DEVELOPING A PATIENT LISTING FOR PEPPER TARGET AREAS

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"What Medicare patient claims were included in the recent PEPPER I reviewed? Can I get a listing of the patients who were included in the statistics?"

INTRODUCTION

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is an educational tool for providers which supports the Centers for Medicare & Medicaid Services' efforts to protect the Medicare Trust fund. PEPPER is a free report summarizing Medicare claims data statistics in areas prone to improper Medicare payments. It is distributed quarterly to short-term acute care hospitals and annually to long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, partial hospitalization programs, hospices, skilled nursing facilities and home health agencies.

PEPPER can be utilized as part of a comprehensive compliance program to assist providers in reviewing documentation and billing issues pertaining to Medicare services. Each PEPPER compares a provider's Medicare claims data statistics with aggregate Medicare claims data for the nation, Medicare Administrative Contractor jurisdiction and the state. Sometimes there is an interest in determining which patients' claims were included in the PEPPER so that a review of medical and/or billing records can be conducted.

Due to patient privacy and contractual restrictions, the PEPPER Team cannot provide case-specific information (a case listing) that identifies the patients whose claims were included in the PEPPER target area numerator and/or denominator. The PEPPER Team encourages providers to generate their own case listings utilizing their internal management information systems.

CASE LISTINGS

In order to generate case listings, providers should first identify the types of claims eligible for inclusion in the PEPPER by reviewing the "claims inclusion criteria," which can be found in the respective PEPPER User's Guide. For example, eligible claims include the following:

- Medicare fee-for-service claims only (Medicare HMO/Medicare Replacement claims are NOT included)
- Medicare secondary payer claims, if Medicare claims payment amount is greater than $0
- The discharge, episode or claim "through" date ends in the reporting period (for example, fiscal quarter, fiscal year or calendar year)

- There are additional criteria specific to each provider type; see the PEPPER user's guide page 4 or 5

The PEPPER User's Guides also include definitions of PEPPER target area numerators and denominators. A provider who wishes to identify the beneficiaries or episodes included in the numerator for a particular target area should review the User's Guide for details. In addition to the claims specifications criteria, the provider should take into account the following:

- Target area definitions for numerator and denominator inclusion and exclusion criteria
- Time periods based on the discharge date or the date the episode of care or episode ends

Once a provider understands the types of claims that are eligible for inclusion in PEPPER and the target area numerator/denominator definition, they can identify potential high risk concerns, compliance issues, and/or quality improvement opportunities related to patient care documentation, coding and billing practices. A provider can seek the assistance of colleagues and query the information management system for information about patients by diagnosis, date of admission, discharge status, lengths of stay, readmission status, etc., in accordance with the PEPPER target areas, utilizing the numerator definitions for each target area. IT professionals, health information management staff, and/or business analysts can develop queries and obtain a listing of patients who meet the required target area specifications for a particular timeframe.

Once a listing of patients is obtained, a provider can coordinate internally to obtain billing information and to review medical record documentation for an individual patient or a sample of patients. A sample of patients might be determined based on length of stay, day of the week the patient was admitted, the admitting physician, the admission source (for example, the emergency department), etc. Hospital professionals and leadership staff may identify potential high risk concerns, compliance issues, and/or quality improvement opportunities related to patient care and coding and billing practices, and select records for review accordingly.

READMISSIONS

A common question received through the PEPPERresources.org Help Desk involves providers requesting assistance with identifying readmissions and analyzing readmission rates. Drilling down to the patient level assists providers with identifying specific factors that may have contributed to patient readmissions. Utilizing information management databases, providers can generate patient listings to identify patients who were readmitted to the hospital within 30 days of discharge, who were admitted to a distinct part unit (DPU) for rehabilitation, psychiatric care or skilled care, and to deduce the number of patients readmitted to another hospital.

<u>Focused Example on Short-term Acute Care Hospital Readmissions</u>

When striving to identify the readmissions included in the Short Term Acute Care Hospital (ST) PEPPER, the provider should utilize the same inclusion/exclusion criteria for PEPPER claims data as listed in the User's Guide. Remember that readmissions are counted in the federal fiscal quarter when the discharge

date of the index (first) admission occurs. For example, if the discharge date of the index admission occurs between October 1 and December 31, the readmission would be counted in the first federal fiscal quarter.

In order to analyze readmission rates and evaluate readmission target areas, the provider should:

- Check on the processes for assigning patient discharge status codes and ensure that codes were properly assigned. Then, the provider can identify the number of patients readmitted to the same hospital, and check to see if these readmissions were on the same day as discharge from the first admission. Medicare same-day same-hospital readmissions for related conditions require combining the two admissions into one. Medicare same-day readmissions for unrelated conditions should be billed using condition code B4 on the claim for the second admission. It is possible that some discharges were coded incorrectly and were actually transfers to another short-term acute care hospital or to a distinct part unit of the STACH.
- Identify the patients readmitted to the same hospital, review the documentation and check to see if these readmissions were possibly due to premature discharges or incomplete discharge planning or other care issues.
- Check on whether the admission should have been billed as a "leave of absence" if patients are readmitted for continuation of care of a prior admission.
- Identify the number of patients "readmitted to the same hospital or elsewhere" and compare the counts for each category. The provider may utilize the data tables from their PEPPER in this exercise.

The data table from the "Readmissions to Same Hospital or Elsewhere" Target Area:

Q1 = Oct-Dec Q2 = Jan-Mar Q3 = Apr-Jun Q4 = Jul-Sep Time Periods	**Target Area Discharge Count (Numerator)**	**Denominator Count**	**Percent (Numerator / Denominator)**
Q2 FY 2014	168	756	**22.2%**
Q3 FY 2014	168	753	**22.3%**
Q4 FY 2014	132	698	18.9%
Q1 FY 2015	148	762	19.4%
Q2 FY 2015	146	714	**20.4%**
Q3 FY 2015	137	652	**21.0%**
Q4 FY 2015	128	651	19.7%
Q1 FY 2016	141	697	**20.2%**
Q2 FY 2016	132	649	**20.3%**
Q3 FY 2016	96	594	16.2%
Q4 FY 2016	90	514	17.5%
Q1 FY 2017	96	589	16.3%

Using these examples for Q1 FY 2017:

- 96 readmissions to same/elsewhere minus 61 readmissions to same = 35 readmissions to another hospital (elsewhere)
- 36% of readmissions are to another hospital

If most of readmissions are to the same hospital, consider:

- Potential for premature discharge, or readmissions for care that should have been provided during the first admission
- Potential for billing errors for transfers to distinct part units
- Inappropriate use of condition code B4

If most readmissions are to another hospital, consider:

- Assignment of correct patient discharge status code (transfers coded as transfers?)
- Potential for premature discharge

From the “Readmissions to Same Hospital or Elsewhere” Target Area:

Q1 = Oct-Dec Q2 = Jan-Mar Q3 = Apr-Jun Q4 = Jul-Sep Time Periods	Target Area Discharge Count (Numerator)	Denominator Count	Percent (Numerator / Denominator)
Q2 FY 2014	120	756	15.9%
Q3 FY 2014	114	753	15.1%
Q4 FY 2014	91	698	13.0%
Q1 FY 2015	104	762	13.6%
Q2 FY 2015	97	714	13.6%
Q3 FY 2015	80	652	12.3%
Q4 FY 2015	78	651	12.0%
Q1 FY 2016	83	697	11.9%
Q2 FY 2016	101	649	**15.6%**
Q3 FY 2016	66	594	11.1%
Q4 FY 2016	54	514	10.5%
Q1 FY 2017	61	589	10.4%

Note that each admission of a patient could serve as an index admission for a subsequent admission to short-term acute care hospitals if it occurs within 30 days of the discharge date of the index admission. Index admissions with a patient discharge status code of “02” (discharged/transferred to a short-term acute care hospital), “82” (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission), or “07” (left against medical advice) are excluded from the numerator count and cannot be identified as an index admission, as are index admissions with rehabilitation or primary psychiatric Clinical Classification Software (CCS) diagnosis categories.

Common billing errors that may result in claims being identified as readmissions include:

- Billing an admission to a distinct part unit of a short-term acute care hospital (e.g., swing-bed unit) to the provider number for the short-term acute care hospital, instead of the provider number for the unit.
- Incorrect coding of the patient discharge status code when the patient is discharged/transferred to another short-term acute care hospital.