accurately reflect care provided?  
3. Is the MDS coordinator involved with ADL coding?  
4. Are nurses and CNAs properly trained on ADL coding? |
| COT assessment | 1. What is the facility’s process to ensure compliance with COT completion requirements?  
2. Does COT utilization reflect clinically appropriate, individualized therapy provision?  
3. Are there instances of skipped COTs? |
| Ultrahigh therapy RUGs; therapy RUGs | 1. Do all aspects of the medical record support reasonable and necessary therapy provision?  
2. Are patients receiving clinically appropriate therapy levels of care to address all of their goals?  
3. Do clinicians understand the Medicare coverage guidelines?  
4. Do clinicians feel comfortable with services rendered? |
| 90+ day episodes of care | 1. Do all aspects of the medical record support a clinically appropriate length of stay?  
2. Are beneficiaries appropriately accessing all benefits granted by their clinical condition’s alignment with Medicare skilled coverage criteria? |

**Table 1.2: Target area evaluation**

Source: Adapted from HHI’s sample FY 2013 SNF PEPPER analysis.
to be aware of the PEPPER website’s recent makeover. Under the new design, which was finalized February 2, SNFs can access their reports by clicking “PEPPER Distribution - Get Your PEPPER” on the home page.

A final reason to access this year’s PEPPER: TMF monitors retrieval rates, which CMS may use to determine the fate of the report in various settings, says Hrehor.

“Some providers may not use it extensively, but I think they should at the very least obtain their PEPPER and review it and ask themselves if the statistics in that report make sense to them,” she says, explaining that in an industry increasingly characterized by payment scrutiny, a free tool centered on billing compliance can be valuable.

“I think it’s important for all providers to ... remember that the Recovery Auditors, the MACs, and other federal contractors have access to ... all of the Medicare claims data, and these organizations have sophisticated data mining software. They have tools, algorithms that they use to identify providers who they want to focus on for review activity,” she explains. “Providers don’t have those types of tools, and so the provision of the PEPPER does give them somewhat of a leg up.”

EDITOR’S NOTE
This article appears in the March 2015 issue of PPS Alert for Long-Term Care, one of HCPro’s monthly newsletters for long-term care providers. To learn more, visit http://hcmarketplace.com/pps-alert-for-long-term-care-1.