PEPPER Sessions Chapter 3 Target Areas
Short-Term Acute Care Hospitals

During this session I am going to review the target areas in the PEPPER for short-term acute care hospitals. The Inpatient Prospective Payment System, or IPPS, drives the reimbursement for short-term acute care hospitals. And it is vulnerable to improper payment due to incorrect coding of diagnoses and procedures, unnecessary admissions, as well as billing errors.

The Office of Inspector General has been conducting studies for many years, focusing on discharges that are vulnerable to improper Medicare payments. The Quality Improvement Organizations and, more recently, the Medicare Administrative Contractors and the Recovery Auditors, as well as other federal contractors, have been identifying these areas of risk. The findings of these organizations have been a major source of the development of the target areas in the PEPPER. We assess those target areas on an annual basis. And we also consider new target areas for additions to the report. As a result, the target areas in the PEPPER have changed, and are going to continue to change over time. For example, there were a number of target-area changes in response to the two-midnight rule, which became effective October 1, 2013. The CERT also identifies improper payments for short-term acute care hospitals. And as an example, the most recent report for 2019 has identified an error rate for Part A inpatient hospitals of 25.2%, with a projected $2.6 billion in error. I might note that there are a number of DRGs that are included in the PEPPER that have been identified by the CERT contractor as having high-projected dollars in errors, or high-error rate. You can find the CERT report at cms.hhs.gov/c-e-r-t.

And, again, PEPPER cannot identify improper Medicare payments. Improper payments can only be confirmed through a review of the medical records to ensure that documentation supports the necessity of the admission, and that the diagnoses and procedures were correctly coded and billed.

Let me move on now to a review of the target areas. Essentially, in the PEPPER, a target area is a clinical condition or a type of hospital admission that's been identified as prone to unnecessary admission or incorrect coding or billing. The PEPPER includes two types of target areas, those focused on admission necessity issues, and those focused on coding related issues. In the PEPPER, target areas are constructed as ratios, where the number---numerator is a count of discharges that are problematic, either from an admission necessity or coding standpoint. And the denominator is a count of discharges of some larger reference group. Let's review these target areas that are in the short-term PEPPER. Again, keep in mind that these target areas are evaluated annually, and have changed over time. It's likely they will continue to evolve in response to policy changes or changes in areas vulnerable to improper Medicare payments. I would refer you to the short-term PEPPER User's Guide for the current listing of target areas. This presentation is going review the target areas that are included in the Q4FY19 release of the PEPPER.

Let's start out with the coding-focused target areas. Again, these are the areas that have been identified as prone to incorrect coding, which can result in an overpayment or an underpayment. Most of these target areas have been under review by the recovery auditors for a number of years. Target areas we're identifying the potential for overcoding, as well as the potential for undercoding.

If the hospital's target-area percent is at or above the national 80th percentile, then that could mean that the hospital is at higher risk for overcoding. If it's at or below the national 20th percentile, then it

might be at risk for undercoding. Now remember to get the complete definition of the target-area numerator and denominator, you can find that in the PEPPER User's Guide, which is available on the PEPPER.CBRPEPPER.org website, or in the definitions page of your hospital's PEPPER.

Target areas focused on stroke, intracranial hemorrhage, respiratory infection, simple pneumonia, and septicemia, these are target areas that have been problematic for a number of years. Mainly, these are primarily concerned with whether the principal diagnosis that's been coded is supported by the documentation in the medical record. The septicemia target area includes DRGs 689, 690, 193, 194, 195, 207, 208, 870, 871, and 872 in the denominator. Those DRGs are included when, as we were reviewing results of record reviews that were shared with us by other contractors, we identified that a number of DRGs, a number of septicemia DRGs, were changed to these simple pneumonia and respiratory system diagnosis DRGs.

Moving on to the unrelated operating room procedures, this is the target area that's been an area that's been under focus for some amount of time. These are coding errors that would be related to the procedure code being unrelated to the principal diagnosis code. We have a number of target areas that look at DRGs with CC or MCC. The target areas medical and the surgical DRGs with CC or MCC, are addressing the concern with that reviewers have seen as far as an upward trend in the DRGs that do have a CC or an MCC. And the concern that there may be some potential overcoding so that hospitals obtain a higher-weighted DRG. So we have two target areas, one that's looking at the medical DRGs, and the other that's looking at the surgical DRGs. I usually suggest to hospitals that they look at the medical DRGs and the surgical DRGs with CC or MCC target areas together. Normally you would expect, if your patient population is healthy or more debilitated, you would expect to see that for both the medical DRGs, as well as for the surgical DRGs. When hospitals are high in one of these target areas, but low in the other, it could be perhaps related to documentation practices for the medical physician versus the surgical physician. Or it could mean that your patient population is legitimately different. Those are some things to think about there as you're looking at your statistics in your PEPPER.

The first target area listed here CC or MCC, we are identifying the proportion of claims that have only one CC or MCC coded. Again, that concern would be that hospitals may be searching for CCs in order to get that higher-weighted DRG. So when you're looking at your statistics for these DRGs, you probably need to think about your patient population, and whether you have a healthier patient population, or one that's more debilitated. That should be reflected in your statistics for the DRGs with CCs or MCCs.

Excisional debridement has been something that's been on the auditor's list for a while. There have been continued issues with coding excisional debridement. And so we still have that target area included in the PEPPER, as well as ventilator support. There have been concerns with the assignment of the procedure code for mechanical ventilation 96 plus hours. Auditors continue to find that the number of hours of mechanical ventilation that are documented in the records do not substantiate the application of that code. So that's why we still have this target area included in the PEPPER.

A target area here, that became effective with the Q4FY17 release, is focused on emergency department evaluation and management visits. This target area was added, and it is related to continued concerns of upcoding for E&M codes. Now, most of the time, the E&M code focus has been on the physician. But here we are looking at the hospital use of the evaluation and management codes for the emergency

department visits. And so we're looking at the proportion of those E&M codes for the emergency department that are coded to the highest severity level, that CPT® code 99285. Now remember, this is only looking at the hospital's claims that are submitted for the ED visit. Then again, we could identify potential overcoding, as well as, potential undercoding with this target area.

Now we're moving on to talk about those areas that are focused on admission necessity issues. Here we have transient ischemic attack, chronic obstructive pulmonary disease, percutaneous cardiovascular procedures. These target areas have been a focus, again, of the recovery auditors.

With the PTCAs, what we're looking at here is, we're assessing the number of PTCAs with a stent, that are performed on an inpatient basis, as compared to all of those performed as an inpatient or an outpatient. Remember, Medicare considers PTCA with stent insertion an outpatient procedure. So there does need to be documentation to support the necessity for an inpatient admission.

These are some additional target areas that are focused on admission necessity. Syncope is one of those that is consistently mentioned in the CERT report, other circulatory system diagnoses, as well as other digestive system diagnoses, medical back problems. These, again, are focused on whether the patient does require an inpatient level of care to address their issue.

The spinal fusion target area, there's been a lot of information and a lot of news about spinal fusions and improper spinal fusions over the past few years. Here we are looking at the medical necessity of the procedure. So, you'll notice that in the numerator we are identifying the number of discharges for spinal fusion. We're comparing that to the denominator, which is all spinal procedures, including the fusions in that all spinal procedures. So, if a hospital is doing a high proportion of spinal fusions then that might show up in the PEPPER.

Three-day SNF days, to qualify for a SNF admission, a patient does have to have had a three-day inpatient stay. And some of these inpatient stays, these three-day stays, are not medically necessary. Remember, outpatient observation is not considered to be part of a three-day inpatient admission. And this area has come into more focus as external reviewers expand to review those SNF admissions.

We have a couple of target areas that are focused on readmissions. Now remember, readmissions have been a long-standing focus of CMS. And actually, over the years, they've been looking at readmissions for other provider types. But it all started in short-term acute care hospitals.

I do want to comment that, we do have two target areas. One is looking at 30-day readmission to the same hospital, or to another hospital, to elsewhere. We are also looking for the second target area, just 30-day readmissions to the same hospital. We are not including in these statistics instances where the patient is transferred to another acute care hospital, or were they left against medical advice. There are additional specifications, I'll refer you to the PEPPER User's Guide here. But remember, that these are statistics that are calculated in the PEPPER.

I should mention here, and I'll cover this a little bit more in detail later, that these statistics here, we have made revisions to these definitions over time to match, as closely as possible, the CMS readmission quality indicators. Now, for these two target areas we are looking at all DRGs. One thing you can do is, you can deduce the number of readmissions to elsewhere, to that other hospital, by comparing your

numerator counts for these two target areas. And that can help you explore any potential concerns related to readmissions. Some of the things you might think about here are billing errors, finding the incorrect patient discharge status code assignment. There might be, if you have high readmission rates, the potential for premature discharge or incomplete care. This probably is a small issue nowadays, but there, also, has been some concern with circumvention of the Prospective Payment System, where the hospital received the multiple DRG payments to treat a condition for which they should have received only one DRG payment.

We have four target areas that are focused on short stays. Over the years, the PEPPER target areas related to short stays have continued to be refined. Now we have four target areas, so, we have two target areas that are looking at two-day stays, and we have two target areas that are focused on one-day stays. Both of these categories are reported out for medical DRGs versus the surgical DRGs. And over the past year we've made some additional exclusions to the denominator, as well as to the numerator to help us focus specifically on those admissions that are only one night, or two nights.

So here, what we're looking at and I'm going to focus on the two-day stays for medical DRGs, in this target area, in the numerator, we have the length of stay equal to 2 days. We exclude instances where the patient is transferred, or left against medical advice, or expired, and we also exclude claims with occurrence span code 72 with a through date on the day of, or the day prior to, the inpatient admission. Occurrence span code 72 identifies outpatient care associated with an inpatient admission, and so we're making that exclusion so that we focus specifically on those admissions that only span one or two midnights. So, we make those exclusions in the numerator, as well as in the denominator.

There are two target areas that are looking at two-day stays for medical and surgical DRGs. And then we have the target areas that are focused on one-day stays for medical DRGs and for surgical DRGs. And I will remind you that if you have a beneficiary who was admitted and discharged on the same day, that is counted as a one-day stay. And so as long they don't meet any of these exclusions in the numerator or denominator, that discharge would be counted in these target areas.

I'll talk a little bit more in detail about the readmission target areas. The short-term PEPPER has included these target areas pertaining to hospital readmissions since its initiation. And that was before readmissions were added to the Inpatient Quality Reporting Program. As CMS began to calculate hospital readmission rates, and then report them publicly on Hospital Compare, we've strived to calculate the PEPPER readmission statistics using a methodology that matches as closely as possible CMS's methodology. However, it does not replicate the CMS methodology. So, therefore, hospitals should expect the readmission statistics in their PEPPER to differ from those that are calculated by CMS and available on Hospital Compare.

There are two measures that continue, Readmissions to Same, and Readmission to Same/Elsewhere, after we heard a number of questions from hospitals about why their statistics in the PEPPER were different from that on Hospital Compare. The bottom line is that the most hospitals wanted us to continue to include these measures. They found them helpful because they were made available on a quarterly basis. And even if they don't replicate exactly what CMS is doing, they felt that it gave them a good overview, and a way for them to compare themselves to other hospitals in the nation, in their

jurisdiction, and in their state. So, if you feel that they're not helpful for you then, probably, the simplest thing to do is just to not spend too much time reviewing those reports in your PEPPER.

Some of the differences here in the PEPPER data, versus that for Inpatient Quality Reporting. The PEPPER measures hospital performance over time for quality improvement. And it's primarily the goal is to support efforts to prevent improper Medicare payment. Whereas the Quality Reporting profiles the hospital performance for public reports.

In the PEPPER, we have two measures, as I reviewed in the target area review. The Quality Reporting has eight measures. Some of them are focused on specific diagnosis groups, and then there is an overall and planned readmission rate. I will mention that hospitals have requested that we add to the PEPPER condition-specific measures. We found, after looking at the data, that a lot of the statistics would be very thin for many hospitals. Remember, the statistics are reported on a quarterly basis. There have to be at least 11 discharges in a quarter for there to be sufficient statistics to display in the PEPPER. And so we opted to just continue with the two overall measures in the PEPPER.

Remember now, that you have different purposes of these measures, and so that does impact the measure's design. Risk adjustment of patient factors is essential for the measures that are publicly reported. However, it does add significant complexity and processing time. And we're just not able to put that amount of effort for the statistics in the PEPPER. In addition, it would require a lot of work for us to exclude planned readmissions. And so, remember, the PEPPER statistics, the readmissions statistics, do not incorporate risk adjustment. And they do not exclude planned readmissions as the Quality Reporting Data do. And there are also some differences with regards to age and coverage requirements.

We do have a little bit different definition of a readmission. Here in the PEPPER, every readmission is counted within a 30-day period. The hospital discharge, and each subsequent readmission, is also counted as an index admission, which differs from the way that the hospital Inpatient Quality Reporting Program does it. It has to meet some other eligibility criteria.

There are some small differences with regards to the data time frame. And, of course, the PEPPER is released on a quarterly basis, whereas the quality reporting are refreshed and reported on an annual basis.

We have received a number of positive comments supporting the continuation of these target areas, generally categorized as: it is important for providers to be able to distinguish between readmissions to the same hospital and readmissions to elsewhere; the provision of both target areas allows hospitals to easily make this distinction. Not all hospitals have the resources to internally track "readmissions to same hospital." Also, It is helpful to have quarterly updates and 12 data points to trend. The national, jurisdiction and state 80th percentiles are valuable statistics for comparison purposes, and the statistics are provided in a more timely manner than CMS' measures.