PEPPER Sessions Chapter 3 Target Areas IRF

In this session, I'm going to review the target areas in the Inpatient Rehabilitation Facilities PEPPER. I'll talk about how they were identified and what they could indicate for the provider.

First, I want to remind you that the PEPPER does not identify improper payments. Those can only be confirmed 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.

IRFs are reimbursed through the IRF Prospective Payment System, or PPS. Just as in other settings of care, IRFs are at risk for unnecessary admissions and incorrect coding, which can impact correct reimbursement. Because there's not been a whole lot of information available from actual medical record reviews on IRF payment risks, the target areas were developed by a review of the IRF PPS and focusing on those areas that could be prone to improper payments. We also worked closely with CMS to develop these areas based on their awareness of areas that are at risk for improper payment.

I also should point out that each year the IRF improper payments are estimated by the Comprehensive Error Rate Testing Contractor, or CERT. In the 2019 Medicare Fee-for-Service Improper Payments Report, free-standing inpatient rehabilitation facilities had a 34.9% error rate with a projected $2.5 billion in error. If you'd like to take a look at that report, you can find it on the CMS website at cms.hhs.gov/cert. Which is C-E-R-T.

What exactly is a target area as it pertains to PEPPER. Basically, it is a clinical condition or a type of admission that's been identified as prone to unnecessary admission or correct coding or billing. In the PEPPER, the target areas are constructed as ratios, where the numerator is a count of discharges that may be problematic, either from an admission necessity or a coding standpoint, and the denominator is a count of discharges of some larger reference group. At this time, we do not have any target areas in the IRF PEPPER that are focused on coding-related issues, so you'll find that they are all related to admission necessity or care treatment issues.

So, let's review these target areas. Complete definitions can be found in the PEPPER User's Guide. Remember that we have a numerator and denominator that we use to identify the numerator and denominator count so that we can calculate the target area percent. And so, these definitions let you know or provide the information as to how we calculate those statistics.

Miscellaneous CMGs calculates the percentage of all Medicare discharges that are for the four miscellaneous CMGs, which include diagnoses such as disability, generalized weakness, and other miscellaneous conditions. We include all tier groups for these CMGs (no comorbidity, high comorbidity, medium comorbidity, low comorbidity). In general, the “Miscellaneous” CMGs do not count towards the 60% compliance threshold, which stipulates that at least 60% of an IRF’s patient population must require treatment for one or more of 13 conditions. Comorbidities that meet certain criteria may determine the compliance threshold. For more information, there is an IRF PPS Payment System Series at on the CMS website in their MLN section, and if you want to search for Inpatient Rehabilitation payments, you can find it there on the CMS website. And they have been noted by MedPAC the increasing over time in volume and percent of IRF discharges. It is possible that these patients did not

require an IRF level of care, or perhaps there was a more definitive diagnosis that should have been assigned.

The CMGs at risk for unnecessary admissions target area calculates the percentage of discharges for eight CMGs as a proportion of all discharges. These eight CMGs represent high-functioning patients with no tier group assignment. That means no co-morbidities. The CMG prefix is letter A. Again, these admissions may also be at risk for unnecessary admissions. It's also possible that it could represent coding-related issues because this target area does not include any discharges that have a co-morbidity assigned. So, if you're high in this target area, and as you sit and think about it that doesn't fit right for you what you know about your patient population, you might want to do a little bit of investigation and make sure that your coding staff are picking up all of those complications of the co-morbidities.

Outlier Payments calculates the percentage of discharges that have an outlier payment amount greater than $0. IRFs 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 wish to review length of stay to ensure continued stay was necessary. And also, you might want to look at the cost-to-charge ratio as submitted in your annual cost report to make sure that's correct, as well.

The next target area-- Short Term Acute Care Hospital Admissions following IRF Discharge calculates the percentage of patients that are admitted to a short-term acute care hospital within 30 days of discharge from the IRF. A high percentage for this target area could indicate that patients and their families are not prepared to handle patient care issues once they get home, that discharge planning wasn't started early enough in the patient's admission, or that there are post-discharge issues regarding medication compliance that could have been monitored or addressed. We did modify this target area some years ago to exclude transfers to IRF and long-term so that we could match more closely the way CMS is calculating the all-cause readmission measure.

Now we get into these two new target areas, short stays. When a patient's pre-admissions screening indicates that the patient is an appropriate candidate for IRF care but this turns out not to be the case, the IRF must immediately begin the process of discharging the patient to another setting of care, recognizing that it could take a day or more for the IRF to find placement for the patient. Instead of denying the entire claim, Medicare authorizes its Medicare administrative contractors to allow the claim to be paid at the appropriate case mix groups for that patient for stays of three days or less.

When our team looked at claims data, we found that about 3% of IRF claims were for length of stay of 3 or fewer days. 2/3 of those short stay claims were transferred to a short-term acute care hospital, discharge status 02. But only 7% of the longer than 3 day stay claims were transferred to a short-term acute care hospital. So based on that information, CMS approved a new target area focused on short stays for addition to the IRF PEPPER.

The three to five-day readmission target area is designed to identify the potential for circumvention of the interrupted stay policy. For the interrupted stay policy, readmissions within three consecutive days from discharge, those are treated as a continuation of the initial admission for reimbursement purposes.

If the patient is readmitted after the fourth consecutive day, then the IRF will receive two separate case mix groups payments.

And so, you can see that there would be some financial incentive to readmit those patients after the interrupted stay period. So, these are the two new target areas that you'll find in your PEPPER.