# Transcript for Inpatient Psychiatric Facility (IPF) PEPPER Review Apr. 24, 2019

I think we'll go ahead and get started. I would like to welcome all of you to today's review of the PEPPER for inpatient psychiatric facility, my name is Kim Hrehor, I work for the RELI group which is contracted with the Centers for Medicare and Medicaid services or CMS to develop, produce and disseminate the PEPPERs. For those of you who are interested in captioning of today's session, you can access the live captioning by clicking on the link in the Q and A panel there, the very first question. Today I'm going to be focusing my discussion on the new release of the PEPPER for inpatient psychiatric facilities, that's the version Q4FY18.

So today I'm going to be focusing on, again, the PEPPER for inpatient psychiatric facilities, what I plan to do is review the newest version, Q4 FY18. Now, this year there are no revisions to any of the target areas in the IPF PEPPER, so it's going to be focused on mainly a high level overview of the PEPPER. We are going to review a sample PEPPER and other resources that you may find helpful.

If after today's session you are – you find that you still have questions, perhaps you're new to PEPPER and you might need a little bit more information or if you feel like we have not covered some of the material to the best of – to help you out, then please review some recorded training sessions that we have available on the PEPPER website. These are available as separate segments, I call them chapters, that review different portions of the PEPPER. They're there on the website, 24-7, for your access, and you can access them at your leisure.

So let me go ahead now and talk more generically about what is the PEPPER?

PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report, and essentially, the PEPPER is a comparative report that summarizes one hospital's or inpatient psychiatric facility's, Medicare claims data statistics for areas that might be at a higher risk for improper Medicare payment, primarily in terms of whether the patient's treatment was necessary and correctly coded and billed. In the PEPPER we call these target areas, and we're going to review the IPF target areas in just a few minutes.

The PEPPER will compare your facility's Medicare claims data statistics with aggregate Medicare data for – of other IPFs in three different comparison groups. So we're looking at all IPFs in the nation, all IPFs in your Medicare administrative contractor or MAC jurisdiction and in your state.

And these comparisons allow us to identify where your facility might be at a risk for improper payments which really just means that your billing practices are different from the majority of other IPFs in the comparison group. Now, there was a question that was submitted before the

webinar today from someone who was interested in how the information is attained within the PEPPER. And I can say that we download the claims for the – for each IPF from the Medicare claims database, and I'll talk about it in a little bit more detail here in a moment, but everything comes from the claims that are submitted by your IPF for Medicare beneficiaries, and these are traditional fee for service Medicare beneficiaries. We do not consider Medicare advantage claims. I would refer you to the PEPPER User's Guide. It does have more details there about the types of claims that are included in the IPF PEPPER.

I also want to stress that the PEPPER itself does not identify the presence of improper payments. Those can only be confirmed through a review of the medical record, but the PEPPER can give you clues as to where your billing patterns differ from those of most facilities in the nation, the jurisdiction, or the state, so then you can take the first step in determining whether any issues might exist or whether you need to take any action.

Many of you are probably aware that the PEPPER has been available for a number of years. It was originally developed in 2003 for short-term acute care hospitals and a couple of years later for long-term acute care hospitals, and back then the PEPPERs were distributed by the quality improvement organizations, and that occurred through 2008. Then in 2010, TMF Health Quality Institute began distributing PEPPERs to all providers in the nation, and along the following years, there were PEPPERs developed for other provider types, so we now have PEPPERs for critical access hospitals, inpatient psychiatric and rehab facilities, hospices, partial hospitalization programs, skilled nursing facilities and home health agencies.

Beginning in 2018, CMS combined the comparative billing report or CBR, and the PEPPER Programs into one contract. And so now RELI group, along with its partners, TMF and CGS, are producing CBRs and PEPPERs, and these are comparative billing reports cover a wide range of providers that we're summarizing now, not only Part A data in the PEPPER, but also Part B Medicare data in the CBRs. And we are now contracted with CMS through the Center for Program Integrity Provider Compliance Group to conduct this work. Now, the change in contractors should be transparent to the provider community, although you might notice a few formatting changes to the PEPPER, we do have a new website, and other folks on our team, but overall, you're going to also that we are going to continue the production of the PEPPERs and the support that the provider community has become accustomed to.

So why are PEPPERs being made available to inpatient psychiatric facilities?

Well CMS is mandated by law to protect the Medicare trust fund from fraud, waste and abuse, and CMS employs a number of strategies to meet this goal such as provider education and early detection through medical review, which might be conducted by the Medicare administrative contractors, the recovery auditors, or other individual groups, as well as data analysis activities. The provision of PEPPERs supports these strategies. CMS considers the PEPPER to be an

educational tool that can help providers identify where they might be at a higher risk for those improper Medicare payments so then they can proactively monitor and take any preventative measures as necessary.

I also like to remind folks that the Office of Inspector General or OIG encourages healthcare providers to establish a compliance program to ensure that systems are established and in place to help protect their operations from fraud and abuse. As part of a compliance program, a provider should be conducting regular audits to ensure that charges for Medicare services are correctly documented and billed and that those services are reasonable and necessary. The PEPPER is provided again as that educational tool to help guide that auditing and monitoring activity.

So let's focus now more specifically on the new release of the PEPPER which is the version Q4 FY18, that simply means that it summarizes the claim data through the end of the fourth quarter of Fiscal Year 2018.

The IPF PEPPERs were made available April 5th, and each release of the PEPPERs summarizes statistics for three Federal Fiscal Years, so this version has the Medicare data summary for 2016, Fiscal Year 2017, and Fiscal Year 2018, and as a reminder, the Federal Fiscal Year starts October 1st, and it runs through September 30th of the following year.

Now, each time we produce a new release of the PEPPER, we download the claim data statistics for all of the time periods for each release, and so if you're looking at your PEPPER – your new PEPPER comparing it with last year's PEPPER, you might see some slight changes in numerator or denominator counts or percents, and the reason for that would be that there might have been adjusted claims submitted, corrected claims, late claims, any of those – any claims activities that would have gone on since last year's PEPPER was produced with the data will be refreshed and the statistics will reflect the claims database at the time we download the data.

And of course each time we produce the PEPPER, the older Fiscal Year rolls off as the new one is added on.

Okay, let's talk about improper payment risks that are pertinent to inpatient psychiatric facilities. The IPFs are reimbursed through the IPF prospective payment system or PPS, and just as with other provider types, IPFs are at risk for unnecessary admissions as well as incorrect coding which can impact reimbursements. The IPF PEPPER target areas were developed based on a review of the IPF PPS with a focus on areas that could be prone to improper payment. We also analyzed national claims data and we also coordinated with CMS subject matter experts to develop the target areas based on potential areas of concern.

Now, these target areas have changed over time. We do assess the target areas each year and coordinate closely with CMS as to whether target areas should be continued or if it might be

time to discontinue them whether that might be based on small numbers of IPFs having sufficient data or other concerns and those of you who are familiar with the PEPPER know that we've had some changes in the target areas over time, so it certainly is possible that that might continue.

Now, I've used this term "target area" a little bit now. What is a target area?

Essentially, it is a clinical condition or a type of admission that's been identified as prone to unnecessary admissions or incorrect coding or billing. The PEPPER includes two types of target areas, admission necessity and coding focused. The coding focused target areas, there's one in the IPF pepper that can be focused on the potential for overcoding as well as the potential for undercoding. In the PEPPER the target areas are constructed as ratios where the numerator is a count of discharges that might be problematic from either the admission necessity or coding standpoint and the denominator is the count of discharges of a larger reference group.

So let's review these target areas in the IPF PEPPER. Now, you will notice that each of the target areas have a numerator definition and a denominator definition, and we use this to identify the number of discharges that are counted in the numerator, and the denominator, which we then use to calculate the target area percent, which you'll see is reflected freely throughout the PEPPER when we get into the sample review. So the comorbidities target area, the first one that's listed here, this is the coding-focused target area in the PEPPER. Here we are calculating the percentage of claims that have at least one comorbidity on the claim. IPFs receive a payment adjustment for a number of comorbid conditions. When IPFs have a high percentage of patients with comorbidities it could be potential overcoding, and on the flip side, if there's a very low percentage of patients with comorbidity, it can be an indication of potential undercoding. Of course, you may expect to have a high or low target area percent for this target area depending on your patient population or whether your billing system allows for the coding of comorbidities. Of course, do consider your patient population when you're interpreting your statistics for this target area.

Next we have a target area that looks at no secondary diagnoses, and here we're calculating the percentage of claims, for discharges where there are no secondary diagnoses coded. Just as a reminder, claims should include the appropriate selection of the principal diagnosis as well as other additional and coexisting diagnoses, and these may not necessarily be psychiatric diagnoses. They can be for any active medical condition. Remember the coding guidelines do specify that those diagnoses should be recorded on the claim so that there's accurate information regarding the beneficiaries receiving the services.

Outlier payments calculates the percentage of total Medicare reimbursement comprised by outlier payments, and IPFs that have a high percentage of patients or outlier payments, dollars there, may wish to examine cases for outlier payments that – to ensure that the care was

medically necessary and that the claim was correctly submitted.

For the next couple of target areas, the three to five day readmissions, we are calculating the percent of patients readmitted within three to five calendar days or four to six consecutive days. This area is intended to assess the risk for potential circumvention of the interrupted stay policy where the patients who are readmitted within three consecutive days are treated as a continuation of the initial admission for reimbursement purposes, so you can see that if a patient is admitted after that consecutive day period, then there would be a whole new DRG assigned and it would be paid as a separate admission. And lastly, 30 day readmissions, as most of us know, CMS has long had concerns about readmissions, and they are focused on reducing readmissions because they are costly to the Medicare program, and they can represent quality of care issues, so we have the readmissions within 30 days target area here to help IPFs address that particular concern.

This slide I've added just as a reminder that if you're interested in the comorbidity categories and the associated ICD 10 diagnosis codes in each of those categories, that information is available on the CMS website at the link here. We used to include that information in the User's Guide, but it got to be very voluminous after ICD-10.

So now we can talk about for a few minutes--percent – target area percents which are calculated of course using that numerator and denominator definition, dividing the numerator by the denominator, multiplying by 100, and that gives us a target area percent. Now, we also use percentiles in the PEPPER. Percentiles are used to identify what we call outliers in the PEPPER and that would be providers who are either at or above the national 80th percentile or at or below the national 20th percentile for the comorbidities target area. I want to spend just a few minutes talking about the percentiles, how we calculate them and what they could indicate for you.

Now, remember, the percents – the target area percents are something that could be calculated by most of us using the access that we have to our own internal claims data. So you could calculate your target area percent, but one of the valuable perspectives of the PEPPER is knowing how your target area percent compares to that of other IPFs in the state, the jurisdiction or in the nation, and the percentiles help give us some context so that we can understand how our percent compares, and if we are relatively high or relatively low, and whether we might--should be concerned about that.

Now, when we calculate percentiles, we take all of the IPFs target area percents for a particular target area and time period, and we sort them from highest to lowest, so on the slide here I have a ladder example, a little ladder image. You can see that we have some target area percents that are sorted from highest to lowest. We identify the point below which 80 percent of the IPFs target area percent falls, and that is identified – that point is identified as the 80th

percentile. Any IPFs that have a target area percent that is greater than the one that's at the 80th percentile identified as high outliers in the PEPPER, and they will see their target area percent visually queued as red bold font. Now, for the comorbidities target area, we also identify the providers who are on the low end, so that would be at or below the national 20th percentile. The 20th percentile is the point below which 20 percent of the IPFs target area percent fall. And so if your target area percent is at or below for that comorbidity target area, then you would be identified as a low outlier with the potential question there is am I undercoding – am I potentially undercoding?

I want you to keep this ladder image in mind as we move into the sample PEPPER that I'm going to run through shortly here, because it will come back and help you identify or understand some of the numbers in the PEPPER.

Okay. You should be seeing on your screen now the first page of the IPF PEPPER. Now, this is a sample PEPPER. It's been de-identified. Those of you who are familiar with PEPPER know that it is a Microsoft excel workbook. You will navigate within the PEPPER by clicking on these worksheet tabs along the bottom of the screen.

When you first open the PEPPER, it opens to this very first page called the purpose page. You'll see your CMS certification number here, and your provider name. This row identifies the most recent Federal Fiscal Year, so this report is summarizing Federal Fiscal Years through the fourth quarter of Fiscal Year 2018. Just a little bit of information about the PEPPER. Scroll down a little bit further on the page, the version number, and then here is the jurisdiction. The MAC jurisdiction comparison group is comprised of all of the IPFs that submit their claims to the same Medicare Administrative Contractor as you do. So those providers make up the jurisdiction comparison group. If you're looking at the statistics in your PEPPER, just keep that in mind.

On the definitions tab, you will find complete numerator and denominator definitions for all of the target areas that are included in this release of the PEPPER. This might be helpful if you're looking through your statistics and you find that you have a question about what does the numerator or the denominator count represent, you can flip over to this worksheet and see the numerator or denominator definition.

This next report here is called the Compare Targets Report, and this is one of the more handy reports in the PEPPER. I like to call it the heart of the PEPPER. It's the only place within the PEPPER that you can see your IPF statistics for all of the target areas all on one page. I should clarify--for all of the target areas for which you have sufficient data to generate statistics.

Now, it does represent only the most recent Federal Fiscal Year, so if we look at the title, this report, this is for the four quarters ending fourth quarter Fiscal Year 2018, so it's only the most

recent year, but it is everything for all of the target areas. Let's take a quick look. So you'll see the target area name and then a brief description of the numerator and denominator for the target area. This will be your numerator count or for outlier payments the numerator amount. When we compare the numerator to the denominator, which is not on this report, we calculate the target area percent. So for the comorbidities target area, you can see we had 208 discharges that had at least one comorbidity coded on the claim. Our target area percent is 17.1 percent. But how do we know how we compare to other IPFs in the nation, in our jurisdiction or in the states?

This is where these percentile values come in very handy. Here we can see that our national percentile is 19.2. So I want you to think about the ladder and our percentile is 19.2. So that means that our target area percent of 17.1, that 19.2 percent of the IPFs have a lower target area percent than we do. So on that ladder, we are toward the bottom end of the distribution. 19 percent of the IPFs have a lower percent than we do. We are below the national 20th percentile, so we see our target area percent here displayed in green italics, so it's a way to help give us some context, how do we compare to all of the IPFs in the nation? Well, we're on the low end, because approximately 80 percent of the IPFs have a low – have a higher target area percent than we do.

Now, if we're comparing ourselves to all of our IPF in our jurisdiction, we are at the 19.4 jurisdiction percentile, so 19.4 percent of all of the IPFs in the jurisdiction have a lower target area percent than we do. And then in the state, 13 percent of the IPFs in the state have a lower target area percent. And these percentiles will be different for the three comparison groups, because we're being compared to a different set of IPFs, so we could expect those to be different. And this is the only place in the PEPPER where you are going to see your exact percentile, only on this report.

The last column here is the sum of payments, this represents the total amount of Medicare reimbursement that you received for these numerator discharges, so just over 3 million in reimbursement for these 208 discharges.

Now, if our provider was above the 80th percentile nationally, we would see our target area percent here in red bold font, but we can see that we don't have any outlier – any high outliers for any of these other target areas all at one glance, we can see, though, that we are at very low national percentiles for a couple of these target areas and so, again, thinking about that distribution of percents on the ladder here for the three to five day readmission, basically there are – there are no IPFs in the nation that have a lower target area percent than we do. Now, there is a blank here, in this cell. What does that mean? The percentiles are not going to be calculated if there are fewer than 11 IPFs in the state that have sufficient data for statistics to be calculated, so in that instance, you'll see a blank cell.

Let's take a quick look at the target area reports that are in the PEPPER. There is a spreadsheet for each of the target areas. And they're all formatted in the same way. This is the comorbidities report here on the graph. You're going to see your IPF's target area percent for these three Fiscal Years graphed as the blue bars. So it's nice to be able to see how your target area percent might be changing over time, and you'll also see the comparative data for the – here is the 80s percentile for nation, which is the solid line, jurisdiction is the dashed, and state is the dotted, so this is the 80th percentile boundary. The 20th percentile is the green line. Again, solid is nation. Dashed is jurisdiction. And dotted is state. So you can see how your target area percent compares to the 20th percentile for the comorbidities target area or to the 80th percentile for the other target areas.

Below the graph is our data table. We'll see our target area percent, and here we can see we have green italics, a visual cue, we are at or below the national 20th percentile for all three of these Fiscal Years. We see the numerator count for this target area, the denominator count, our average length of stay for the numerator discharges, our average length of stay for the denominator discharges, and then we see the average Medicare reimbursement and the total amount of Medicare reimbursement again for these numerator discharges.

Below our data table is the comparative data. These are the percent values that are at the 80th percentile for nation, jurisdiction, and state. And then the percent values that are at the 20th percentile for nation, jurisdiction and state.

These are the values that are graphed as the red and green lines up here in our graph.

And lastly, all of our target area reports include at the very bottom what we call suggested intervention. Suggested interventions for high outliers and for this target area for low outliers. Very generalized suggestions what this might mean and perhaps if you were interested in reviewing a sample of records, what types of records might you think about looking at? These are the same suggested interventions that are included in the PEPPERs' User's Guide, we've just included them within the PEPPER for ease of access.

So I'm just going to click through some of these other target areas. This is no secondary diagnoses. You can see there are no blue bars in this graph, and if we look at the data table – I'm sorry, the blue bar is very small but it's almost invisible, but the target area percent is really low. What this means when there are no data in the – in the table, and there are no blue bars in the graph, it simply means that your numerator count was less than 11, too small to calculate statistics. And it doesn't mean there's anything wrong with your PEPPER, it just means there wasn't sufficient data to generate the data there. Here is the outlier payments target area. Similar thing there, this IPF, does it have sufficient data for outlier payment?

Three to five day readmissions. This is a nice example of the provider having a steady decrease

from one year to the next in their target area percent. So if this was something that they were working on addressing in one way or another, their efforts seem to have had some success, because we can see their target area percent is decreasing every year. Although they never were a high outlier, their percent has been decreasing. And then here is the 30 day readmissions. Again, this provider is not a high outlier for this target area, small decrease every year, so that would be probably something the provider would welcome seeing. There are a couple of additional reports in the IPF PEPPER. These are supplemental data. They don't have any bearing on whether you might be considered an outlier in your PEPPER. They're just extra information for your own use. This top DRGs report summarizes the top DRGs for your IPF for the most recent Fiscal Year. You'll see the DRG here, description, the total number of discharges for that DRG, the proportion of discharges for each DRG, the total discharges and then the facility's average length of stay for that DRG. Each report will contain up to 20 DRGs. To be listed, they have to have at least 11 discharges, and there are some summary lines here for the top DRGs and all. And then there's another report in here that identifies the top DRGs for all providers in your jurisdiction, the jurisdiction name would be up here in the top of the report. And again, it just summarizes the same type of information, have the jurisdiction average length of stay for the DRG, as well as the national average length of stay.

So that's a quick look at a sample IPF PEPPER. Go back to my presentation now and continue on. Now, sometimes I'll get the question from providers, okay, so what do I have to do as a result of my PEPPER? Am I required to access my PEPPER and use it? No, there are no stringent requirements on whether you access, utilize, take any response to your PEPPER, you're not – there's no reason that you would feel forced to do so. But I always like to remind providers that there are other contractors that are sifting through the entire Medicare paid claims database. They might be looking for providers that could benefit from some educational intervention or maybe case review or some other type of assistance. I think it would be helpful for you to know when your statistics look different from the majority of other providers, so that way you can simply have that head's up, be aware, and you can determine whether your PEPPER statistics reflect what you know given your organization's operation, your patient population, the services you provide, the staffing that you offer and so on, or if it's something that might be concerning and you feel like maybe you should take another look. So I just encourage you to use this free report to examine how your statistics compare?

How do you obtain your PEPPER? The IPF PEPPERs are distributed through QualityNet to QualityNet administrators and to other – to those that have basic QualityNet accounts. This is new this year. CMS has asked us to distribute the critical access hospital PEPPERs through our portal instead of through QualityNet, so any IPF units of critical access hospitals will now access their PEPPERs through the portal. The majority of the IPF PEPPERs are distributed through QualityNet, same way as last year, and we do plan to continue to distribute the PEPPER on an

annual basis. For those critical access hospital units, the – there was a validation code that was sent by e-mail to your hospital's QualityNet administrator. If you're having trouble locating that, please contact us through our help desk and we can help you get access to your PEPPER.

Once you do have your PEPPER, let's just say that you see a lot of red or a lot of green in there, well, first thing I want you to not do is panic. Remember, just because you're an outlier, it does not mean that there are compliance issues that exist or that you're doing anything wrong, but again, think about why you are an outlier, does that make sense for your IPF?

Are there specialized circumstances that might impact the way your data look? If you feel like something doesn't fit right, if you've got a little queasy feeling in your stomach, encourage you to sample some claims, review the documentation and make sure that everything is coded and billed appropriately, that everything is documented fully in the medical record and so on.

Basically, just ensure that you're following those best practices, even if you're not an outlier.

A few other resources that we have available for you that we maintain every year after we release a PEPPER, we have national level and state level data for the target areas that are available on the PEPPER website. Again that's PEPPER.CBRPEPPER.org on the data page. We have for all the target areas as well as the top DRGs, and then we also segregate out some information for free-standing IPFs versus distinct part units. And those have been updated for this release.

We started putting together peer group bar charts a few years ago. This would be of value to you if you feel like you want to compare your target area percents from your PEPPER to the group that you consider to be your peer or closest to your peer. These peer group bar charts identify the 20th percentile, the 50th percentile, and the 80th percentile for IPFs in three different categories, when you're looking at size which is based on number of discharges. Locations, which is urban versus rural, and ownership types, that is profit or physician owned versus nonprofit or church owned versus Government. These bar charts are going to be updated on an annual basis. I will say that the bar charts have not been replaced yet. I expect they will be replaced any day now. Our team is working on finishing those up. If you disagree with your ownership type or your location, just comment here that we do utilize the Provider of Services file which is maintained by CMS to get those variables and so I would encourage you to contact CMS if you have any updates or correction to those variables.

And this is just an example of a peer group bar chart. This one is for outlier payments. It is for last year, 20 – calendar year 20 – I'm sorry, Fiscal Year 2017. We can see that we've got the 80th percentile, the 50th percentile, and the 20th percentile there on the vertical or Y axis. The bars there show how these different – different segments compare for the 80th percentile. We can see the size is the top graph. The smallest one third of the IPFs have the greatest 80th

percentile, 50th, and 20th, compared to the other two size categories, location, the darker red bar there are the rural providers who have higher percentiles and then the ownership type is also showing some differences, it looks like the Government owned, the middle green bar has the highest percentile.

There are a number of other resources that you can access on our website, again that's the new website, PEPPER.CBRPEPPER.org, you'll access the User's Guide there. There is a spreadsheet that identifies the number of IPFs in each MAC jurisdiction in total and then also by state. We have those recorded PEPPER training sessions. There is a sample IPF PEPPER there, as well as a history of target area changes and the impact on the statistics.

If you need assistance with your PEPPER or with obtaining your PEPPER, if you don't find the answer you need in the user's guide, please visit the website and click on the help/contact us tab. There's a help desk button, you just click on that and complete the online form, and a member of our team will respond promptly to assist you. Encourage you not to contact other organizations if you have questions about PEPPER.

This is a look at our home page. You can see there the resources for IPFs, the big blue arrow pointing there. Smack dab in the middle of the screen. We have the user's guide, the training and resources page, and the PEPPER distribution page easily accessible right there from the front page.