CMS Adds Many New Targets to ‘PEPPER’ Reports Based Partly on RAC Findings

CMS is adding a slew of new targets to the Program for Evaluating Payment Patterns Electronic Report (PEPPER), with an emphasis on the necessity of hospital admissions, RMC has learned. They mirror many of the recovery audit contractor (RAC) and Medicare administrative contractor (MAC) targets, but point hospitals in the direction of their own errors often before external auditors show up.

“PEPPERS” are free CMS electronic reports on hospital billing available to all short-term acute care hospitals. Because PEPPER compares hospitals to one another in what will soon be at least 28 risk areas, hospitals can focus their monitoring on coding and admission-necessity outliers.

“CMS sees the PEPPERS as one piece of the pie that can help prevent improper payment on the front end and help avoid pay and chase on the back end,” says Kim Hrehor, project director for the TMF Health Quality Institute, the Texas-based Medicare quality improvement organization that generates PEPPER for CMS.

Here are the four new coding targets being added to PEPPER, Hrehor says:

- Unrelated operating room procedures,
- Complications/comorbidities (CCs) and major CCs (MCCs) for surgical DRGs,
- Excisional debridement, and
- Ventilator support.

There are at least 14 new PEPPER admission-necessity targets, which address whether it was necessary to perform the services on an inpatient versus outpatient/observation basis:

- Unrelated operating room procedures,
- Chronic ischemic attack,
- Circulatory system diagnoses,
- Other digestive system disorders,
- 30-day readmissions to the same hospital,
- Two-day stays for other vascular procedures,
- Two-day stays for heart failure and shock,
- Two-day stays for cardiac arrhythmia,
- Two-day stays for esophagitis/gastroenteritis,
- Two-day stays for nutritional/metabolic disorders,
- Transient ischemic attack,
- Chronic obstructive pulmonary disease,
- Percutaneous cardiovascular procedure with stent insertion (both drug eluting and non-drug eluting stents),
- Syncope,
- Ambulatory/Outpatient
  - Neither inpatient admission nor outpatient observation is expected.  Contact Utilization Review: 729-2000 (ABC Hospital) 403-1916 (EFG Hospital) with questions.
  - When more time is needed to evaluate a patient’s condition, response to treatment, and/or to determine the need for inpatient admission.  (Alternative to inpatient admission.)
  - Patient has complications following ambulatory/outpatient procedure.
- Admit Inpatient
  - Meets inpatient criteria.  Contact Utilization Review: 729-2000 (ABC Hospital) 403-1916 (EFG Hospital) with questions.
  - Procedure is listed on Medicare “inpatient only” listing (i.e., carotid endarterectomy, coronary artery bypass graft, open cholecystectomy, total shoulder replacement, radical neck dissection).
  - Admission to critical care.

Improving Site-of-Service Compliance: Patient Status Order

With government auditors hot on the trail of claims for inpatient admissions that they think should have been observation or outpatient cases, hospitals could go a long way toward reducing their recoupment risk with a more effective physician order. Donna Wilson, senior director at Compliance Concepts, Inc., says it helps to define what the different status types mean — and give examples of Medicare inpatient-only procedures. Contact Wilson at dwilson@ccius.com.

Patient Status Order Sheet — Initial Order Set

Clearly indicate ONLY ONE CHOICE of Patient Status on arrival (CHECK ONE).

PATIENT STATUS MUST BE INDICATED PRIOR TO BED ASSIGNMENT

ABC Hospital Patients please fax order to Bed Management: 729-4000
EFG Hospital Patients please fax order to Bed Management: 403-1900

- Ambulatory/Outpatient
  - Neither inpatient admission nor outpatient observation is expected.  Contact Utilization Review: 729-2000 (ABC Hospital) 403-1916 (EFG Hospital) with questions.
  - When more time is needed to evaluate a patient’s condition, response to treatment, and/or to determine the need for inpatient admission.  (Alternative to inpatient admission.)
  - Patient has complications following ambulatory/outpatient procedure.

- Admission to critical care.

Physician Signature Date/Time:
Nursing Signature Date/Time:
Two-day stays for renal failure, and
One-day stays for chest pain/atherosclerosis (which is a hybrid of the existing one-day stay for chest pain target and a new risk area for atherosclerosis).

“If you do a side-by-side comparison of PEPPER versus RAC, they are looking at pretty much the same things, especially one-day stays,” says consultant Donna Wilson, a senior director with Compliance Concepts, Inc. “This will be helpful from a benchmarking standpoint.”

Hrehor says hospital-specific data in these new areas will be made available to all short-term acute care hospitals in the next batch of PEPPERS around Feb. 24. The hospitals will also continue to receive statistics on the original risk areas, which for coding are:
- Stroke/intracranial hemorrhage,
- Respiratory infections,
- Simple pneumonia,
- Septicemia, and
- CC/MCC for medical DRGs.

For admission necessity, they include:
- DRGs for medical back problems,
- Three-day hospital stays prior to a skilled nursing facility admission,
- 30-day admissions to the same hospital or to another short-term acute care hospital,
- One-day stays excluding transfers, and
- One-day stays for medical DRGs.

CMS also has instructed TMF to develop PEPPERS for other types of facilities in addition to the PEPPERS currently available for long-term acute-care hospitals, which will be released in April. Hrehor says critical access hospitals will get PEPPER data in April, and PEPPERS will be released to inpatient psychiatric facilities in June and inpatient rehabilitation facilities in September. “The PEPPER for each setting will have individualized target areas for discharges prone to improper payments,” Hrehor says.

PEPPER Doesn’t Identify Errors

PEPPER doesn’t identify billing errors; it provides customized data so hospitals can assess their risk for underpayments and overpayments and prioritize their audits. PEPPER compares each hospital to all other hospitals in the state, in the MAC or fiscal intermediary (FI) jurisdiction, and in the nation.

PEPPER flags 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 nation.

PEPPER data are also provided at the other end for coding targets, which means hospitals will be informed when their percentage of claims for a risk area is lower than all but 20% of the hospitals in the state, MAC/FI jurisdiction and/or nation. Either of these extremes is a signal that a hospital should delve into its medical records to see if there are overpayments or underpayments versus some innocent explanation for the outlier.

Most new targets were added because they were identified as error-prone by the RAC demonstration and/or national program, Hrehor says. Also, “several of these target areas were added at the request of hospitals,” she says. For example, hospitals asked for PEPPER data on 30-day readmissions to the same hospital. “That will help hospitals evaluate readmissions to their own hospital, as well as determine how many of their patients are discharged and readmitted to another short-term acute care hospital.” Similarly, hospitals requested data on CCs and MCCs for surgical DRGs.

Confusion Exists About Use of Data

CMS first presented PEPPER data to hospitals under the now-defunct Hospital Payment Monitoring Program (HPMP), a nine-year vehicle to reduce inpatient payment errors. After a dormant period, PEPPER resurfaced in February 2010, a survivor of HPMP (RMC 2/1/2010, p. 1).

Although hospitals welcome back PEPPER, there is confusion over how to apply it, Hrehor and Wilson say. In response, the next batch of PEPPERS will elaborate on the use of the data. “We heard from hospitals that they wanted more guidance on what to do with PEPPER integrated into the report itself,” Hrehor says. “We are trying to make it easier for hospitals to understand the data and use them.” For example, if Hospital ABC identifies an increasing trend in a target area over the past six quarters, “we would encourage them to conduct a review of medical records and think about what might cause this increase.”

The improved PEPPER format will also include suggested interventions, which are currently included in the PEPPER User’s Guide but will be added to the PEPPER itself to assist hospitals with thinking about next steps. “We want to give hospitals as much assistance within the PEPPER itself as possible, so they can take the report and run with it,” she says. To see a sample of the redesigned PEPPER, visit PEPPERresources.org.

Wilson says PEPPER data can be applied more effectively when the coding, compliance, clinical documentation improvement and case management departments understand the mechanics. The PEPPER comparisons are based on a fraction. The numerator is the more serious, higher-paying version of a DRG cluster or the admissions that may be unnecessary, and the denominator is a combination of the less and more
serious DRG in the same cluster. Take the PEPPER target of strokes. The numerator is all of a hospital’s cases for DRGs 61 to 66, which include acute stroke with or without the use of a thrombolytic agent and intracranial hemorrhage or cerebral infarction with or without CCs or MCCs. The denominator is the DRGs in the numerator — plus cerebrovascular accidents or transient ischemic attacks (DRGs 67 to 69), Wilson says.

The numerator for another target is the individual hospital’s simple pneumonia or pleurisy with CC or MCC (DRG 193 and 194). The denominator is simple pneumonia or pleurisy with CC or MCC and chronic obstructive pulmonary disease (COPD) with and without CC or MCC (DRGs 195 and 190 to 192).

Breaking down the math helps hospitals get to the root of potential overpayments and underpayments. Sometimes hospitals are making billing errors. But “coding and documentation may be excellent, allowing the correct code assignment into a major condition, which skews the fraction and puts a hospital above the 80th percentile,” Wilson says. “On the flip side, documentation may be weak, causing the coder to default to a minor condition.”

If, for example, your hospital is in the 90th percentile for strokes according to PEPPER, Wilson advises hospitals to pull all medical records for MS-DRGs 61 to 68 for a recent Medicare billing quarter. Ask coders to review the coding and DRG assignment, and have clinical documentation improvement specialists assess documentation, she says. “Analyze the results as a team and decide on the next steps,” she says. Maybe there are no errors; PEPPERS are red flags, not a foregone conclusion. Or “you may need to educate coders,” neurologists or internal medicine/family practice physicians.

One Physician Can Be the Culprit

One hospital-client, for example, had what it called a PEPPER meeting and “we found a pattern,” Wilson says. One physician was responsible for the hospital being below the 20th percentile because he documented cerebrovascular accident when patients had more serious strokes, which meant hospitals took a loss on treating those patients, she says.

The same analysis applies to the PEPPER targets addressing the necessity of hospital admissions. For example, with one-day stays for chest pain, the numerator is one-day stay chest-pain patients (DRG 313) except patients sent to another short-term acute-care facility or who left against medical advice or died, Wilson says. The denominator is still DRG 313, but it includes all discharged chest pain patients regardless of their length of stay and reason for leaving, she says.

When hospitals monitor patient status, they are better able to distinguish who belonged in observation. Improving physician orders can go a long way to getting patient status right.

“When analyzing one-day stay patients, make sure you educate cardiologists,” Wilson says. “Go before them and talk about PEPPER reports and tell them where you stand,” but keep your presentation brief and to the point. “Show them PEPPER is a tool the government is using to analyze our data, and that, for example, we are a little high on chest pain admissions and need to find out why.” But she advises against having these discussions until they are cleared with the department chairman or vice president of medical affairs. An outlier may boil down to one physician who never met a chest-pain patient he didn’t admit.

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