Transcript for Inpatient Rehabilitation Facility (IRF) PEPPER Review
April 18, 2019

Okay. I think we'll go ahead and get started. I'd like to welcome you all to this review of the PEPPER for inpatient rehabilitation facilities. My name is Kim Hrehor, and 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 captioning by clicking on the link that's in the Q&A panel. It's the first question there. Now, today I'm going to be focusing my discussion on the new release of the PEPPER for inpatient rehabilitation facilities, that's the PEPPER version Q4FY18.

As I mentioned today I'm going to be focusing on the PEPPER for inpatient rehabilitation facilities most specifically the new PEPPER that was released about two weeks ago, the version Q4FY18. Now, as in previous years we don't have any changes implemented to the target areas for the inpatient rehab facility PEPPER. For those of you who are familiar with the PEPPER, we are not going to be covering any new information. Today's session is mostly going to be a review. Those new to PEPPER are going to find this session the most helpful. I will be reviewing the target areas. I'll take a brief look at the sample PEPPER, and I will share other helpful resources that you can find on our website.

If you're new to PEPPER and/or if after today's session you still have questions about PEPPER, you feel you need additional training or information, I would encourage you to access the recorded training sessions that are available on the training and resources page at pepper.cbrpepper.org. I've made these available as several chapters. They're short segments that you can access at your leisure.

So what is PEPPER? PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report. And essentially the PEPPER is a comparative data report that summarizes one provider's Medicare claims data statistics for areas that might be at a higher risk for improper Medicare payment, primarily in terms of whether the claim was correctly coded and billed and whether the treatment provided to the patient was necessary and in accordance with Medicare payment policy. In the PEPPER we refer to these risk areas as target areas. The PEPPER summarizes your Medicare claims data statistics in these areas and it compares them with aggregate Medicare data of other providers in three different comparison groups. All providers in the nation, all providers in your Medicare Administrator Contractor, or MAC, jurisdiction and all providers in the state. These comparisons are the first step in

identifying where you might be at a higher risk for improper payments, which means that your billing practices look different from the majority of other providers in your comparison group.

Now, I do want to stress that the PEPPER cannot identify the presence of improper Medicare payments, but it can alert you if your statistics look unusual so then you can consider whether you might need to look a little deeper, conduct a review, and take any necessary next steps.

So the PEPPER has been available for a number of years. It was originally developed back in 2003 for short-term acute care hospitals and then a couple of years later a long-term acute care hospital PEPPER was developed. At that time the PEPPER was made available through the quality improvement organization. Then in 2010, TMF health quality institute began distributing PEPPERs to all providers in the nation and developed PEPPERs for other provider types, including critical access hospitals, inpatient psych and rehab facilities, hospices, partial hospitalization programs, field facilities and most recently home health agencies.

Beginning in 2018, CMS combined the comparative billing report or CBR, and the PEPPER programs into one contract. And now RELI Group and its partners, TMF and CGS are producing CBRs and PEPPERs. Now this change should be transparent, mostly transparent, anyway, to the provider community. You might notice a few formatting changes to the PEPPER. We do have a new website, but know our team is continuing the production of the PEPPERs and the support that the provider community has become accustomed to.

So why does CMS feel that the provision of PEPPERs to providers is supportive of agency goals? Well, CMS is protected – I'm sorry, 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, early detection through medical review, which could be conducted by the Medicare administrative contractors, the recovery auditors or another federal contractor, and data analysis activities. The provision of PEPPERs to providers supports these strategies. The PEPPER is an educational tool that can help providers identify where they may – might be at a higher risk for improper payment, so then they can proactively monitor and take any preventative measures if necessary. I also should mention that the Office of Inspector General or OIG encourages providers to have a compliance program in place to help protect their operations from fraud and abuse. And an important component of a compliance program is conducting regular audits to ensure that charges for Medicare services are correctly documented and billed and that those services are reasonable and necessary.

So the PEPPER can help support that auditing and monitoring component of a compliance program.

Now today I'm going to focus on the new PEPPER, Q4FY18, and what that means is this release of PEPPER summarizes statistics through the fourth quarter of fiscal year 2018. So when you

look at your new PEPPER you'll see the statistics for three federal fiscal years, 2016, 2017, and 2018, and just a reminder the federal fiscal year starts October 1, and it runs through September 30 of the following year.

Now, each time we produce a new release of the PEPPER we refresh the statistics for all three years in that report. So if you look at this PEPPER and compare it to last year's PEPPER, you might see some slight differences in numerator or denominator counts or percents or even percentile values and that would occur because there are probably a few late claims that are processed by your MAC or adjusted or corrected claims processed. All of those corrections and late claims and adjustments will be taken into account and all of the statistics will be refreshed with the data that are in the database at the time we pulled the data.

So keep that in mind if you're seeing some small changes in your statistics, comparing this year's to last year's PEPPER.

And of course we always roll off the oldest fiscal year as we add on the most recent one.

So let's talk about the improper payment risks that are pertinent to inpatient rehabilitation facilities. Now, again, remember the PEPPER doesn't identify improper payments. Those can only be confirmed through a review of the documentation in the medical record to support the treatment and diagnoses and procedure codes that were submitted on the claim. Inpatient Rehabilitation Facilities are reimbursed through the IRF PPS, or prospective payment system, and just as with other types of care providers, IRFs are at risk for unnecessary admissions and incorrect coding which can impact correct reimbursement. The target areas which really haven't changed much since we developed the PEPPER, they were developed by a review of the IRF PPS with a focus on areas that could be prone to improper payment. We also worked closely with CMS subject matter experts to develop these target areas, again, based on areas that they saw as potentially vulnerable.

We do assess the target areas on an annual basis to make sure that the target areas have continued applicability to the provider community.

One thing I also might mention is that there is another contractor, the comprehensive error rate testing contractor, and this company does a random – they conduct random reviews to estimate improper Medicare payments across all provider types, part A, part B, for CMS, and they put out an annual report, the CERT report. The most recent is the 2018 Medicare fee for service improper payments report and I thought I would mention that in the most recent report the IRFs have a 41.5 percent error rate with a projected $2.9 billion in error. And if you'd like to take a closer look at the report you can find it on the CMS website, CMS.HHS.gov/cert.

Now, in the PEPPER we construct our target areas as ratios, basically these target areas, they are the clinical condition or a type of admission that's been identified as prone to either

unnecessary admissions or not so much for the IRFs incorrect coding or billing, again these are ratios where there's numerator, which is a count of discharges that might be problematic from either an admission necessity or coding standpoint and then the denominator is the count of discharges of a larger referenced group. And right now the IRF PEPPER does not have any target areas that are focused on coding-related issues.

So let's move on right into a review of the target areas in the IRF PEPPER. We have four target areas. The first one here on the slide is called miscellaneous CMGs and you'll note we have a numerator definition, N, and denominator definition D. For the miscellaneous CMGs we're calculating the percentage of all Medicare discharges for the four miscellaneous CMGs, those include diagnosis such as stabilities, generalized weakness, other miscellaneous conditions and we do include all tier groups for these CMGs, so no comorbidity, the high comorbidity, the medium and the low. In general, these miscellaneous CMGs do not count toward the 60 percent compliance threshold which stipulates that 60 percent of an IRF population has to require treatment for one or more of 13 different conditions.

If you have a high target area percent for this target area, it could be possible that these patients do not require an IRF level of care or another way to think about it is perhaps there was a more definitive diagnosis that could have been assigned so it could be something related to correct coding.

The next target area CMGs at risk for unnecessary admissions calculates the percentage of discharges for eight CMGs as the proportion of all discharges. These eight CMGs represent higher functioning patients with no tier group assignment, so that means they have no comorbidities, the CMG prefix letter is A, and, again, these admissions could be at risk for unnecessary admissions and it's also possible, again, that there could be some coding concerns. Remember this target area doesn't have any discharges that have a comorbidity assigned. So these couple of target areas can help highlight the importance of that accurate coding of the principle and secondary diagnoses.

We also have a target area that looks at outlier payments where we're calculating the percentage of discharges that have an outlier payment amount greater than zero dollars. And then the last target area short-term acute care hospital admissions following IRF discharge, here we're looking at the percent of patients who are admitted to a short-term acute care hospital within 30 days of being discharged from an IRF. And here a high target area percent could possibly indicate that the families of patients are not prepared to handle the patient care issues once the patient is home. It could also indicate that the discharge planning process wasn't begun early enough in the patient's admission, or maybe there are post-discharge issues regarding medication compliance that could have been monitored or addressed. There are a lot of contributing factors to this, just something to think about.

Now using those numerator and denominator definitions we calculate a target area percent for each of those target areas and for each of the time periods. So in the PEPPER you're going to see your target area percent for all of those target areas. We also use percentiles in the PEPPER to identify what we call outliers in the PEPPER. I'll spend just a couple minutes describing or talking about the differences between percents and percentiles and how the percentiles are derived.

So here in the slide you see a ladder, and associated with each rung on the ladder is a percent, let's think of these as target area percents for a particular target area. So what we do is we take all of the target area percents for all of the hospitals, let's just say in the nation, and we sort them from highest to lowest. Now, this is for one particular target area, one particular time period, we sort those percents highest to lowest.

The point below which 80 percent of the IRFs target area percent falls, that point is identified as the 80th percentile. So any IRFs that have a target area percent that is at or above the national 80th percentile in the PEPPER they are identified as an outlier and you would see your target area percent displayed in red bold font, the visual cue there. If you have a target area percent that is below the 80th percentile you're not going to be identified as an outlier. You are going to have your percent in just plain regular black font.

The reason that this is important is because it helps to give you some context about where your hospital falls as compared to all the other IRFs in either the nation, the jurisdiction or the state, and it can help give you some context because we all can calculate our own specific target area percents for these target areas, but knowing how we compare to the other providers is really one of the biggest values of the PEPPER.

I'm going to switch right now to a sample PEPPER. And we'll do a quick walk-through for those of you who are new to the IRF PEPPER.

So what you're seeing on your screen now is the first page of the IRF PEPPER. The PEPPER is distributed electronically. It's a Microsoft Excel workbook, to navigate through the PEPPER, you would click on the worksheet tabs along the bottom of the screen. When you first open your PEPPER it opens to this page called the purpose page. You would see here your CMS certification numbers, six digits, CMS certification number and here is your IRF's name. On row nine we're going to see the most recent fiscal year that's summarized in the PEPPER, so this tells us it's the most recent three federal fiscal years through the fourth quarter of fiscal year 2018. Little information about the PEPPER. The version number, which is the same as the most recent time period. And then here you would see your jurisdiction, your MAC jurisdiction. This is your jurisdiction comparison group, and all of the hospitals – I'm sorry, all of the IRFs that bill to – or submit their claims to the same Medicare administrative contractor are – they comprise the MAC jurisdiction comparison group. So when you're looking in your PEPPER, we have three

comparison groups, nation, which is all IRFs in the nation, jurisdiction, which is all the IRFs that bill to your same jurisdiction, your MAC jurisdiction, and then the state, which is all IRFs that submit their claims to the state.

So here is where you would be able to identify if you don't know off the top of your head what MAC jurisdiction your hospital is in.

The second tab of the PEPPER includes the complete numerator and denominator definition for all of the target areas that are included in your PEPPER. The reason we have a whole worksheet here for this is because you might be looking at your PEPPER target area statistics and maybe you're trying to remember, well, what discharges are included in the numerator here, what is the denominator including? And so you can flip to the definitions worksheet and see here exactly the – what makes up the numerator and denominator counts.

The next report is called the compare targets report. I like to call this report the heart of the PEPPER. It's the only place in the PEPPER where you can see all of your target area statistics all on one page. It does represent only the most recent fiscal year. So this is the four quarters ending the Q4FY2018. I'll give a quick review here. The compare report has some uniqueness throughout the entire PEPPER.

So here you're going to see the target area name. In this cell is a brief description of the numerator and denominator for the target area. The number of target discharges is the number of discharges that met the numerator definition. So here we see we have 29 discharges for those four miscellaneous CMGs. When we compare the numerator count to all discharges, which is the denominator. Denominator is not on this report, but we calculate our target area percent of 4.4 percent. So 4.4 percent of all of our discharges are for the miscellaneous CMG. So we can calculate that.

But standing alone we really don't know how we compare to the other IRFs in the nation, jurisdiction, and state. That's where the percentiles can be really helpful. Here we're going to see our IRFs national percentile. Our national percentile is 1.7 percent. I want you to think about that ladder and the distribution of target area percents from highest to lowest. Now, this hospital's percent of 4.4 percent places them at the national percentile of 1.7. So that means that only 1.7 percent of all of the IRFs in the nation have a lower target area percent than we do. So thinking about that ladder, this hospital's percent is almost at the very bottom of that distribution.

The percentiles can help give you that context so you know where your hospital's percent value falls in that larger distribution.

Now, when we compare ourselves to all of the other IRFs in our MAC jurisdiction, our percentile is 5.6. So 5.6 percent of the IRFs in the jurisdiction have a lower target area percent than ours

does. So still pretty low, almost at the very bottom of that distribution.

And when we're comparing ourselves to all of the other IRFs in our state, our percentile is 3.2. So 3.2 percent of the IRFs in the state have a lower target area percent than we do.

And then this last column shows us the sum of payments. This is the total amount of Medicare reimbursement that the IRF received for these numerator discharges, these 29 miscellaneous CMG discharges.

So this type of information is reported for each of the target areas, and we can see here that this IRF does not exceed the national 80th percentile for any of the target areas. So this target area, the short-term acute care admissions is following IRF discharge at the 48.6 national percentile. So they are – their target area percent of 12.4 is right about in the middle of that distribution from highest to lowest. You can see how the percentile changes from nation to jurisdiction to state, and we would expect that because we're being compared to different – a different group of IRFs for each of those comparisons.

Couple of things about the compare targets. This is the only place where you're going to see your exact percentile value. And nowhere else in the PEPPER will you see these numbers except for on the compare targets report.

Okay. I want to go ahead and move on. Now, for each of the target areas there is a target area report. They are all formatted in the same manner. So once you get used to looking at the target area report, it becomes second nature. There is a target area graph that will show for you your target area percent over these three fiscal years. This is your percent value, your blue bars. And we also include on the graph three trend lines that identify for us the percent that is at the 80th percentile for nation, which is the solid line, for the Medicare administrative contractor jurisdiction, which is the dashed line, and for state, which is the dotted line.

The graphs are nice because it allows you to see how your target area percent might be changing over time in this instance. There is really basically no change. And it also can show you how close or how your percent compares to this 80th percentile boundary, which is what we use, again, for identifying the outliers in the PEPPER.

Below the graph is the table that has all of the numbers behind the blue bars. So, again, for each of these three time periods, the fiscal years, you're going to see your target area percent, your numerator count, your denominator count, the numerator average length of stay, denominator average length of stay, the average Medicare reimbursement for these numerator discharges and then the total amount of Medicare reimbursement for these numerator discharges. So a little extra information that can sometimes help you in thinking about your numbers.

Below your data table is the comparative data table that shows us the percent that is at the 80th percentile for nation, for jurisdiction, and for state. So, again, if we are thinking about that ladder, this the percent at that 80th percentile point. This is the boundary between outlier and no outlier.

And the last thing on all of our target area reports, at the very bottom we include this section called suggested interventions. If you're a high outlier for this target area, these are suggested interventions, very general, that you could think about when you're trying to decide if you want to take another look, if you want to audit some records, what types of records might you look at? And what might you be looking for? So these are the suggested interventions. And these suggested interventions are also included in the PEPPER user's guide.

All right. Let's take a quick look at some of these other target areas. I'm not going to go into great detail. For this one you can see how this hospital's – this IRF's percent for CMGs at risk for unnecessary admissions has decreased quite a bit over the past few years. You can see the oldest time period, they were right at the 80th percentile. Their target area percent is displayed here in red bold print, and you can see how they have decreased that value over time.

For outlier payments, small changes from year to year here. Short-term acute care hospitals following IRF discharge. Below the 80th percentile and not significant change. Now, some of you might notice that when you're looking through some of your reports there might be a blue bar that's missing for one or two or all time periods. There may not be statistics in the data table below. I just want to point out that will occur if your hospital doesn't have sufficient data to generate statistics if your numerator or denominator count is less than 11, then we will not be calculating statistics or displaying data for that target area and for that time period.

Real quickly, we've got a couple of supplemental reports in the PEPPER that don't have any bearing on whether you're considered an outlier in your PEPPER. They're simply summary data provided for your own internal use. This first one identifies the top CMGs or case mixed groups, for the most recent fiscal year. So we identified a CMG number. Here's the description. The total number of discharges for that CMG. Proportion of discharges for each CMG to total discharges, and your average length of stay for that CMG.

We will include up to 20 CMGs here. They have to have at least 11 discharges in order to be included on this report. And then here are a couple of summary rows that will summarize the top CMGs and then give you information for all of your CMGs.

The jurisdiction report is basically formatted the same as the IRF-specific report. This is summarizing information for all of the IRFs in the jurisdiction, in your jurisdiction. And this might be helpful or interesting if you want to compare your numbers to the jurisdiction numbers. I'll point out that we do include the national average length of stay in addition to the

jurisdiction average length of stay.

A relatively new report, the average length of stay by CMG tier and discharge destination, this report gives us the number of discharges, another statistics average length of stay for CMG tier levels, tier level A – well, actually it's going to be in descending order for a number of discharges, so for A, B, C, and D, all the tier levels of that information is reported here. Then we also have some information by discharge destination. The discharge destination will identify home with home health, two home discharges or transfers to SNF, transfers to short-term acute care hospitals, or other. And, again, number of discharges, proportion, length of stay information.

There's one report for your hospital, your IRF, and then there's another report that is at the jurisdiction level.

So that's a quick walk through of a sample PEPPER. I'll go back to my presentation now and continue on. Sometimes I get the question, what do I need to do with my PEPPER? Do I have to use it? Do I have to take any action as a result of the statistics in my PEPPER?

So the answers to those questions are, no, you're not required to use the PEPPER. And of course you don't have to take any action in response to your PEPPER because it's – doesn't identify the presence of improper payments. But I do want to just remind you that there are other contractors that are sifting through, mining the Medicare claims data looking to – perhaps they might benefit from educational intervention, from maybe a case review, other activities, so the PEPPER can give you a heads-up that your statistics look different in these target areas anyway. And I would hope that that would be a way to give you a heads-up that your statistics do look different, so then you can think about whether that's something that you would expect to see in your PEPPER, given what you know about your organization, the services that you offer, your patient population, that type of thing, or if there's something that doesn't quite feel right and maybe you might want to take a closer look, dig a little deeper, and see if there's something that needs to be addressed.

So I would encourage you to just take advantage of this free report that is provided by CMS through our contract.

So how do you get your PEPPER? The IRF PEPPER is distributed on an annual basis, generally in April. And the distribution method does differ based on whether you're a free-standing inpatient rehabilitation facility or whether you're hospital based. I'll go over that--I just want to remind you that we can't send an PEPPER through email. Every once in a while we do get folks who ask us to do that, but we can't send it through an email. If you are a unit of a short term acute care hospital your PEPPER has been delivered through the QualityNet, through the QualityNet administrators and those who have basic user accounts and the PEPPER recipient

role with the hospital. So most of the time the Q net administrators are involved in submitting the hospital's quality data, so that would be the first place to start looking if you're a unit of a short-term acute care hospital and you're interested in getting your PEPPER.

The PEPPER file is available for 60 days from the time that we upload it to the QualityNet account so we always encourage IRF units to access their PEPPER as soon as possible because otherwise we will have to upload it again to QualityNet and you'll need to contact us and ask us to do so.

The free-standing inpatient rehabilitation facilities and the few IRF units of critical access hospitals now receive their PEPPER through the portal. For the free-standing IRFs this is not a change. We have the portal available. It's been in operation for several years. The process has not changed. So you would visit the website, pepper.cbrpepper.org, click on that PEPPER distribution link, and go ahead and access your PEPPER. We do keep those PEPPERs out there for approximately two years from the original release date, so if you didn't access last year's PEPPER you're in luck because it's still there for you.

I do want to just say a couple words about the critical access hospital units. This year CMS has asked us to transition distribution of the PEPPERs for critical access hospitals to the portal. And so that means that the units, the IRF units of critical access hospitals, are also receiving their PEPPER through the portal. There was an access code that was sent by email to the critical access hospital QualityNet administrator, and so that's the access code that you'll need to use to get your PEPPER.

When you do go to the portal, if that's the way that you receive your PEPPER, you will need your six digit CMS certification number and then either a patient control number or medical record number from a claim for a Medicare beneficiary receiving services during this time frame. Those few – units of critical access hospitals will use your special access code.

Okay. So once you have your PEPPER in hand, let's just say that you check it out and you see lots of red in there. What should you do? First thing, don't panic. I want you to remember that just because you're an outlier doesn't mean that there's any compliance issues that exist. Remember you're an outlier, it simply means you're in the top 20 percent of all of the critical access hospitals in the nation. So it doesn't mean you're doing anything wrong. It just means your statistics look different. I do want you to think, though, about why you are an outlier. Again, some of those questions I just mentioned, do those statistics reflect your operation? Referral sources can be a big thing. External health-care environment. Maybe your IRF has some specialized services that might be related to CDA or ortho, spinal, TDI, whatever it is, think about those things and how they might affect the way your statistics look.

Bottom line is even if you're following best practice – just ensure you're following best practices

even if you're not an outlier.

Real quickly, couple of other resources that are available for you on your website. The national level and state level data that summarizes information for all of the target areas. As well as both of those top reports that I just covered, that's available on the data page. We also have a report that segregates statistics for all IRFs in the nation, and then we compare the free-standing IRFs and the distinct part units. And these data are updated following each release. They are – they have been updated for this most recent release so if you want to go to the website and check that out, you'll find Q4FY18 data there.

We also over the past few years have been putting together these peer group bar charts that can help you compare your PEPPER statistics to the group that you might consider to be your peers. Essentially in each of these target areas we identify the 20th, the 50th, and the 80th national percentile for these – for the IRFs in three different categories. We look at size, based on number of discharges, we look at location, which is urban versus rural, and then we look at ownership type, for profit or physician-owned versus nonprofit or church-owned versus government.

Now, these bar charts are going to be updated annually. The most recent bar charts have not been updated yet. I know our analytical team is working on updating these. I'm thinking they'll probably be available within the next couple of weeks. There is a methodology document and a peer group file that have additional details. If you don't agree with your ownership type or location, I would encourage you to contact CMS with that because we obtain the ownership type and the location information from the provider of services file, which is maintained by CMS.

And this is just an example of one of the peer group bar charts. This is for CMGs at risk for unnecessary admissions. You can see – I know it's really small, but you can see how these 20th, 50th, and 80th percentiles differ, for example, the top graph is based on size, total discharges. So we're looking at small, medium and large. The middle graph is location, darker color is rural, lighter color bar is urban. And the ownership type is the very bottom graph, and it's just another way for you to compare your statistics with the group that you might consider your peer.

Of course there are a number of other references, resources available on the website. There is the user's guide. There's the spreadsheets, the jurisdiction spreadsheet that identifies for you the total number of IRFs, in each of those MAC jurisdictions in total and by state. There are those recorded PEPPER training sessions that I mentioned earlier. And there is a sample IRF PEPPER.

If you need assistance with PEPPER, whether it's the question about the data in your report or if

you're just having trouble accessing your PEPPER, please contact us through our help desk. Go to our website, click on that help contact us button, click on the help desk button. There's an online form there that you'll complete and a member of our staff will respond promptly to assist you. Please don't contact other organizations for assistance with PEPPER. We are the official source of information. We want to make sure that you get the right answer.

This is a quick screenshot of our website. This is the pepper.cbrpepper.org website. The resources for inpatient rehabilitation facilities are easily accessible there from the home page. You can see the blue arrow is pointing to it. There's the user's guide, training and resources, and the distribution page.