Develop a Taste for PEPPER: Interpreting Your Organizational Results

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Objectives

- *Increase awareness and understanding of PEPPER data*

- *Develop basic analysis skills for the interpretation of organizational PEPPER data*

- *Discuss the relationship between organizational PEPPER data and vulnerability to RAC scrutiny*

Hospital Vulnerability

- *A recent article in Healthcare Highlights quotes Asst. U.S. Attorney Robert Trusiak as he discusses the False-Claims Act & PEPPER data*
  - ⇨"if hospitals receive {PEPPER data} information that their billing is way out of line, the government expects them to act on it. . . When hospitals are outliers in a risk area, they are expected to audit medical records and find out if there's a compliance problem or a reasonable explanation. . . A hospital needs to police the PEPPER reports . . . To assess, analyze and explain billing outliers."

Hospital Vulnerability

- ***Failure to review PEPPER data can be interpreted as reckless disregard or deliberate ignorance in a False Claims Act case according to this article***
  - *Some Compliance Programs May Fail to Reduce the Risk of False Claims, Sept. 27, 2011; Wolters Kluwer Law & Businesses*

What is PEPPER?

- *P=Program for*
- *E=Evaluating*
- *P=Payment*
- *P=Patterns*
- *E=Electronic*
- *R=Reports*

PEPPER data is based on <u>paid</u> Medicare claims data

What is PEPPER?

- ***A <u>free</u> resource released quarterly for short-term acute care hospitals through QualityNet***

    ⇨Access is restricted to QualityNet

    ⇨Identify your facility's administrator to request the quarterly report or to obtain access to QualityNet

    ⇨Basically, hospitals are expected by Medicare to review this report

PEPPER Basics

- *Provides a quarterly analysis of hospital-specific Medicare inpatient claims (MS-DRG) that are vulnerable to improper payment*
  - ⇨Potential overpayments
  - ⇨Potential underpayments
- *Use an Internet browser to search "PEPPER Resources"*

PEPPER Basics

- ***The Recovery Audit Contractors (RACs)***
  - ⇨Created under section 302 of the Tax Relief and Health Care Act of 2006
  - ⇨Permanent program implemented 1/1/10
    - o *Each RAC contractor posts issues approved for audit e.g., DRG assignment, medical necessity, etc.*
  - ⇨Identify ***improper payments*** made on claims for healthcare services provided to Medicare beneficiaries

Microsoft Office Excel

- *The PEPPER report is distributed as an Excel file*
  - ⇨ Each workbook (file) has pages, which are accessed by the "tabs" at the bottom of the screen
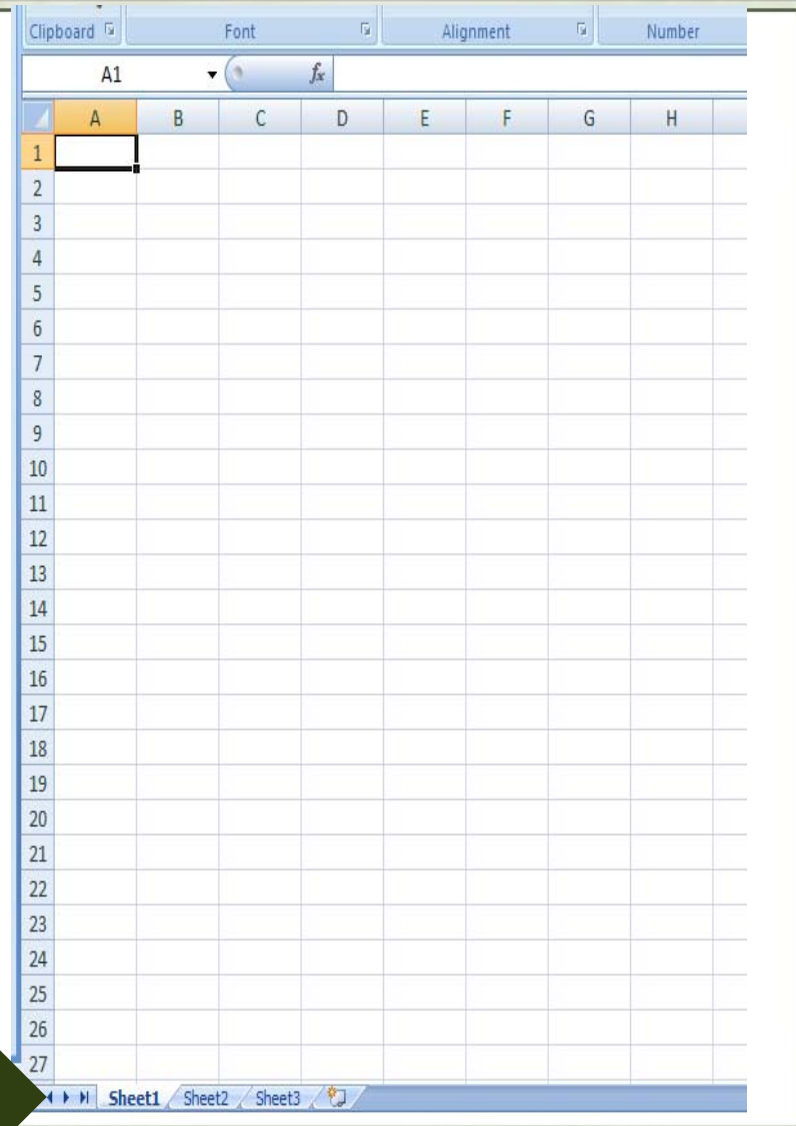
These are the "tabs"

Definitions Page

- ***The MS-DRG target areas included in PEPPER are defined on this page and generally fall into one of two categories***
  - ⇨ Coding-focused
    - ○ *MS-DRG assignment*
    - ○ *CC/MCC capture rates*
  - ⇨ Medical Necessity
    - ○ *Short stay (one or two days) admissions*
    - ○ *Readmissions*
    - ○ *Top one day stays medical DRGs*
    - ○ *Top one day stays surgical DRGs*

Definitions Page

- ***Each MS-DRG target will have two additional pages useful for in-depth analysis***
  - ⇨Two years of historical data by quarters with jurisdictional (MAC) outlier value
    - o *Quarters with < 11 cases will not have data points*
  - ⇨A graph depicting the organization's historical data compared to the outlier threshold(s) for its corresponding jurisdiction, corresponding state and the Nation

Definitions Page

- ***DRG target area definition***
  - ⇨ What MS-DRGs are used to create the numerator (top number) and denominator (bottom number)
  - ⇨ The actual volume of quarterly **paid Medicare claims** within each MS-DRG target for the particular organization will determine the percentage (%) or "rate" of occurrence within each target
  - ⇨ These percentages will be used to rank each organization in comparison to the others

Coding Focus Targets

⇨ The numerator (top number) consists of those discharges **prone to MS-DRG coding errors**

⇨ The denominator (bottom number) includes the numerator MS-DRGs as well as the **MS-DRGs to which the claim is often reassigned**

$$\frac{Numerator}{Denominator}$$

Coding Focused Target

Respiratory infections

    Are cases being inaccurately assigned to the **higher weighted respiratory infections** (**MS-DRG 177 & 178**) compared to simple pneumonia (MS-DRG 193, 194, 195)?

$$\frac{\textit{MS-DRG 177 \& 178}}{\textit{MS-DRG 177, 178, 179 \& 193, 194, 195}}$$

Medical Necessity Target

⇨ The numerator (top number) consists of those **discharges within a MS-DRG that is prone to unnecessary admissions**

⇨ The denominator (bottom number) includes **all discharges** for the applicable MS-DRGs

$$\frac{Numerator}{Denominator}$$

⇨ Having fewer than 11 cases (no data point) is a positive in these targets

Medical Necessity Target

Transient Ischemic Attack (TIA)

What proportion of TIA (MS-DRG 69) claims are being billed at an inpatient level of care that can be treated in a lesser setting e.g., as outpatient observation?

$$\frac{MS\text{-}DRG\ 069}{MS\text{-}DRGs\ 061\ \text{-}\ 069}$$

Compare Page

- *Summary of an organization's paid Medicare claims data for each target during a particular <u>quarter</u> as benchmarked against other facilities*
  - ⇨ The <u>volume</u> of discharges for each target
  - ⇨ The percent (%) of cases for each target based on the target definition
  - ⇨ How each target ranks by **<u>percentile</u>** in comparison to other organizations
    - o *Jurisdiction, state and the Nation*
  - ⇨ Associated total <u>value</u> ($) of the paid claims (sum of payments)

Compare Page

- ***When an organization's percentage of cases within a target reaches a particular percentile ranking or "threshold" it is referred to as an <u>outlier</u>***
  - ⇨ Organizations whose data falls at or above the 80th percentile are identified as high outliers and may be vulnerable to **overpayment**
    - o *Percentages that qualify as a high outlier will appear in* **red bold**
    - o *Both coding and medical necessity targets will have an upper threshold*

Compare Page

⇨Organizations whose data falls at or below the 20th percentile are identified as low outliers and may be vulnerable to **underpayment**

- *Percentages that qualify as a low outlier will appear in green italics*
- *These organizations may benefit from a clinical documentation improvement (CDI) department or may need to reorganize and existing CDI dept.*
- *Only coding focus targets have a lower threshold as there is essentially no risk associated with having too few cases in a medical necessity target area*

Compare Page

- ***Identification of outliers***
  - ⇨ The range of percentages for organizations within a target may be narrow or wide
    - ○ *All organizations have a percentage in the range of XX % to XX %*
      - ▪ *25% to 41%*
      - ▪ *11% to 63%*
  - ⇨ It is not the actual percent of cases that matter, rather it is how the percent value ranks against other organizations - in which percentile does the percentage fall?

The "Bar" Is Always Shifting

Jurisdiction 80th Percentile	Jurisdiction 20th Percentile
35.9%	21.1%
45.2%	26.9%
48.1%	28.1%
41.5%	24.6%
39.5%	22.8%
40.0%	22.4%
40.4%	26.7%
35.0%	22.4%
36.2%	22.2%
41.4%	26.3%
45.8%	24.5%
42.3%	24.0%

- For the most recent quarter (bottom) if the facility's percentage (%) of cases within the target is between 24.0% and 42.3% they are not an outlier
- What qualifies as an outlier changes each quarter in relation to how organizations rank
- If an organization maintained a rate of **42.3%** some quarters they would be a high outlier

Reviewing Your PEPPER data

- *Scan your compare page for any* **red bold** *and* *green italics*

- *The target(s) associated with any value in* **red bold** *will need additional review*

  ⇨ Depending on your organization it may be reasonable for it to be a high outlier on a particular or all coding targets

    o *Academic medical center? Tertiary care center? Specialty hospital?*

Reviewing Your PEPPER Data

- *An academic medical center is likely to be a high outlier in many targets at the state, jurisdiction and National level*

- *A tertiary care center may be a high outlier within their state and maybe their jurisdiction without being a high outlier in the Nation*

- *A small, community hospital that refers out most complicated cases will probably not be a high outlier*

Percent (%) Column

Target	Description	Number of Target Discharges	Percent
Respiratory Infections	Proportion of discharges with DRG = 177 (respiratory infections & inflammations w/ MCC), 178 (respiratory infections & inflammations w/ CC) compared to discharges with DRG = *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)*	*13*	*13.1%*
		18	23.1%
		29	**52.0%**

The volume of cases will vary across organizations so translating the results into % creates a rate allowing comparison for organizations of varying

Hospital Jurisdiction (MAC) Percentile

Target	Description	Percent	Hospital Jurisdiction Percentile
Respiratory Infections	Proportion of discharges with DRG = 177 &178 compared to discharges with DRG = 177, 178, 179 , 193 , 194 & 195	*13.1%*	*2.7*
		23.1%	57.7
		52.0%	**92.6**

Remember % is a relative term for ranking. It is not a range from 0% to 100%. In fact, there is usually a small amount of variance among percentages. Even an organization with what would be considered a relatively low % of cases could be at the top of the list (100 percentile) of all organizations within the jurisdiction.

Hospital State Percentile Column

Target	Description	Percent	Hospital State Percentile
Respiratory Infections	Proportion of discharges with DRG = 177 &178 compared to discharges with DRG = 177, 178, 179 , 193 , 194 & 195	*13.1%*	*11.1*
		23.1%	59.9
		52.0%	**95.0**

Know your organization – is it concerning to be an outlier for the target within your state or is your hospital a referral site for these types of patients so you expect an over representation of them at your organization?

Hospital National Percentile Column

Target	Description	Percent	Hospital National Percentile
Respiratory Infections	Proportion of discharges with DRG = 177 &178 compared to discharges with DRG = *177, 178, 179 , 193 , 194 & 195*	*13.1%*	*0.3*
		23.1%	60.0
		52.0%	**95.2**

How do you compare to other hospitals within the United States? It is much harder to rationalize outlier status within this comparison group as you may be a "flagship" within your state, but not within the Nation.

Sum of Payments: The Bottom Line

Target	Description	Number of Target Discharges	Sum of Payments
Respiratory Infections	Proportion of discharges with DRG = 177 &178 compared to discharges with DRG = 177, 178, 179 , 193 , 194 & 195	*13*	*$133,361* ($10,258)
		18	$244,949 (13,608)
		29	**$407,445** ($14,049)

If an organization is within the high outliers there is a **potential of overpayment** by Medicare. This column shows how much $ is vulnerable to RAC audit.

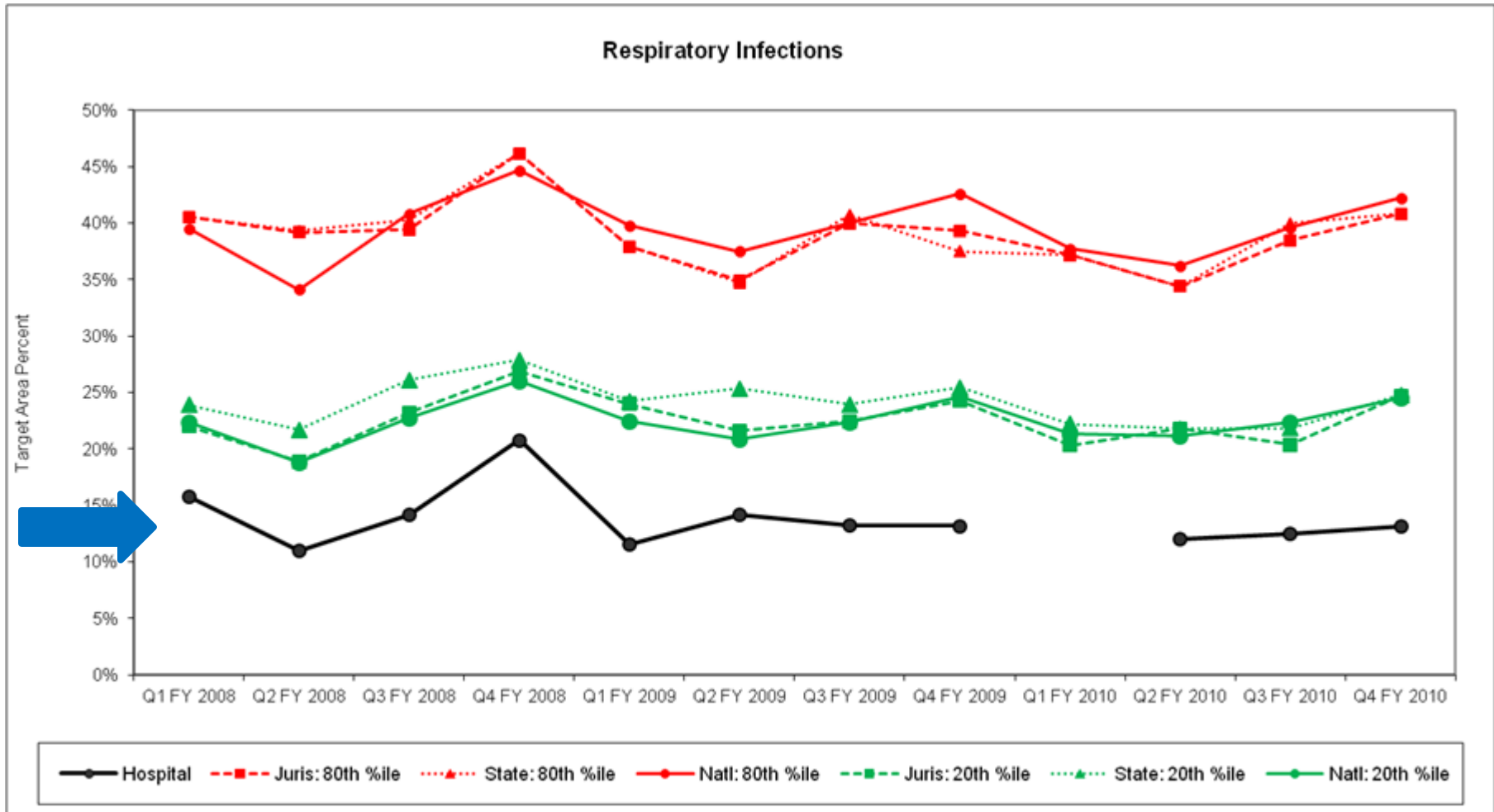# Sum of Payments: Medical Necessity

Target	Description	Number of Target Discharges	Sum of Payments
One-day Stays Excluding Transfers	Proportion of discharges with LOS of ≤ 1 day excluding patient discharge status code of 02, 07, or 20 and excluding one-day stays that have prior observation (revenue code 760 or 762) of > 24 hours	*123*	*$633,361*
		308	$1,244,949
		529	$3,407,445

The medical necessity targets that are high outliers are the most vulnerable to RAC audit because of the strong potential of overpayment by Medicare regardless of type of organization.

Identifying Trends: Graph Page

- ***As they say, a picture is worth a thousand words***

  ⇨ The data and outlier status is helpful when looking at a particular quarter, but all the data is relative so it is often hard to identify trends by looking at the raw numbers

  ⇨ The graph page associated with each target translates a series of data points into a picture that easily reveals trends
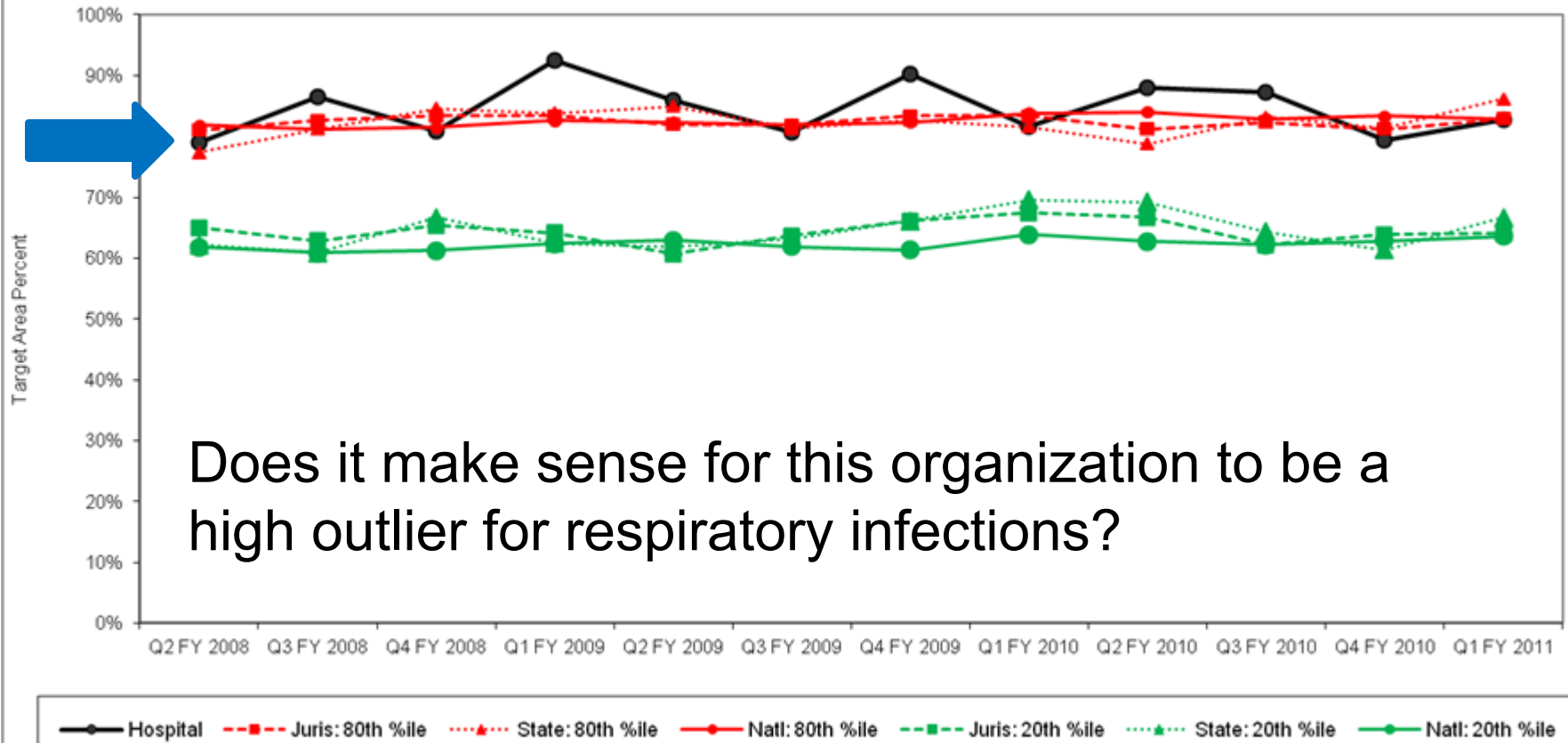
Respiratory Infection Graph: Low Outlier
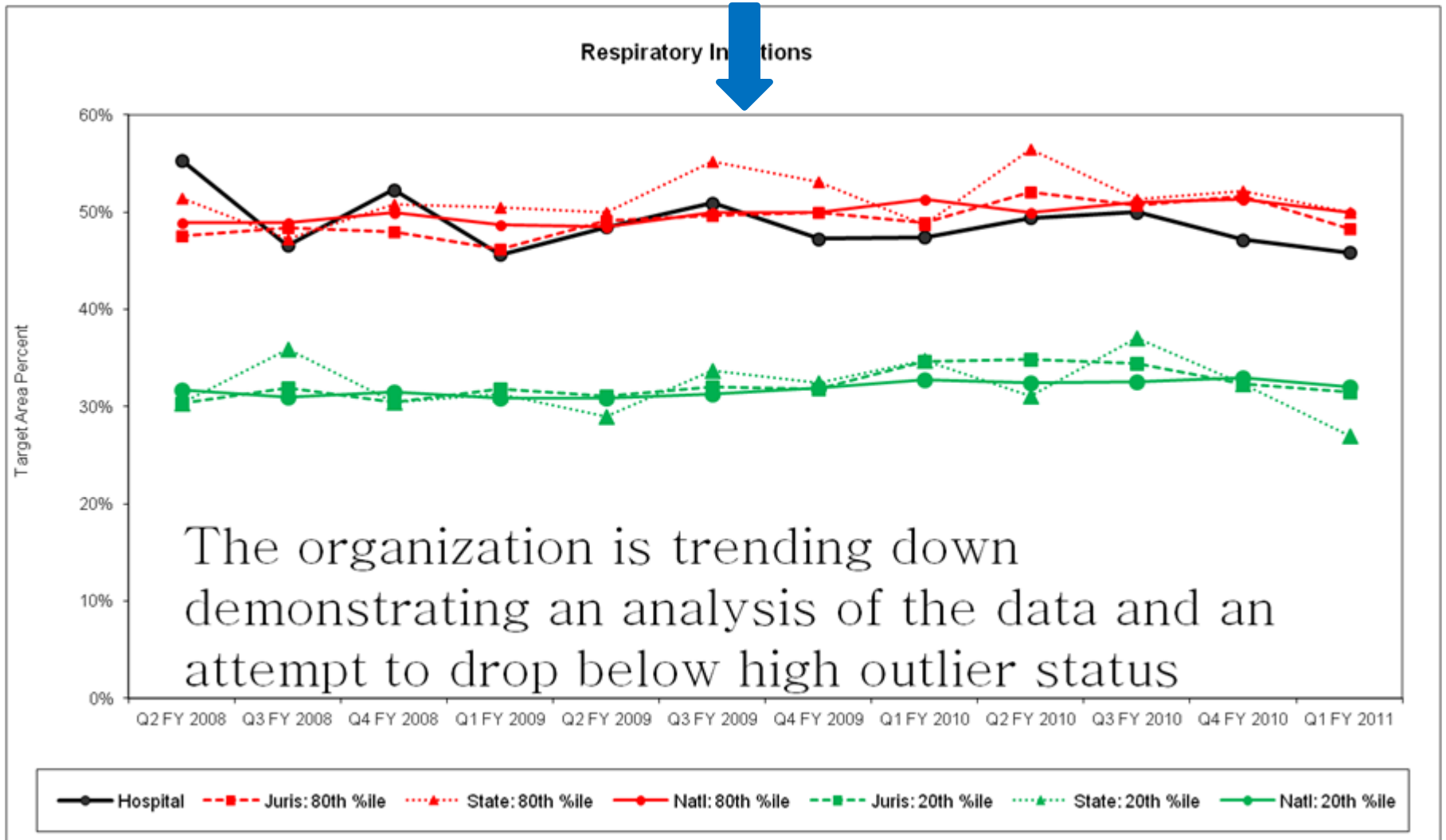
Respiratory Infection Graph: Variable Movement

Respiratory Infections

It is difficult to identify a trend as the data is all over – could be a lack of volume issue
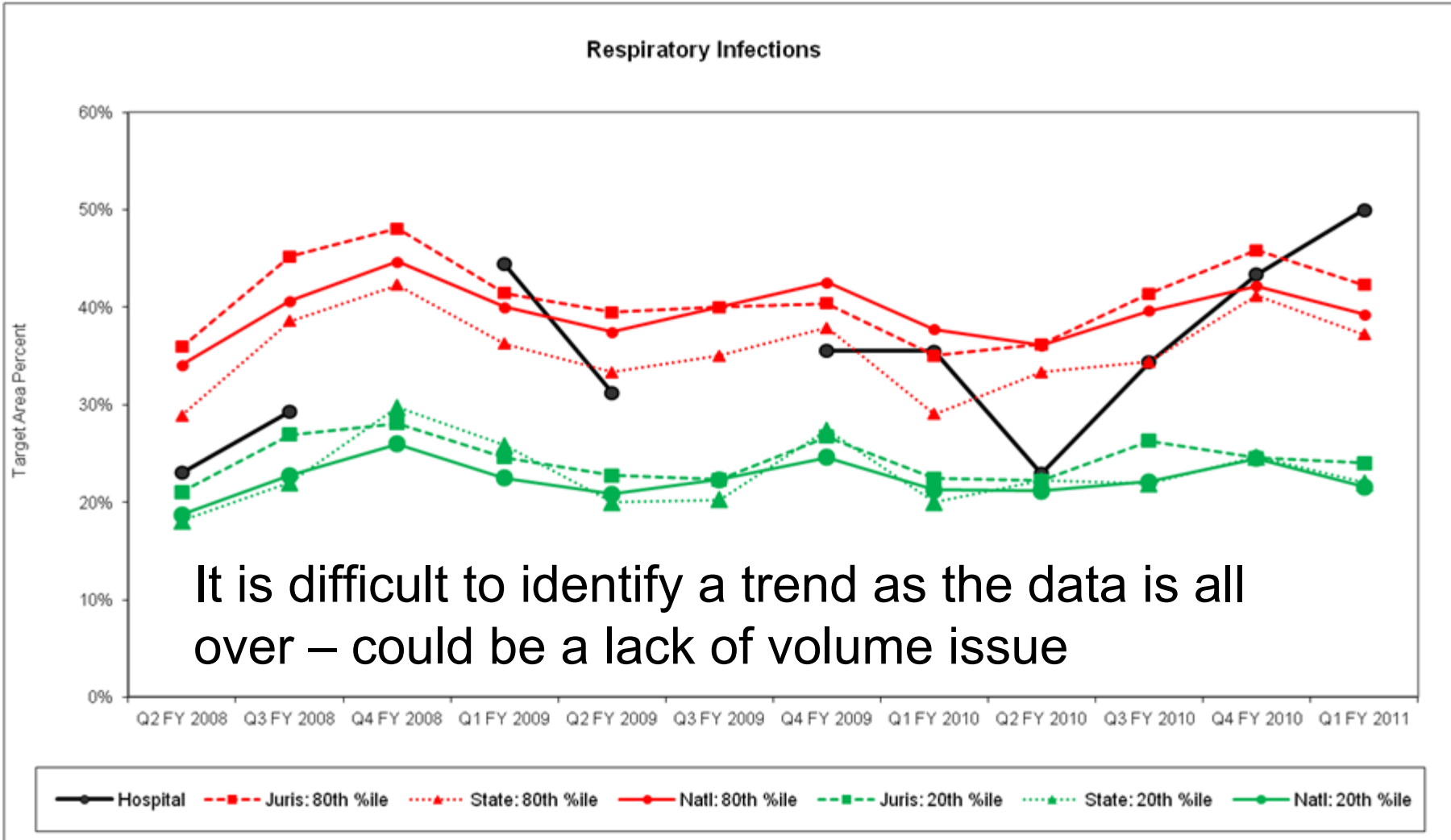
Respiratory Infections: High Outlier

Does it make sense for this organization to be a high outlier for respiratory infections?

Respiratory Infections: Intervention

Key Targets for Particular Areas

- ***Clinical Documentation Improvement***
  - ⇨ Medical DRGs with CC or MCC
    - ○ *Can demonstrate the success of the department*
  - ⇨ Surgical DRGs with CC or MCC
    - ○ *Can demonstrate the success of the department*
  - ⇨ Respiratory infections
    - ○ *Queries/education for the identification of the organism associated with pneumonia*
  - ⇨ Queries/education for symptom Pdx
    - ○ *TIA, Syncope, chest pain and atherosclerosis*

Key Targets for Particular Areas

- ***Utilization Review***

  ⇨ One day stays excluding transfers

  - *Some Medicare inpatient only surgical DRGs may appear on this list and generally do not require additional review*

  ⇨ One day stays for medical DRGs

  ⇨ Symptom DRGs

  - *TIA, Syncope and Chest pain*
  - *These often correlate with one day stays and often these DRGs will appear on the one day stays lists*

Key Targets for Particular Areas

- ***Utilization Review***

  ⇨ One day stay MS-DRG targets

    o *Any part of an inpatient stay that occurs before midnight is counted as one day*

  ⇨ Two day stay MS-DRG targets

    o *These are new targets as many organizations are slow at discharging patients extending their stay beyond one day without significantly changing the treatment plan or demonstrating the initial acuity of the patient*

Key Targets for Particular Areas

- ***Case Management***
  - ⇨ Three day Skilled Nursing Facility qualifying admissions
    - o *Patient who spend three, consecutive midnights as an acute inpatient qualify for Medicare to cover some SNF days – many cannot afford SNF care unless Medicare covers it*
  - ⇨ 30 Day readmissions - VBP
    - o *This is also a UR issue as many patients with frequent admissions have chronic conditions that can often be treated in the outpatient setting (observation) than as an inpatient*

NEXT STEPS

- *Review the PEPPER User Guides*
- *Look for upward trends and spikes*
- *Develop process improvement methods*
- *Be proactive/educate – ignorance is NOT a defense*
- *Share internal auditing of high outlier MS-DRGs results with all key players*
- *Review medical records with coding, utilization review/case management, and CDI*