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PEPPER 2020 – Unconvential Charge Capture & Compliance

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Presented By

William L. Malm, ND, RN, CRCR, CMAS, CHIAP, is a member of the Vitalware Client Strategies team where he specializes in Pharmacy and charge capture initiatives. He is also a nationally recognized author and speaker on topics such as healthcare compliance, chargemasters, CMS recovery audits, and international population health reimbursement. Malm brings over 25 years of experience with a combination of clinical and financial healthcare knowledge that encompasses all aspects of revenue integrity. Previously, Malm played a key role in providing revenue integrity and data expertise for an national software chargemaster vendor. He has also served at a large IDN as the director of revenue integrity. He currently serves as the president for the Certification Council of Medical Auditors. Malm has extensive experience with pre- and post-payment audits, having previously worked as a systems compliance officer at a large for-profit healthcare system. He also co-hosts Appeal Academy's "Finally Friday" discussions.

Agenda

- Overview
  - Source authorities (short-term acute care hospitals)
  - PEPPER version and updates
  - PEPPER resources
  - How to use the PEPPER
- PEPPER Reports and Implications for Success
  - Importance of Medicare Spending Per Beneficiary
  - PEPPER another tool in charge capture environment
  - Integrating PEPPER into all aspects of revenue integrity

Objectives

- Identify source authorities
- Describe the types of PEPPER reports
- Differentiate coding versus admission types
- Explain the importance of Medicare Spending Per Beneficiary
- Understand different uses for the PEPPER in your institution

What Is PEPPER and Why Is It Important?

- To be utilized as part of a comprehensive compliance program
- ACA and OIG have both stressed the importance of a working compliance program to ensure that claims are accurate and supported by documentation
- *"PEPPER is an electronic data report that contains a single hospital's claims data statistics for Medicare-severity diagnosis related groups (DRG) and discharges at risk for improper payment due to billing, coding and/or admission necessity issues. Each PEPPER contains statistics for the most recent twelve federal fiscal quarters for each area at risk for improper payments (referred to in the report as 'target areas')"*
  - (PEPPER Manual V. 28)

CMS Compliance Is the Heart of PEPPER

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Data-Analysis/index.html

Education and Outreach

Programs to Evaluate Payment Patterns Electronic Report – PEPPER

PEPPER is an electronic report that provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER cannot be used to identify the presence of payment errors, but it can be used as a guide for auditing and monitoring efforts to help providers identify and prevent payment errors. PEPPERs are sent to facilities such as Short-Term Hospitals, Long-Term Hospitals, Critical Access Hospitals, Hospices, Inpatient Rehabilitation Facilities, Partial Hospitalization Programs, Skilled Nursing Facilities, Inpatient Psychiatric Facilities, and Home Health Agencies. For more information on PEPPER, click here.

Comparative Billing Report – CBR

A CBR is an educational tool that provides data on Medicare billing trends, allowing a health care provider to compare their billing practices to their peers in the same state and across the nation. A CBR educates providers about Medicare's coverage, coding, and billing rules, provides educational resources, and acts as a self-audit tool for providers. For more information on CBR, click here.

Provider Compliance Tips

Provider Compliance Tips serve as a quick reference fact sheet to educate and provide high-level guidance to providers about claim denial issues and provide claim submission and documentation guidance. The tips cover Part A, B, and DME services with high Medicare improper payment rates. These tips are posted to the Medicare Learning Network and they are updated annually. For more information on Provider Compliance Tips, click here.

2020 - Resources & Source Authority

- **Short-Term Acute Care Program for Evaluating Payment Patterns Electronic Report User's Guide**
- Twenty-Eighth Edition, effective with the Q4FY19 release
- No update in 2020 as yet
- https://pepper.cbrpepper.org
- PEPPER Training Resources
  - https://pepper.cbrpepper.org/Training-Resources/Short-term-Acute-Care-Hospitals

Types of PEPPER Reports

SHORT-TERM ACUTE CARE HOSPITALS

- User's Guide (PDF, 27th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER

CRITICAL ACCESS HOSPITALS

- User's Guide (PDF, 8th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER
- Map of CAH PEPPER Retrievals by State

HOME HEALTH AGENCIES

- User's Guide (PDF, 4th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER
- Map of HHA PEPPER Retrievals by State

HOSPICES

- User's Guide (PDF, 8th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER
- Map of Hospice PEPPER Retrievals by State

INPATIENT PSYCHIATRIC FACILITIES

- User's Guide (PDF, 9th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER

INPATIENT REHABILITATION FACILITIES

- User's Guide (PDF, 9th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER

LONG-TERM ACUTE CARE HOSPITALS

- User's Guide (PDF, 13th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER
- Map of LT PEPPER Retrievals by State

PARTIAL HOSPITALIZATION PROGRAMS

- User's Guide (PDF, 7th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER

SKILLED NURSING FACILITIES

- User's Guide (PDF, 7th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER
- Map of SNF PEPPER Retrievals by State

PEPPER Manual

- Twenty-eighth edition, effective with Q4, fiscal year 2019 release
  - Updated regularly through the year
  - Manual updated with the distribution of the PEPPER
    - Ex: Quarterly, on or about December 4, 2018; March 6, 2019; June 3, 2019; September 3, 2019
  - Key to use the most current version as coding and admission criteria changes
- Obtaining your documents:
  - For acute care, go through the QualityNet portal – this is an electronic download through a secure portal and not available by any other method
    - Every facility should identify personnel who will be responsible for this activity quarterly and ensure distribution to all stakeholders

PEPPER Internal Stakeholders

- Stakeholders include, but not limited to:
  - Revenue integrity (charge capture team)
  - Compliance
  - Case management
  - Patient financial services
  - HIM/coding
  - CDI
  - Medical staff/providers
    - Physician advisors
- Creation of an accessible intranet site is recommended

PEPPER Resources – Short Term Acute Care Hospital

- Anyone can learn from these resources – easy to understand and very thorough
  - Chapter 1 – What is PEPPER
  - Chapter 2 – What kind of data is summarized in PEPPER
  - Chapter 3 – What are the target areas
  - Chapter 4 – Difference between percent and percentile
  - Chapter 5
    - 5.1 – Top medical and surgical 1-day DRGs
    - 5.2 – Medicare Spending Per Beneficiary
  - Chapter 6 – Comparison groups
  - Chapter 7 – How to use the PEPPER
  - Chapter 8 – National & state-level data
  - Chapter 9 – How to obtain PEPPER from QualityNet.org

PEPPER: Short-Term Acute Care Hospitals

- Currently, there are 26 target areas
  - **11 coding-focused DRG validation targets**
  - **15 medical necessity targets (admissions)**
- Three years (12 quarters) of data on a rolling basis
- For each target area, CMS has defined a ratio that is calculated from your hospital's billing data
- The general form:

  CMS-identified **target area** DRGs (numerator)

  A larger pool of related DRGs (denominator)

PEPPER Targets: *Coding*

1. Stroke Intracranial Hemorrhage
2. Respiratory Infections
3. Simple Pneumonia
4. Septicemia
5. Unrelated OR Procedure
6. Medical DRGs with CC or MCC
7. Surgical DRGs with CC or MCC
8. Single CC or MCC
9. Excisional Debridement
10. Ventilator Support
11. Emergency Department Evaluation and Management Visits

PEPPER Targets: *Admission/Medical Necessity*

1. Transient Ischemic Attack
2. Chronic Obstructive Pulmonary Disease
3. Percutaneous Cardiovascular Procedures
4. Syncope
5. Other Circulatory System Diagnoses
6. Other Digestive System Diagnoses
7. Medical Back Problems
8. Spinal Fusion
9. Three-Day Skilled Nursing Facility–Qualifying Admissions
10. 30-Day Readmissions to Same Hospital or Elsewhere
11. 30-Day Readmissions to Same Hospital
12. One-Day Stays for Medical DRGs
13. One-Day Stays for Surgical DRGs
14. Two-Day Stays for Medical DRGs
15. Two-Day Stays for Surgical DRGs

Percentages and Percentiles – They Matter

- The simple pneumonia ratio (numerator/denominator) creates a **percentage.** For example, 48% (percentage, not percentile) of your pool of PN and COPD inpatients might be discharged with a DRG of 193 or 194.
- PEPPER **ranks your percentages** in each target area with other hospitals so you can see where you stand and whether you should internally audit.
- ***The percentile is the rank,*** from 0 to 100, of **where your hospital stands in comparison to others.**

Percentile Ranking

- For example, if your 48% result for the simple pneumonia ratio at your hospital is greater than 70% of other hospitals' results, you rank in the 70th percentile. 30% of hospitals will have a result greater than your 48%, and 70% will have a result lower than yours.
- Understand the difference between percentage and percentile with PEPPER:
  - https://pepper.cbrpepper.org/Portals/0/Documents/PEPPER/PEPPER%20Training%20Chapters/Chapter4_PercentsPercentiles_ST_LT_CAH_IPF_IRF_508.pdf

Percentile Ranking - High & Low Coding Percentiles

- High and Low percentile only applicable to coding percentiles
- PEPPER ***arbitrarily*** defines the ***80th percentile*** as the threshold for high outlier status.
- PEPPER ***arbitrarily*** defines the ***20th percentile*** as the threshold for low outlier status ***for the coding-focused areas***.
  - There is ***no low outlier percentile defined for the medical necessity areas***

- ***KEY CONCEPT:*** The percentiles are arbitrary in definition so they act only as a guideline to judge your performance

Coding: High Outlier Percentile (80%)

- Generally, if you are a **HIGH outlier (≥ 80th percentile), you *may be receiving improper payments and are at risk***. Validate your discharges in the target area to ensure that your documentation supports the DRG assignment.
  - Example: Stroke ICH. Out of your pool of cerebrovascular disease inpatients (stroke and TIA), how often did you bill Medicare for the higher-paying DRGs such as 061 (acute stroke with thrombolysis with MCC)?
  - If this result puts your hospital in the 80th percentile or higher, internally review cases for the target DRGs to make sure that the documentation fully supports assigning those DRGs at discharge.
    - Or, it could mean that you're treating a large number of very complicated stroke patients!
    - Audit the DRG focus areas proactively and randomly, and ensure that documentation supports the DRG.

Coding: Low Outlier Percentile (20%)

- Generally, if you are a ***LOW outlier (< 20th percentile), you may have an opportunity for improvement***. You might choose to internally review those areas.
  - Example: Surgical CC/MCC. Out of your pool of surgical patients discharged during the reporting period, how many were assigned a DRG that includes a CC or MCC?
  - If this result puts your hospital below the 20th percentile, you might choose to review surgical discharges without a CC or MCC to see if improvements could be made in surgeons' documentation or the coding/billing process.
    - Or, it could just mean that you are doing surgery on very healthy, uncomplicated patients!
- NOTE: There is no low outlier for admission/medical necessity targets, only for the coding targets.

PEPPER Tells You the Numerator/Denominator

TARGET AREA Full and Abbreviated Title	TARGET AREA DEFINITION
Stroke Intracranial Hemorrhage (Stroke ICH)	*Numerator (N):* count of discharges for DRGs 061 (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with MCC), 062 (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with CC), 063 (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent without CC/MCC), 064 (intracranial hemorrhage or cerebral infarction with MCC), 065 (intracranial hemorrhage or cerebral infarction with CC or tPA in 24 hours), 066 (intracranial hemorrhage or cerebral infarction without CC/MCC) *Denominator (D):* count of dischages for DRGs 061, 062, 063, 064, 065, 066, 067 (nonspecific CVA and precerebral occlusion without infarct with MCC), 068 (nonspecific CVA and precerebral occlusion without infarct without MCC), 069 (transient ischemia without thrombolytic)

Medicare Spending Per Beneficiary

- **Medicare Spending Per Beneficiary by Claim Type Report**
  - Hospital-level Medicare Spending Per Beneficiary (MSPB) is calculated and reported annually ***to support the Hospital Value-Based Purchasing Program***. Hospital-level statistics are available on the Hospital Compare website at *https://www.medicare.gov/hospitalcompare/Data/spending-per-hospital-patient.html*.
  - Report is designed to make spending data actionable.
  - These statistics can be valuable to hospitals to inform them on ***the total cost of care***; however, the existing format of the data is not easily digestible.
  - This report is intended to give a hospital a ***quick look at where their costs are higher or lower than the national median hospital***.

Medicare Spending Per Beneficiary

- "The MSPB measure ***evaluates hospitals' efficiency***, as reflected by Medicare payments made during an MSPB episode, relative to the efficiency of the median hospital in the nation.
- Each episode includes all Medicare Part A and Part B claims with a start date falling during the period from **three days prior to a hospital admission (i.e., index admission) through 30 days after discharge from the hospital**. Medicare payment amounts are risk-adjusted and price-standardized.
- The PEPPER Team has summarized and reported the MSPB statistics for the most recent year available (calendar year 2017). Please note that this report is populated for hospitals that have more than 25 episodes in the calendar year. The MSPB calculations do not include the following episodes:
  - Episodes where at any time 90 days before or during the episode the beneficiary was enrolled in a Medicare Advantage plan or Medicare was the secondary payer.
  - Episodes where the beneficiary becomes deceased during the episode."
    - (PEPPER Short-Term Acute Manual v. 27)

Medicare Spending Per Beneficiary

- “Episodes in which the index admission inpatient claim had $0 actual payment or a $0 standardized payment.
- Acute-to-acute transfers (where a transfer is defined based on the claim discharge code) are not considered index admissions. In other words, these cases do not generate new MSPB episodes; neither the hospital that transfers a patient to another subsection (d) hospital nor the receiving subsection (d) hospital will have an index admission or associated MSPB episode attributed to them.
- Admissions to hospitals that Medicare does not reimburse through the IPPS system (e.g., cancer hospitals, critical access hospitals, hospitals in Maryland) are not considered index admissions and are therefore not eligible to begin an MSPB episode. If an acute-to-acute hospital transfer or a hospitalization in a PPS-exempt hospital type happens during the 30-day window following an included index admission, however, it will be counted in the measure.”
    - (PEPPER Short-Term Acute Manual v. 27)

Why is Medicare Spending Important

- Provides a comparison to peer group
- Assists in performing improvement activities for both cost and charges
- Over utilization of charges will result in a higher spending
- **Right Time – Right Test or Service – Right Patient – Right Setting**
- Charge capture teams can notice, through patterns, increases in charges where more judicious use would lead to cost efficiencies
  - Example: Laboratory Utilization – Cleveland Clinic
  - https://clevelandcliniclabs.com/wp-content/assets/pdfs/publications/2014-test-utilization.pdf

PEPPER Limitations

- PEPPER data is only based on ***Medicare fee-for-service patient*** discharges
  - No commercial insurers, no Medicare Advantage, no Medicaid
- PEPPER only includes inpatient data, with two exceptions:
  - Percutaneous cardiovascular procedures
  - Emergency room E/M coding
- PEPPER compares your hospital to others **without regard for demographics, service lines, bed count, or geography**
  - The 11+ case per quarter minimum is the only validity check, and it applies to all hospitals regardless of size

PEPPER Is Designed to Raise a Question, Not Answer It

- **PEPPER *will never answer a question—it is designed to RAISE questions* that you will then answer with an internal audit/chart review of outlier areas and non-outlier areas alike**

Each Facility's Obligation

- Previously, revenue cycles waited for the PEPPER to arrive and come up with an action plan
- With enhanced auditing by all payers, it is incumbent upon each facility to create reports, such as PEPPER, internally and in real time
- You may not be able to track your progress against outside institutions, but you can track your progress against yourself
  - **Identify aberrancies**
  - **Perform root cause analysis**

PEPPER REPORTS

Example Report – PEPPER

- https://pepper.cbrpepper.org/Portals/0/Documents/Data/Q4FY19/003212_DMSTR_STPEPP_Q4FY19_Hospital_R3212.xls
- Workbooks:
  - Definitions
  - Comparison
  - Outlier rank
  - Workbooks for each coding metric
  - Workbooks for each admission / medical necessity metric
  - Medicare Spending Per Beneficiary

Compare Tab – Instructions

- The Compare Targets Report displays statistics for target areas that have reportable data (11+ target discharges) in the most recent time period.
- Percentiles indicate how a hospital's target area percent compares to the target area percent for all hospitals in the respective comparison group.
  - For example, if a hospital's jurisdiction percentile (see below) is 80.0, 80% of the hospitals in the Medicare Administrative Contractor (MAC) comparison group have a lower percent value than that hospital. The hospital's state percentile (if displayed) and the hospital national percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target areas, or at or below the 20th percentile for coding-focused target areas indicate that the hospital may be at a higher risk for improper Medicare payments (outlier status). The greater the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

Compare Tab – National, State, Jurisdiction, & Sum of Payments

Target	Description	Number of Target Dischs	Percent	Hospital National %ile	Hospital Jurisdict. %ile*	Hospital State %ile*	Sum of Payments
Respiratory Infections	Proportion of discharges with DRG equal to 177 (respiratory infections & inflammations w/ MCC), 178 (respiratory infections & inflammations w/ CC), to discharges with DRG equal to 177, 178, 179 (respiratory infections & inflammations w/o CC/MCC), 193 (simple pneumonia & pleurisy w/ MCC), 194 (simple pneumonia & pleurisy w/ CC), 195 (simple pneumonia & pleurisy w/o CC/MCC)	23	51.1%	86.9	84.9	83.7	$214,763
Simple Pneumonia	Proportion of discharges with DRG equal to 193 (simple pneumonia & pleurisy w/ MCC), 194 (simple pneumonia & pleurisy w/ CC), to discharges with DRG equal to 190 (chronic obstructive pulmonary disease w/ MCC), 191 (chronic obstructive pulmonary disease w/ CC), 192 (chronic obstructive pulmonary disease w/o CC/MCC), 193, 194, 195 (simple pneumonia & pleurisy w/o CC/MCC)	22	52.4%	56.8	47.6	44.9	$176,774
Septicemia	Proportion of discharges with DRG equal to 870 (septicemia or severe sepsis w/ mechanical ventilation >96 hours or peripheral ECMO), 871 (septicemia or severe sepsis w/o mechanical ventilation >96 hours with MCC), 872 (septicemia or severe sepsis w/o mechanical ventilation >96 hours w/o MCC), to discharges with DRG equal to 193 (simple pneumonia and pleurisy with MCC), 194 (simple pneumonia and pleurisy with CC), 195 (simple pneumonia and pleurisy without CC/MCC), 207 (respiratory system diagnosis with ventilator support >96 hours or peripheral ECMO), 208 (respiratory system diagnosis with ventilator support < 96 hours), 689 (kidney & urinary tract infections w/ MCC), 690 (kidney & urinary tract infections w/o MCC), 870, 871, 872	157	73.4%	84.6	88.0	89.4	$2,238,463
Unrelated OR Procedure	Proportion of discharges with DRG equal to 981 (extensive OR procedure unrelated to principal diagnosis w/ MCC), 982 (extensive OR procedure unrelated to principal diagnosis w/ CC), 983 (extensive OR procedure unrelated to principal diagnosis w/o CC/MCC), 987 (non-extensive OR procedure unrelated to principal diagnosis w/ MCC), 988 (non-extensive OR procedure unrelated to principal diagnosis w/ CC), 989 (non-extensive OR procedure unrelated to principal diagnosis w/o	25	5.1%	88.6	92.0	94.1	$640,046

Prioritize – Sum of Payments

- The “Sum of Payments” and “Number of Target Discharges” can also be used to help prioritize areas for review.
- The Compare Targets Report may show that the hospital is at the 85th national percentile for the Septicemia target area and at the 83rd national percentile for the Single CC or MCC target area.
- The Single CC or MCC target area has a ***higher “Sum of Payments”*** and “Number of Target Discharges” than the Septicemia target area. In this scenario, the Single CC or MCC target area might be given priority over the Septicemia target area.

National High Outlier Ranking

- Out of all the possible data points in PEPPER (***26 target areas x 12 quarters = 312***), how many times did you have a result that placed you above the 80th percentile?
  - Add them up, rank them with the other 3,000+ hospitals, and determine your percentile
  - Drawbacks:
    - ***This is biased toward larger hospitals having a greater number of high outliers*** (smaller hospitals have more areas with unreported data due to fewer than 11 cases)
    - This does not direct your internal chart reviews to any areas of concern
    - High outlier results from as long as 3.5 years ago continue to affect this ranking

National High Outlier Tab

- The National High Outlier Ranking report provides a comparison to all other short-term acute care hospitals in the nation
- Your hospital's national percentile is used to determine high outlier status
- All the quarters for which your hospital is at or above the national 80th percentile are added up for all the target areas
- ***The hospital with the greatest total number of high outliers is assigned a rank of 1***
- The hospital with the second greatest number is assigned a rank of 2, and so on

National High Outlier Tab

Ranking: 15 out of a total of 3337

Target Area	Q2 FY 2016	Q3 FY 2016	Q4 FY 2016	Q1 FY 2017	Q2 FY 2017	Q3 FY 2017	Q4 FY 2017	Q1 FY 2018	Q2 FY 2018	Q3 FY 2018	Q4 FY 2018	Q1 FY 2019	Total
Stroke Intracranial Hemorrhage													0
Respiratory Infections	0	0	0	0	0	0	0	0	0	1	1	1	3
Simple Pneumonia	0	1	0	0	1	1	0	0	1	0	0	0	4
Septicemia	0	0	0	0	0	0	0	0	0	1	1	1	3
Unrelated OR Procedure	1	1	1	0	0	1	0	0	0	0	0	1	5
Medical DRGs with CC or MCC	0	0	0	0	0	0	0	1	1	1	1	1	5
Surgical DRGs with CC or MCC	1	1	1	1	1	1	1	1	1	1	1	1	12
Single CC or MCC	0	0	0	0	0	0	0	0	0	0	0	0	0
Excisional Debridement		0	0	0			0	0			0		0
Ventilator Support	0	0	0	0	0	0	0	0	0	0	0	0	0
Emergency Dept E and M Visits	1	1	1	1	1	1	1	1	1	0	1	0	10
Transient Ischemic Attack													0
COPD	0	0	0	0	0	0	0	0	0	0	0	0	0
Percutaneous Cardiovascular Proced	0	0	0	0	0	0	0	0		0	0	0	0
Syncope		0			0	0	0						0
Other Circulatory System Diagnoses	1	1	1	1	1	0	1	1	1	1	1	1	11
Other Digestive System Diagnoses	1	0	1	0	0	1	0	1	1	1	0	1	7
Medical Back Problems													0
Spinal Fusion													0
3-day SNF-qualifying Admissions	0	0	0	0	0	0	0	0	0	0	0	0	0
30-day Readm to Same or Elsewhere	1	1	1	1	1	1	1	1	1	1	1	1	12
30-day Readm to Same Hospital	1	1	1	1	1	1	1	1	1	1	1	1	12
2DS Medical DRGs	0	0	0	0	0	0	0	0	0	0	0	0	0

Coding Tabs – Example Respiratory Infections Comparing You to You

Short-Term Acute Care PEPPER

Visit PEPPERresources

Respiratory Infections

003184 Hospital R3184

Link to Definitions Worksheet

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Percents (4th column in the table below) that are consistently red (high outlier) or green (low outlier)
- A trend of increasing or decreasing Percents over time resulting in outlier status
- Your Percent is above the national 80th percentile (see graph on the following worksheet)
- Your Percent is below the national 20th percentile (see graph on the following worksheet)

Q1 = Oct-Dec Q2 = Jan-Mar Q3 = Apr-Jun Q4 = Jul-Sep Time Periods	Target Area Discharge Count (Numerator)	Denominator Count	Percent (Numerator/ Denominator)	Target Area Average Length of Stay (ALOS)	Denominator Average Length of Stay (ALOS)	Target Average Medicare Payment	Target Sum Medicare Payments
Q2 FY 2016	18	61	29.5%	6.9	4.9	$9,947	$179,048
Q3 FY 2016	19	63	30.2%	11.7	6.8	$13,348	$253,605
Q4 FY 2016	14	40	35.0%	12.1	6.7	$9,517	$133,233
Q1 FY 2017	26	57	45.6%	7.8	6.1	$9,736	$253,149
Q2 FY 2017	27	92	29.3%	8.6	5.8	$9,523	$257,124
Q3 FY 2017	13	41	31.7%	9.7	6.1	$14,419	$187,449
Q4 FY 2017	15	39	38.5%	10.8	7.6	$11,975	$179,626
Q1 FY 2018	15	52	28.8%	8.7	5.0	$9,927	$148,910
Q2 FY 2018	17	97	17.5%	6.2	5.1	$9,764	$165,991
Q3 FY 2018	19	39	48.7%	7.4	5.3	$10,616	$201,710
Q4 FY 2018	21	39	53.8%	6.8	5.6	$10,304	$216,374
Q1 FY 2019	23	45	51.1%	8.5	6.8	$9,338	$214,763

Note: Data for hospitals with fewer than 11 discharges in the numerator of a target area have been suppressed due to confidentiality requirements.
Note: Target area discharge count (numerator) = count of discharges for DRGs 177 and 178 (see Definitions worksheet for complete target area definitions).

SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS

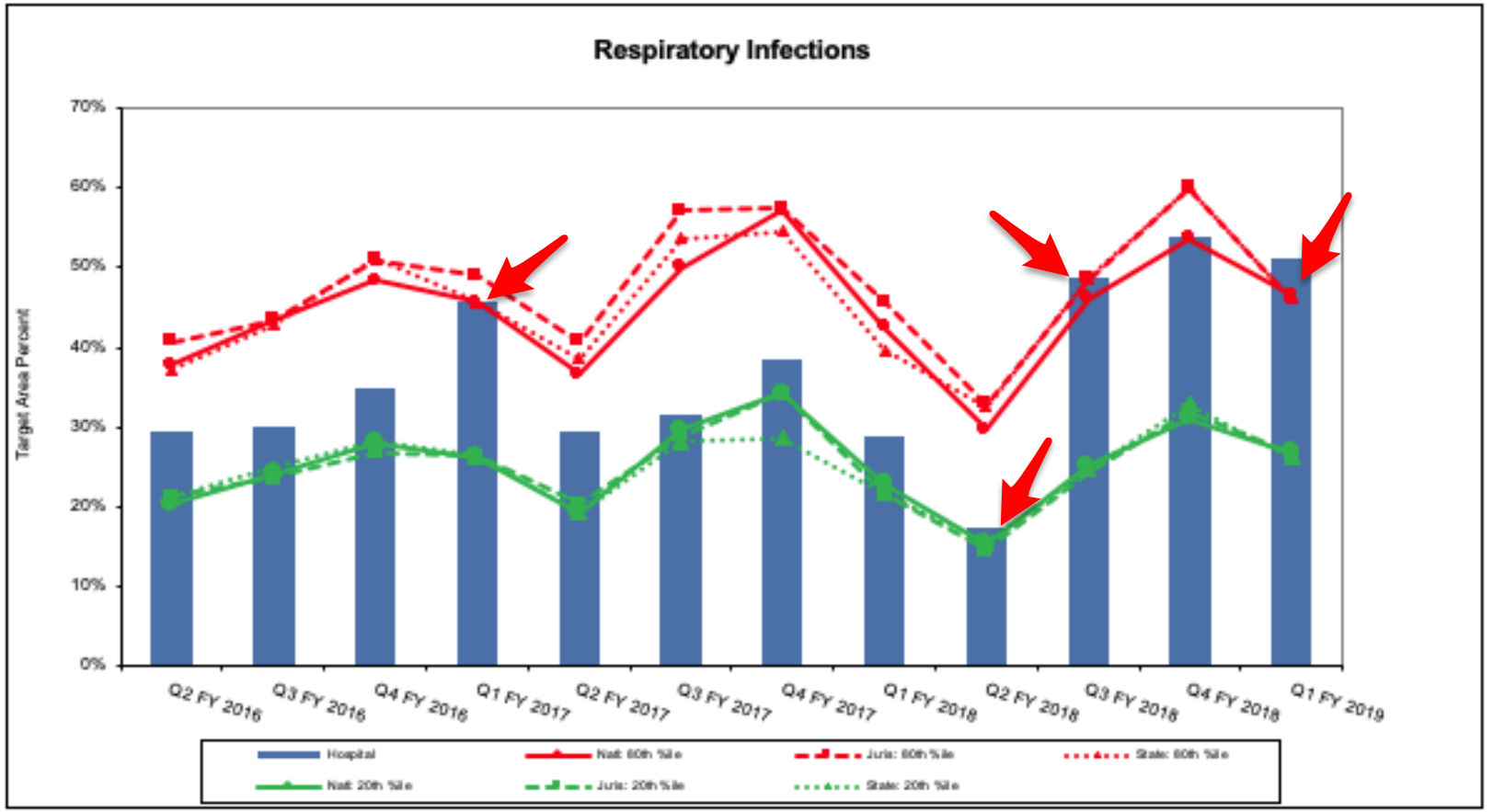
This could indicate that there are coding or billing errors related to over-coding for DRGs 177 or 178. A sample of medical records for these DRGs should be reviewed to determine if coding errors exist. Hospitals may generate data profiles to identify cases with principal diagnosis codes of ICD-10-CM code J69.0 (pneumonitis due to inhalation of food or vomit), ICD-10-CM code J15.64 (pneumonia due to other (aerobic) gram negative pneumonia) or ICD-10-CM code J15.8 (pneumonia due to other specified bacteria) to ensure that documentation supports the principal diagnosis.

Coding Tabs – Graphs

Short-Term Acute Care PEPPER
Respiratory Infections
003184 Hospital R3184

Visit PEPPERresources

Link to Definitions Worksheet



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Medical Necessity/Admission Tabs

Short-Term Acute Care PEPPER Visit PEPPERresources

Syncope

003184 Hospital R3184 Link to Definitions Worksheet

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Percents (4th column in the table below) that are consistently red (high outlier)
- A trend of increasing Percents over time resulting in outlier status
- Your Percent is above the national 80th percentile (see graph on the following worksheet)

Q1 = Oct-Dec Q2 = Jan-Mar Q3 = Apr-Jun Q4 = Jul-Sep Time Periods	Target Area Discharge Count (Numerator)	Denominator Count	Percent (Numerator/ Denominator)	Target Area Average Length of Stay (ALOS)	Denominator Average Length of Stay (ALOS)	Target Average Medicare Payment	Target Sum Medicare Payments
Q2 FY 2016							
Q3 FY 2016	11	221	5.0%	2.3	5.0	$4,528	$49,803
Q4 FY 2016							
Q1 FY 2017							
Q2 FY 2017	15	236	6.4%	2.7	5.2	$3,565	$53,474
Q3 FY 2017	21	261	8.0%	2.0	5.1	$3,615	$75,920
Q4 FY 2017	14	236	5.9%	2.5	4.7	$3,718	$52,057
Q1 FY 2018							
Q2 FY 2018							
Q3 FY 2018							
Q4 FY 2018							
Q1 FY 2019							

Note: Data for hospitals with fewer than 11 discharges in the numerator of a target area have been suppressed due to confidentiality requirements.

Note: Target area discharge count (numerator) = count of discharges for DRG 312 (see Definitions worksheet for complete definitions).

SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS

This could indicate that there are unnecessary admissions related to failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRG 312. A sample of medical records for DRG 312 should be reviewed to determine if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). Note: code to the underlying cause of syncope if known.

Medical Necessity/Admission Tabs

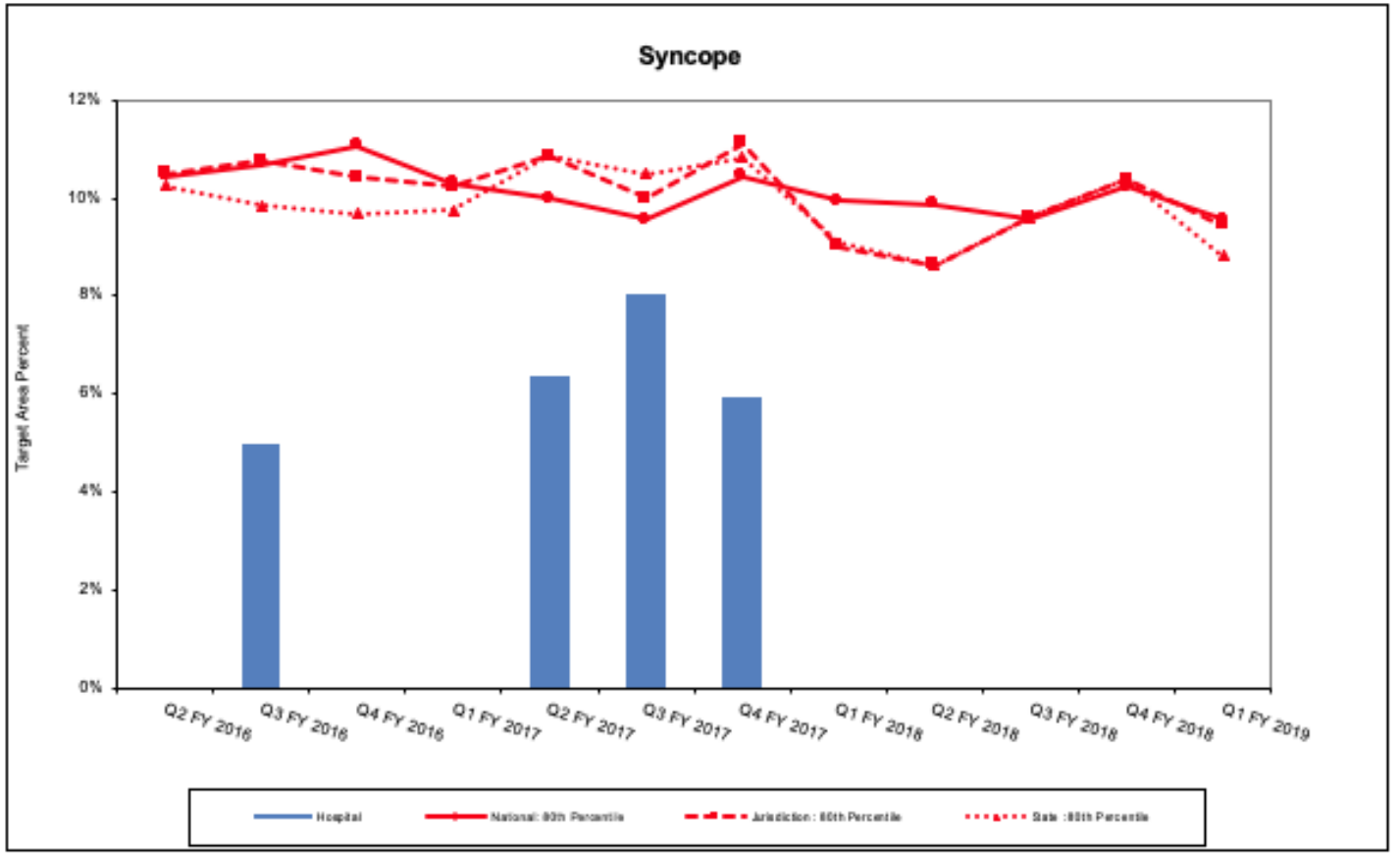
- On the medical necessity/admission tabs, you will notice:
  - Many of the quarters have no data
  - No-data quarters are due to the fact there was less than 11 admissions; therefore, they are not reported
  - You will also notice there is no lower percentile data or graph
    - Only the coding targets have both an upper and lower percentile
- Priority ranking using Sum of Payments would still be used
- High outliers involving medical necessity/admissions should still be addressed

Medical Necessity/Admission Graph

Short-Term Acute Care PEPPER
Syncope
003184 Hospital R3184

Visit PEPPERresources

Link to Definitions Worksheet



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Medicare Spending Per Beneficiary

MEDICARE SPENDING PER BENEFICIARY

SPENDING BREAKDOWN BY CLAIM TYPE

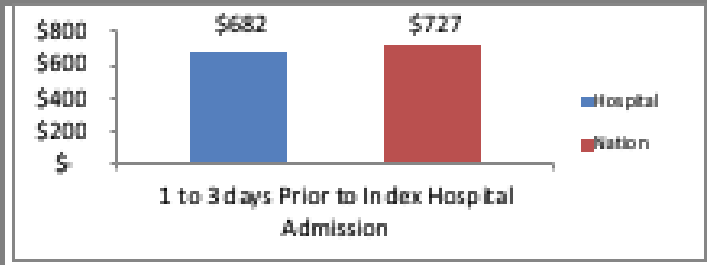
Hospital R3184 — Compared to the **Nation**

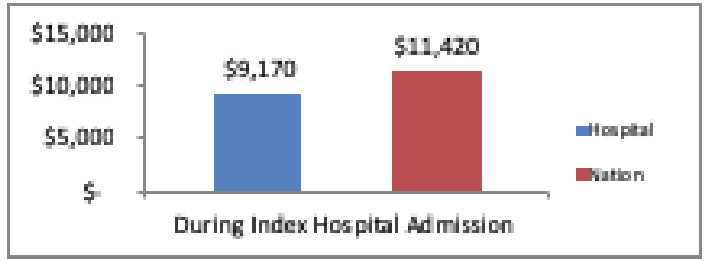
A quick look at where your hospital spent more or less than the national median hospital in CY 2017

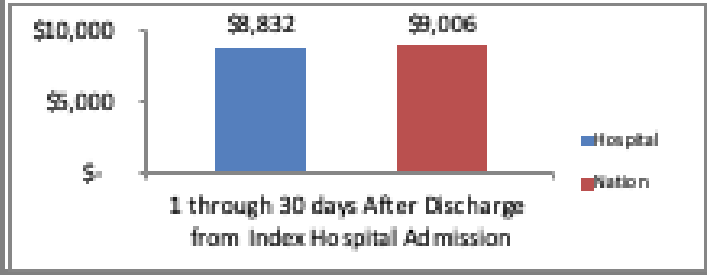
How did spending by Claim Type compare to the Nation?

	Avg Spending Per Episode Hospital	Greater or Less Than Nat'l Median Hospital
Inpatient	$ 10,319	-19%
Carrier (Physician / Supplier)	$ 2,856	-12%
SNF	$ 3,741	16%
Outpatient	$ 806	-14%
HHA	$ 781	-9%
Hospice	$ 113	-22%
DME	$ 68	-37%

How did spending by Episode phase compare to the Nation?







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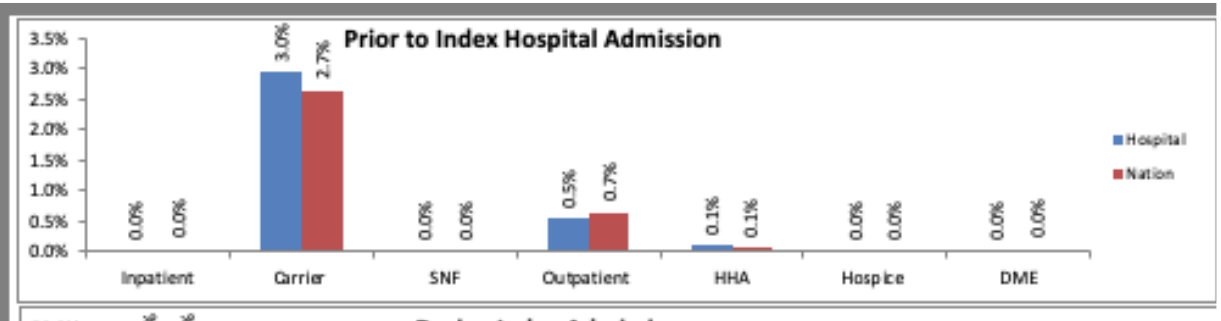
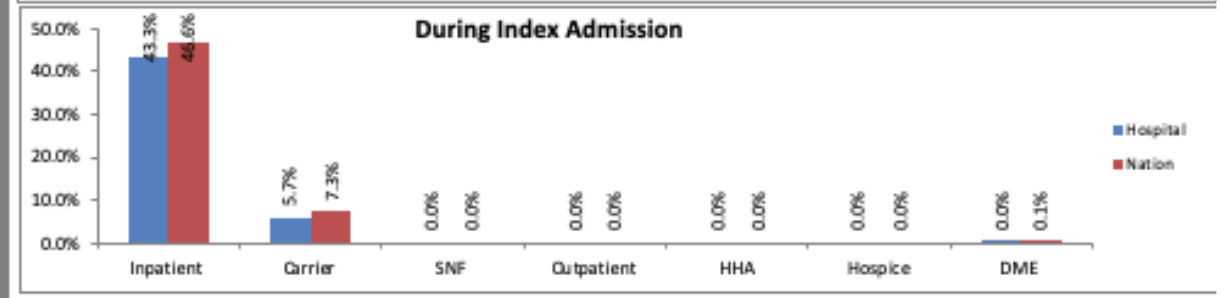
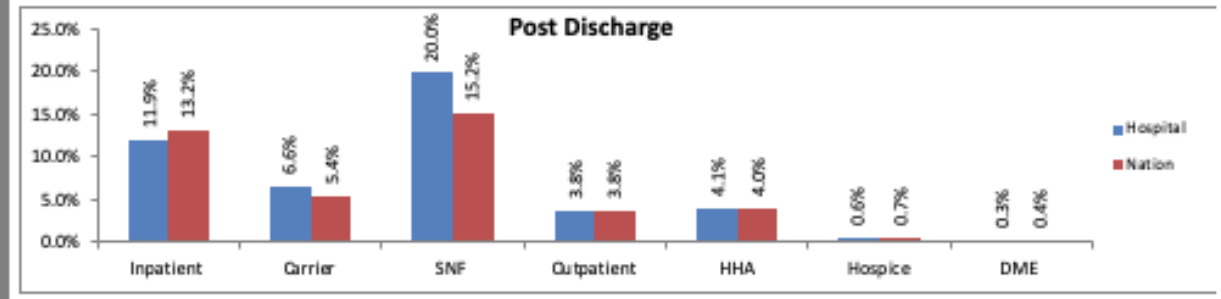
Medicare Spending Per Beneficiary

Which cost centers were the major drivers of each phase of the episode?







Percentages may display as zero due to rounding

This report is populated for hospitals that have more than 25 episodes in the calendar year. See the MSPB Measure Information Form for additional information: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350

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Revenue Integrity & Charge Capture Implications

Key Implications

- Coding opportunities if over or under the threshold percentiles
- Utilization of services can be a significant concern with value based programs – Medicare Spending Per Beneficiary
- PEPPER is key to a functional compliance program
- Use PEPPER as a template for internal audit protocols
  - Work with IT / Decision Support / Internal audit to create real time reports using the numerator / denominator scenarios
  - No need to wait until next PEPPER is released – real time data analysis

PEPPER and Revenue Management

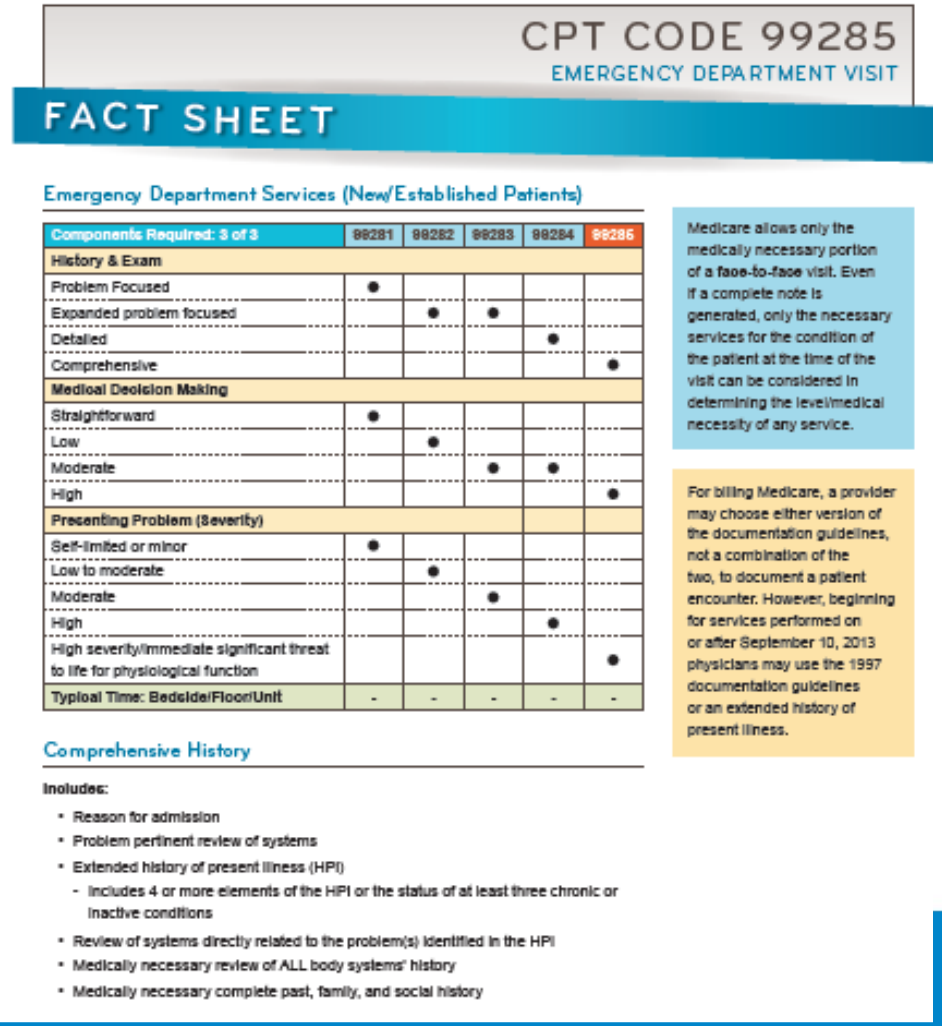
- Revenue management
  - Revenue management/revenue integrity is a match between ensuring retention of earned revenue and compliance functions
  - To ensure revenue integrity is integrated into high-risk operations, the (ST) PEPPER can be invaluable
  - Example: Evaluation and Management
    - Level 5 (99285) has been part of a number of reviews by the OIG
    - Remains a risky E&M
    - System “calculators” may be directionally constructed to a higher E & M
    - ***Very little front-end auditing*** is performed in most facilities; therefore, automated concurrent PEPPER could fit the bill to enhance your compliance

99285 Is a Risk We Often Ignore

TARGET AREA Full and Abbreviated Title	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)

CGS Medicare – E/M Risk – Documentation Education

https://cgsmedicare.com/partb/mr/pdf/99285.pdf



CPT CODE 99285
EMERGENCY DEPARTMENT VISIT

FACT SHEET

Emergency Department Services (New/Established Patients)

Components Required: 3 of 3	99281	99282	99283	99284	99285
History & Exam					
Problem Focused	●				
Expanded problem focused		●	●		
Detailed				●	
Comprehensive					●
Medical Decision Making					
Straightforward	●				
Low		●			
Moderate			●	●	
High					●
Presenting Problem (Severity)					
Self-limited or minor	●				
Low to moderate		●			
Moderate			●		
High				●	
High severity/immediate significant threat to life for physiological function					●
Typical Time: Bedside/Floor/Unit	-	-	-	-	-

Medicare allows only the medically necessary portion of a face-to-face visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level/medical necessity of any service.

For billing Medicare, a provider may choose either version of the documentation guidelines, not a combination of the two, to document a patient encounter. However, beginning for services performed on or after September 10, 2013 physicians may use the 1997 documentation guidelines or an extended history of present illness.

Comprehensive History

Includes:

- Reason for admission
- Problem pertinent review of systems
- Extended history of present illness (HPI)
  - Includes 4 or more elements of the HPI or the status of at least three chronic or inactive conditions
- Review of systems directly related to the problem(s) identified in the HPI
- Medically necessary review of ALL body systems' history
- Medically necessary complete past, family, and social history

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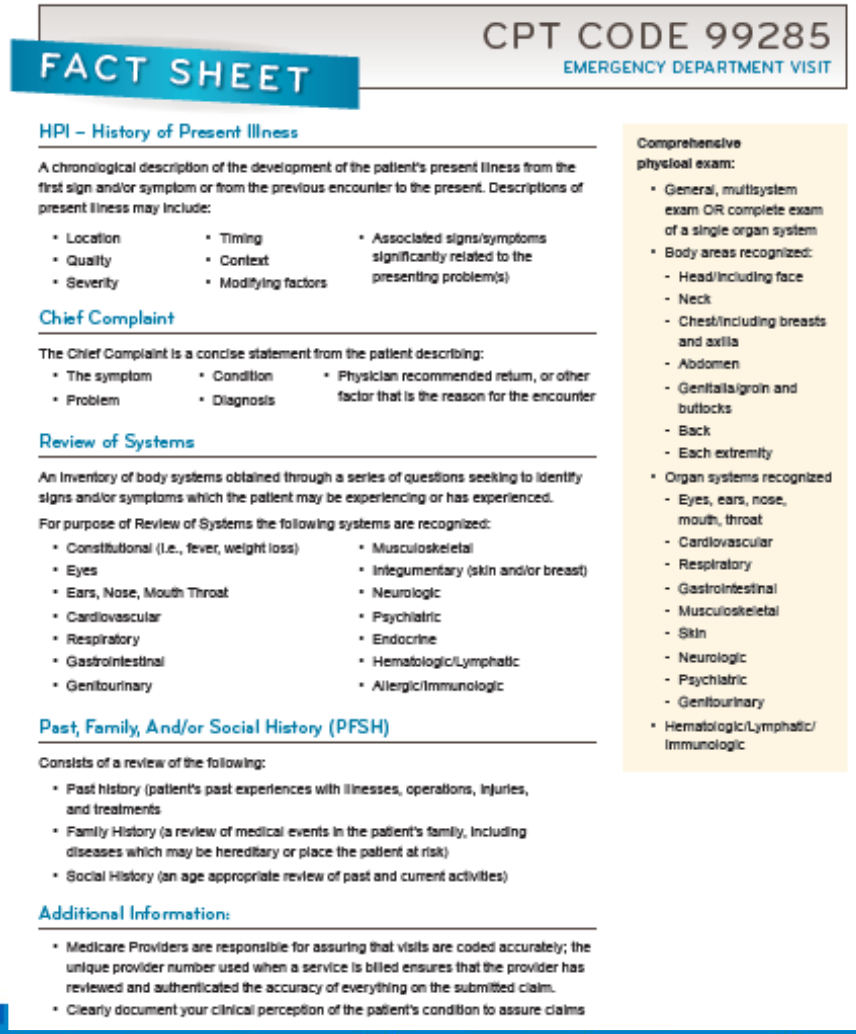
CGS Medicare



FACT SHEET

CPT CODE 99285

EMERGENCY DEPARTMENT VISIT

HPI – History of Present Illness

A chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. Descriptions of present illness may include:

- Location
- Quality
- Severity
- Timing
- Context
- Modifying factors
- Associated signs/symptoms significantly related to the presenting problem(s)

Chief Complaint

The Chief Complaint is a concise statement from the patient describing:

- The symptom
- Problem
- Condition
- Diagnosis
- Physician recommended return, or other factor that is the reason for the encounter

Review of Systems

An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purpose of Review of Systems the following systems are recognized:

- Constitutional (i.e., fever, weight loss)
- Eyes
- Ears, Nose, Mouth Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurologic
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Past, Family, And/or Social History (PFSH)

Consists of a review of the following:

- Past history (patient's past experiences with illnesses, operations, injuries, and treatments
- Family History (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
- Social History (an age appropriate review of past and current activities)

Additional Information:

- Medicare Providers are responsible for assuring that visits are coded accurately; the unique provider number used when a service is billed ensures that the provider has reviewed and authenticated the accuracy of everything on the submitted claim.
- Clearly document your clinical perception of the patient's condition to assure claims

Comprehensive physical exam:

- General, multisystem exam OR complete exam of a single organ system
- Body areas recognized:
  - Head/including face
  - Neck
  - Chest/including breasts and axilla
  - Abdomen
  - Genitalia/groin and buttocks
  - Back
  - Each extremity
- Organ systems recognized
  - Eyes, ears, nose, mouth, throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Genitourinary
- Hematologic/Lymphatic/ Immunologic

Regular Monitoring Is Mandatory

- Claim submission data is now key to many program payment and integrity structures
- Data analytics has never been stronger, so waiting until the next PEPPER to show improvement is **NOT AN OPTION!**
- Decision support will need to prepare ongoing monitoring
  - ***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)
  - Decision support/analytics will need to prepare this for daily tracking and compile weekly, monthly, and quarterly—BE PROACTIVE

Regular Monitoring

- With the monitoring, consistent feedback must be given to the providers
- **Outliers must be resolved urgently—initiate Six Sigma remediation**
- **Keys to doing this in real time or close to real time:**
  - **Review documentation**—is your EHR helping or hindering the case?
  - **Review coding**—diagnosis codes and procedure codes are much more granular with ICD-10
  - **Audit team** should be re-deployed to proactive auditing, not just defence
  - Rebill as necessary prior to timely filing
  - Rebilling can prevent outlier status if appropriate

PEPPER Monitoring

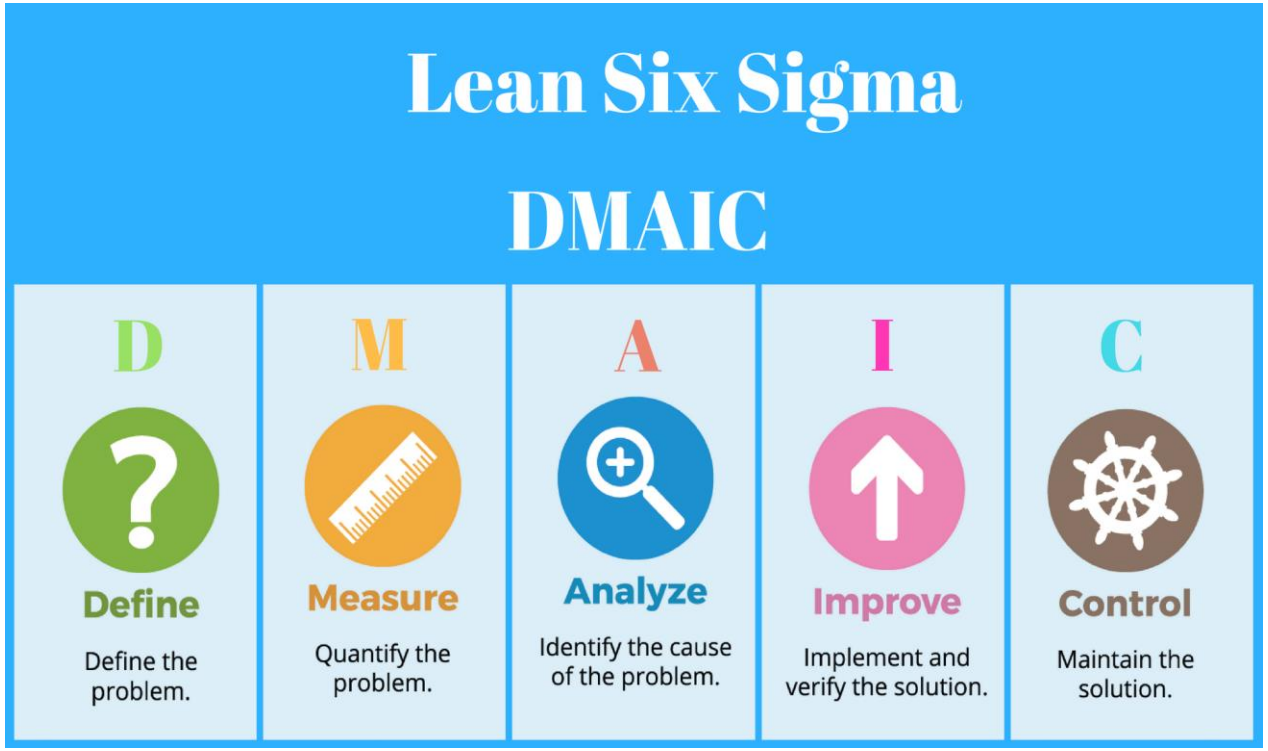
- The monitoring should be divided into two components
  - Coding
  - Medical necessity
- Operationally, these may differ in the approach toward remediation
- Teaching—definitely can have an impact on the overall results as many of the electronic records do not differentiate the attending from the resident documentation
  - **Review your own documentation**
  - **PRINT THE RECORD and review**

What PEPPER Suggests

- "Comparative data for several consecutive quarters can be used to help identify **whether the hospital's target area percent changed significantly in either direction from one quarter to the next**. This could be an indication of a procedural change in admitting, coding or billing practices, staff turnover, or a change in medical staff."
  - https://www.pepperresources.org
- As a facility, real-time or very close to real-time monitoring can indicate a shift long before the reports become available.
- **KNOW YOUR TRENDS AND PATTERNS OF BEHAVIOR!**
- These monitoring activities are required as part of a comprehensive compliance program.

Be Proactive – Determine Root Cause

- Once data analytics is prepared, the data must be reviewed and **root cause evaluation must occur**



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Six Sigma Integrated Into PEPPER

- Institutions should seek out Six Sigma–trained staff
- Integration of a Six Sigma review process for root cause should be integrated into the PEPPER process
- Diversify PEPPER concept outside of the limitations of PEPPER and create a more robust internal auditing program
- Use daily monitoring of charges as part of your six sigma DMAIC (Define, Measure, Analyse, Improve & Control) design

Performance Improvement

- PEPPER can be another tool in the revenue integrity toolkit
- Performance improvement is based on achieving best practice key performance indicators (KPI)
- All of the data tables, graphs, and reports in PEPPER were designed to assist the hospital in **identifying potential overpayments as well as potential underpayments**
- *Key Takeaway – compare yourself to others but also compare your performance to your historical performance*

Performance Improvement

- ***Track the percentages in real time*** if possible
  - Each percentage has a calculated relationship to the percentile
  - Create ongoing tracking mechanisms to monitor the percentage each week
  - Use the defined numerator and denominators and have reports written so that you can replicate the PEPPER at any time
- ***The key to performance improvement is to make it ongoing, sustainable and real- time—do not wait until the next PEPPER release!***

Summation

- Ensure you have a dedicated PEPPER team
- Ensure all stakeholders are on the team
- Designate a person(s) to download from QualityNet and put in secure folder on your intranet
- Review PEPPER trend and involve Six Sigma and perform a root cause analysis
- Create internal auditing processes that review the pattern from time of first presentation through admission, delivery of care, and finally discharge
- Don’t wait for your PEPPER to arrive—achieve data concurrently to ***avoid SURPRISES***

Questions?

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