E-BRIEF SERIES

Healthicity

The PEPPER and You: How to Easily Improve Your Audit Program, One Outlier at a Time

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The Program for Evaluating Payment Patterns Electronic Report

Introduction

The Program for Evaluating Payment Patterns Electronic Report, more commonly known as PEPPER or the PEPPER Report is an invaluable tool used to support facility auditing and compliance efforts. The PEPPER is an electronic report that interprets the statistical data from a single hospital or facility on their Medicare-Severity diagnosis related groups (MS-DRGs) and discharges. Using this information, the report identifies areas that are at risk for improper payment due to the common billing, coding, and admission issues statistically related to those DRGs. While the PEPPER cannot identify an actually improper Medicare payment, it *can* provide a summary pinpointing a high-risk area your facility should monitor or review to ensure compliance. The PEPPER also compares your facility's Medicare reimbursement to state and national averages. The information that PEPPER provides can be extremely helpful in identifying possible areas of abnormal changes in length of stay (LOS) and over- or under-coding issues. Below, I'll discuss how you can incorporate the results of the PEPPER to optimize your audit process and develop a well-rounded compliance program.

How to Audit Based on the Results?

The first step is identifying what a possible "high-risk" result is within one of the target areas. This is done by determining your facility's percentile in relation to the comparison group. These percentiles indicate specific outliers based on preset control limits. They will draw your attention to any results that are at, or above, what is considered the upper control limit or a high outlier, which is a result in the 80th percentile - or those in the lower control limit, or low outlier indicated by being in the 20th percentile. A possible "high-risk" result is anything in the 80th or 20th percentile.

For Example: If a hospital is consistently reporting higher than average admissions for septicemia related DRGs (i.e., 870, 871, or 872) versus other hospitals in the state, region or nation, this could indicate a number of possible issues. For instance, there could be compliance issues related to medical necessity on admission, or coding and billing errors, like improper DRG assignment and querying practices.

Depending on the target area, these results can indicate the need for different action plans. Following or updating your action plan should include a compliance review, or a target-focused audit. The PEPPER will offer suggested interventions for when percentages fall into high-risk percentiles, for both high outliers and low outliers.

It should be noted that just because the hospital may fall into an outlier, it does not necessarily mean there is noncompliance. Which is why it is extremely important to determine your action plan. If it's determined that an audit should be performed, be sure to reference the PEPPER prior to proceeding.

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, 871 or 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.

If you determine an audit is needed for a hospital reporting as a high outlier for Septicemia, the action plan should include the suggested interventions from the PEPPER. But please note, these suggestions do not represent a complete audit program, but rather are additions to your audit program.

Now, let's take a look at another example.

For example:

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Ventilator Support (Vent Sup)	This could indicate that there are coding or billing errors related to over-coding of DRGs 003, 004, 207, 870, 927 or 933. A sample of medical records for these DRGs should be reviewed to determine if the type of tracheostomy and mechanical ventilation were coded correctly. Verify that the number of continuous invasive mechanical ventilation hours was coded accurately.	This could indicate under-coding related to incorrect computation of the number of hours the patient was receiving continuous invasive mechanical ventilation. Review cases with ICD-10-PCS procedure codes 5A1935Z (mechanical ventilation less than 24 consecutive hours) and 5A1945Z (mechanical ventilation 24-96 consecutive hours) to verify that the number of continuous invasive mechanical ventilation hours was coded accurately.

If an audit is determined to be needed for a high or low outlier for Ventilator Support, the action plan should include the suggested interventions from the PEPPER. Such as, determining if the number of continuous invasive mechanical ventilation hours were counted and coded accurately, ensuring ICD-10-PCS codes correspond correctly to the number of continuous invasive mechanical ventilation hours reported in the documentation, or that the type of tracheostomy was reported correctly. After an audit, findings might indicate anything from the need for better documentation practices clearly defining ventilation hours to education in tracheostomy coding best practices.

How Often Should Your Organization Review the PEPPER?

Both CMS and the OIG use the PEPPER as a gauge to determine a hospital's strengths and weaknesses. They support its use in evaluating internal processes for compliance. As such, best practices suggest your organization reviews the report each quarter. However, it's important to note that the PEPPER will include data from six to nine months previous. This information will need to be kept in mind if your facility has implemented changes from audit findings, as the data may not reflect improvements until a couple of quarters later.

What Should You do if Your Scores Don't Improve?

If you identify your hospital consistently ranks as an outlier in a particular area, it may be time for an internal audit focusing on several different areas. The focus of your audit or compliance review should be to determine where exactly the deficiencies are originating, and if policy reform is required to correct the deficiencies. Is education indicated? And for whom? CDI personnel, physicians, coders, and billers?

When in doubt, focus on documentation. It's important that your medical records remain clear, consistent, and complete. Deficiencies in these critical aspects of your facility's documentation can be established and pinpointed through an internal audit. Audits can determine errors within your facility's EHR, disorganized or illegible paper records, insufficient or inconsistent physician documentation, and poor querying practices. Fewer areas of confusion and inadequacy within the medical record equate to fewer coding and billing errors. This can be a contributing factor in improving your facility's PEPPER results.

It's important to remember that just because the PEPPER may indicate you have an outlier status, it does not reflect the quality of care your facility provides–or that you have fraudulent coding or billing practices.

In Conclusion

Outlier status should be evaluated in a specific priority order, starting at the national level, then jurisdictional, then lastly, state specific. After first identifying a high-risk target area from the PEPPER, be sure to take a proactive and preventative approach. Identify whether it is an area of compliance, or if it necessitates an audit, or both. If an audit is required, we recommend you follow the suggested interventions provided by the PEPPER. However, those are generalized suggestions, and may not apply to your specific situation. We also recommend you follow the user guides located online for each facility type, which can be found at https://pepper.cbrpepper.org/. The website also includes several free training videos and other resources to help you along the way.

The PEPPER is a valuable tool we highly recommend adding to your current audit process. By monitoring the PEPPER on a regular basis, your facility can help your organization support and ensure an effective compliance program.

Sources:

- https://pepper.cbrpepper.org/
- https://www.cms.gov/
- https://www.pepperresources.org/

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AUTHOR BIO

Ms. Williamson is the Education Specialist for the inpatient curriculum at AAPC. Her career began 11 years ago as a dental assistant before transitioning to an outpatient multi-specialty medical facility. She has been a medical coder for over 6 years and enjoyed being the sole on-site coder for a 40-bed full-service hospital. She is currently pursuing a degree in Health Information Management. She has a passion for inpatient modalities, cardiothoracic specialties, and pathophysiology.

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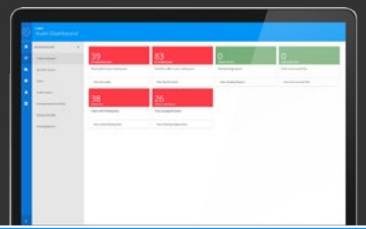

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