Using PEPPER and CERT Reports to Reduce Improper Payment Vulnerability

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Objectives

• *Increase awareness and understanding of CERT and PEPPER*

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

• *Discuss the relationship between CERT, organizational PEPPER data and vulnerability to governmental audits*
Hot Topics for Organizations

Although there are many different government audits, Comprehensive Error Rate Testing (CERT) and Program for Evaluating Payment Patterns Electronic Report (PEPPER) provide an organization with foresight into potential vulnerabilities that can result in denied claims and recoupment.
CERT

- CERT was established by the Centers for Medicare & Medicaid Services (CMS) to monitor the accuracy of claim payment in the Medicare Fee-For-Service program.
- The CERT Program supports CMS’s primary objective of ensuring the Medicare Administrative Contractors (MAC) are paying claims appropriately.
- Beginning with the FY 2009 reporting, the CERT program became fully responsible for sampling and reviewing all Medicare FFS claims, including inpatient and outpatient hospital claims, and durable medical equipment claims for purposes of measuring improper payments.
CERT

• The CERT Documentation Contractor (CDC) randomly selects claims and reviews supporting documentation for the billed services to determine if the claim was paid correctly
• When an error is determined, the claim is adjusted by the MAC who takes the payment back from the provider
• Vulnerabilities are identified and education is developed to prevent future payment errors
CERT Reports

Why be concerned about CERT findings?
• The 2008 error rate was 3.6%

Revised and improved methodology was implemented in 2009
• The 2009 error rate significantly increased to 12.4% equaling $35.4 billion

• The 2010 error rate dropped to 10.5% equaling $34.3 billion in improper payments

Medicare Fee-For-Service 2010 Improper Payment Report
• “Pursuant to the President’s directive to reduce improper payments, CMS established a goal to reduce the 2009 error rate by 50 percent, or 6.2 percent, by 2012. CMS strives to eliminate improper payments in the Medicare program, maintain the Medicare trust funds and protect its beneficiaries.”

• Although Medicare Part B error rates decreased in 2010, the improper payments error rate for inpatient hospital claims increased significantly in 2010
CERT Error Categories

- **No documentation**
  - Failure to submit requested records

- **Insufficient documentation**
  - The submitted medical documentation is inconclusive to support the rendered service

- **Medically unnecessary service**
  - Review staff are able to determine from the submitted medical records that the services billed were not medically necessary based on Medicare coverage policies

Medicare Fee-For-Service 2010 Improper Payment Report
CERT Error Categories

- Incorrect coding
  ➞ The medical documentation supports a different code than the code billed, the service was done by someone other than the billing provider, the billed service was unbundled, or a beneficiary was discharged to a site other than the one coded on a claim.

- Other
  ➞ This category includes claims that do not fit into any of the other categories (e.g., duplicate payment error, non covered or unallowable service).
2010 CERT Findings

• **Medically necessary services provided in an incorrect setting of care**
  - Provided in an acute inpatient hospital

• **Medical necessity errors**
  - Short stay acute inpatient hospital admissions with services that could have been proved as outpatient observation

• **Three day stays for SNF placement**

• **Procedures failing to meet NCD and LCD resulting in DRG reassignment**

Medicare Fee-For-Service 2010 Improper Payment Report
2010 CERT Report

• A large number of inpatient payment errors were due to clinical care and procedures provided in an acute inpatient hospital that should have been provided in an outpatient hospital or another less intensive setting, meaning the clinical service was medically necessary but the place of service was incorrect.

• Under the current Medicare statute, these claims must be denied in full. These inappropriate “place of service” errors accounted for projected improper payments of $5.1 billion.
For inpatient hospital claims, a large percentage of medically unnecessary errors are related to hospital stays of short duration. In many cases, those services could have been rendered at a lower level of care, such as outpatient observation services.
A smaller, but persistent amount of medically unnecessary payment errors are for inpatient hospital stays of three to five days, many of which resulted in a transfer to a skilled nursing facility (SNF). Some of these patients may have been admitted solely to satisfy the requirement for a minimum of three days as an inpatient in order to qualify for a SNF stay.
A portion of medical necessity errors for inpatient hospital claims is related to the denial of an invasive procedure that affected the Diagnosis Related Group (DRG) payment.

If an invasive procedure did not meet the requirements of a Local Coverage Determination (LCD) or National Coverage Determination (NCD) and affected the DRG payment, the procedure was denied as a medically unnecessary service.
2010 CERT Report

• In these cases, the DRG was reclassified after removing the medically unnecessary procedure.

• If the inpatient hospital stay included other Medicare covered services the improper payment amount was the difference between the billed DRG and the reclassified DRG.

• If no other covered services were provided the entire payment was considered improper.
Impact of the 2010 CERT Report

- **PEPPER Short-term Acute Care Hospital Targets**
  - Short stays
  - Three day stays
  - Error prone DRG assignments

- **Recovery Audit Contractor (RAC) focus areas**
  - Medical necessity
  - DRG assignment

- **Medicare Demonstration Projects**
• **Part A to Part B Rebilling:**

.allow hospitals to rebill for 90 percent of
the Part B payment when a Part A
inpatient short stay claim is denied as not
reasonable and necessary due to the wrong
setting (outpatient vs. inpatient). Currently,
when outpatient services are billed as
inpatient services, the entire claim is
denied in full.
Impact of the 2010 CERT Report

- **Recovery Audit Prepayment Review**
  - Will allow Medicare Recovery Auditors (RACs) to review claims before they are paid to ensure that the provider complied with all Medicare payment rules; thereby, preventing improper payments.
  - Focus on claims that historically result in high rates of improper payments.
  - Focus on seven states with high populations of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO) for a total of 11 states.
An 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. . .”

Failure to review PEPPER data can be interpreted as reckless disregard or deliberate ignorance in a False Claims Act case.

Some Compliance Programs May Fail to Reduce the Risk of False Claims, Sept. 27, 2011; Wolters Kluwer Law & Businesses
What is PEPPER?

- **CERT findings are based on a random sample of paid claims**
  - Identification of “types” of claims prone to payment error
- **RAC identifies improper payments by a particular organization targeting claims that are prone to payment error**
- **PEPPER data is based on paid Medicare claims data**
  - Raking system among all organizations receiving Medicare payments which identifies outliers
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”
• 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”
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
• *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
• **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**

\[
\begin{array}{c}
\text{Numerator} \\
\hline
\text{Denominator}
\end{array}
\]
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)?
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

Numerator

Denominator

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

**MS-DRG 069**

**MS-DRGs 061 - 069**
Compare Page

• Summary of an organization’s paid Medicare claims data for each target during a particular quarter as benchmarked against other facilities
  ➡ The volume of discharges for each target
  ➡ The percent (%) of cases for each target based on the target definition
  ➡ How each target ranks by percentile in comparison to other organizations
    ◦ Jurisdiction, state and the Nation
  ➡ Associated total value ($) of the paid claims (sum of payments)
When an organization’s percentage of cases within a target reaches a particular percentile ranking or “threshold” it is referred to as an outlier.

Organizations whose data falls at or above the 80th percentile are identified as high outliers and may be vulnerable to overpayment.

- Percentages that qualify as a high outlier will appear in red bold.
- Both coding and medical necessity targets will have an upper threshold.
Organizations whose data falls at or below the 20\textsuperscript{th} 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 an 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.
• **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

- 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 and others they would not
Interpreting Your Organizational Data
• **Outlier rank**

> Provides a “snapshot” of the status of each target area for the previous twelve quarters

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Q1 FY 2009</th>
<th>Q2 FY 2009</th>
<th>Q3 FY 2009</th>
<th>Q4 FY 2009</th>
<th>Q1 FY 2010</th>
<th>Q2 FY 2010</th>
<th>Q3 FY 2010</th>
<th>Q4 FY 2010</th>
<th>Q1 FY 2011</th>
<th>Q2 FY 2011</th>
<th>Q3 FY 2011</th>
<th>Q4 FY 2011</th>
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<td>Stroke Intracranial Hemorrhage</td>
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<td>1</td>
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<td>1</td>
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<td>Simple Pneumonia</td>
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<td>Medical DRGs with CC or MCC</td>
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<td>1</td>
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<td>1</td>
<td>1</td>
<td>11</td>
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<td>Transient Ischemic Attack</td>
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</tbody>
</table>
Reviewing Your PEPPE 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

  ◦ 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

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Number of Target Discharges</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Infections</td>
<td>Proportion of discharges with DRG = 177 (respiratory infections &amp; inflammations w/ MCC), 178 (respiratory infections &amp; inflammations w/ CC) compared to discharges with DRG = 177, 178, 179 (respiratory infections &amp; inflammations w/o CC/MCC), 193 (simple pneumonia &amp; pleurisy w/ MCC), 194 (simple pneumonia &amp; pleurisy w/ CC), 195 (simple pneumonia &amp; pleurisy w/o CC/MCC)</td>
<td>13</td>
<td>13.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18</td>
<td>23.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>29</td>
<td>52.0%</td>
</tr>
</tbody>
</table>

The volume of cases will vary across organizations so translating the results into % creates a rate allowing comparison for organizations of varying sizes.
## Hospital Jurisdiction (MAC) Percentile

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Percent</th>
<th>Hospital Jurisdiction Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Infections</td>
<td>Proportion of discharges with DRG = 177 &amp; 178 compared to discharges with DRG = 177, 178, 179, 193, 194 &amp; 195</td>
<td>13.1%</td>
<td>2.7</td>
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<td></td>
<td></td>
<td>23.1%</td>
<td>57.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>52.0%</td>
<td>92.6</td>
</tr>
</tbody>
</table>

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 (100th percentile) of all organizations within the jurisdiction.
# Hospital State Percentile Column

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Percent</th>
<th>Hospital State Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Infections</td>
<td>Proportion of discharges with DRG = 177 &amp; 178 compared to discharges with DRG = 177, 178, 179, 193, 194 &amp; 195</td>
<td>13.1%</td>
<td>11.1</td>
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<td></td>
<td></td>
<td>23.1%</td>
<td>59.9</td>
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<tr>
<td></td>
<td></td>
<td>52.0%</td>
<td>95.0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Percent</th>
<th>Hospital National Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Infections</td>
<td>Proportion of discharges with DRG = 177 &amp; 178 compared to discharges with DRG = 177, 178, 179, 193, 194 &amp; 195</td>
<td>13.1%</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23.1%</td>
<td>60.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>52.0%</td>
<td>95.2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Number of Target Discharges</th>
<th>Sum of Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Infections</td>
<td>Proportion of discharges with DRG = 177 &amp; 178 compared to discharges with DRG = 177, 178, 179, 193, 194 &amp; 195</td>
<td>13</td>
<td>$133,361 ($10,258)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18</td>
<td>$244,949 (13,608)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>29</td>
<td>$407,445 ($14,049)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Number of Target Discharges</th>
<th>Sum of Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-day Stays Excluding Transfers</td>
<td>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 &gt; 24 hours</td>
<td>123</td>
<td>$633,361</td>
</tr>
<tr>
<td></td>
<td></td>
<td>308</td>
<td>$1,244,949</td>
</tr>
<tr>
<td></td>
<td></td>
<td>529</td>
<td>$3,407,445</td>
</tr>
</tbody>
</table>

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

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

  ➞ **Two day stay MS-DRG targets**
  
  ◦ *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
    - 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
    - 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 CERT report
- 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