At the same time that partial hospitalization programs (PHPs) got a tongue lashing from the HHS Office of Inspector General, they became a new focus of the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The PEPPER data, which was sent to PHPs this week, will help them identify billing errors in five risk areas.

OIG found suspicious billing at about half of the community mental health centers (CMHCs) providing partial hospitalization. Based on past PHP audits and the new audit of 2010 claims, OIG identified nine “questionable billing characteristics” at community mental health centers. Among them:

◆ Beneficiaries who had no mental-health diagnoses a year before the PHP admission;
◆ Beneficiaries not referred or evaluated by a physician while in the PHP; and
◆ Medically unnecessary services because beneficiaries had cognitive disorders, such as Alzheimer’s.

“Approximately one-third of these CMHCs had at least two of the characteristics,” OIG concluded.

While the OIG report focused only on PHPs at community mental health centers, hospital-based PHPs are a prime target of several zone program integrity contractors (ZPICs) — CMS’s fraudhunters — on the Medicare Part A side (RMC 8/22/11, p. 1).

In light of the growing scrutiny, PHP operators may want to increase their compliance monitoring. The free PEPPER data, which are generated for CMS by the TMF Health Quality Institute, are designed to help hospitals and other providers tailor their compliance monitoring to outliers unique to their facilities. PEPPERs were first provided to short-term acute care hospital outpatient departments, 150 through freestanding psychiatric facilities, 50 through inpatient psych units of hospitals, 170 through community mental health centers and a handful variously through long-term care hospitals, rehab hospitals and children’s hospitals, Hrehor says.

Medicare pays for partial hospitalization on a per-diem basis under the outpatient prospective payment system. There are four APC payment rates: level one, for up to three services a day, and the higher-paying level two, which requires four or more services a day. Two of the APCs apply to hospital-based PHPs and two apply to community mental health center PHPs.

PEPPERs will compare each PHP’s billing in five risk areas to their peers in the state, Medicare administrative contractor (MAC) jurisdiction and nation. When a PHP’s billing in a risk area is at or above the national 80th percentile, which means it bills a higher percentage for that target area than 80% of all PHPs nationally, that’s a red flag. The PHP should then look into whether there are billing errors versus a reasonable explanation for their billing statistics.

The five PHP risk areas are:

◆ **Days of service with exactly four units billed:** “The higher-paying APC requires four or more services a day. Because there is a risk of PHPs providing only the minimum amount of services to obtain the higher-paying APC, we developed this target area that looks at the proportion of days of service billed that have exactly four units,” Hrehor says.

◆ **Group therapy:** The proportion of all units billed by the PHP that were for group therapy. Because it’s less expensive to provide than individual therapy, there could be a financial incentive to favor group when individual therapy might be more appropriate, Hrehor says.

◆ **No individual psychotherapy or psychological testing:** While not a requirement, Medicare has a general expectation that PHPs provide some individual therapy and testing during a patient’s course of treatment, Hrehor says. This is one of the nine billing characteristics noted in the OIG report.
◆ **60 or more days of service:** The percentage of beneficiaries who have greater than or equal to 60 days of service at the PHP. Although CMS does not cap PHP services, they could continue beyond the point of medical necessity, Hrehor says. The OIG report identifies long durations of PHP as a risk.

◆ **30-day readmissions:** When beneficiaries leave a PHP and return within 30 days of discharge — to the same or a different PHP — something could be amiss. Hrehor says readmissions tend to be more of a quality issue. Maybe beneficiaries were discharged early or discharge planning is ineffective, or patients are not compliant with their medication regimen.

“The OIG report should be a wake-up call for folks in this industry to ensure that they are adhering to Medicare regulations and that their programs are patient-centered,” Hrehor says. “Although OIG only focuses on CMHCs, other PHPs should also pay attention and consider looking more closely at some of the risk areas that OIG noted.”

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