The time is ripe for self-audits at skilled nursing facilities (SNFs) with the imminent release of the first Program for Evaluating Payment Patterns Electronic Reports (PEPPER) for SNFs and the Affordable Care Act’s new compliance program mandate.

SNFs will start to receive the first round of PEPPER at the end of August, says Kim Hrehor, project director for TMF Health Quality Institute, which generates the data under contract with CMS. Therapy (physical, speech and occupational) is the focus of the SNF PEPPER because it drives Medicare reimbursement.

PEPPER, a free compliance monitoring tool, is already distributed to short-term acute-care hospitals, long-term care hospitals, critical access hospitals, hospices, inpatient psychiatric and rehabilitation facilities and partial hospitalization programs. The reports are used to identify potential overpayments and underpayments.

TMF has focused on SNFs partly because of an HHS Office of Inspector General 2012 report, which found that they were overpaid $1.5 billion in 2009. Meanwhile, the Affordable Care Act requires SNFs and nursing homes to implement a compliance program by March 2013. CMS has not issued regulations, but the requirement is in effect anyway, lawyers say.

Medicare beneficiaries are admitted to SNFs (after a qualifying inpatient stay) for up to 100 days of intensive treatment for strokes and other conditions that impede their ability to perform activities of daily living (ADL). Medicare pays SNFs per diems based on resource utilization groups (RUGs). SNFs assign RUGs according to a beneficiary’s scores on the minimum data set (MDS), which represents his or her clinical condition, functional status and use of services, but therapy drives RUG assignment. According to the OIG report, RUGs were billed incorrectly on 23% of claims, and in a lot of cases, SNFs billed “ultrahigh therapy RUGs when they should have billed for lower levels of therapy or non-therapy RUGs.”

CMS hopes PEPPER will be used by SNFs to identify and reduce their own errors. PEPPER compares a facility’s Medicare billing to other SNFs in the state, Medicare administrative contractor (MAC) jurisdiction and nation in certain risk areas. When billing in a risk area is at or above the 80th percentile, it means the SNF bills a higher percentage for that risk area than most SNFs nationally. It’s up to the SNF to determine whether billing errors exist or there is some reasonable explanation.

TMF will provide the nation’s 15,700 SNFs with PEPPER data in these six risk areas, according to Hrehor:

1. (1) and (2) —Therapy RUGs with high ADL and nontherapy RUGs with high ADL: These two risk areas address concerns with accurate reporting on the MDS of the assistance beneficiaries need with ADL, Hrehor says. For example, SNFs may report that beneficiaries required more assistance than is reflected in the medical record, which causes overpayments, she says. Reporting less assistance than documented causes underpayments.

2. (3) Ultrahigh therapy RUGs: The number of days billed for ultrahigh therapy RUGs is compared to the number of days billed for all therapy RUGs in this risk area.

3. (4) All-therapy RUGs: This risk area compares days billed for all-therapy RUGs to days billed for all RUGs.

4. (5) Change of therapy assessment: SNFs have been required since fiscal year 2012 to evaluate beneficiaries to determine whether therapy should be adjusted as the stay progresses. CMS believes if SNFs are conducting a lot of assessments, “it could be an indication the SNF is having trouble anticipating or delivering the services the beneficiary needs,” Hrehor says. At the same time, few or no assessments are “not necessarily a good thing” and may be targeted by recovery audit contractors and Medicare administrative contractors.

5. (6) SNF stays of 90 days or longer: The question is whether beneficiaries really need skilled services for so long and whether they are receiving them the entire time. SNFs have to become more vigilant in light of the ACA’s compliance program mandate, OIG report and PEPPER, say attorneys Brian Bewley and Barbara Miltenberger, with Husch Blackwell in Jefferson City, Mo., and Kansas City, Mo., respectively. Skilled nursing facilities often contract out for therapy, which complicates oversight, Bewley notes. But the SNFs submit the claims so they are the ones on the line. “SNFs will have to become more vigilant to ensure documentation supports the services provided,” Miltenberger says.
Suppose the beneficiary had a stroke and requires occupational therapy to regain right-hand function. “When they start, they can’t feed themselves, but as they progress they can do more and their ADL scores improve,” Miltenberger says. “Facilities need to evaluate whether the patient still needs 500 minutes a week of therapy or if fewer minutes are more appropriate. That is what the PEPPER is trying to have facilities evaluate — how much therapy patients need.” A beneficiary with a broken hip who can’t walk 50 feet but walks 300 feet in two weeks may not need as much physical therapy at that point, she says.

Certification also is a compliance hot spot. “SNFs have to have certification for continued therapy at certain periods of time in their Medicare stay and it must be signed by the physician and dated before billing,” Miltenberger says. If SNFs have trouble with timely certifications, medical directors can prod physicians because they respond better to their peers on some regulatory requirements, she says.

Now that PEPPER exists for SNFs, Bewley advises facilities to spring into action and use them to determine if the organization has received improper payments. “Down the road, if you become the subject of a whistleblower lawsuit and the allegations overlap with any areas highlighted in PEPPER, the government can use your failure to take it seriously as potential evidence you acted in reckless disregard,” Bewley says.

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