Transcript for Long-term Acute Care Hospital (LT) PEPPER Review April 17, 2019

Okay. I think we'll go ahead and get started. Good afternoon. I would like to welcome you to this review of the PEPPER for long-term acute care hospitals. My name is Kim Hrehor, and I work for the RELI Group, which is contracted with the Centers for Medicare and Medication Services, or CMS, to develop, produce and disseminate the PEPPERs. For those of you who are interesting in live captioning of today's session, you can access the captioning by clicking on the link in the Q & A panel. It's the first question there. Today I'm going to be focusing on the most recent release of the PEPPER for long-term acute care hospitals. That's going to be version Q4FY18 which was just recently released April the 5th. There was one revision made to the excisional debridement target area which includes the addition of procedure codes to the list of excisional debridement. And also there are DRGs that have been added to the list of DRGs affected by the addition of the excisional debridement procedure code. We'll review some other resources and we'll also take a look at the sample PEPPER during today's session. Today's session is going to be a high-level review of the long-term acute care hospital PEPPER. If you're new to PEPPER or if you still have questions after today's session, I would encourage you to visit our website and to access the recorded sessions that are available on the training and resources page at – at PEPPER.CRBPEPPER.org. Those sessions are available as short chapters which are segments. You can access those at your own leisure. So what is PEPPER? PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report. The PEPPER is essentially a comparative report that summarizes one Medicare provider's claims data for statistics in areas that might be at 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 line with Medicare payment policy. We call these target areas. The PEPPER summarizes your Medicare claim statistics in had these areas and then compares them with aggregate Medicare data for other provides in the nation and your Medicare administrative contractor or MAC jurisdiction and also in your state. And these comparisons are the first step in identifying where you might be at a higher risk for improper Medicare payments, which means that your billing practices are different from the majority of other providers in your comparison group.

I do need to stress that the PEPPER cannot identify the presence of improper payment. That can only be identified through a review of the documentation in the medical record. But the PEPPER can alert you if your statistics look unusual so you can determine if you might need to take another step and perhaps audit some claims.

Now, PEPPER has been around for a number of years. It was originally developed in 2003 for short-term acute care hospitals. And then a few years later for long-term acute care hospitals. TMF began distributing PEPPERs to all providers in the nation in 2010 and over the years,

PEPPERs were developed for other provider types. As you can see on the slide, we have a PEPPER available for critical access hospitals, inpatient, psychiatric facilities, inpatient rehab facilities, hospices, partial hospitalization programs, skilled nursing facilities, as well as home health agencies. These PEPPERs are all customized to report data on the areas that areas vulnerable to improper payments for each individual provider type.

Now beginning in 2018, CMS combined the Comparative Billing Reports, or CBR, and the PEPPER programs into one contract. And start anything 2018, the RELI Group, along with its partners and TMF and CGS produced and distribute the PEPPERs. This change should be transparent to the provider of community, also you might notice a few formatting changes to the PEPPER or some of the other resources. But know that our team is continuing the production of the PEPPERs and the support that the provider community has become accustomed to.

So why are providers receiving PEPPERs? Well, CMS has indicated that the provision of PEPPERs to providers supports their agency goals. They are 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, recovery auditors or other federal contractors, as well as data analysis activities. The provision of PEPPER to providers supports these strategies.

The PEPPER is an educational tool that can help providers identify where they might be at a higher risk for improper payment so then they can proactively monitor and take any preventive measures they find necessary. I should also 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.

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 supports that auditing and monitoring component of a compliance program.

So now moving on to a specifically focus on the new release, the Q4FY18 PEPPER release, which as I mentioned earlier became available April the 5th. This release of PEPPER summarizes statistics for three federal fiscal years, fiscal years 2016, 2017 and 2018. And just as reminder action the federal fiscal year starts October 1st and it runs through September 30th of the following year.

Now, each time we produce a PEPPER, we refresh the statistics for all of the time periods that are included in that release. And so what that means is that there could be some small changes in numerator or denominator counts or percents or percentiles from the previous release, which could be the factor of having late claims submitted over the time – over the most recent years, perhaps adjusted or corrected claims, anything like that would be – those statistics are going to be refreshed and so the data in your PEPPER has all been refreshed as of the most recent point in time when we downloaded the data. So you might see some slight changes

when you're comparing it to last year's release. And we do roll off the oldest fiscal year as the new one is added.

So let's talk about improper payment risk that are pertinent to long-term acute care hospitals. Long-term acute care hospitals are reimbursed through the long-term prospective payment system which is almost identical to the acute care prospective payment system which short term acute care hospitals use. The main difference is that the DRG weights for the long-term acute care hospitals are greater to compensate them for the increased complexity of the types of patients that they serve.

Now, that being said, long-term acute care hospitals are at risk for improper payments in several of the same areas as short-term acute care hospitals. For example, excisional debridement and septicemia.

Now, originally, the target areas in the long-term PEPPER were identified based off of the medical record reviews that were conducted by quality improvement organizations some years ago. As well as a review of literature regarding payment vulnerabilities and also a review of the long-term PPS and analysis of national claims data. Over time, these target areas have changed as new information about payment vulnerable in the long-term care community changed as well as response to feedback from some in the community. We actually had added a target area some years ago based on some feedback from particular providers.

I might also mention that the comprehensive error rate testing contractor, that's a contractor that performs random reviews to estimate the improper Medicare payments for CMS. They issue an annual report. It's called the – the most recent one is the 2018 Medicare fee-for-service improper payments report. And in there, they identify for the long-term acute care hospitals, they have a 3 percent error rate, with a projected $95.9 million in improper payments. If you're interested, you can find the entire report at CMS.HHS.gov/CERT.

Now let's talk about the target areas as they pertain to PEPPER. Basically these are service – services or types of care that have been identified as potentially prone to improper Medicare payments. In the PEPPER we construct the target areas as ratios where the numerator is a count of discharges that may be problematic, and the denominator is a larger reference group that contains the numerator and allows us to calculate a target area percent.

I'm going to quickly review the current target areas that are in the long-term PEPPER. The first two here, septicemia and excisional debridement are on coding errors. We're looking for the potential for overcoding as well as the potential for undercoding here. In septicemia, the numerator, you can see according to this table, is the discharges for septicemia, DRGS 870, 871, and 872 and in the denominator, we have some other DRGs, which includes simple pneumonia which is DRGs 193, 194, 195, respiratory system diagnoses with ventilator support, that's 207 and 208, and kidney and urinary tract infections, which is 689 and 690.

So when we calculate the target area percents we're using these numerator definitions and denominator definitions to then calculate that target area percent. And we can see when we go into the review of the PEPPER in a few minutes, you'll see how those numbers are utilized and presented in the PEPPER.

Now, for excisional debridement, here we're looking at the excisional debridement procedures. So in the numerator, we're looking at the discharges for those DRGs that are affected by the procedure codes for excisional debridement that actually have an excisional debridement procedure code on the claim and the denominator are all of those discharges for the DRGs that might be impacted. This is where we made some changes for this release of the PEPPER. So you'll need to look in the appendix of the PEPPER users guide to get a complete picture of all of those procedure codes and all of those DRGs.

Some of you might notice that there are some changes after we've implemented this – this revision to the – to the target area. There are some providers that will notice that their target area percent increased. That will be about 20 percent. But about 20 percent of providers saw a decrease in their target area percent. So you just keep that in mind when you're looking at your PEPPER from – and comparing it to last year's.

The short stays target area is looking at the – is a numerator – that were counting discharged on the day or the day after the short stay outlier threshold was met. We're comparing that in the denominator to all of the discharges. Those of you who are familiar with the long-term PPS know that long-term acute care hospitals receive a reduced DRG payment when the length of stay for a patient is less than five-sixths of the average length of stay for the DRG. So there is a financial incentive to keep the patient until after that short stay outlier threshold is met, so the full DRG payment is received and that is what this target area is looking at, the potential for – for hospitals to recognize and work towards that financial incentive. We also have a similar target area that is looking at short stays or respiratory system diagnosis. This is very similar to the regular short stay target area. But we're just focused on those respiratory system diagnosis DRGs. This one was added a few years ago. One of the Medicare administrative contractors did a special study and they found a high rate of errors for these particular DRGs. And so that's why it's included in the PEPPER.

For outlier payments, we're looking at all of the DRGs that have a DRG outlier approved amount greater than zero dollars. That's what the numerator is. The denominator is all discharges. Outlier payments do have the potential for financial reward. So that's, of course, a focus in the PEPPER.

And then the readmissions – 30-day readmissions really are a focus of CMS across the board from any different provider type. Readmissions in general represent potential quality of care issues or billing errors. And extreme isolated instances, they could represent a potential circumvention of the prospective payment system. And so that's what the 30-day readmission target area is concerned with.

The last target area here short-term acute care hospital admissions following discharge from a long-term acute care hospital, this one is really more related to quality of care. We're look at the percent of those beneficiaries that then go to a short-term acute care hospital within 30 days of being discharged from the long-term acute care hospital, which could be an indicator of perhaps the patients aren't Medically cable stable tore prepared for discharge. Maybe their patients or their families aren't prepared to handle them. So there could be some – some

overarching concerns there with this particular target area. So that's why we're including it here.

For each the target areas, we do have that numerator, denominator definition and we calculate a target area percent. And you'll see the target area percents in the PEPPER. When we are calculating the percentiles, though, which is what we use to identify what we call an outlier in the PEPPER, sometimes folks get confused about the difference between a percent and percentile.

So this slide, I'm going to give a quick review of how we calculate these percentiles in PEPPER. So what we do when we calculate the percentile s is we take all of the hospital's target area percents for a particular target area and time period and we order those from highest to lowest. So as you look at the – at this slide, you can see that the target area percents there which are associated with each rung on the ladder are sorted from highest to lowest. Then we identify the point below which 80 percent of the hospitals target area percent falls. And that point is the 80th percentile

Now, in the PEPPER, any providers whose percent is at or above the national 80th percentile, they are identified as outliers in the PEPPER. There is a visual cue there of the percent being red bold font, so you'll know that when you're at or above the 80th – the national 80th percentile in your PEPPER.

Now, for the coding focus target areas, the septicemia and excisional debridement only, which can be vulnerable to potential under coding, we also identify potential --those are the providers whose target area percent is at or below the national 20th percentile. Of the 20th percentile, is that point below which 20 percent of the hospitals target area percents fall. So the percentiles can help give you some context as to how your hospital – your hospital's target area percent compares to all the others in those comparison groups, either the nation, the jurisdiction, or the state. And it can help you understand where in that distribution your hospital is so then you can think about your data, whether or not there might be something that you should be concerned with, or whether you expect to have statistics that look different for a particular target area.

Let me go ahead and take this opportunity to share a sample PEPPER with you now.

You should be seeing on your screen a PEPPER for long-term acute care hospitals. The PEPPER is a Microsoft Excel workbook. It is distributed electronically. So when you access it, you'll open it and it will come to this page. This is called the purpose page. When you navigate within your PEPPER, you're going to click on these worksheet tabs along the bottom of the screen to access each report. Here in the PEPPER, you're going to see your CMS certification number. This will be your provider name. On row 9 will tell you the most recent fiscal years through the fourth quarter of fiscal year 2018. A little bit of information here about PEPPER here, where you can get assistance. You'll see your hospital's jurisdiction comparison group here. The jurisdiction – the MAC jurisdiction is the comparison group for the – is – the where the hospital submits their claims for Medicare reimbursement to that contractor. All of the other hospitals that submit their claims to that same contractor make up the MAC jurisdiction comparison group. So when

you see the jurisdiction comparison group, just know that you're being compared to all of the other hospitals that submit their claims to the same MAC for reimbursement.

The next worksheet tab is called the definitions tab. And here we have the complete numerator and denominator definition for all of the target areas in the PEPPER, so that if you're looking through your report and you're trying to remember what does the numerator represent or what does the denominator represent, you can simply come to the definitions tab and find that information.

Then we have the compare targets report. Now this is a – a special report. I like to call it the heart of the PEPPER. It is the only place within your PEPPER that can you see your hospital's statistics for all of the target areas all on one page. It does represent the statistics only for the most recent fiscal year. So here we see this is the four quarters ending – the fourth quarter 2018.

Quick review of this information here. We identify for you the target area, a brief description of the numerator and denominator. This is the number of numerator discharges, your hospital's target area percent. So when we compare the numerator to the denominator, which is not on this report, we calculate that target area percent.

Now, I want you to think back about to that ladder that we just had on the previous slide, because it's going to help you in understanding what these percentile values mean. This hospital's national percentile value is 4.9. So when we place this hospital's percent of 15.5 in that distribution from highest to lowest of all of the other hospital's percent values in the nation, their national percentile is 4.9, which means that 4.9 percent of the hospitals in the nation have a lower target area percent than this hospital does. So they're really way to the bottom of that ladder. So this is a way for us to get some context. We know that our hospital's is pretty low compared to all the other hospitals in the nation. That's why it's color coded in green italics because we are at or below the national 20th percentile and perhaps we could be at risk for undercoding.

Now, you'll notice the jurisdiction and the state percentile columns here are empty, they are blank. That is going to occur when there are fewer than hospitals in either the jurisdiction or the state that have sufficient data to report statistics. And when there are fewer than eleven hospitals, we can't calculate those percentiles and so those columns are blank.

Now, keep in mind there's only about 420 long-term acute care hospitals in the nation, so depending on your jurisdiction and your state, there may or may not be percentiles for jurisdiction and state calculated. And then the last column is the sum of payments. This is the total amount of Medicare reimbursement that the hospital received for these eleven numerator discharges.

So if we scroll down then, we can see, for example, for the short stays target area, this hospital's percent was 13.1 – national percentile of 49.5. So about right smack dab in the middle of the distribution from highest to lowest again thinking about that ladder. Similar short stays respiratory system diagnosis, our national percentile, 41.6. So 41.6 of the hospitals have a lower target area percent. And we see here some red for the 30-day readmissions to same

hospital or elsewhere target area action the hospital's target area percent of 9.6 places them at the 86.5 national percentile. So for this one they're towards the top end of that ladder. 86.5 percent of the hospitals in the nation have a lower target area percent, so they're in that top 20 percent. They're identified here as an outlier and similarly short-term acute care hospital admissions following long-term discharge, are at 87.5 national percentile.

All right. Let's move on real quickly. Now, for each of the target areas, there is a target area report in the PEPPER that both graphically and tabular format reports your data. So for septicemia, we can see here on the graph, this is the hospital's target area percent. And we do display for the most recent three years, although you can see for this oldest time period, there is no blue bar, which is an indication that the hospital did not have sufficient data to calculate statistics. If there are not at least 11 discharges in the numerator or denominator, we have to suppress those statistics. So we can see this hospital's target area percent for the most recent two years and we can also see how we compare to the 20th percentile, which is this green solid line. This is the national 20th percentile. And then this is the national 80th percentile. So you will be able to see how your target area percent is comparing to both of those, I would call them, points in the sand.

Now, below the graph is the data table that will show you the numbers behind those bars. You'll see your target area percent here for each of the fiscal years, your numerator count, your denominator count, the average length of stay for the numerator discharges and the average length of stay for the denominator discharges. Here is your average amount of Medicare reimbursement for these numerator discharges and then the total amount of Medicare reimbursement for these numerator discharges. This comparative data table identifies for you the target area percent that is at the 80th percentile for nation, jurisdiction and state and the percent that is at the 20th percentile for nation, jurisdiction and state. And remember, we do not have sufficient – or at least eleven hospitals in the jurisdiction or the state to calculate the jurisdiction and state percentiles here. So there is zero.

At the very bottom of the report is what we call suggested interventions. And these are very general guidelines. What you might think about if you are a high outlier or if you are a low outlier for a particular target area, these are suggestions – if you're thinking about maybe pulling some records and conducting a little audit, what types of records might you pull, what might you look at.

And these suggested interventions can also be found in the PEPPER user's guide. So if we click on these tabs, as we kind of go through the PEPPER, you'll see that they're all formatted in the same way. This is excisional debridement. This hospital did not have sufficient data for the most recent two time periods, so we only see the oldest time period here.

Short stays. This hospital is below the national 80th percentile. Short stays for respiratory diagnosis. Here is the outlier payments tab. And we can see here that their outlier payments, while they never were even close to the 80th percentile, it looks like they might be coming down a little bit year over year.

30-day readmission to the same hospital or elsewhere. This hospital had a higher target area percent in the oldest – in fiscal year 2016, came down slightly for 2017 and 2018, but still above that national 80th percentile. And then short-term acute care hospitals following discharge from the long-term acute care hospital, small little increases year over year resulting in now our hospital being a high outlier for this most recent time period.

Now, there are a couple of additional reports in the PEPPER that are supplemental. They don't have any bearing on outlier status, they're simply provided as additional information for your own internal use if you'd like.

There is a report that identifies the top DRGs for the hospital, for the most recent fiscal year. We will identify up to 20 DRGs. There do have to be at least 11 short stay outliers in order for to us display the data. But we can see for each of these DRGs, what is the description, the short stay outlier count, the total number of discharges for the DRG and the proportion of short stay outliers to total discharges for that DRG and what the hospital's average length of stay is.

Now, this is all for the hospital. There's another tab that has the information all aggregated at the national level. So if you'd like it compare this information with what you have for your hospital, certainly that is an option. So that was a quick review of the PEPPER for long-term acute care hospitals. I'll go back to the presentation and continue on here.

So sometimes I'm asked, you know, what do I need to do? Do I need to take any action as a result of my PEPPER? Am I required to use my PEPPER? And the answers to those questions is no. You're not required to use your PEPPER. You're not required to take any action in response to your statistics. Remember, these are just claims data that are summarized and compare you to others. So they can't identify the presence of improper payments. But we also know that there are other contractors that are sifting through the Medicare paid claims database. They might be looking for providers that could possibly benefit from some educational intervention or perhaps even a medical record review. And so it would be helpful for you to know if your statistics looked different. So then if there's something that you might--should be concerned about, you can take the first step and investigate and put any corrective measures in place as you deem necessary. So just consider it a roadmap to help you identify those vulnerable areas or improper payments. And remember, this is a free comparative data report that is being provided to you by CMS.

How do you obtain your PEPPER? Well, as I mentioned, we distribute the long-term PEPPER annually in electronic format. You will access your PEPPER through a secure portal. You'll visit PEPPER.CBRPEPPER.org and review those instructions and access the portal. If you're new to this, you might find it a – a new experience, but a lot of you have been accessing your PEPPER through the portal for a number of years. Also if you didn't access your PEPPER last year, you're in luck, because it's still available for you. We keep these PEPPERs out there for two years. And so you can access last year's PEPPER if you haven't yet done so.

And just a comment, because we are requested occasionally to email the PEPPER and we cannot send it by email. When you go to the portal, as reminder, you will need a couple of pieces of information. You'll need your six digit CMS certification number and then for

verification purposes, we ask for either a patient control number or a medical record number from a claim for a traditional fee for service Medicare beneficiary that received services between July 1st and September 30th of last year.

Also, a reminder that validation code is refreshed with each new release of PEPPER. So a validation code that you used last month to access your PEPPER or last fall will no longer be accepted. You will need a new validation code to access this year's PEPPER. I do want to stress, though, that if you're having trouble accessing your PEPPER – we don't want you to get frustrated. We want you to access your PEPPER. So contact us through the help desk and we'll make sure that we assist you with obtaining your PEPPER.

And as of yesterday, it looks like about 9 percent of the long term acute care hospitals have accessed their PEPPER, so if you haven't yet done so, now is a good time. Once you do have your PEPPER, let's say that you see a lot of red or a lot of green. First thing I encourage you not no do is panic. Remember, just because you're an outlier doesn't mean that there is anything going on that, you're doing anything wrong, that compliance issues exist. But do think about why are you an outlier. Think about whether the statistics in your PEPPER reflect what you know about your hospital, about the way it's operated. Do you have specialized programs or services that would affect the way your data look? Does it – could it have something to do with your patient population or referral sources or other providers in the external healthcare environment?

If you have any questions or feel uneasy looking at your statistics, I encourage you to sample some claims, review the documentation in the medical record, make sure that everything was coded and billed appropriately based on the documentation, that the services provided were necessary and in accordance with Medicare payment policy. Just basically ensure that you're following the best practices. And even if you're not an outlier.

Now, each year, we do make available national level data for these target areas and the top DRGs. That is available on the data page on the PEPPER website. PEPPER.CBRPEPPER.ORG. They are updated annually following each report released and we do have the 2018 statics that have been replaced, refreshed out there on the websites. You'll also find a number of other resources. There is the PEPPER user's guide. There is a jurisdictions spreadsheet out there that identifies the number of hospitals in each jurisdiction. In total and by state mentioned already those record PEPPER training sessions. There is a sample PEPPER as well as a document that identifies the history of target area changes and the potential impact on those statistics.

If you need assistance with PEPPER and you don't find what you're looking for in the user's guide, visit the PEPPER website, PEPPER.CRBPEPPER.org. There is an online form there that you complete and a member of our staff will promptly assist you and just a reminder not to contact any other organizations for assistance with PEPPER. We are the official source of information and want to make sure that we correctly address your questions.

This is a quick screenshot of the website. And you can see there the resources for long-term acute care hospitals are easily accessed from the homepage. You can access the user's guide,

the training and resources page, the PEPPER distribution as well as map of the PEPPER – the access – the PEPPERs that have been accessed for long-term acute care hospitals.

I will say that the maps are usually updated on the 20th of the month and so they're not quite updated yet, but we will have that available soon.