New MAC Audits Target High Error Rates; Short Stays, Procedures Are Seen as Focus

In the long run, hospitals with good compliance track records will experience fewer audits under CMS’s new “targeted probe and educate” strategy, which probably will focus on short stays and expensive procedures, some experts say.

The “targeted probe and educate medical review strategy” will concentrate on providers and suppliers with “the highest claim error rates or billing practices that vary significantly from their peers,” according to the CMS website. Medicare administrative contractors (MACs) will run the targeted probe and educate strategy—TPE, as CMS calls it—and identify high-risk providers through “data analysis,” although CMS didn’t specify the nature of the data analysis.

The targeted probe and educate strategy is like a dog whistle calling for hospitals to do more to reduce their billing errors, says Nancy Perilstein, a senior manager with Deloitte Advisory in Philadelphia. “They are asking hospitals to identify outliers using their own data analytics or PEPPER,” which is the Program for Evaluating Payment Patterns Electronic Report, the free CMS reports on comparative billing rates in certain medical necessity and coding areas, she contends.

The TPE will be different from MACs’ previous probe audits, CMS says. Usually, MACs select a service, such as cataract surgery (RMC 3/27/17, p. 1), and review all providers in their jurisdiction. This time around, MACs are hunting for providers who cross some still-unidentified line. “This eliminates burden to providers who, based on data analysis, are already submitting claims that are compliant with Medicare policy,” CMS says.

Here’s the process: The MACs will start with a review of 20 to 40 claims, followed by provider-specific education if they find errors. There’s a round two for providers with “moderate and high error rates”—which have not been defined by CMS—and more education. Then there’s a third round of audits, and providers that do poorly could be put on 100% prepayment review, referred to a recovery audit contractor or face other action. On the bright side, “providers suppliers may be removed from the review process after any of the three rounds of probe review if they demonstrate low error rates or sufficient improvement in error rates as determined by CMS,” according to the website (see flowchart, p. 3). After CMS piloted this in one MAC jurisdiction in June 2016 and three more in July, it decided to expand TPE nationally.

Data obviously is pivotal because MACs determine what error rates constitute “moderate” and “high.” To generate data for some of the highest risk areas, the MACs could turn to the First-look Analysis Tool for Hospital Outlier Monitoring (FATHOM), which they can use to generate reports for the PEPPER risk areas. They receive FATHOM from the TMF Health Quality Institute, which generates PEPPERs for CMS, says Kim Hrehor, TMF project director.

PEPPERs are provided quarterly to all short-term acute-care hospitals and annually to long-term acute-care hospitals, critical access hospitals, inpatient psychiatric facilities, inpatient rehab facilities, hospices, home health agencies, skilled nursing facilities and partial hospitalization program providers. The purpose of PEPPERs is to help hospitals

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point their compliance monitoring in more productive directions—toward outliers, which could mean overpayments or underpayments depending on the reason billing is outside the norm.

The PEPPER data is specific to each hospital. It compares the hospital’s billing statistics for risk areas to other hospitals in the nation, MAC jurisdiction and state. It’s a red flag when a hospital’s billing in a risk area is at or above the 80th national percentile, which means it bills a higher percentage for that target area than 80% of all hospitals nationally. That doesn’t necessarily mean there was an error, but it’s up to the hospitals to determine whether there’s a compliance issue or some reasonable explanation.

**Short Stays Are Where the Money Is**

Because PEPPERs may take center stage with the new target probe and educate strategy, hospitals should double down on their PEPPER use, Perilstein says. “Investigate your outliers. Conduct a deep dive by reviewing records to understand why a targeted area is an outlier,” she suggests.

The way she sees it, short hospital stays under the two-midnight rule will be the center of the targeted probe and educate strategy. It’s essentially a supplement to the inpatient vs. outpatient reviews now underway by quality improvement organizations (QIOs). “QIOs are looking at a much smaller number than previous auditors were looking at and CMS needs help,” Perilstein says. Even though the probe and educate strategy refers to a wide range of providers, “I suspect the emphasis is still on inpatient vs. outpatient,” she says.

That makes sense, Hrehor says. “If they want the bang for the buck, that’s where they will go,” she says. Hospitals might want to get a jump on things with the PEPPERs. “It would be logical for hospitals that have a high percentile for one-day stays to do a second look,” Hrehor says. If they have a very high percentile—greater than 95% compared to other hospitals in the nation—that “will make them stick out like a sore thumb,” she says.

Four of the PEPPER risk areas are about short stays: two-day stays for medical MS-DRGs, two-day stays for surgical MS-DRGs, one-day stays (including same-day stays) for medical MS-DRGs and for one-day stays for surgical MS-DRGs.

When this data is crunched, TMF doesn’t filter out admissions for inpatient-only procedures, Hrehor says. “We look at the DRG level, and there isn’t a one-on-one crosswalk between ICD-10 codes or CPT codes,” which CMS uses to identify inpatient-only procedures in Addendum E of the outpatient prospective payment system regulation. That means hospitals have to take an extra step with their PEPPERs, she says. If they don’t perform a lot of inpatient-only procedures but still have a high percentile for the one- and two-day stay risk areas, they should examine whether these admissions are supported in the documentation. “It could be the physician anticipates the patient requires two or more midnights, but something unusual happens and the patient can be discharged sooner,” Hrehor says. “The documentation must substantiate it.”

Although short stays probably will dominate the targeted probe and review strategy, “that’s not to say they won’t look elsewhere,” Hrehor notes. She doubts coding will be a big draw, but if MACs go there, it may be toward septicemia, which is a PEPPER risk area. “It keeps cropping up as a coding problem,” Hrehor says.

Hospitals probably also will face audits of procedures with the target probe and educate strategy. “Surgical DRGs pay a lot more than medical DRGs,” she notes. Spinal fusion is high on the list, Hrehor and Perilstein say. The thrust is whether patients really needed the operations or could have been better managed with conservative treatment (e.g., medication, physical therapy).

Some MAC targets may straddle both. Cardiac defibrillators or percutaneous cardiovascular procedures, for example, could be challenged in terms of whether there was medical necessity and/or whether the inpatient admission for the procedure was supported by documentation, Hrehor says.
Walking Through CMS’s New Targeted Audit Strategy

CMS on Aug. 14 introduced its “targeted probe and educate medical review strategy,” which will concentrate on providers and suppliers with “the highest claim error rates or billing practices that vary significantly from their peers,” according to the website. Here’s CMS’s flowchart explaining the process. Visit http://tinyurl.com/y958thet.

**Targeted Probe & Educate**

Round 1

- Select Topics/Providers for Targeted Review Based Upon Data Analysis *
- Probe 20-40 Claims Per Provider/Supplier
- Compliant?
  - Yes
  - No

Round 2

- Educate – Can Occur Intra-Probe
- Allow ≥45 Days (so provider has time to improve)
- Improvement - Provider Compliant?
  - Yes
  - No

Round 3

- Educate – Can Occur Intra-Probe
- Allow ≥45 Days (so provider has time to improve)
- Improvement - Provider Compliant?
  - Yes
  - No

- MAC Shall Refer the Provider to CMS for Possible Further Action**
- Discontinue For at least 12 months

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**Will Process Improvement Be Delayed?**

Numbers alone won’t tell the whole story. “It’s up to the hospitals to determine whether it’s normal for them,” she says. A heart hospital obviously will have different cardiovascular procedure rates than a general acute-care hospital. “You have to dig deeper” once the PEPPER data comes in, Hrehor says. “Ask questions and find out whether you’re complying with Medicare payment policy and whether the documentation is sound.”

Perilstein notes that PEPPER data is six months old, so hospitals are looking at trends in their admissions and procedure billing. “If outliers continue quarter after quarter, that will get the attention of CMS auditors,” she says. “They will want to investigate further.” It’s an argument for hospitals to do a similar review internally that will take place with the target probe and educate strategy, Perilstein says. She also suggests hospital case managers review zero- and one-day stays for billing compliance before the bills drop.

There’s a carrot and a stick here, with either fewer audits or RAC referrals (or whatever CMS decides will be the consequences for repeat offenders). But it may take a while.

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*Data Analysis definition per PUB 100-08, §2.2 available at http://go.cms.gov/2vzUrPQ.
**Further Action May Include Extrapolation, Referral To ZPIC/UPIC, etc.
“I’m a bit surprised that CMS is requiring three rounds of audits by the MACs before having to refer the provider back to CMS for further scrutiny,” says Ronald Hirsch, M.D., vice president of R1 Physician Advisory Services. CMS indicates that each round will be delayed after education to enable providers to improve their practices before auditing again, which would imply CMS wants to see improvement by round two or get tipped off, he says. “I hope this extended timeline will not diminish the urgency of process improvement by hospitals that are selected for audit,” Hirsch remarks.

There’s a glimmer of hope that the target probe and educate strategy will not backfire. “I feel like we are compliant. The workload may increase slightly, but if we are doing what we are supposed to do, maybe we will be OK,” says Linda Chandler, audit/appeals specialist at United Regional Health Care System in Wichita Falls, Tex. She doesn’t perceive the probe and educate strategy as limited to inpatient vs. outpatient claims or procedures. “I am thinking it will probably be doors wide open.”

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