With RAC recoupments skyrocketing in recent months, hospitals may want to drill down into billing data from CMS’s Program to Evaluate Payment Patterns Electronic Report (PEPPER). CMS uses RAC findings when deciding the content of “PEPPERS,” which are hospital-specific reports on billing for admission necessity and coding. While PEPPERS are free, the reports may wind up on the cutting-room floor before compliance officers get their hands on them. And even if compliance officers or auditors access PEPPERS, they may not make the most of them.

PEPPERS cover 29 target areas for short-term acute-care hospitals. Nearly every hospital receives PEPPERS, which show how their volume of billing in the target areas compares to other hospitals in their state, in their Medicare administrative contractor (MAC)/fiscal intermediary (FI) jurisdiction, and nationally. If there are billing outliers, it’s up to the hospitals to determine whether they translate into over (or under) payments or there’s some logical explanation.

Compliance Officers Should Seize PEPPERS

PEPPERS are generated by TMF Health Quality Institute, a CMS contractor. The admission necessity target areas include syncope, two-day stays for cardiac arrhythmia and 30-day readmissions. The coding target areas include septicemia, ventilator support and unrelated operating room procedures; the latter two are the top issues for two RACs (RMC 5/2/11, p. 1).

“I suspect there are still people out there who know about PEPPER but don’t use it. They may not realize what type of resource it might be,” says Kim Hrehor, project director at TMF. The biggest challenge may be in compliance officers getting their hands on PEPPERS. QualityNet — a secure CMS server used by hospitals to report data for Medicare’s Internal Quality Reporting (IQR) program — is the only CMS-approved method to electronically distribute PEPPERS. Because all short-term acute care hospitals must participate in IQR, they all have a QualityNet administrator who is likely to be the person who sends in quality data to Medicare, Hrehor says. The problem is, when PEPPER data comes from TMF on QualityNet, the administrator may have no idea what it is. “These people get the report and don’t know what it is and just dump it,” she says. Compliance officers should get their own QualityNet account to ensure they receive PEPPERS. Hrehor suggests asking the QualityNet administrator at their hospital to set it up.

Although the comparisons in PEPPERS come in three flavors — state, MAC/FI jurisdiction and national — the national ranking is the most important in terms of compliance monitoring, Hrehor says. “While both the jurisdiction and national percentiles are important to consider, if you are an outlier compared to the nation, that is something you should sit up and look at because the nation is the largest comparison group,” with 3,400 short-term acute-care hospitals.

PEPPERS flag when a hospital is at or above the 80th percentile in any risk area, which means it submits a higher percentage of claims for that target than 80% or more of the hospitals in that MAC/FI jurisdiction. PEPPERS also alert hospitals when their percent of claims for a coding-related risk area is lower than all but 20% of the hospitals in the MAC/FI jurisdiction. PEPPERS also alert hospitals when their percent of claims for a coding-related risk area is lower than all but 20% of the hospitals in the MAC/FI jurisdiction.

“We encourage hospitals to use the national [benchmark] as the highest priority,” Hrehor says. As they prioritize internal reviews, hospitals should consider the reimbursement implications because program-integrity contractors tend to focus on high-value targets. “If you are in the top 20%, that is more an indication of being [an outlier] than if you are in the top 20% of, say, 300 hospitals in your MAC jurisdiction.” Plus, the jurisdiction comparison group may reflect regional differences in practice patterns that are not pronounced in the national comparison group.

When hospitals get their PEPPERS, Hrehor recommends they look at the Compare worksheet first. “That’s the heart of PEPPERS because it’s the only place where hospitals can see at a glance all the target areas for the most recent quarter and whether they are an outlier in any of them,” she says. The Compare worksheet also shows hospitals how many discharges occurred and how much money in total they received that quarter for each risk area.
It’s All in the Math

Understanding what the percents and percentiles mean is important. In calculating the percents, the numerator is the total number of claims your hospital submitted that quarter in a particular risk area, such as medical back problem MS-DRGs. The denominator is based on the same claims during the same period, but TMF uses a bigger piece of the hospital billing pie. “The denominator is a larger reference group we use to calculate a percent for the target area,” Hrehor says.

Take the example of an admission-necessity target that’s been a long-time risk area: one-day stays for chest pain and atherosclerosis. The numerator includes patients discharged in one day with MS-DRGs 313 (chest pain), 302 (atherosclerosis with MCC) and 303 (atherosclerosis without MCC). The denominator includes all patients discharged with any of these MS-DRGs regardless of their length of stay.

Then TMF divides the numerator by the denominator and multiplies that figure by 100. The result is a percentage that represents how many of your hospital’s claims for MS-DRGs 313, 302 and 303 are one-day stays. On its face, that’s not necessarily a bad thing. The next step, calculating percentiles, takes hospitals a lot closer to finding out whether they should audit the target area for overpayments. After TMF gets percentages for all 3,400 short-term acute care hospitals in this target (and the other 28 targets), it ranks them from smallest to largest in each comparison group (nation, jurisdiction, state). If 80% of the nation’s hospitals have a lower percent than your hospital for one-day stays for chest pain and atherosclerosis (i.e., your hospital’s percent is greater than 80% of all hospitals in the nation), consider pulling medical records and finding out why. There could be a physician with a penchant for admitting every chest-pain patient regardless of Medicare and InterQual guidelines, and that means potentially a lot of overpayments. But it’s possible that for most of those patients there’s a reasonable explanation, such as the opening of a nearby nursing home, which attracts many new patients with multiple serious conditions who may warrant admissions. PEPPERs just point you in the direction of questionable claims; they don’t equate with overpayments.

The coding ratios work a little differently. With septicemia, for example, the numerator includes the number of discharges for MS-DRGs 870, 871 and 872. MS-DRG 870 is septicemia and severe sepsis with mechanical ventilation 96+ hours; 871 is septicemia and severe sepsis without the vent but with major complications and comorbidities (MCC); and 872 is septicemia and severe sepsis without vent or MCCs. Because a diagnosis of urinary tract infections (UTI) may have been upcoded to septicemia or severe sepsis, the denominator adds MS-DRG 689 (kidney and urinary tract infections with MCC) and 690 (kidney and urinary tract infections without MCC) to the septicemia and sepsis MS-DRGs.

Even though septicemia is a coding risk area, Hrehor encourages hospitals to contrast the patients’ lengths of stay in the numerator and denominator. Patients in the numerator theoretically would have a longer length of stay than patients in the denominator because septicemia is more serious than UTI and kidney infections. Compliance officers can ask the health information management or information systems departments to run a list of patients who were discharged with 870, 871 or 872 and look at lengths of stay for those patients and do the same for DRGs 689 and 690. “You expect patients with septicemia to have a longer length of stay,” especially if they are on a respirator for four or more days, she says.

Visit the PEPPER website at www.pepperresources.org. Contact Hrehor at khrehor@txqio.sdps.org.