Understanding the PEPPER

and What It Means to Your IRF

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MILESTONE HEALTHCARE is based in Richardson, Texas, and provides management and consulting services for:

- IRFs
- LTACs
- SNFs
- Geropsych
- Therapy staffing
- Nurse staffing
Can It Mean Heartburn?

Or Will It Be the Spice of Life?
Objectives

1. Provide insight into what the **PEPPER** is.
2. Provide an understanding of each target area and why it was identified as an indicator.
3. Provide meaning to the established targets and implications.
4. Explore ideas on how to use the UDS-PRO® System to reverse established negative trends.
5. Communicate potential opportunities for IRFs using the PEPPER.

Knowledge of where you are, where you are going, and where you want to be is essential for reaching your intended destination.
Who?

- TMF Health Quality Institute, under contract with CMS, began providing the PEPPER to acute care hospitals in January 2010
- The initial IRF PEPPERs were released in September 2011 for the most recent twelve federal fiscal quarters (April 1, 2008, to March 31, 2011)
- The most recent PEPPER for IRFs was released on March 23 for the period from October 1, 2008, to September 30, 2011
- Next PEPPER will be released in September 2012
What?

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a Microsoft® Excel file that contains hospital-specific data statistics for target areas often associated with Medicare improper payments due to billing issues, CMG coding issues, and admission necessity issues.

The PEPPER compares an IRF’s data to that of the state, the IRF’s MAC jurisdiction, and the nation to identify aberrant patterns.
Where?

- Freestanding IRF PEPPERs were distributed in hardcopy format to hospital CEOs.
- Distinct-part units within hospitals had their PEPPERs distributed via My QualityNet to each hospital’s QualityNet administrator’s web account.
- IRF PEPPERs will be distributed semiannually. The next is due on or about September 25, 2012.
Why?

- We are currently in an “era of medical reviews”
  - Quality initiatives
  - Performance measures
  - Data collection and reporting
  - Pay for performance

- The PEPPER does not identify the presence of payment errors, but it can be used as a guide for auditing and monitoring efforts
  - Compare claims over time
  - Identify areas of potential concern
  - Identify changes in billing practices
How?

- All data statistics are collected from the paid inpatient Medicare UB-04 claims processed by the MAC (Medicare administrative contractor) or FI (fiscal intermediary).

- It compares the facility’s data with state, MAC jurisdiction, and national data.
**IRF Target Areas**

<table>
<thead>
<tr>
<th>TARGET AREA</th>
<th>TARGET AREA DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous CMGs (Misc)</td>
<td><strong>Numerator (N):</strong> count of discharges for Case-Mix Groups (CMGs) 2001 (Miscellaneous M&gt;49.15), 2002 (Miscellaneous M&gt;38.75 and M&lt;49.15), 2003 (Miscellaneous M&gt;27.85 and M&lt;38.75) or 2004 (Miscellaneous M&lt;27.85)**</td>
</tr>
<tr>
<td>CMGs at Risk for Unnecessary Admissions (CMGs)</td>
<td><strong>Denominator (D):</strong> count of all discharges</td>
</tr>
<tr>
<td>Outlier Payments (Outlier Pmts)</td>
<td><strong>N:</strong> count of discharges with an outlier approved amount greater than $0</td>
</tr>
<tr>
<td>STACH Admissions Following IRF Discharge (STACH Admiss)</td>
<td><strong>N:</strong> count of beneficiaries (identified using the Health Insurance Claim number) discharged from the IRF during the 12-month time period that were admitted to a short-term acute care hospital within 30 days of discharge from the IRF; patient discharge status code of the index (IRF) admission is not equal to 02 (discharged/transfered to a short-term acute care hospital)</td>
</tr>
<tr>
<td></td>
<td><strong>D:</strong> count of all discharges excluding patient discharge status code 20 (expired) (See Appendix 1 for how STACH admissions following IRF discharge are identified.)</td>
</tr>
</tbody>
</table>

These PEPPER target areas were approved by CMS because they have been identified as potentially prone to improper Medicare payments in IRFs.
How Risk Is Calculated

- **Reportable data**: There are eleven or more numerator discharges for a given target area for given time period (if fewer than eleven, statistics are not displayed in the PEPPER)
  - **Numerator**: Discharges identified as potentially problematic in reference period
  - **Denominator**: Total discharges for reference period (includes numerator)
How Risk Is Calculated

- **Percentages:**
  \[
  \text{Number of cases targeted} \times 100 = \text{Percentage}
  \]
  \[
  \frac{\text{Number of cases targeted}}{\text{Number of total discharges}} \times 100 = \text{Percentage}
  \]

- **Percentile:**
  - Percentage of IRFs with a lower target area
  - Ranks facility and compares nation, MAC/FI jurisdiction, or facility’s state
How Risk Is Calculated

If the IRF’s target area percentage is at or above the 80th percentile, the IRF is identified as an “outlier” or outside the “norm”.

80th Percentile

Identified in RED BOLD PRINT on the PEPPER
## Miscellaneous CMGs

- Potentially prone to “unnecessary” IRF admissions

<table>
<thead>
<tr>
<th>CMG</th>
<th>Weighted Motor Score on Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>M &gt; 49.15</td>
</tr>
<tr>
<td>2002</td>
<td>M &gt; 38.75 and M &lt; 49.15</td>
</tr>
<tr>
<td>2003</td>
<td>M &gt; 27.85 and M &lt; 38.75</td>
</tr>
<tr>
<td>2004</td>
<td>M &lt; 27.85</td>
</tr>
</tbody>
</table>
Impairment Group Codes That Fall to CMG 2001–2004

**Congenital Deformities:**
- 12.1 Spina Bifida
- 12.9 Other Congenital

**Other Disabling Impairments:**
- 13 Other Disabling Impairments

**Developmental Disability:**
- 15 Developmental Disability

**Debility:**
- 16 Debility (Non-cardiac, Non-pulmonary)

**Medically Complex:**
- 17.1 Infections
- 17.2 Neoplasms
- 17.31 Nutrition with Intubation/Parental Nutrition
- 17.32 Nutrition without Intubation/Parental Nutrition
- 17.4 Circulatory Disorders
- 17.51 Respiratory Disorders – Ventilator Dependent
- 17.52 Respiratory Disorders – Non-ventilator Dependent
- 17.6 Terminal Care
- 17.7 Skin Disorders
- 17.8 Medical/Surgical Complications
- 17.9 Other Medically Complex Conditions

The impairment group codes referenced on this slide are the property of UDSMR.
IRF PEPPER
000992, Hospital H0992

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

Increasing Target Percents over time resulting in outlier status
Your Target Percent (first row in the table below) is above the national 80th percentile

### YOUR HOSPITAL

<table>
<thead>
<tr>
<th></th>
<th>4/1/08 - 3/31/09</th>
<th>4/1/09 - 3/31/10</th>
<th>4/1/10 - 3/31/11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Percent</strong></td>
<td>16.3%</td>
<td>9.9%</td>
<td>5.4%</td>
</tr>
<tr>
<td><strong>Target Discharge Count</strong></td>
<td>176</td>
<td>108</td>
<td>55</td>
</tr>
<tr>
<td><strong>Denominator Count</strong></td>
<td>1083</td>
<td>1094</td>
<td>1026</td>
</tr>
<tr>
<td><strong>Target Average Length of Stay</strong></td>
<td>$11,147</td>
<td>$10,582</td>
<td>$11,472</td>
</tr>
<tr>
<td><strong>Denominator Average Length of Stay</strong></td>
<td>11.7</td>
<td>11.8</td>
<td>12.6</td>
</tr>
</tbody>
</table>

### COMPARATIVE DATA

<table>
<thead>
<tr>
<th></th>
<th>National 80th Percentile</th>
<th>Jurisdiction 80th Percentile</th>
<th>State 80th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Percent</strong></td>
<td>18.5%</td>
<td>16.9%</td>
<td>17.0%</td>
</tr>
<tr>
<td><strong>Target Sum of Payments</strong></td>
<td>$1,961,846</td>
<td>$1,142,831</td>
<td>$630,943</td>
</tr>
</tbody>
</table>

*Data not available when target discharge count less than 11

**Note**: State Percentiles are zero when there are fewer than 11 hospitals in the jurisdiction’s state or when there are no hospitals with at least 11 target discharges.
Suggested Analysis If You Are at or above the 80th Percentile

- Is it clear in the documentation that the patient’s admission to rehab was “reasonable and necessary,” as defined by the criteria?
- Could the patient be appropriately treated in a lower level of care (OP, SNF, HH)?
- Focus on why the patient needed an acute level of care and functional improvements
CMGs at Risk for Unnecessary Admissions

CMGs:
- 0101, Stroke
- 0501, Non-traumatic SC
- 0601, Neurological
- 0801, Replacement of LE Joint
- 0802, Replacement of LE Joint
- 0901, Other Orthopaedic
- 1401, Cardiac
- 1501, Pulmonary

No tier group assignment
Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

Increasing Target Percent over time resulting in outlier status
Your Target Percent (first row in the table below) is above the national 80th percentile.

![Graph showing CMGs at Risk for Unnecessary Admissions](image_url)

### YOUR HOSPITAL

<table>
<thead>
<tr>
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<th>4/1/09 - 3/31/10</th>
<th>4/1/10 - 3/31/11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Percent</strong></td>
<td>7.1%</td>
<td>7.6%</td>
<td><strong>12.0%</strong></td>
</tr>
<tr>
<td><strong>Target Discharge Count</strong> (Numerator: count of discharges with no tier group assignment for CMGs 0101 (Stroke M=51.05), 0501 (Non-traumatic Spinal Cord Injury M=51.35), 0601 (Neurological M=47.75), 0801 (Replacement of Lower Extremity Joint M=49.55), 0802 (Replacement of Lower Extremity Joint M=37.05 and M=49.55), 0901 (Other Orthopedic M=44.75), 1401 (Cardiac M=48.65), or 1501 (Pulmonary M=49.25))</td>
<td>11</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td><strong>Denominator Count</strong> (see Definitions worksheet for complete definition)</td>
<td>156</td>
<td>157</td>
<td>125</td>
</tr>
<tr>
<td><strong>Target Average Length of Stay</strong></td>
<td>7.2</td>
<td>6.3</td>
<td>8.1</td>
</tr>
<tr>
<td><strong>Denominator Average Length of Stay</strong></td>
<td>13.8</td>
<td>11.1</td>
<td>11.0</td>
</tr>
<tr>
<td><strong>Target Average Payment</strong></td>
<td>$7,338</td>
<td>$6,606</td>
<td>$8,331</td>
</tr>
<tr>
<td><strong>Target Sum of Payments</strong></td>
<td>$80,720</td>
<td>$79,274</td>
<td>$124,959</td>
</tr>
</tbody>
</table>

*Data not available when target discharge count less than 11

### COMPARATIVE DATA

<table>
<thead>
<tr>
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<th>National 80th Percentile</th>
<th>Jurisdiction 80th Percentile</th>
<th>State 80th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13.0%</td>
<td>13.7%</td>
<td>11.9%</td>
</tr>
<tr>
<td></td>
<td>11.2%</td>
<td>13.2%</td>
<td>12.8%</td>
</tr>
<tr>
<td></td>
<td><strong>11.3%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: State Percentiles are zero when there are fewer than 11 hospitals in the jurisdiction's state or when there are no hospitals with at least 11 target discharges.*
Suggested Analysis If You Are at or above the 80th Percentile

- Review list of comorbid conditions for tiers, and educate physicians and pre-admission nurses
- Was it a necessary admission?
  - Could the patient have been treated appropriately in a lower level of care (OP, SNF, HH)?
- Were the admission FIM® ratings correct?
  - All indicate an admission motor FIM® rating greater than 44–51
Suggested Analysis If You Are at or above the 80th Percentile

- What are the scoring competencies and processes for late/weekend admissions?
- Are you capturing the true “burden of care”?
Outlier Payments

- Complex set of calculations that are not easily understood or controlled on the clinical operations of the IRF
- CMS sees outlier payments as “excessive” and potentially fraudulent or improper
- Clinical and finance departments must work together to analyze the problem and understand the issues
Outlier Payments

**Problem:**

- Facility is submitting a high percentage of claims that result in outlier payments
- What causes the “overpayment”?
- Is this an “appropriate” patient for an IRF?
Outlier Payments

- 2012 threshold for outlier payment: $10,713 FR CN
- **CMG example:** D0108, Stroke (LOS 23 days)
  - Payment for CMG D0108 = $26,222
  - Assume high charges $80,000 (diagnostics, dialysis, drugs)
    - CCR 0.4850 x charges = $38,800 ("cost")
    - $38,800 – ($26,222 + $10,713 ) = $1,865
    - $1,865 x 0.80 = **outlier payment of $1,492**
- **Total payment = $26,222 + $1,492 = $27,714**
Suggested Analysis If You Are near, at, or above 80th Percentile

Any reimbursement analysis must involve your finance department

- Accurate cost-to-charge ratio (CCR)
  - How is it determined?
  - Review of chargemaster
  - Room rates
  - High ancillary charges
  - Low volume
  - High-cost patients
Suggested Analysis If You Are near, at, or above 80th Percentile

- Any reimbursement analysis must involve your finance department
  - Long LOS
  - Complex patients can be costly—are they appropriate for inpatient rehabilitation?

- Some are expected—the latest PEPPER data shows that the national 80th percentile is 26.2%
STACH Admissions following IRF Discharge (within 30 Days)

- Does not include patients transferred back to acute care for medical complications during IRF admission
- Indicates that a patient is not medically stable or prepared for discharge
- Includes patients discharged to SNFs who come back to the acute hospital
- Not easily tracked or known to the IRF, especially if a patient is admitted to another facility
Suggested Analysis If You Are at or above the 80th Percentile

- Look at your discharge FIM® ratings
  - Do your patients meet the goals?
  - Examine the FIM® Profile Report at 50th percentile target goals

- Discharge planning and patient/family education
  - Are you overlooking opportunities and needs?

- Are discharges to skilled nursing appropriate?
Suggested Analysis If You Are at or above the 80th Percentile

- Do you follow up with patients immediately after discharge?
  - How are they doing?

- Combine your efforts with acute care on their PEPPER’s standing on readmission rates
  - Could provide an opportunity for referrals to rehabilitation
<table>
<thead>
<tr>
<th>Target Area</th>
<th>Q2 FY 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous CMGs</td>
<td>$735,331,278</td>
</tr>
<tr>
<td>CMGs at risk for unnecessary admissions</td>
<td>$136,058,580</td>
</tr>
<tr>
<td>Outlier payments</td>
<td>$642,455,804</td>
</tr>
<tr>
<td>STACH admissions following IRF discharge</td>
<td>$848,762,853</td>
</tr>
<tr>
<td><strong>Total dollars spent</strong></td>
<td><strong>$2,362,608,515</strong></td>
</tr>
</tbody>
</table>
### Inpatient Rehabilitation Facility (Hospitals and Units) Q2FY11 Report

**Nationwide Top Rehabilitation Impairment Categories (RICs)**

Discharges for most recent 4 quarters, ending Q2 FY2011

In Descending Order by Total Discharges Per RIC

<table>
<thead>
<tr>
<th>RIC</th>
<th>RIC Description</th>
<th>Total Discharges for RIC</th>
<th>Proportion of Discharges for Each RIC to Total Discharges</th>
<th>Average Length of Stay for RIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Stroke</td>
<td>72,817</td>
<td>19.9%</td>
<td>15.6</td>
</tr>
<tr>
<td>07</td>
<td>Fracture of lower extremity</td>
<td>51,703</td>
<td>14.1%</td>
<td>13.3</td>
</tr>
<tr>
<td>20</td>
<td>Miscellaneous</td>
<td>46,763</td>
<td>12.8%</td>
<td>11.9</td>
</tr>
<tr>
<td>08</td>
<td>Replacement of lower extremity joint</td>
<td>40,868</td>
<td>11.2%</td>
<td>9.7</td>
</tr>
<tr>
<td>06</td>
<td>Neurological</td>
<td>35,873</td>
<td>9.8%</td>
<td>13.0</td>
</tr>
<tr>
<td>09</td>
<td>Other orthopedic</td>
<td>25,347</td>
<td>6.9%</td>
<td>11.9</td>
</tr>
<tr>
<td>14</td>
<td>Cardiac</td>
<td>18,063</td>
<td>4.9%</td>
<td>11.1</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>354,696</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Two New Listings Distributed: #1

- Top jurisdiction CMGs for most recent four quarters
  - Includes all tiers (A, B, C, and D)
  - Total discharges
  - Proportion of discharges for each CMG to total discharges
  - Jurisdiction average length of stay for CMG
  - Must have at least eleven discharges per CMG
### Inpatient Rehabilitation Facility PEPPER

IRFs for J4 TrailBlazer Health Enterprises (04001)
Top CMGs

#### Jurisdiction Top CMGs, Most Recent 4 Qtrs.
In Descending Order by Totals Per CMG

<table>
<thead>
<tr>
<th>CMG</th>
<th>Description</th>
<th>Total Discharges</th>
<th>Proportion of Discharges for Each CMG</th>
<th>Jurisdiction Average Length of Stay for CMG</th>
</tr>
</thead>
<tbody>
<tr>
<td>0704</td>
<td>Fracture of lower extremity, M20.15</td>
<td>4,965</td>
<td>6.6%</td>
<td>14.4</td>
</tr>
<tr>
<td>2004</td>
<td>Miscellaneous, M17.05</td>
<td>2,862</td>
<td>3.9%</td>
<td>13.8</td>
</tr>
<tr>
<td>0110</td>
<td>Stroke, I63.25 and M44.0</td>
<td>2,559</td>
<td>3.5%</td>
<td>20.1</td>
</tr>
<tr>
<td>0022</td>
<td>Replacement of lower extremity joint, M33.25 and M19.63</td>
<td>2,479</td>
<td>4.1%</td>
<td>17.8</td>
</tr>
<tr>
<td>2003</td>
<td>Miscellaneous, M27.05 and M23.75</td>
<td>2,383</td>
<td>4.7%</td>
<td>11.2</td>
</tr>
<tr>
<td>0004</td>
<td>Rep of lower ext joint, M22.05 and M28.05 and A183.5</td>
<td>2,233</td>
<td>4.4%</td>
<td>9.2</td>
</tr>
<tr>
<td>0004</td>
<td>Neurosurgical, M15.05</td>
<td>1,830</td>
<td>3.6%</td>
<td>15.3</td>
</tr>
<tr>
<td>0703</td>
<td>Fracture of lower extremity, M31.15 and M24.15</td>
<td>1,722</td>
<td>3.4%</td>
<td>12.0</td>
</tr>
<tr>
<td>0003</td>
<td>Other orthopedic, M01.15 and M06.95</td>
<td>1,441</td>
<td>3.8%</td>
<td>11.8</td>
</tr>
<tr>
<td>0003</td>
<td>Neurosurgical, M15.05 and M28.05</td>
<td>1,403</td>
<td>2.8%</td>
<td>11.9</td>
</tr>
<tr>
<td>0002</td>
<td>Replacement of lower extremity joint, M22.05 and M28.05</td>
<td>1,374</td>
<td>2.7%</td>
<td>11.1</td>
</tr>
<tr>
<td>0702</td>
<td>Fracture of lower extremity, M46.15 and M42.15</td>
<td>1,367</td>
<td>2.7%</td>
<td>10.3</td>
</tr>
<tr>
<td>0002</td>
<td>Miscellaneous, M13.25 and M19.65</td>
<td>1,304</td>
<td>2.7%</td>
<td>9.3</td>
</tr>
<tr>
<td>0004</td>
<td>Other orthopedic, M23.15</td>
<td>1,181</td>
<td>2.3%</td>
<td>13.9</td>
</tr>
<tr>
<td>0704</td>
<td>Stroke, M10.15 and M10.05</td>
<td>1,078</td>
<td>2.1%</td>
<td>10.5</td>
</tr>
<tr>
<td>0002</td>
<td>Other orthopedic, M34.35 and M44.75</td>
<td>1,000</td>
<td>2.0%</td>
<td>9.4</td>
</tr>
<tr>
<td>0003</td>
<td>Amputation, lower extremity, M38.25</td>
<td>933</td>
<td>1.8%</td>
<td>14.1</td>
</tr>
<tr>
<td>0003</td>
<td>Stroke, M14.15 and M10.05</td>
<td>952</td>
<td>1.9%</td>
<td>12.5</td>
</tr>
<tr>
<td>0404</td>
<td>Corneal, M18.25</td>
<td>917</td>
<td>1.8%</td>
<td>12.7</td>
</tr>
<tr>
<td>0003</td>
<td>Stroke, M10.15 and M10.05</td>
<td>460</td>
<td>1.7%</td>
<td>12.7</td>
</tr>
</tbody>
</table>

**Top CMGs: Jurisdiction-wide**
34,720 | 68.4% | 12.6

**APCS: Jurisdiction-wide**
5,167 | 12.5

**Note:** CMGs will display if they had at least 11 discharges in the most recent four quarters.
*Includes all tiers (A, B, C, and D).*

Source: Medicare PPS Inpatient Hospital Discharge Data

File: 080006_04001_IRF_PEP01_4QFY11_MONITOR03_MEM031.cnx
Page 1
Two New Listings Distributed: #2

- Top IRF CMGs for most recent four quarters
  - In descending order by totals per CMG
  - Must have had at least eleven discharges in the most recent four quarters
  - Includes all tiers (A, B, C, and D)
  - Total discharges for each CMG per facility
  - Proportion of discharges for each CMG to total discharges
  - Facility average length of stay for CMG
Why Are These Listings Important?

- How much do you vary from the norm?
- Why?
  - Programs
  - Services
  - Coding practices
UDSMR® On-Demand Reports

- Profile Report
  - Use 50th percentile for goal targets

- Rehab Metrics Report
  - Use comparative time frames
  - Only include Medicare non-MCO

- Percentage of Cases by Comorbidity Tier Report
Resources

- Handouts:
  - List of top CMGs
  - Sample FIM® Profile Report
  - Common comorbidity tiers for 2011
  - PEPPER website info
Resources

References:

- *Inpatient Rehab to Get First PEPPER Data in September as Medicare Concerns Grow; Report on Medicare Compliance, Vol. 20, #31, Sept. 5, 2011*
- *PEPPER Is Back: Using Medicare Data Reports for Auditing and Monitoring; March 2010.* www.hcca-info.org
Resources

References:

– *Utilizing PEPPER Data to Support Your Compliance Efforts;* August 17, 2011. [www.racmonitor.com](http://www.racmonitor.com)

– *Using the New Inpatient Rehab Facility PEPPER to Support Auditing and Monitoring Efforts;* Kim Hrehor; September 23, 2011, CMS Webinar

– *Using UDSMr® On-Demand Reports to Track PEPPER Areas;* Maggie Divita, UDSMr® Webinar, November 2011
Don’t Be Afraid to “Spice up Your Life”

- Stumbling blocks:
  - Initial fear
  - Feeling overwhelmed
  - Midway slump (“This is not fun!”)
  - Dropout rate: 90% vs. 10%

- Take-away: Sit down with your TEAM to really understand the PEPPER for your facility

“To be happy, we need to find a balance between comfort and adventure.” —Mary Jaksch
Thank You!

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