Medicare watchdogs are turning up the heat on inpatient rehabilitation facilities (IRFs) and in the process helping them nail down their errors. In mid to late September, CMS will release the first Program for Evaluating Payment Patterns Electronic Report (PEPPER) for IRFs, which indicates there are problems in this area. Meanwhile, Medicare reviewers and a zone program integrity contractor (ZPIC) — CMS’s fraud and abuse hunter — have been scrutinizing inpatient rehab billing.

PEPPERs are free electronic reports on billing rates in certain risk areas. They are designed to help hospitals focus their compliance monitoring on outliers unique to their facilities. PEPPERs were first provided to short-term acute care hospitals and later to long-term acute care hospitals, critical access hospitals and inpatient psychiatric facilities. Now it’s the IRFs’ turn, says Kim Hrehor, project director for the TMF Health Quality Institute, which generates PEPPERs for CMS. PEPPERs compare an IRF’s billing to that of other IRFs in the state, Medicare administrative contractor (MAC) jurisdiction and nation in four “target areas,” she says. When an IRF’s billing in a target area is at or above the 80th percentile — which means it bills a higher percentage for that target area than do 80% of all IRFs nationally — PEPPER will light a flare. It’s up to the IRFs to follow up and determine whether there’s a compliance issue or some reasonable explanation.

There are 1,169 IRFs in the country, and 80% are hospital based. The rest are freestanding rehab hospitals. Under Medicare’s 60% rule, 60% of every IRF’s patients must have one of 13 diagnoses: stroke, brain injury, amputation, spinal cord injury, hip fracture, neurological disorders, major multiple trauma, congenital deformity, burns, three arthritis conditions (after aggressive outpatient therapy failed) and joint replacement for both knees or hips (when surgery immediately precedes admission, age is equal to or greater than 85, and body mass index is equal to or greater than 50).

Medicare uses a prospective payment system to reimburse IRFs. The payment unit is case mix groups, and there are 100 CMGs. They are based on rehabilitation impairment categories, functional status (motor and cognitive), age and comorbidities (additional disorders). Patients are classified into a CMG based on the patient assessment instrument (PAI), which is completed by IRF staff. IRFs enter the patient’s age, level of impairment and functional independence measure (FIM) into the PAI. Every CMG also has a tier assigned to it that corresponds to the patient’s comorbidities. It takes greater resources to treat patients with more comorbidities, so IRFs get paid more for them. Tier one carries the highest reimbursement because the patient has the most comorbidities. Tier two is the second highest, tier three is lowest (fewer comorbidities, less reimbursement), and tier four means no comorbidities. A little calculating magic occurs, and the IRF has a CMG payment.

Medicare covers IRF admissions only when documentation demonstrates that patients required multiple therapies (e.g., physical therapy and/or speech and occupational therapy and/or prosthetics/orthotics) and three hours of daily therapy at least five days a week.

**PEPPERs Have Four Target Areas**

To help IRFs evaluate their admission necessity and billing compliance, they will receive PEPPERs in four target areas:

1. **Miscellaneous CMG:** The focus here is on CMGs 2001 to 2004, which fall outside the conditions that help IRFs qualify for the 60% rule, Hrehor says. Miscellaneous CMGs include certain conditions, such as debility or generalized weakness, that aren’t classified in other CMGs. Medicare has received more claims for them in recent years, and there is growing concern that patients with these CMGs don’t require expensive inpatient rehab.

2. **CMGs at risk for unnecessary admission:** Certain CMGs may not pass admission-necessity muster (e.g., knee and hip replacement, high-functioning stroke patients), she says. “We are looking at eight CMGs that have no tier assignment and represent higher functioning patients, so there’s a question of whether they really needed an inpatient level of care,” Hrehor says.
(3) **Outlier payments:** Some IRFs submit a high percentage of claims with outlier payments, which are bonuses for patients that have unusually high costs associated with their cases, Hrehor says. Documentation may not support a level of care beyond what’s required for the CMG. “Also, there’s concern some IRFs may keep their patients too long to artificially run up costs to receive the outliers,” she says. Errors in the IRF’s annual cost report — which could translate into an incorrect cost-to-charge ratio and affect outlier payments — also could be a contributing factor, she says.

(4) **Admissions to short-term acute care hospitals after discharge from the IRF:** TMF found that roughly 20% of patients discharged from an IRF are admitted to a short-term acute care hospital within 30 days. “That was a little worrisome,” Hrehor says. CMS felt that IRFs may not be preparing patients and their families for discharge and all it entails (e.g., equipment that enables patients to bathe, get out of bed). Discharge planning should begin at admission, according to CMS. Christine Newgren, chief compliance officer for University of Colorado Hospital in Aurora, says the readmission issue could have a ripple effect given the crackdown on readmissions generally (RMC 8/8/11, p. 5). “The risk is this could affect our quality indicators and reputation, potentially impacting future revenues,” and trigger an audit with the potential for recoupment and possibly fines and penalties if egregious billing errors are discovered, she says.

Newgren calls IRFs an “easy target for CMS” because of rigorous documentation requirements. “The necessary information supporting appropriate IRF status is either there or not, period,” she says. IRFs put themselves at compliance risk if patients are not assessed appropriately for admission. For example, IRFs should determine whether patients could be treated in an outpatient setting and lack “significant extenuating circumstances” (e.g., medical history, ability to tolerate three hours of therapy a day), Newgren says. IRFs also must ensure they have a physician order for the patient.

Be vigilant about CMGs for hips and knees, she says. They’re a popular condition for CMGs, but stand a good chance of falling outside the 60% rule. Newgren suggests generally keeping an eye on CMGs in terms of the 60% threshold and confirming there’s an effective process to capture accurate comorbidities.

IRFs are on the government’s radar screen. “There were numerous probe audits from 2004 and 2010,” says one national inpatient rehab expert who asked not to be identified. Cahaba, a MAC, is auditing IRFs extensively in Tennessee, the expert says. And at least one ZPIC has found IRF problems.

Adding PEPPER ups the ante. As TMF grows more adept at data mining and reporting, “different areas are hitting the PEPPER report to provide information to providers to use on a proactive audit basis,” Newgren says.

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