Critical-access hospitals will soon receive free CMS data designed to help them perform compliance monitoring in 29 risk areas.

CMS is expanding its distribution of PEPPER — the Program to Evaluate Payment Patterns Electronic Report — to the nation’s 1,300 critical-access hospitals. And the timing of this expansion is good, since recovery audit contractors (RACs) have apparently started auditing claims from the small, rural hospitals.

PEPPERs are free electronic reports on hospital billing outliers in certain coding and admission necessity risk areas. Until now, they have been produced only for short-term acute-care hospitals and long-term-care hospitals, but that’s changing, says Kim Hrehor, project director for TMF Health Quality Institute, the Texas-based Medicare quality improvement organization that generates PEPPER for CMS.

Admission Necessity Is a Greater Concern

CMS is providing PEPPERs to critical-access hospitals in part due to requests for the reports. These facilities are facing the same compliance risks as other hospital types, though admission necessity is a greater concern because critical-access hospitals are not paid based on MS-DRGs. “This allows them to strengthen their compliance program and prepare for external auditors,” Hrehor says. “CMS wants to come at this problem of waste, fraud and abuse in many different ways, not just do pay and chase, and PEPPER is a tool that hospitals can use to help prevent improper payments before they happen.” The critical-access hospital data will be sent in late April on QualityNet, a secure CMS server.

Hospitals use PEPPERs to assess their risk for underpayments and overpayments. For short-term acute-care hospitals, PEPPER compares each hospital to all other hospitals in the state, Medicare administrative contractor (MAC)/fiscal intermediary (FI) jurisdiction, and/or the nation.

PEPPERs flag when a hospital is at or above the 80th percentile in billing for a particular risk area, which means it submits a higher percentage of claims for that risk area than 80% or more of the hospitals in that state, MAC/FI jurisdiction and/or the nation. PEPPERs are also provided at the other end for coding targets; hospitals are informed when their percentage of claims for a coding-related risk area is lower than all but 20% of hospitals in the state, MAC/FI jurisdiction and/or the nation. Either of these extremes tells hospitals they should review the medical records to find out if they have errors.

It works a bit differently for critical-access hospitals. Their PEPPERs will flag when a hospital is at or above the 80th national percentile for a risk area, and when their percentage of claims for a coding-related risk area is lower than 20% of hospitals in the nation.

CMS recently decided to more than double the number of risk areas for short-term acute-care hospitals. In late February, TMF will send the nation’s 3,400 short-term acute-care hospitals PEPPERs for 29 coding and admission necessity targets, including excisional debridement MS-DRGs and admission necessity for two-day stays for heart failure/shock and syncope (RMC 12/13/10, p. 1). Acute-care hospitals get data quarterly.

Critical-access hospitals will receive data on the same targets, at least for now. But PEPPERs will be generated annually because the discharge volume is much smaller and TMF wants to ensure the comparisons are meaningful, Hrehor says.

“Critical-access hospital” is a special designation sought by small, rural hospitals that are worried about breaking even. Medicare pays them cost plus 1% instead of MS-DRGs under a prospective-payment system. To qualify for the designation, critical-access hospitals must meet certain criteria. For example, they must be located in a rural area at least 35 miles from any other hospital, have no more than 25 beds, and maintain a yearly average length of stay of 96 hours per inpatient for acute care, according to the CMS website. They are spread all over the country, but the states with the most critical-access hospitals are Iowa (92), Kansas (83),
Minnesota (79), Texas (77), Nebraska (65) and Wisconsin (59). The states with the fewest are Massachusetts (3), Alabama (3), South Carolina (5), New Mexico (6) and Virginia (7).

There is an additional motivation for some critical-access hospitals to use the PEPPER data. “We’ve heard from some critical-access hospitals who say they want to assess this data in consideration of whether to remain a critical-access hospital or consider converting to a short-term acute-care hospital,” she says. MS-DRG reimbursement may be more advantageous, despite the risks and complexities.

TMF will produce PEPPERs for inpatient psychiatric facilities in June. CMS also produces “comparative billing reports,” which are similar to PEPPERs, for non-inpatient providers (RMC 8/23/10, p. 1).

Visit www.pepperresources.org for information on PEPPER and stay tuned there for an upcoming webinar for critical-access hospitals. Contact Hrehor at khrehor@txqio.sdps.org.