# PEPPER Sessions Chapter 3 Target Areas
# Inpatient Psychiatric Facilities

In this session I'll review the target areas for inpatient psychiatric facilities and talk about how they were identified and what they could mean for the provider.

I'd like to point out that the PEPPER does not identify improper Medicare payments. Those can only be identified through a review of the documentation in the medical record to support the treatment and diagnosis and procedure codes that were submitted on the claim. IPFs are reimbursed through the IPF prospective payment system or PPS. Just as in other inpatient settings of care, IPFs are at risk for unnecessary admissions and incorrect coding, which can impact correct reimbursement. Because there hasn't been a whole lot of information available from actual medical record reviews for IPF, the target areas for the *IPF PEPPER* were developed by a review of the IPF PPS and focusing on areas that could be prone to improper Medicare payments.

In addition, we analyzed national IPF claims data, and we coordinated with CMS to develop the areas based on those that may be at higher risk for improper Medicare payments. I should note that we assess the target areas each year. And so the target areas have changed and they will probably continue to change over time as a result of this assessment. We may add or remove target areas or make some slight changes to the existing target areas.

Our goal is to provide statistics that can help identify a higher risk of improper Medicare payment, while understanding and considering the services that IPFs provide. I should note that these target areas may change over time as we continue to assess improper payment risks that are pertinent for the IPFs.

A target area in the PEPPER is basically a clinical condition or a type of admission that's been identified as prone to unnecessary admission, or incorrect coding, or billing issues. A PEPPER includes two types of target areas — admission necessity and coding. The coding target areas are focused on the potential for over-coding, as well as the potential for under-coding, which would result in an underpayment for the IPF. Now we construct the target areas as ratios, where the numerator is the count of discharges that may be problematic, either from an admission necessity or coding standpoint. And the denominator is the count of discharges from some larger reference group.

Let's review the target areas in the *IPF PEPPER*. The *Comorbidities* target area is the only target area in the PEPPER or IPF that is focused on coding-related issues. So that means that we identify not only the potential for over-coding but also the potential for under-coding. So we identify providers whose target area percent is at or above the national 80th percentile, which could be potential for over-coding and also at or below the national 20th percentile, which could result in eventually under-coding. Remember, all of our target areas are structured so that we have the numerator and the denominator, and so that we use those numerator denominator counts to calculate the target area percent. So the *Comorbidities* target area identifies the percentage of claims where there is at least one comorbidity coded on the claim.

IPFs receive payment adjustments for a number of comorbid conditions when IPFs have a high percentage of patients with comorbidities. It could be an indication of potential over-coding, and,

likewise, if there's a very low percentage of patients with comorbidities, it could be an indication of potential under-coding. Providers might expect to have a high or low percent for this target area depending on their patient population or on whether their billing system allows the coding of comorbidities.

The next target area, *No Secondary Diagnoses*, calculates the percentage of claims for discharges where there are no secondary diagnoses coded. The claims should include the appropriate selection of the principal diagnosis code as well as other additional and coexisting diagnoses. And again, these may not necessarily be psychiatric diagnoses. But for any active medical condition, coding guidelines specify that all of the patient's coexisting or additional diagnoses should be reported on the claim to provide accurate information regarding the beneficiaries receiving services. If IPFs do not code secondary diagnoses on the claim, they may not be coding comorbidities. And again, reimbursement may be affected.

The outlier payment target area calculates the percentage of discharges that have an outlier amount of greater than $0. IPFs that have a high percentage of patients with outlier payments may wish to examine those cases to ensure that care was medically necessary and that the claim was correctly submitted. You may also want to examine your admission and discharge policies in conjunction with this review.

The *3- to 5-Day Readmission* target area calculates the percentage of patients readmitted within three to five calendar days or four to six consecutive days. This target area is intended to assess the risk for potential circumvention of the interrupted stay policy. Where patients readmitted within three consecutive days from discharge are treated as a continuation of the initial admission for reimbursement purposes.

Circumvention of the interrupted stay policy would mean that the IPF would receive two DRG payments when only one was necessary.

The *30-Day Readmissions* target area focuses on, again, readmissions which are a high priority. In terms of CMS's priorities, CMS is currently focused on reducing readmissions in many settings of care. So that's why we have this readmission target area in the *IPF PEPPER*. Now actually, both readmission target areas may help access for premature discharge. Please note that we exclude transfers to IPF with planned acute care hospital readmissions — that is code 93 — as well as patients who left against medical advice from the numerator.

We're also excluding instances where the beneficiary was transferred to an IPF. We don't want to count that in the statistics here.