Improper Payment Risks

- ST hospitals are reimbursed through the Inpatient Prospective Payment System (IPPS), which can be vulnerable to coding and billing errors and unnecessary admissions.
- Many of these risk areas were identified by the Office of Inspector General, Quality Improvement Organizations, Medicare Administrative Contractors (MACs) and Recovery Auditors.
- The target areas will change over time.
- PEPPER does not identify improper payments.

Target Area

- Area identified as at risk for improper payments.
- Focused on coding or admission necessity.
- Constructed as a ratio:
  - Numerator = discharges identified as problematic (likely to be miscoded or admitted unnecessarily).
  - Denominator = larger reference group that contains the numerator.
- Refer to the current ST PEPPER user's guide at PEPPER.CBRPEPPER.org for current target area definitions.

ST PEPPER Coding Target Areas

Target Area	Target Area Definition
Stroke Intracranial Hemorrhage	*Numerator (N):* count of discharges for DRGs 061, 062, 063, 064, 065, 066 *Denominator (D):* count of discharges for DRGs 061, 062, 063, 064, 065, 066, 067, 068, 069
Respiratory Infections	*N:* count of discharges for DRGs 177, 178 *D:* count of discharges for DRGs 177, 178, 179, 193, 194, 195
Simple Pneumonia	*N:* count of discharges DRGs 193, 194 *D:* count of discharges for DRGs 190, 191, 192, 193, 194, 195
Septicemia	*N:* count of discharges for DRGs 870, 871, 872 *D:* count of discharges for DRGs 689, 690, 193, 194, 195, 207, 208, 870, 871, 872

ST PEPPER Coding Target Areas, 2

Target Area	Target Area Definition
Unrelated OR Procedure	*N:* count of discharges for DRGs 981, 982, 983, 987, 988, 989 *D:* count of discharges for surgical DRGs
Medical DRGs with CC/MCC	N: count of discharges for medical DRGs with "w CC," "w MCC," or "w CC/MCC," excluding DRGs assigned on the basis of a CC, MCC, or medication administration (DRGs 065, 838) D: count of discharges for medical DRGs with "w CC," "w MCC," "w CC/MCC," "wo CC," "wo MCC," or "wo CC/MCC" excluding DRGs assigned on the basis of a CC, MCC, or medication administration (DRGs 065, 838)
Surgical DRGs with CC/MCC	N: count of discharges forsurgical DRGs with "w CC," "w MCC," or "w CC/MCC," excluding DRGs assigned on the basis of a CC, MCC, or a procedure (DRGs 005, 016, 023, 029, 041, 129, 246, 248, 469, 518 D: count of discharges for surgical DRGs with "w CC," "w MCC," "w CC/MCC," "wo CC," "wo MCC," or "wo CC/MCC", excluding DRGs assigned on the basis of a CC, MCC, or a procedure (DRGs 005, 016, 023, 029, 041, 129, 246, 248, 469, 518)

ST PEPPER Coding Target Areas, 3

Target Area	Target Area Definition
Single CC or MCC (Single CC MCC) *revised as of the Q4FY19 release	N: count of discharges for DRGs assigned on the basis of a CC or MCC with only one CC or MCC coded on the claim, excluding DRGs that can be assigned on the basis of a CC, MCC, or a procedure D: count of discharges for DRGs assigned on the basis of a CC or MCC, excluding DRGs that can be assigned on the basis of a CC, MCC, or a procedure
Excisional Debridement	N: count of discharges for DRGs affected by ICD-10-PCS procedure codes for excisional debridement that have an excisional debridement procedure code on the claim D: count of discharges for the DRGs
Ventilator Support	*N:*count of discharges for DRGs 003, 004, 207, 870, 927, 933, with procedure code identifying ventilator support 96+ hours on the claim *D:*count of discharges for DRGs 003, 004, 207, 208, 870, 871, 872, 927, 928, 929, 933, 934

ST PEPPER Admission Target Areas

Target Area	Target Area Definition
Emergency Department Evaluation and Management Visits (ED E&M)	N: count of emergency department (ED) evaluation and management (E&M) visits, highest severity (CPT® = 99285, highest level code) D: count of all ED E&M visits (CPT®= 99281, 99282, 99283, 99284, 99285)
Transient Ischemic Attack	*N:* count of discharges for DRG 069 *D:* count of discharges for DRGs 061, 062, 063, 064, 065, 066, 067, 068, 069
Chronic Obstr. Pulmonary Disease	*N:* count of discharges for DRGs 190, 191, 192 *D:* count of all discharges for medical DRGs in MDC 04 (respiratory system) (DRGs 175 through 208)
Percutaneous Cardiovascular Procedures	*N:* count of discharges for DRGs 246, 247, 248, 249 *D:* count of discharges for DRGs 246, 247, 248, 249 plus outpatient claims with CPT codes 92928, 92933, 92937, 92941, 92943 or with HCPCS codes C9600, C9602, C9604, C9606, C9607

ST PEPPER Admission Target Areas, 2

Target Area	Target Area Definition
Syncope	*N:* count of discharges for DRG 312 *D:* count of discharges for medical DRGs in MDC 05 (circulatory system) (DRGs 280 through 316)
Other Circ. Syst. Diagnoses	*N:* count of discharges for DRGs 314, 315, 316 *D:* count of discharges for medical DRGs in MDC 05 (circulatory system) (DRGs 280 through 316)
Other Digest. Syst. Diagnoses	*N:* count of discharges for DRGs 393, 394, 395 *D:* count of discharges for medical DRGs in MDC 06 (digestive system) (DRGs 368 through 395)
Medical Back Problems	*N:* count of discharges for DRGs 551, 552 *D:* count of all discharges for medical DRGs in Major Diagnostic Category (MDC) 08 (Musculoskeletal System and Connective Tissue) (DRGs 533 through 566)

ST PEPPER Admission Target Areas, 3

Target Area	Target Area Definition
Spinal Fusion	*N:* count of discharges that have spinal fusion procedure codes on the claim *D:* count of discharges that have spinal procedure codes on the claim
3-day SNF	*N:* count of discharges to a SNF with a three-day length of stay *D:* count of all discharges to a SNF

ST PEPPER Admission Target Areas, 4

Target Area	Target Area Definition
30-day Readmissions To Same/Else.	*N:* count of index admissions for which a readmission occurred within 30 days to the same hospital or to another short-term acute care PPS hospital; patient discharge status of the index admission is not equal to 02, 82, 07; see guide for additional specifications *D:* count of all discharges excluding patient discharge status 02, 82, 07, 20
30-day Readmissions To Same	*N:* count of index admissions for which a readmission occurred within 30 days to the same hospital; patient discharge status of the index admission is not equal to 02, 82, 07; see guide for additional specifications *D*: count of all discharges excluding patient discharge status 02, 82, 07, 20 (see Appendix 6 for more specifics regarding how readmissions are identified)

ST PEPPER Admission Target Areas, 5

Target Area	Target Area Definition
Two-day Stays Medical DRGs	*N*: count of discharges for medical DRGs with a length of stay equal to two days, excluding patient discharge status codes 02, 82, 07, 20, excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission *D*: count of discharges for medical DRGs, excluding patient discharge status codes 02, 82, 07, 20, excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission
Two-day Stays Surgical DRGs	*N*: count of discharges for surgical DRGs with a length of stay equal to two days, excluding patient discharge status codes 02, 82, 07, 20, excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission *D*: count of discharges for surgical DRGs, excluding patient discharge status codes 02, 82, 07, 20, excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission

ST PEPPER Admission Target Areas, 6

Target Area	Target Area Definition
One-day Stays Medical DRGs	*N*: count of discharges for medical DRGs with a length of stay equal to one day, excluding claims with patient discharge status codes 02, 82, 07, 20, and with occurrence span code 72 with "through" date on or day prior to inpatient admission *D*: count of discharges for medical DRGs, excluding claims with patient discharge status codes 02, 82, 07, 20 and with occurrence span code 72 with "through" date on or day prior to inpatient admission
One-day Stays Surgical DRGs	*N*: count of discharges for surgical DRGs with a length of stay equal to one day, excluding claims with patient discharge status codes 02, 82, 07, 20 and with occurrence span code 72 with "through" date on or day prior to inpatient admission *D*: count of discharges for surgical DRGs, excluding claims with patient discharge status codes 02, 82, 07, 20 and claims with occurrence span code 72 with "through" date on or day prior to inpatient admission

30-day Readmission Target Areas:

- Have been included in PEPPER since initiation in 2003.
- Are calculated differently from CMS' Inpatient Quality Reporting measures.
- Measures Include
  - Readmissions to Same
  - Readmission to Same/Elsewhere

PEPPER vs. Inpatient Quality Reporting

	PEPPER	IQR
Use/Purpose	Measure hospital performance over time for quality improvement project monitoring; support efforts to prevent improper Medicare payments that result from billing errors or quality of care issues	Profile hospital performance for public reporting

PEPPER vs. Inpatient Quality Reporting, 2

	PEPPER	IQR
Measures	Two measures: • 30-day readmissions to same hospital (all DRGs) • 30-day readmissions to same hospital or another short-term acute care hospital (all DRGs)	Seven measures: • 30-day readmission for AMI patients • 30-day readmission for heart failure patients • 30-day readmission for pneumonia patients • 30-day readmission for hip/knee replacement patients • 30-day readmission for CABG patients • 30-day readmission for COPD patients • 30-day overall rate of unplanned readmission after discharge from the hospital (hospital-wide readmission). (Note: This measure includes patients admitted for internal medicine, surgery/gynecology, cardiorespiratory, cardiovascular and neurology services. It is not a composite measure.)

PEPPER vs. Inpatient Quality Reporting, 3

	PEPPER	IQR
Risk Adjustment	No risk adjustment.	Hospital-level 30-day all-cause risk standardized readmission measures
Planned Readmissions	Planned readmissions not excluded	Planned readmissions excluded
Age Requirements	Includes Medicare beneficiaries regardless of age	Excludes Medicare beneficiaries under the age of 65
Coverage Requirements	No coverage requirements	Medicare beneficiary must have 12 months of Part A coverage prior to the index admission and up to 30 days after discharge

PEPPER vs. Inpatient Quality Reporting, 4

	PEPPER	IQR
Readmission Definition	Every readmission is counted within a 30 day period of a hospital discharge. Each subsequent readmission is also counted as an index admission.	The condition-specific readmission measures assign readmission status as a dichotomous "yes/no" value regardless of the number of times the patient was readmitted during the 30-day post-discharge time period. For HWR measure, readmission is also eligible to be counted as a new index admission if it meets all other eligibility criteria.

PEPPER vs. Inpatient Quality Reporting, 5

	PEPPER	IQR
Data timeframe	Index admissions are identified as those with a discharge date that falls within the quarter. The timeframe is extended 30 days beyond the end of the quarter to capture readmissions.	For condition-specific measures, index hospitalizations are identified using 3 years of data; for HWR measure, 1 year of data. 3 years of data are required to obtain sufficient precision of the estimate for condition-specific measures.
Frequency of updates	Quarterly	Annually