Using technical safeguards to thwart phishing attacks

an interview with Adam Greene
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See page 16
Could your therapy or billing practices be raising a red flag for auditors?

A free report generated on behalf of the Centers for Medicare & Medicaid Services (CMS) can give you a heads-up, if so. Figure 1 (see page 64) is an example of the home health agency (HHA) Program for Evaluating Payment Patterns Electronic Report (PEPPER), which shows how one HHA’s billing and therapy practices compare with other HHAs. The agency depicted in Figure 1 has had an increase in high therapy utilization episodes over the past two years (depicted by the blue bars), and is now above the 80th percentile when compared to all HHAs in the nation, jurisdiction, and state (the red lines represent the 80th percentile for these comparison groups). Could this be you?

HHAs (and other providers) are under an ever-increasing focus by the Office of Inspector General, Recovery Auditors (RAs), Medicare Administrative Contractors (MACs) and other federal contractors that mine Medicare claims data to identify providers that may be at risk for fraud, waste, and abuse. Wouldn’t you like to know if your agency “sticks out”? The PEPPER can be the “first look” to let providers know if they do.

The PEPPER is a free report summarizing three years of an HHA’s Medicare billing practices, comparing them with other HHAs for six areas at risk for improper Medicare payments (see sidebar “HHA PEPPER Target Areas”). CMS has contracted with TMF® Health Quality Institute to develop and distribute the HHA PEPPER. PEPPERS are also available for short-term acute care hospitals, long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, hospices, partial hospitalization programs, and skilled nursing facilities.

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 nation, MAC jurisdiction, and state. These comparisons provide context, so that providers can determine if they might “stick out” for areas at risk for improper Medicare payments. If so, they can review medical record documentation and 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.

**Using PEPPER to support compliance efforts**

How can PEPPER help you? The first thing to remember is that PEPPER data categories were chosen by CMS. Take that a step further, and you can imagine that these are areas that CMS considers risk areas and will be monitoring through its own data analysis and contractor activity. If your agency is in the top percentiles, further review by outside entities may be more probable. Having that information can be another weapon in your arsenal. It can help you examine your documentation and practices and be prepared if outside scrutiny does occur.

When you are reviewing the PEPPER, first look to see if your agency is at/above the 80th percentile in any category. If your agency comes up at/above the 80th percentile in the “Average Case Mix” area, look deeper into your non-Low Utilization Payment Adjustment (non-LUPA) and non-Partial Episode Payment (non-PEP) medical records. You want to make sure that your documentation and the physician face-to-face encounter supports the scoring on the Outcome and Assessment Information Set (OASIS) and the Health Insurance Prospective Payment System (HIPPS) billed. Maybe your agency has a higher-than-average population of clinically complex and functionally compromised patients. That’s fine, but knowing that can prepare you to respond in the event of a MAC, RA, or other type of review.

What if you come up at/above the 80th percentile for the “Average number of episodes”
area (see Figure 2)? Look at your recertification episodes and multiple admit patients. Does the documentation support the need for continued skilled services? Does the patient still qualify for the benefit? Is your agency doing everything that can be done to prepare the patient for discharge right from the beginning of the episode, so that recertification is not needed for discharge needs that should have been addressed earlier? Have the appropriate services and resources been made available to the patient to avoid repeat admissions for the same reason? If everything in your documentation supports your agency’s practices, you should fare well in a CMS review (see Figure 2).

Being at/above the 80th percentile in the “Episodes with 5 or 6 visits” or “non-LUPA” areas should be reviewed in much the same manner as the others. You should review documentation to ensure that it supports the need for a full home health episode for the patient. Could your agency have been more efficient in the care rendered, accomplished goals, and billed a LUPA? Does the medical record support the need for skilled care and that the patient qualifies for the home health benefit?

You want to pay attention to all your agency documentation and any outside notes, including that physician face-to-face encounter for all the categories, but the “High therapy” and “Outlier” areas may be the most closely scrutinized by CMS contractors, because of their relation to increased reimbursement. For these areas, focus your attention on each visit note. Does that note by itself support the episode, the skilled care need, and the medical necessity of the care rendered? Does the note show progress in the patient’s condition or explain clearly why not, and what is being changed or altered by that skilled clinician to support the visit? Does the note explain why the skills of the clinician are needed and the care cannot be rendered by a non-skilled caregiver? If you can answer yes to those questions for each note, then the sum of all the notes will support the episode and that increased reimbursement.

The last thing to review is each PEPPER area over time. Even if your agency is not at/above the 80th percentile, if you have a steady upward trend over time or a big spike (see Figure 3, page 66), you need to do an analysis of possible causes. You may want to analyze your admission processes and patient population, in addition to all the documentation. Has something changed that would explain the trend? Do you have a new admission source that can explain it? Do you have new staff who are specialists in an area that allows you to admit patients with specialized needs? If nothing has changed, you may want to look deeper for the reason. Maybe you will determine that there are staff
training needs that will ensure consistency when met. Perhaps a new staff member needs reinforcement and is creating the spike. Or it might just be time to review regulations and documentation requirements with all your staff. Again, that trend or spike may not indicate that your agency is doing anything wrong, but it can prepare you for the review that may come due to that change (see Figure 3).

**Organizational use of PEPPER**

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 identifying you as being at risk for improper payments, such as the type of services offered, patient case mix/population, reimbursement policy/regulatory changes, and external events in your community, such as opening/closing of other healthcare providers.

Where can I learn more?
The PEPPER for HHAs is distributed annually. The next release is scheduled for July 2016. To access your current PEPPER and to learn more about PEPPER, visit www.PEPPERresources.org where recorded training sessions, PEPPER user’s guides, sample reports, national- and state-level comparative data, and other resources are available. Questions can be submitted through the “Help Desk” on the website.

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