E-BRIEF SERIES

Healthicity

# The PEPPER Report: An Introduction to Risk Monitoring

Heather Greene MBA, RHIA, CPC, CPMA, CDIP

# An Introduction to Risk Monitoring

## Introduction

When building a compliance program, there are a number of free resources at your disposal that can help ensure program effectiveness. One such resource is the Program for Evaluating Payment Patterns Electronic Report, commonly known simply as the PEPPER Report. The PEPPER Report gives your facility a bird's eye view of your billing practices and compares it to regional and national numbers. The PEPPER Report was created by TMF Health Quality Institute (TMF) to prioritize hospital-specific findings and provide guidance on areas in which hospitals such as yours may want to focus its auditing and monitoring efforts. You should, however, note that the PEPPER Report cannot identify improper Medicare payments, instead it is only a comparison report.

## What is the PEPPER Report?

The PEPPER Report is an electronic report that summarizes Medicare data statistics for one provider in areas ("target areas") that may be at risk for improper Medicare payments. The report uses the UB-04 to gain information, such as the facility type, insurance, valid medical record number, Medicare payment amount, and final action. The PEPPER Report includes all Medicare claims, including those claims where Medicare is not the primary payor. The report does exclude HMOs.

The PEPPER Report is summarized and distributed by fiscal year quarters according to the discharge date on the claim. Each federal fiscal year begins October 1 and ends September 30.

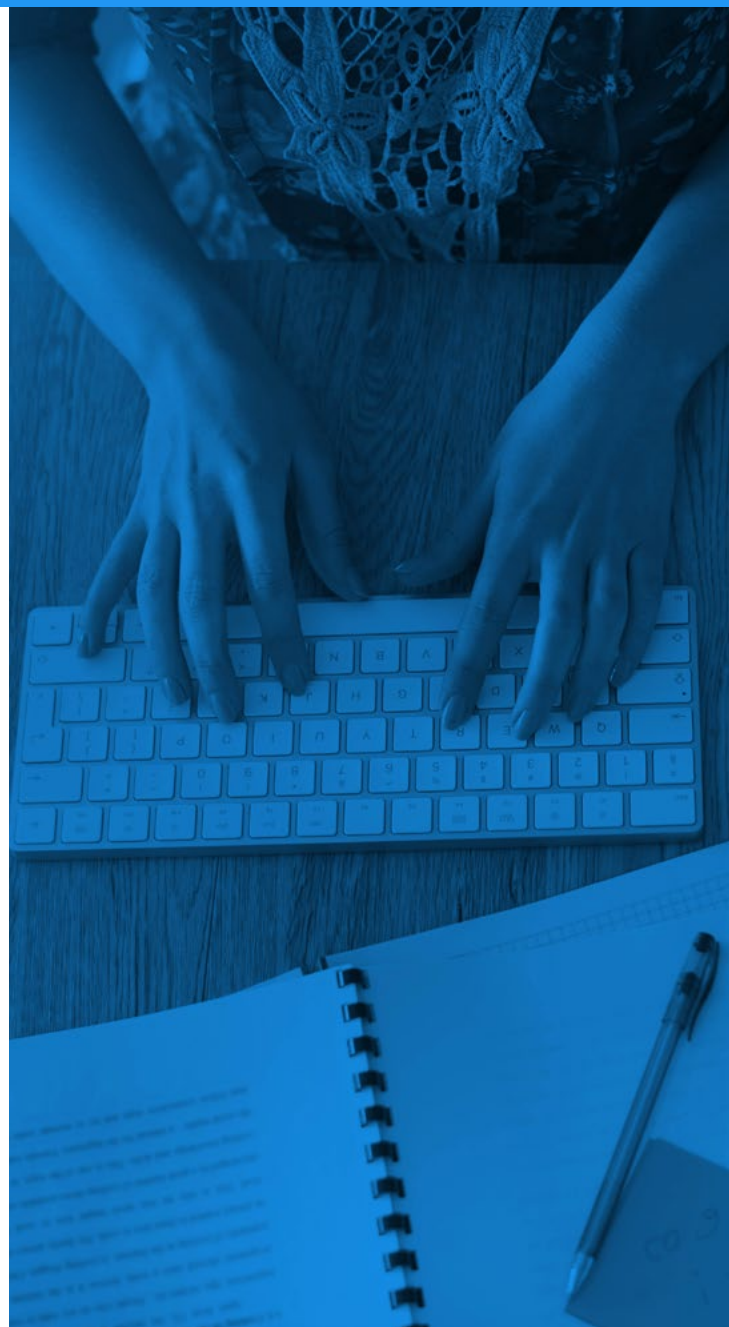
- Q1 = October - December
- Q2 = January - March
- Q3 = April - June
- Q4 = July - September

TMF waits four months after the most recent month in a quarter before downloading the claims data to analyze for inclusion in the report. Data for Q4FY18 (July - Sept. 2018) were downloaded at the end of January 2019. The production of the report takes several more weeks, explaining the delay of delivering the data.

The PEPPER Report identifies areas of potential over-coding and under-coding as well as areas that may be questionable in terms of medical necessity of the admission. The PEPPER Report is created for the following facility types:

- Short-term (ST) Acute Care Hospital
- Long-term (LT) Acute Care Hospital
- Critical Access Hospital (CAH)
- Inpatient Psychiatric Facility (IPF)
- Partial Hospitalization Programs
- Hospice
- Inpatient Rehabilitation Facility
- Home Health Agencies

For our purposes, let's keep this discussion related to acute care hospitals. When the numerator or denominator is below 11 for a target area, The PEPPER Report will not display that information. Therefore, a facility may not see data for a time period or, in some cases, not have a report to review. Once the target area information goes above 11, the system will start reporting it again.



## What are the Target Areas?

Below is a list of the target areas currently being monitored by The PEPPER Report. The list includes both the full and abbreviated title:

- Stroke Intracranial Hemorrhage (StrokeICH)
- Respiratory Infections (Resp Inf)
- Simple Pneumonia (Simp Pne)
- Septicemia (Septicemia)
- Unrelated OR Procedure (Unrel OR Px)
- Medical DRGs with CC or MCC (Med CC MCC)
- Single CC or MCC (Single CC MCC)
- "Excisional Debridement (ExcisDeb) *revised as of the Q4FY18 release"
- Ventilator Support (Vent Sup)
- Emergency Department Evaluation and Management Visits (ED E&M)
- Transient Ischemic Attack (TIA)
- Chronic Obstructive Pulmonary Disease (COPD)
- Percutaneous Cardiovascular Procedures (Perc CV Px)
- Syncope (Syncope)
- Other Circulatory System Diagnoses (Circ Sys Dx)
- Other Digestive System Diagnoses (Dig Sys Dx)
- Medical Back Problems (Med Back)
- Spinal Fusion (Spinal Fusion)
- Three-day Skilled Nursing Facility-qualifying Admissions (3-Day SNF)
- 30-day Readmissions to Same Hospital or Elsewhere (Readm)
- 30-day Readmissions to Same Hospital (Readm Same)
- Two-day Stays for Medical DRGs (2DS Med)
- Two-day Stays for Surgical DRGs (2DS Surg)
- One-day Stays for Medical DRGs (1DS Med)
- One-day Stays for Surgical DRGs (1DS Surg)

## How Do I Read the PEPPER Report?

The PEPPER Report has the target area calculated by percentage. This is done by dividing the number of target discharges by the number of denominator discharges for each hospital for each time period, then multiplying by 100. This percentage lets the provider know its billing patterns.

It's good practice to monitor provider billing patterns. By comparing for The PEPPER Report, the more useful information is derived from the percentile calculations. The percentile calculations are not the same as the percentage calculations. The percentile calculations let you know where you stand in your comparison group (national or state-wide jurisdiction). These calculations "rank" providers in each target area. For example, if 40% of a provider's Septicemia percents were lower than your 83.64%, then your facility would be in the 40th percentile.

**EXAMPLE: SEPTICEMIA**

$$\frac{\textbf{46 Discharges for DRGs 870, 871, 872}}{\textbf{55 Discharges for DRGs 689, 690, 870, 871, 872}} \times \textbf{100} = \textbf{83.64\%}$$

Being in the 40th percentile indicates the provider's billing practices are similar to those it is compared to in the report. The PEPPER Report will identify clearly if the provider's billing practices fall above 80th percentile, by noting it in red, or if it is below the 20th percentile, by noting it in green. Remember, the report does not identify improper payments, it only identifies your possible risks.

The PEPPER Report also provides suggested interventions that may be useful for your facility to review and find out if there truly is a risk, or if the ranking (percentile) is accurate and supported. Using the suggestions can help you to decide your next steps. And it's also a great way to start the process of monitoring your risk areas. Below are a few of the target areas, along with the suggested interventions.

| TARGET AREA | SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE) | SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE) |
|---|---|---|
| Septicemia (Septicemia) | This could indicate that there are coding or billing errors related to over-coding of DRGs 870, 871 or 872. 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 a principal diagnosis code of ICD-10-CM code A41.9 (unspecified septicemia) to ensure documentation supports the principal diagnosis | This could indicate that there are coding or billing errors related to under-coding of DRGs 870, 871or 872. A sample of medical records for other DRGs, such as DRGs 689, 690, 193, 194, 195, 207 and 208 should be reviewed to determine if coding errors exist. Remember that a diagnosis of septicemia/sepsis must be determined by the physician. A coder should not code based on a laboratory finding without seeking clarification from the physician. Note: There is no ICD-10-CM code for urosepsis |
| Unrelated OR Procedure (Unrel OR Px) | This could indicate that there are coding or billing errors related to over-coding of DRGs 981, 982, 983, 987, 988 or 989. A sample of medical records for these DRGs should be reviewed to determine if the principal diagnosis and principal procedure are correct | This could indicate that the principal diagnosis is being billed with the related procedures. No intervention is necessary |

| TARGET AREA | SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE) | SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE) |
|---|---|---|
| Medical DRGs with CC or MCC (Med CC MCC)<br>Surgical DRGs with CC or MCC (Surg CC MCC)<br>Single CC or MCC (Single CC MCC) | This could indicate that there are coding or billing errors related to over-coding due to unsubstantiated CCs or MCCs. A sample of medical records for medical and/or surgical DRGs with CCs or MCCs (a single CC or MCC for the "Single CC or MCC" target area) should be reviewed to determine if coding errors exist. Hospitals may generate data profiles to identify proportions of their CCs or MCCs to determine if there are any particular medical and/or surgical DRGs on which to focus. Remember that a diagnosis of a CC or MCC must be determined by the physician. A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. If particular diagnoses are found to be problematic, provide education. Note: Effective Oct. 1, 2015, a principal diagnosis can also be a CC or MCC. Principal and secondary diagnosis codes should be reviewed to determine if they are a CC/MCC | This could indicate that there are coding or billing errors related to under-coding for CCs or MCCs. A sample of medical records for medical and/or surgical DRGs without a CC or MCC should be reviewed to determine if coding errors exist. Remember that in order for a diagnosis to be coded as a CC or MCC, it must be substantiated by documentation. A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. Consider whether the use of a physician query would have substantiated a CC or MCC. Note: Effective Oct. 1, 2015 a principal diagnosis can also be a CC or MCC. Principal and secondary diagnosis codes should be reviewed to determine if they are a CC/MCC. |

The PEPPER Report is valuable tool you should be leveraging to help your facility monitor and address areas of concern and/or risk. To understand your risk areas and know where you may have outliers is vital information to have at your fingertips. If your facility is an outlier in any given area, it is your responsibility to ensure you are billing correctly.

Citations: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## Heather Greene

MBA, RHIA, CPC, CPMA, CDIP


AUTHOR BIO

With nearly 20 years of experience in the healthcare industry, Heather has extensive experience working in a variety of key healthcare information management roles.

Heather demonstrates exceptional communication skills with extensive public speaking/presentation experience. Her well-developed capacity to build trusting relationships, enthuse, motivate and encourage collaboration from stakeholders, staff and management, has proven her to be an invaluable asset to multiple projects. Heather undoubtedly leads by example and can successfully motivate and facilitate effective training programs.

Heather is skilled at bringing trying information to life and incorporate relevant resources for clinical and administrative staff. Heather's presentation style is energetic, anecdotal and learner-focused, with a view not only to help participants improve their knowledge levels, but also to enhance their willingness and ability to apply what they've learned in a practical setting.

As a conscientious member of the healthcare community, Heather regularly attends conferences, seminars and takes advantage of many opportunities to interact with other nationally recognized HIM and coding experts where she can stay on top of the ever-changing regulations that impact the industry.

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