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FEATURE STORY

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Hospitals are turning to PEPPER's data that compare diagnosis-related groups as a useful tool to enhance compliance efforts and strengthen processes.

AT A GLANCE

Hospitals should take several steps in using data from the Program for Evaluating Payment Patterns Report (PEPPER) to enhance compliance efforts and identify risk areas for improper payments:

> Designate one person to monitor PEPPER releases and download the quarterly report.
> Review the reports and list all areas where the hospital is most at risk for improper payments.
> Prioritize at-risk areas with the national comparison, followed by jurisdictional and state comparison.
> Conduct small-sample case reviews in at-risk areas and determine next steps, such as process improvement or rebilling.
> Include hospital finance, compliance, legal, case management, and coding experts as part of discussion.

The evolution of the Centers for Medicare & Medicaid Services (CMS) has resulted in Medicare and Medicaid moving from simply being passive payers of claims to active purchasers of valuable products. Both participate in value-based purchasing, resulting in the current era of increased accountability and audits.

This new era is characterized by regulatory enforcement initiatives that have introduced many types of Medicare and Medicaid Program integrity contractors, including Medicare administrative contractors (MACs), recovery audit contractors (RACs), zone program integrity contractors (ZPICs), and Medicaid integrity contractors (MICs). Providers should understand these different contractors' roles and know how to address their findings and file appeals, if necessary. But most important, hospitals should implement programs to proactively ensure compliance with all regulatory guidelines.

Financial Implications of Noncompliance

Medicare and Medicaid payments represent a significant portion of most hospitals' operating revenues. To prevent and recoup erroneous payments, CMS has increased the number of auditing agencies, along with the scope of their audits. These agencies are particularly interested in medical necessity and the determination of inpatient versus outpatient services. Although the concept of medical necessity has met increasing scrutiny, hospitals have been forced to become adept at ensuring compliance with medical necessity requirements under federal rules and regulations for every patient case.

In addition to possible financial implications, inappropriate decisions regarding medical necessity of setting can affect hospital performance metrics, such as length of stay and mortality rates. Patients' financial responsibilities also can be impacted. Every hospital's medical necessity compliance goal should be to ensure that every patient case is correctly coded and compliant.

Failing to implement a compliant medical necessity review process could culminate in misclassification of inpatient cases as outpatient observation services, resulting in the hospital not receiving appropriate inpatient payment. Alternatively, if observation cases are misclassified as inpatient cases, the hospital will be required to return inappropriate payments and pay possible penalties and interest on the misclassifications identified during an audit.

Identifying Potential Risks

Hospitals should take the initiative in identifying risk areas and avoiding any noncompliance and financial repercussions. One helpful tool to enhance compliance efforts and identify risk areas for improper payments is the Program for Evaluating Payment Patterns Electronic Report (PEPPER).

Originally created as part of the Payment Error Prevention Program (PEPP) in 1999, PEPPER reports were distributed to hospitals by state Medicare Quality Improvement Organizations (QIOs) in support of the Hospital Payment Monitoring Program until early 2009. After a year-long hiatus, PEPPER has been reinstated by Austin, Texas-based TMF Health Quality Institute, under contract by CMS, to provide comparative data reports to hospitals and MAC/fiscal intermediaries (FIs) to help reduce improper Medicare fee-for-service payments.

PEPPER compares a hospital's diagnosis-related groups (DRGs), or Medicare severity-adjusted DRGs (MS-DRGs), with those of other hospitals to determine whether the hospital has outliers in comparison with other hospitals. Medicare uses DRGs to classify hospital cases into diagnostically similar groups. The PEPPERs serve as helpful tools for hospitals to identify potential areas requiring compliance review, particularly those in DRGs in which all patients are expected to require similar levels of hospital resources for their treatment. If a hospital is using more or less resources for a DRG than are being used by its geographic peers, the hospital is deemed an outlier and potentially at a higher risk for audit.

Hospitals should prioritize these areas for ongoing internal compliance assessment.

As hospital executives discover the value of PEPPER, they may be unsure how to retrieve PEPPER data. A PEPPER report is an individualized report released quarterly via a My QualityNet secure file exchange to each hospital's My QualityNet administrator and to those set up in the My QualityNet system in a PEPPER recipient role. (My Quality Net is a secure website, accessible at www.qualitynet.org, established by CMS for communications and data exchange.) PEPPER is available to acute care hospitals, long-term acute care, and critical access hospitals, and will be available to inpatient psychiatric and inpatient rehabilitation hospitals later in 2011.

A PEPPER report for a short-term acute care hospital can review data for the past 12 quarters for each of the CMS target areas. Such a report provides data only to acute care hospitals subject to Medicare's inpatient prospective payment system, and compares a hospital's data against data for other hospitals in the hospital's state and FI/MAC jurisdiction, as well as nationally. It does not compare hospitals by size, demographics, or types of service, however. The only outpatient service covered by a PEPPER report is a target area that includes both inpatient and outpatient cardiac stents. PEPPER does not include Medicare Advantage claims or other payers.

Since 2009, PEPPER has continued to expand its reach. For short-term acute care hospitals, it includes one- and two-day stays, specific DRGs, three-day qualifying stay for skilled nursing facilities, and 30-day readmissions. In addition to these changes, four DRG validation targets were added in the 2011 reports.

Identifying Potential Coding Errors

PEPPER identifies potential coding errors by calculating the ratio of target cases (numerator) to a defined subset of hospital claims (denominator), and determining a percentile compared with other hospitals. To test for possible "up-coding" or "down-coding" in MS-DRGs, PEPPER compares,

for each of the measures listed in the previous paragraph, the ratio of higher-severity MS-DRGs to a broader group of related MS-DRGs. For example, for simple pneumonia, PEPPER looks at the following ratio:

High Severity DRGs

Count of discharges for MS-DRGs 193 and 194 (simple pneumonia with comorbidities or complications [CC] or major CC [MCC])

All Related DRGs

Count of discharges for MS-DRGs 190, 191, and 192 (chronic obstructive pulmonary disease [COPD] with or without CC/MCC) + Count of discharges for MS-DRGs 193, 194, and 195 (simple pneumonia with or without CC/MCC)

The ratio compares the number of simple pneumonia cases (the numerator in the ratio) with the number of those cases, plus chronic obstructive pulmonary disease (the denominator in the ratio). If a hospital's ratio is significantly higher or lower than that of other hospitals, CMS would place it in a high-risk category for possible improper coding.

To indicate whether a hospital is an outlier within each group, PEPPER examines the percentage of target areas in the 80th and 20th percentiles. For a single hospital compared with others in its jurisdiction, the PEPPER report indicates whether the hospital is in the 80th percentile by highlighting the hospital's results in bold red text. Results that fall into the 20th percentile are highlighted in bold green text. In the exhibit below, three of the four quarters in FY10 were in the top 80 percentile for simple pneumonia cases in the jurisdiction (note that none fall into the 20th percentile in this example). The last column, Target Sum Medicare Payments, shows the potential financial risk to a hospital and areas for audit by RACs.

Hospital comparisons among peers can be made in graph tabs, as illustrated in the simple pneumonia sample graph on page 5. In this example, the hospital is trending up with the 80th percentile of hospitals in the same jurisdiction.

Identifying Potential Medical Necessity Compliance Issues

The second topic covered in a PEPPER report indicating potential improper payment is medical necessity. Areas closely examined include all one-day stay cases, medical one-day stay cases, and several diagnosis-specific short stay targets, such as one-day stays for chest pain, two-day stays for heart failure, and other two-day stay DRGs. These targets were chosen based on known error rates (improper payments) as determined by Medicare audits by the QIOs, MAC/FIs, the Office of Inspector General (OIG), and most recently, the RAC program.

The ratio presented in a PEPPER for one-day stays is the number of one-day stay cases compared with the total number of cases in the category. For example, for chest pain cases, the ratio is:

Number of one-day cases with MS-DRG 313

Total number of cases with MS-DRG 313

SAMPLE PEPPER TABLE FOR SIMPLE PNEUMONIA IN JURISDICTION

Time Periods	Target Area Discharge Count (Numerator)	Denominator Count	Percentage (Numerator/ Denominator)	Target Area Average Length of Stay (ALOS)	Denominator ALOS	Target Average Medicare Payment	Target Sum Medicare Payments
Q1 FY10	95	205	**46.3%**	5.5	5.1	$5,734	$544,696
Q2 FY10	136	275	**49.5%**	5.6	5.3	$5,503	$748,388
Q3 FY10	90	205	43.9%	5.4	4.6	$5,652	$508,668
Q4 FY10	70	140	**50.0%**	5.5	5.1	$5,738	$401,694

The higher the ratio, the more likely CMS will question the appropriate use of admission screening criteria and admission statuses at the hospital. A sample of how a PEPPER report presents a hospital's data compared with benchmarks is shown in the exhibit on page 6.

By providing data over a longer period, CMS expects hospitals will note changes in the ratios over time and identify potential underlying causes for changes. CMS suggests in its 2010 *User's Guide* that "this could be an indication of a procedural change in admitting, coding or billing practices, staff turnover, or a change in medical staff."

Incorporating PEPPER into a Compliance Program

Hospitals should make it a point to leverage the data in their individual PEPPER reports to further enhance compliance efforts. A recommended best-practice approach involves the following steps.

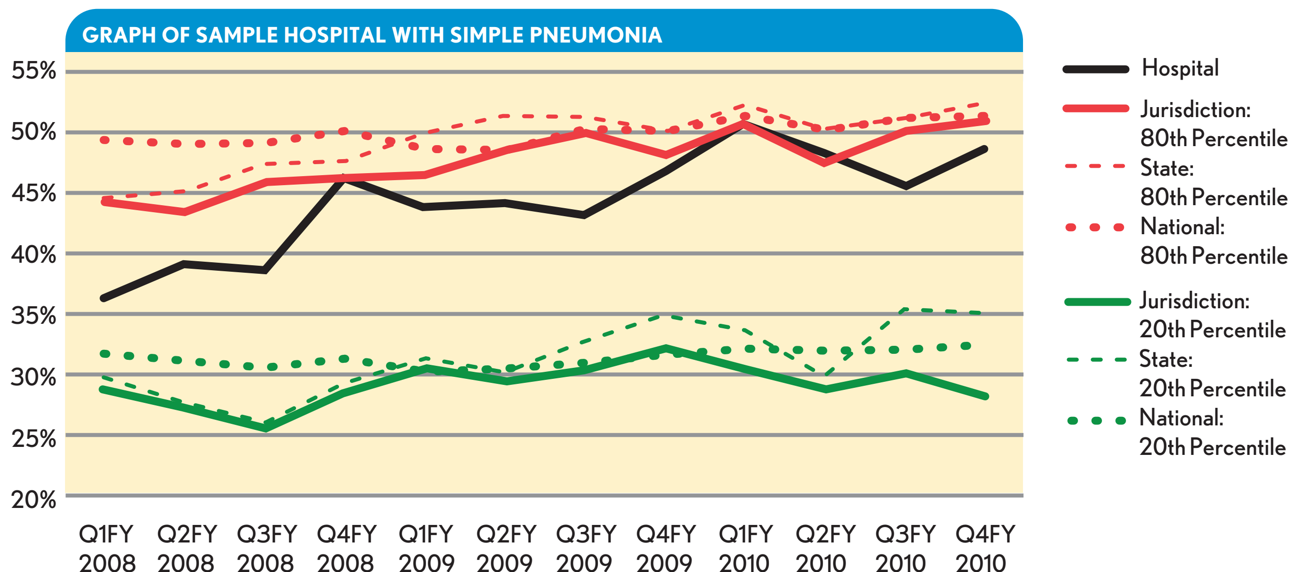
Designate one person, such as a PEPPER administrator, to monitor PEPPER releases and download the report each quarter. Instructions to access the report are located on the PEPPER website, www.pepperresources.org/pepper/downloadingpepper.aspx.

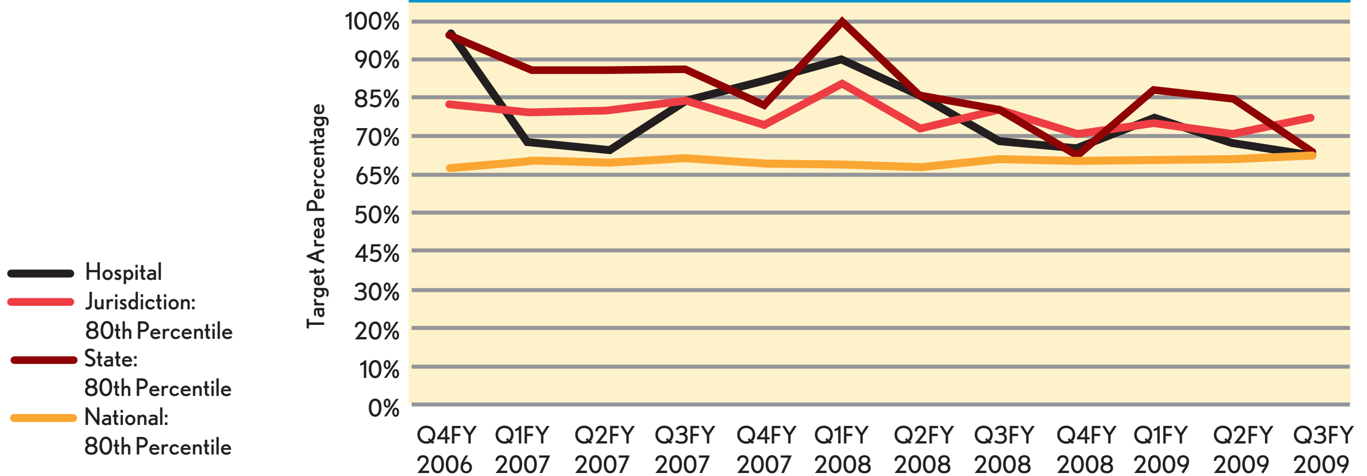
Identify key stakeholders within the organization with whom the PEPPER administrator should share the reports. Some key departments that should be afforded access to PEPPER data include compliance, utilization review/management, case management, and health information management.

Review each quarter and list all areas where your hospital is most at risk for improper payments. Ideally, this review should be part of the utilization review function. In most instances, the risk areas are those where a hospital is above the 80th percentile as compared with other hospitals in the hospital's state, jurisdiction, or nationally. Again, to ensure potential risk areas are easily identifiable, CMS will highlight these areas in red.

For example, consider that a PEPPER report indicates that the 80th percentile for all medical back cases in a hospital's jurisdiction is equal to 1.5 percent of all of the hospital's admissions. If a given hospital's medical back cases represent 2 percent of total admissions, then that hospital is above the 80th percentile and may be targeted for audit due to an unusually high comparative percentage of medical back cases in its PEPPER report.

In this case, the 2011 PEPPER user's guide gives the following guidance: "A sample of medical records for MS-DRGs 551 and 552 should be reviewed to determine if inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis."





Note: for illustrative purposes, the colors from the PEPPER have been modified to more clearly display the hospital benchmark trend lines.

Such a review is important, because hospitals should proactively review all PEPPER variances to determine whether an identified variance is appropriate or is due to noncompliance with regulatory requirements and requires immediate compliance intervention and remediation.

The Compare Target Report for the most recent quarter may be especially helpful to identify areas of focus. This report provides a synopsis of a hospital's data in comparison with the national, jurisdictional, and state benchmarks. CMS recommends that hospitals prioritize focus on at-risk areas beginning with the national comparison, followed by jurisdictional and state comparison.

Once an organization has reviewed PEPPER and identified at-risk areas, it should conduct small-sample case audits. The audits' outcomes should drive next steps, which might include process improvement, rebilling, or other analytic actions, such as an expanded audit of a statistically credible sample.

Conversely, an internal review may disclose that a facility is in full compliance and following best practices, regardless of PEPPER outliers. These outliers are useful indicators to guide self-evaluation, but they do not independently determine the appropriateness of services billed. It is important that the hospital's finance, compliance, legal, case management, and coding experts be involved in the discussion of PEPPER's results, implications, and next steps.

In today's age of healthcare audit accountability, hospitals should recognize that audit activity regarding program integrity is inevitable. Using PEPPER to identify potential gaps in compliance can play a large part in ensuring a strong, compliant process within a hospital. These best practices have assisted hundreds of hospitals in strengthening processes. ●

About the author

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