Hospital Payment Monitoring Program (HPMP)

Kimberly Hrehor, MHA, RHIA, CHE
Project Director – HPMP QIOSC
April 23, 2006
Objectives

• Define HPMP
• Discuss payment error trends, risk areas
• Learn about QIO resources that support compliance efforts
• Learn about successful payment error prevention projects
QIO Contract with CMS

• Assist providers in developing capacity to achieve excellence through transformational change
  – Nursing home, home health, hospital, critical access/rural hospital, physician practice, physician practice underserved populations, physician practice pharmacy benefit (Part D)
• Protects beneficiaries and the Medicare program
  – Beneficiary protection, HPMP
• Three-year contract launched August 1, 2005
Beneficiary Protection

• Case review activity
  – Quality of care; admission necessity; DRG assignment
  – Emergency Medical Treatment and Labor Act
  – Referrals from carriers, FIs, other contractors
  – Hospital requests for higher-weighted DRG Note: the record is reviewed for admission necessity and “gross and flagrant” quality issues
  – Outlier review
  – Reviews for HPMP

• Beneficiary complaints
HPMP

- Purpose of HPMP is to measure, monitor, and reduce the incidence of improper fee-for-service inpatient payments
HPMP

• Goal is to protect Medicare trust fund
• Analyze and identify patterns of payment errors
  – Unnecessary admissions, DRG errors, billing errors
• Help hospitals to reduce errors through system improvement
• QIOs develop tools, education, comparative data (i.e., PEPPER) to share with hospitals to help prevent payment errors
QIO HPMP Activities

• QIOs conduct HPMP project(s)
  – a focused intervention involving a specific area prone to payment errors and/or specific hospitals

• New focus: long-term, acute-care hospitals (LTCHs)
  – QIOs will monitor LTCH data
  – QIOs may conduct an LTCH HPMP project
QIO HPMP Activities

- QIOs receive data in areas identified as at risk for payment errors
- CMS will continue to select a monthly random sample to monitor payment error trends for the nation and each state
Data: The Foundation for HPMP

• Each year 38,000+ records (744 per state) randomly selected for HPMP

• Records are screened at the Clinical Data Abstraction Center (CDAC); records failing screening are forwarded to the QIO for review
Data: The Foundation for HPMP

- Review results allow estimation of Medicare dollars in error, as reported annually by the Centers for Medicare & Medicaid Services (CMS) in the Improper Medicare Fee for Service Payments Report (www.cms.hhs.gov/cert)
- Guides QIO HPMP projects and interventions
- Data are available for FYs 1998, 2000-2004
Numbers of Claims in Error, FY 2004, National Data

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records in Sample</td>
<td>38,448</td>
<td></td>
</tr>
<tr>
<td>Total Claims in Error</td>
<td>3,490</td>
<td>(9.1%)</td>
</tr>
<tr>
<td>• DRG Changes</td>
<td>1,310</td>
<td>(3.4%)</td>
</tr>
<tr>
<td>• Admission Denials*</td>
<td>1,786</td>
<td>(4.6%)</td>
</tr>
<tr>
<td>• Billing Errors</td>
<td>245</td>
<td>(0.6%)</td>
</tr>
<tr>
<td>• Technical Denials</td>
<td>82</td>
<td>(0.2%)</td>
</tr>
<tr>
<td>• Maryland LOS</td>
<td>67</td>
<td>(0.2%)</td>
</tr>
</tbody>
</table>

*includes cases with both confirmed admission denial and DRG change
### Gross Dollars in Error, FY 2004, National Data

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount (in dollars)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Sample Payment</td>
<td>$292,246,901</td>
<td></td>
</tr>
<tr>
<td>Total Gross Dollars in Error</td>
<td>$12,461,028 (4.3%)</td>
<td></td>
</tr>
<tr>
<td>• DRG Changes</td>
<td>$3,004,579 (24.1%)</td>
<td></td>
</tr>
<tr>
<td>• Admission Denials*</td>
<td>$7,674,322 (61.6%)</td>
<td></td>
</tr>
<tr>
<td>• Billing Errors</td>
<td>$1,089,796 (8.7%)</td>
<td></td>
</tr>
<tr>
<td>• Technical Denials</td>
<td>$597,113 (4.8%)</td>
<td></td>
</tr>
<tr>
<td>• Maryland LOS</td>
<td>$95,218 (0.8%)</td>
<td></td>
</tr>
</tbody>
</table>

*includes cases with both confirmed admission denial and DRG change
Gross Dollars in Error, FY 2004, National Data

- 61% Adm Den
- 24% DRG Cng
- 9% Bill Err
- 5% TD
- 1% LOS
# Net Dollars in Error, FY 2004, National Data

<table>
<thead>
<tr>
<th>Category</th>
<th>Dollars in Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Sample Payment</td>
<td>$292,246,901</td>
</tr>
<tr>
<td>Total Net Dollars in Error</td>
<td>$9,878,683 (3.4%)</td>
</tr>
<tr>
<td>• DRG Changes</td>
<td>$422,234 (4.3%)</td>
</tr>
<tr>
<td>• Admission Denials*</td>
<td>$7,674,322 (77.7%)</td>
</tr>
<tr>
<td>• Billing Errors</td>
<td>$1,089,796 (11.0%)</td>
</tr>
<tr>
<td>• Technical Denials</td>
<td>$597,113 (6.0%)</td>
</tr>
<tr>
<td>• Maryland LOS</td>
<td>$95,218 (1.0%)</td>
</tr>
</tbody>
</table>

*includes cases with both confirmed admission denial and DRG change
Net Dollars in Error, FY 2004, National Data

- DRG Cng: 4%
- Adm Den: 6%
- Bill Err: 1%
- TD: 11%
- LOS: 78%
Top 10 DRGs – Volume of Error (any error) FY 2004

1. DRG 143 – chest pain
2. DRG 182 – esophagitis, gastroenteritis, & misc dig disorders w cc
3. DRG 296 – nutritional & misc metabolic disorder w cc
4. DRG 243 – medical back problems
5. DRG 089 – simple pneumonia & pleurisy
6. DRG 127 – heart failure & shock
7. DRG 183 – esophagitis, gastroenteritis, & misc dig disorders wo cc
8. DRG 320 – kidney & UTI w cc
9. DRG 125 – circulatory disorders ex AMI, w card cath w/o comp
10. DRG 524 – transient ischemia
Top 10 DRGs – Gross Dollars in Error (any error) FY 2004

1. DRG 182 – esophagitis, gastroenteritis, & misc dig disorders w cc
2. DRG 296 – nutritional & misc metabolic disorder w cc
3. DRG 143 – chest pain
4. DRG 478 – other vascular procedures w cc
5. DRG 243 – medical back problems
6. DRG 125 – circulatory disorders ex AMI, w card cath w/o comp
7. DRG 209 – major joint & limb reattachment proced of lower ext
8. DRG 127 – heart failure & shock
9. DRG 527 – percutaneous car vas proc w drug elut stent wo cc
10. DRG 174 – GI hemorrhage w cc
Top 10 DRGs – Volume of Admission Denials, FY 2004

1. DRG 143 – chest pain
2. DRG 182 – esophagitis, gastroenteritis, & misc dig disorders w cc
3. DRG 243 – medical back problems
4. DRG 296 – nutritional & misc metabolic disorder w cc
5. DRG 183 – esophagitis, gastroenteritis, & misc dig disorders wo cc
6. DRG 125 – circulatory disorders ex AMI, w card cath w/o comp
7. DRG 524 – transient ischemia
8. DRG 174 – GI hemorrhage w cc
9. DRG 127 – heart failure & shock
10. DRG 012 – degenerative nervous system disorder
Top 10 DRGs – Gross Dollars in Error Adm Den, FY 2004

1. DRG 182 – esophagitis, gastroenteritis, & misc dig disorders w cc
2. DRG 143 – chest pain
3. DRG 296 – nutritional & misc metabolic disorder w cc
4. DRG 243 – medical back problems
5. DRG 125 – circulatory disorders ex AMI, w card cath w/o comp
6. DRG 478 – other vascular procedures w cc
7. DRG 174 – GI hemorrhage w cc
8. DRG 116 – other perm card pacemaker implant
9. DRG 127 – heart failure & shock
10. DRG 524 – transient ischemia
Admission Denials and Short Stays

- 41% of all admission denials are for lengths of stay (LOS) of one day
- 78% of all admission denials are for LOS of 3 days or less
- Admissions with LOS = 3 days to qualify for SNF admission have a higher unnecessary admission rate
QIO Reasons for Admission Denial

• 80% - medical condition appears not to require inpatient hospital level of care
• 38% - services rendered appear to not require hospital level of care
• 3% - admission solely for a procedure that appears unnecessary

Note: a record can have more than one reason for denial
Top 10 DRGs – Volume of DRG Change FY 2004

1. DRG 089 – simple pneumonia & pleurisy
2. DRG 182 – esophagitis, gastroenteritis, & misc dig disorders w cc
3. DRG 296 – nutritional & misc metabolic disorder w cc
4. DRG 015 – nonspecific CVA & precereb occlusion wo infarct
5. DRG 320 – kidney & UTI w cc
6. DRG 127 – heart failure & shock
7. DRG 138 – card arrhythmia & conduction disorder w cc
8. DRG 416 – septicemia
9. DRG 143 – chest pain
10. DRG 331 – other kidney and urinary tract dx w cc
Top 10 DRGs – Gross Dollars in Error DRG Change FY 2004

1. DRG 468 – extensive OR proc unrelated to princ diagnosis
2. DRG 416 – septicemia
3. DRG 089 – simple pneumonia & pleurisy w cc
4. DRG 475 – respiratory system diagnosis w vent support
5. DRG 331 – other kidney and urinary tract dx w cc
6. DRG 001 – craniotomy w cc
7. DRG 415 – OR proc infectious/parasitic diseases
8. DRG 079 – resp infection & inflammation w cc
9. DRG 182 – esophagitis, gastroenteritis, & misc dig disorders w cc
10. DRG 148 – major sm & lg bowel procedure w cc
Top 10 DRGs for Overcoding, FY 2004

1. DRG 468 – extensive OR proc unrelated to princ diagnosis
2. DRG 475 – respiratory system diagnosis w vent support
3. DRG 001 – craniotomy w cc
4. DRG 415 – OR proc infectious/parasitic diseases
5. DRG 416 – septicemia
6. DRG 148 – major sm & lg bowel procedure w cc
7. DRG 483 – trach w mech vent 96+hrs
8. DRG 316 – renal failure
9. DRG 079 – resp infection & inflammation w cc
10. DRG 170 – other digest syst OR proc w cc
Top 10 DRGs for Undercoding, FY 2004

1. DRG 479 – other vascular proc wo cc
2. DRG 149 – major sm & lg bowel proc wo cc
3. DRG 223 – maj shldr/elbow/other upper ext procedure
4. DRG 321 – kidney & UTI wo cc
5. DRG 419 – fever of unknown origin w cc
6. DRG 320 – kidney & UTI w cc
7. DRG 015 – nonspecific CVA & precereb occlusion wo infarct
8. DRG 125 – circulatory disorders ex AMI, w card cath w/o comp
9. DRG 473 – acute leukemia wo major OR procedure
10. DRG 119 – vein ligation & stripping
Top 10 DRG Change Pairs – FY 2004

1. DRG 015 to 014 (+)  
2. DRG 140 to 132 (+)  
3. DRG 182 to 183 (-)  
4. DRG 089 to 079 (+)  
5. DRG 143 to 132 (+)  
6. DRG 296 to 182 (-)  
7. DRG 175 to 174 (+)  
8. DRG 125 to 124 (+)  
9. DRG 320 to 416 (+)  
10. DRG 090 to 089 (+)

(+) indicates changed to higher weighted DRG; (-) indicates changed to lower weighted DRG
QIO Reasons for DRG Change

- 34.8% - principal diagnosis not principal reason for hospitalization
- 29.4% - non-clinical or non-medical errors that affect the DRG (procedure code error)
- 14.5% - principal diagnosis not present at admission
- 8.0% - complication/comorbidity/secondary diagnosis billed, but not substantiated by the record

Note: a record can have more than one reason for a DRG change
## Trending of Dollars in Error

<table>
<thead>
<tr>
<th></th>
<th>FY 2001</th>
<th>FY 2002</th>
<th>FY 2003</th>
<th>FY 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Sample Reimb</strong></td>
<td>$395,353,587</td>
<td>$376,322,491</td>
<td>$278,736,319</td>
<td>$292,246,901</td>
</tr>
<tr>
<td><strong>Total Gross Dollars in Error</strong></td>
<td>$16,042,640</td>
<td>$15,962,229</td>
<td>$11,875,988</td>
<td>$12,461,028</td>
</tr>
<tr>
<td><strong>Gross Error Rate</strong></td>
<td>4.1%</td>
<td>4.2%</td>
<td>4.3%</td>
<td>4.3%</td>
</tr>
<tr>
<td><strong>Total Net Dollars in Error</strong></td>
<td>$11,366,132</td>
<td>$11,486,714</td>
<td>$8,986,640</td>
<td>$9,878,683</td>
</tr>
<tr>
<td><strong>Net Error Rate</strong></td>
<td>2.9%</td>
<td>3.1%</td>
<td>3.2%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>
# Gross Value of Dollars in Error by Error Type

<table>
<thead>
<tr>
<th>Error Type:</th>
<th>FY 2002</th>
<th>% of gross</th>
<th>FY 2003</th>
<th>% of gross</th>
<th>FY 2004</th>
<th>% of gross</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG Change</td>
<td>$4,805,624</td>
<td>30%</td>
<td>$3,036,709</td>
<td>26%</td>
<td>$3,004,579</td>
<td>24%</td>
</tr>
<tr>
<td>Adm Denial</td>
<td>$8,806,431</td>
<td>55%</td>
<td>$7,277,194</td>
<td>61%</td>
<td>$7,674,322</td>
<td>61%</td>
</tr>
<tr>
<td>Billing Error</td>
<td>$1,126,099</td>
<td>7%</td>
<td>$112,542</td>
<td>1%</td>
<td>$1,089,796</td>
<td>9%</td>
</tr>
<tr>
<td>Tech Denial</td>
<td>$1,057,941</td>
<td>7%</td>
<td>$504,539</td>
<td>4%</td>
<td>$597,113</td>
<td>5%</td>
</tr>
<tr>
<td>LOS Concern</td>
<td>$166,134</td>
<td>1%</td>
<td>$945,004</td>
<td>8%</td>
<td>$95,218</td>
<td>1%</td>
</tr>
</tbody>
</table>
## Net Dollars in Error by Error Type

<table>
<thead>
<tr>
<th>Error Type</th>
<th>FY 2002</th>
<th>% of net</th>
<th>FY 2003</th>
<th>% of net</th>
<th>FY 2004</th>
<th>% of net</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG Change</td>
<td>$330,110</td>
<td>3%</td>
<td>$147,361</td>
<td>2%</td>
<td>$422,234</td>
<td>4%</td>
</tr>
<tr>
<td>Adm Denial</td>
<td>$8,806,431</td>
<td>77%</td>
<td>$7,277,194</td>
<td>81%</td>
<td>$7,674,322</td>
<td>78%</td>
</tr>
<tr>
<td>Billing Error</td>
<td>$1,126,099</td>
<td>10%</td>
<td>$112,542</td>
<td>1%</td>
<td>$1,089,796</td>
<td>11%</td>
</tr>
<tr>
<td>Tech Denial</td>
<td>$1,057,941</td>
<td>9%</td>
<td>$504,539</td>
<td>6%</td>
<td>$597,113</td>
<td>6%</td>
</tr>
<tr>
<td>LOS Concern</td>
<td>$166,134</td>
<td>1%</td>
<td>$945,004</td>
<td>11%</td>
<td>$95,218</td>
<td>1%</td>
</tr>
</tbody>
</table>
CMS HPMP Target Areas

<table>
<thead>
<tr>
<th>Coding</th>
<th>DRG 014</th>
<th>Cerebral infarct</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DRG 079</td>
<td>Complex pneumonia</td>
</tr>
<tr>
<td></td>
<td>DRG 089</td>
<td>Simple pneumonia</td>
</tr>
<tr>
<td></td>
<td>DRG 416</td>
<td>Septicemia</td>
</tr>
<tr>
<td></td>
<td>DRG CC pairs</td>
<td>Multiple DRGs</td>
</tr>
</tbody>
</table>
### CMS HPMP Target Areas, cont.

<table>
<thead>
<tr>
<th>Medical Necessity</th>
<th>DRG 243</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-day stays/DRGs:</td>
<td></td>
</tr>
<tr>
<td>• 127</td>
<td></td>
</tr>
<tr>
<td>• 143</td>
<td></td>
</tr>
<tr>
<td>• 182/183</td>
<td></td>
</tr>
<tr>
<td>• 296/297</td>
<td></td>
</tr>
<tr>
<td>• 1-day stays excl. transf.</td>
<td></td>
</tr>
<tr>
<td>For discharges to SNF, med. neces. of 3-day stays</td>
<td></td>
</tr>
<tr>
<td>Readmissions w/in 7 days to same/other</td>
<td></td>
</tr>
</tbody>
</table>

Medical back
- Heart failure
- Chest pain
- GI DRG pair
- Metabolic DRG pair
PEPPER

- Program for Evaluating Payment Patterns Electronic Report (PEPPER)
- Hospital-specific and statewide comparative claims data for CMS focus areas
- Data are current
- Assists hospitals with prioritizing auditing/monitoring activities
<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Outlier Value</th>
<th>Number of Target Dischs</th>
<th>Outlier Value Times Number of Dischs</th>
<th>Percent</th>
<th>State-Wide Percentile</th>
<th>Status (Hospital Use)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Day Stay Excl Transfers</td>
<td>Proportion of discharges with length of stay less than or equal to one day excluding patient status of 23 (expired), 07 (left against medical advice), or 02 (transfer to another short-term general hospital for inpatient care), of all discharges excluding transfers.</td>
<td>2.0</td>
<td>117</td>
<td>234.0</td>
<td>18.03%</td>
<td>75.00%</td>
<td></td>
</tr>
<tr>
<td>7-Day Readmissions</td>
<td>Proportion of index (first) admissions for which a readmission occurred within 7 days to the same hospital or elsewhere for the same beneficiary (identified using the Health Insurance Claim number)</td>
<td>2.0</td>
<td>63</td>
<td>126.0</td>
<td>8.82%</td>
<td>75.00%</td>
<td></td>
</tr>
<tr>
<td>1-Day Stay DRG 127</td>
<td>Proportion of discharges with DRG 127 (heart failure and shock) with length of stay less than or equal to one day excluding patient status of 20 (expired), 07 (left against)</td>
<td>10.0</td>
<td>6</td>
<td>60.0</td>
<td>17.14%</td>
<td>100.00%</td>
<td></td>
</tr>
</tbody>
</table>
PEPPER
One-Day Stay Excluding Transfers, % of All Discharges Excl Transfers
990003 Hospital C

% of One-Day Stay Discharges (excluding deaths, transfers, and leaves against medical advice) to All Discharges Excl Transfers

<table>
<thead>
<tr>
<th>Measures</th>
<th>FY 2003</th>
<th>Q2 FY 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target area discharge count</td>
<td>117</td>
<td>117</td>
</tr>
<tr>
<td>Denominator count (All Discharges Excl Transfers)</td>
<td>549</td>
<td>649</td>
</tr>
<tr>
<td>Percent (Target area count / Denominator)</td>
<td>18.03%</td>
<td>18.03%</td>
</tr>
<tr>
<td>Target area Avg Length of Stay (ALOS)</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Denominator Average Length of Stay (ALOS)</td>
<td>4.9</td>
<td>4.9</td>
</tr>
<tr>
<td>Target Avg Medicare Payment</td>
<td>$3,395</td>
<td>$3,995</td>
</tr>
<tr>
<td>Target Sum Medicare Payments</td>
<td>$467,469</td>
<td>$467,469</td>
</tr>
</tbody>
</table>

1) Target discharges = total one-day stay discharges (excluding deaths, transfers, and leaves against medical advice) in the time period

Statewide Comparative Data for Target Proportion:

<table>
<thead>
<tr>
<th>Percentile</th>
<th>FY 2003</th>
<th>Q2 FY 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>90th</td>
<td>18.24%</td>
<td>18.24%</td>
</tr>
<tr>
<td>75th</td>
<td>18.03%</td>
<td>18.03%</td>
</tr>
<tr>
<td>Median</td>
<td>13.92%</td>
<td>13.92%</td>
</tr>
<tr>
<td>10th</td>
<td>9.45%</td>
<td>9.45%</td>
</tr>
</tbody>
</table>

Summary
change from FY 2001 to Q2 FY 2004

<table>
<thead>
<tr>
<th>From FY2001</th>
<th>To Q2 FY 2004</th>
<th>Percentage Point Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hosp Proportion</td>
<td>12.24%</td>
<td>18.03%</td>
</tr>
<tr>
<td>State Median</td>
<td>10.50%</td>
<td>13.92%</td>
</tr>
</tbody>
</table>

Statewide comparative data were calculated using percentages from PPS hospitals.

Medicare fiscal year (FY) = October 1 through September 30
HPMP Compliance Workbook

- Finalized in December 2005
- Includes guidance, examples, tools
- Also available on hpmpresources.org
Working with your QIO

• QIOs work collaboratively with hospitals to achieve the goal of HPMP
• QIOs develop tools to assist hospitals
• QIOs can provide educational assistance (conference calls, WebEx, presentations)
• Contact the HPMP department in your state’s QIO as a resource (to find your QIO go to www.ahqa.org and click on the “QIO finder” link)
Contact Information

Kimberly Hrehor, MHA, RHIA, CHE
Project Director, HPMP QIOSC
TMF Health Quality Institute
khrehor@txqio.sdps.org
281-859-0331

This material was prepared by TMF Health Quality Institute, the Medicare HPMP Quality Improvement Organization Support Center under contract with the Centers Medicare & Medicaid Services (CMS) as an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-TX-HPMPQ-06-01