PEPPER Sessions Chapter 3 Target Areas PHP

In this session, I'm going to review the target areas in the PHP PEPPER. I'm going to talk about how those were identified, and what they could indicate for providers.

Before I get started, I do want to remind you all that the PEPPER cannot identify improper Medicare payments. Those can only be confirmed through a review of the documentation in the medical record that supports the treatment that the beneficiary received as a PHP. So, PHPs are reimbursed on a per-diem basis under the Outpatient Prospective Payment System, or OPPS, for care provided to Medicare beneficiaries. Because there hasn't been a whole lot of information from actual medical record reviews of PHP records, the PHP target areas were developed based on a review of the PHP reimbursement methodology, a review of issues identified by other regulatory agencies, and by consulting with CMS subject matter experts, who identified potentially vulnerable areas. We also analyzed national level PHP claim status to identify these areas which could be at risk. Our goal is to provide statistic scenarios that can help identify a higher risk of improper Medicare payment, while also understanding and taking into account the services that PHPs provide.

While we are talking about these risk areas, I'd like to make sure that you are aware of this report that the OIG released on "Questionable Billing by Community Mental Health Centers," for PHP services. This report was released a few years ago and it includes nine questionable billing characteristics for Community Mental Health Center or CMHC PHP services. This report can be found at the link on this slide. Two of the questionable billing characteristics are similar to PHP target areas that are included in the PEPPER. While this OIG report is focused on PHPs administered through CMHCs, it would be applicable to all PHPs administered through outpatient hospital departments or others. So, that it might be worth reviewing and considering the issues that were raised by the OIG.

I've used this term target area a few times, so what is a target area. Basically, it's a service or a type of care that's been identified as potentially prone to improper Medicare payment. In the PEPPER, target areas are constructed as ratios, where the numerator is a count of episodes of care that may be problematic, and the denominator is the larger reference group that contains the numerator and allows us to calculate the target area percent.

As we move into a review of the PEPPER target areas, you'll notice that there is the numerator and a denominator definition for each of these areas. And this is how we determine the numerator count and the denominator count and ultimately the target area percent. The first target area here is titled Group Therapy. Group therapy is less costly to provide than individual therapy. And therefore, there may be a financial incentive for a PHP to provide group therapy when individual therapy may be more appropriate for the beneficiary. The PHP PEPPER identifies the proportion of all episodes of care where the beneficiary received only group therapy. No individual therapy is received by the beneficiary during the entire episode of care. This target area is one of those risk areas that was identified in the OIG report that I just mentioned. Beginning with the Q4 calendar year 16 release, we began identifying group therapy using the HCPCS code instead of Revenue Code.

The next target area is looking at no individual psychotherapy. Here we are calculating the number of episodes ending in the report period where there are no units of individual psychotherapy. This target

area identifies again those proportions where the beneficiary did not receive any individual psychotherapy during their entire episode. You may notice that this target area no longer counts psychiatric testing in the numerators. So, we are only focused on the individual psychotherapy with those HCPCS codes there. While the provision of individual psychotherapy is not a Medicare requirement, since PHP is in lieu of inpatient psychiatric hospitalization, there is a good general expectation that PHPs provide some amount of individual psychotherapy, as well as a range of services during a Medicare beneficiary's course of treatment.

We also have a target area that looks at longer lengths of stay, which is another of those risk areas identified by the OIG. There is no limit on the length of time a beneficiary may receive PHP services. So therefore, there is a risk that a PHP may continue those services beyond the point where they are necessary. So, we are identifying, with this target area, beneficiaries who receive greater than 60 days of service. These are actual days of service, not the difference between the from date on the first claim, and the through date of the last claim. We are counting actual days of service.

And the last target area is looking at 30-day readmissions. Reducing readmissions is the focus of CMS for many provider types. Readmissions can be an indication of incomplete care, premature discharge, inadequate patient discharge instructions, or patient noncompliance. We identify here the proportion of Medicare beneficiaries who are readmitted to the same PHP, or to another PHP, within 30 days of the last date of an episode of care. And this could indicate that the beneficiary was discharged prematurely or perhaps that the discharge planning process could be strengthened.