PEPPER and Data Analytics for Skilled Nursing Facilities, Hospices and Inpatient Rehabilitation Facilities

April 19, 2015
Kimberly Hrehor

Agenda

- What is PEPPER?
- Focus: Hospice PEPPER
- Focus: SNF PEPPER
- Focus: IRF PEPPER
- Review strategies to mitigate audit risk
- Questions and Answers
- Target area listings for other providers
Providers are Under Focus:

- Office of Inspector General Work Plan
- Recovery Auditors
- Medicare Administrative Contractors

What is PEPPER?

- Program for Evaluating Payment Patterns Electronic Report (PEPPER) summarizes Medicare claims data statistics for one provider in areas (“target areas”) that may be at risk for improper Medicare payments.
- PEPPER compares the provider’s Medicare claims data statistics with aggregate Medicare data for all other providers in the nation, MAC jurisdiction and state.
- PEPPER cannot identify improper Medicare payments!
What is PEPPER?

- PEPPER was originally developed in 2003 for short-term acute care PPS hospitals; it was made available through the Quality Improvement Organizations in support of efforts to identify and prevent improper Medicare payments through 2008.
- PEPPER is also available for long-term (LT) acute care PPS hospitals, critical access hospitals (CAHs), inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs), partial hospitalization programs (PHPs), hospices, skilled nursing facilities (SNFs) and in 2015 for home health agencies (HHAs).

Why are Providers Receiving PEPPER?

- CMS is tasked with protecting the Medicare Trust Fund from fraud, waste and abuse.
- The provision of PEPPER supports CMS’ program integrity activities.
- PEPPER is an educational tool that is intended to help providers assess their risk for improper Medicare payments.
PEPPER Summarizes Medicare Data

- Paid Medicare claims (no other payers)
  - Medicare claim payment amount > $0
  - Exclude HMO (Medicare Advantage) claims
  - Exclude canceled claims
  - Medicare secondary payer claims included if Medicare payment > $0

PEPPER Data

- Organized in three 12-month time periods based on federal fiscal year (FY).

<table>
<thead>
<tr>
<th>FY 2012</th>
<th>FY 2013</th>
<th>FY 2014</th>
</tr>
</thead>
</table>

Short-term Acute Care Hospital

PEPPER Data

- Summarized by federal fiscal year quarters according to the discharge date on the claim.

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

Target Area

- Area identified as potentially at risk for improper payments.
- Focused on admission necessity or coding issues
- Constructed as a ratio:
  - Numerator = discharges identified as potentially problematic (likely to be miscoded or admitted unnecessarily)
  - Denominator = larger reference group that contains the numerator
Target Area Percents

- Target area percents are calculated by dividing the number of target discharges/episodes by the number of denominator discharges/episodes for each provider for each time period, then multiplying by 100.

- Example: Miscellaneous CMGs
  
  \[
  \frac{15 \text{ discharges for CMGs 2001, 2002, 2003, 2004}}{60 \text{ total discharges}} \times 100 = 25\%
  \]

Percent vs. Percentiles

- The target area percent measures the provider’s billing patterns for each target area over time.

- Percentiles show how the provided compares to others in the nation, jurisdiction and state.

- Percentiles provide context...
Context.....

- Where do you fall among the distribution?
- Does that make sense?
- Should you be concerned?
Comparisons in PEPPER

- PEPPER provides state, MAC jurisdiction and national comparisons.
MAC Jurisdictions

Consolidated A/B MAC Jurisdictions

Home Health/Hospice MACs
National-level Data

- National-level data for the target areas (number of discharges for the numerator/denominator, average length of stay, total payments) is available at PEPPERresources.org on the “Data” page.
- The reports are updated following each release.
How do I obtain my PEPPER?

- PEPPER is distributed in electronic format.
- PEPPER is no longer mailed to providers in hard-copy format.
- PEPPER cannot be sent via email.

STACH, CAH, IPF, Distinct Part Units (SNF, IRF, PHP) of Hospitals

- PEPPER is distributed via QualityNet to the hospital QualityNet Administrators and those with basic user accounts and the PEPPER recipient role.
- Available for 60 days from date TMF uploads the file.
- Providers can request we re-upload the file (contact us through the Help Desk at PEPPERresources.org).
Hospices, LTCHs, Free-standing SNFs, IRFs, PHPs

- PEPPER Resources Portal
  - Visit PEPPERresources.org
  - Click on the “PEPPER Distribution – Get Your PEPPER” link
  - Review instructions and access portal
  - Each release will be available for approximately two years from the original release date
Who has Access to PEPPER?

- PEPPER is only available to the individual provider.
- PEPPER is not publicly available, cannot be released to consultants, etc.
- TMF does not send PEPPERs to MACs/Recovery Auditors, but does provide them with an Access database that contains the PEPPER statistics for providers in their jurisdiction/region.
For assistance with PEPPER:

› Visit PEPPERresources.org for the PEPPER User’s Guide and training materials.
› Submit request for assistance at PEPPERresources.org “Help/Contact Us” tab.

Strategies to Consider....

› Do Not Panic!
  – Indication of high outlier does not necessarily mean that compliance issues exist.
› But: Determine Why You are an “Outlier”
  – Sample claims using same inclusion criteria.
  – Review documentation in medical record.
  – Review claim; was it coded and billed appropriately based upon documentation in medical record?
› Ensure following best practices, even if not an outlier.
## Hospice PEPPER Target Areas

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Live Discharges</strong></td>
<td><strong>For discharges prior to July 1, 2012:</strong></td>
</tr>
<tr>
<td><em>(revised as of the Q4FY13 release)</em></td>
<td><em>N:</em> count of beneficiary episodes discharged alive by the hospice (patient discharge status code not equal to “40”, “41” or “42” with occurrence code “42” (date of termination of hospice benefit)</td>
</tr>
<tr>
<td></td>
<td><em>Denominator (D):</em> count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)</td>
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<td><strong>Live Discharges</strong></td>
<td><strong>For discharges beginning July 1, 2012:</strong></td>
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<td><em>N:</em> count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to “40”, “41”, “42”, excluding: beneficiary transfers (patient discharge status code “50” or “51”); beneficiary revocations (occurrence code “42”); beneficiaries discharged for cause (condition code “H2”); beneficiaries who moved out of the service area (condition code “52”)</td>
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<tr>
<td>Long Length of Stay</td>
<td><strong>N:</strong> count of beneficiary episodes discharged (by death or alive) by the hospice during the report period whose combined days of service at the hospice is greater than 180 days (obtained by considering all claims billed for a beneficiary by that hospice)</td>
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<td><strong>D:</strong> count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period</td>
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<tr>
<td>Continuous Home Care Provided in an Assisted Living Facility</td>
<td><strong>N:</strong> count of beneficiary episodes discharged (by death or alive) by the hospice during the report period where at least eight hours of Continuous Home Care (revenue code = &quot;0652&quot;) were provided while the beneficiary resided in an Assisted Living Facility (HCPCS code = “Q5002”)</td>
</tr>
<tr>
<td>*new as of the Q4FY14 release</td>
<td><strong>D:</strong> count of all beneficiary episodes ending in the report period that indicate the beneficiary resided in an assisted living facility (HCPCS code = “Q5002”) for any portion of the episode</td>
</tr>
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### Hospice PEPPER Target Areas, 5

<table>
<thead>
<tr>
<th>Target Area</th>
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</table>
| Routine Home Care Provided in an Assisted Living Facility *new as of the Q4FY14 release | N: count of Routine Home Care days (revenue code = “0651”) provided on claims ending in the report period that indicate the beneficiary resided in an assisted living facility (HCPCS code = “Q5002”)  
D: count of all Routine Home Care days (revenue code = “0651”) provided by the hospice on claims ending in the report period |

### Hospice PEPPER Target Areas, 6

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
</table>
| Routine Home Care Provided in a Nursing Facility *new as of the Q4FY14 release | N: count of Routine Home Care days (revenue code = “0651”) provided on claims ending in the report period that indicate the beneficiary resided in a nursing facility (HCPCS code = “Q5003”)  
D: count of all Routine Home Care days (revenue code = “0651”) provided by the hospice on claims ending in the report period |
### Hospice PEPPER Target Areas, 7

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
</table>
| Routine Home Care Provided in a Skilled Nursing Facility | *new as of the Q4FY14 release*  
N: count of Routine Home Care days (revenue code = "0651") provided on claims ending in the report period that indicate the beneficiary resided in a skilled nursing facility (HCPCS code = "Q5004")  
D: count of all Routine Home Care days (revenue code = "0651") provided by the hospice on claims ending in the report period |

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### SNF PEPPER Target Areas

<table>
<thead>
<tr>
<th>Target Area</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Therapy RUGs with High ADL</td>
<td></td>
</tr>
</tbody>
</table>
N: count of days billed with RUG equal to RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB  
D: count of days billed for all therapy RUGs |
| Nontherapy RUGs with High ADL |  
N: count of days billed with RUG equal to SSC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 in RUG III; HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1 in RUG IV  
D: count of days billed for all nontherapy RUGs |
| Change of Therapy Assessment |  
N: count of assessments with AI second digit “D”  
D: count of all assessments |
### SNF PEPPER Target Areas, 2

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrahigh Therapy RUGs</td>
<td>(N): count of days billed with RUG equal to RUX, RUL, RUC, RUB, RUA (D): count of days billed for all therapy RUGs</td>
</tr>
<tr>
<td>Therapy RUGs</td>
<td>(N): count of days billed for all therapy RUGs (D): count of days billed for all therapy and nontherapy RUGs</td>
</tr>
<tr>
<td>90+ Day Episodes of Care</td>
<td>(N): count of episodes of care at the SNF with LOS 90+ days (D): count of all episodes of care at the SNF</td>
</tr>
</tbody>
</table>

### IRF PEPPER Target Areas

<table>
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<tr>
<th>Target Area</th>
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</tr>
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<tbody>
<tr>
<td>Miscellaneous CMGs</td>
<td>(N): 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) (D): count of all discharges</td>
</tr>
<tr>
<td>CMGs at Risk for Unnecessary Admissions</td>
<td>(N): count of discharges with no tier group assignment for CMGs 0101 (Stroke M&gt;51.05), 0501 (Non-traumatic Spinal Cord Injury M&gt;51.35), 0601 (Neurological M&gt;47.75), 0801 (Replacement of Lower Extremity Joint M&gt;49.55), 0802 (Replacement of Lower Extremity Joint M&gt;37.05 and M&lt;49.55), 0901 (Other Orthopedic M&gt;44.75), 1401 (Cardiac M&gt;48.85), or 1501 (Pulmonary M&gt;49.25) (D): count of all discharges</td>
</tr>
</tbody>
</table>
### IRF PEPPER Target Areas, 2

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</thead>
</table>
| Outlier Payments                  | **N:** count of discharges with an outlier approved amount greater than $50  
**D:** count of all discharges                                                                                                           |
| STACH Admissions following IRF Discharge | **N:** count of beneficiaries 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; excluding beneficiaries that were transferred to a STACH, LTCH or IRF within one day of discharge as evidenced by a subsequent claim; excluding patient discharge status codes 07 (left against medical advice), 20 (expired)  
**D:** count of all discharges excluding beneficiaries that were transferred to a STACH, LTCH or IRF within one day of discharge as evidenced by a subsequent claim; and excluding patient discharge status codes 07, 20 |

### HHA PEPPER Target Areas

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<tr>
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</tr>
</thead>
</table>
| Outlier Payments                  | **N:** dollar amount of outlier payments received by the HHA during the report period  
**D:** dollar amount of total payments received by the HHA during the report period                                                              |
| Average Number of Episodes        | **N:** count of episodes paid to the HHA during the report period  
**D:** count of beneficiaries served by the HHA during the report period                                                                          |
| Average Case Mix                  | **N:** sum of case mix weight for all episodes paid to the HHA during the report period, excluding LUPAs and PEPs  
**D:** count of episodes paid to the HHA during the report period, excluding LUPAs and PEPs                                                         |
HHA PEPPER Target Areas, 2

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<tbody>
<tr>
<td>Episodes with 5 or 6 Visits</td>
<td>$N$: count of episodes with 5 or 6 visits paid to the HHA during the report period $D$: count of episodes paid to the HHA during the report period</td>
</tr>
<tr>
<td>Non-LUPA Payments</td>
<td>$N$: count of episodes paid to the HHA that did not have a LUPA payment during the report period $D$: count of episodes paid to the HHA during the report period</td>
</tr>
<tr>
<td>High Therapy Utilization Episodes</td>
<td>$N$: count of episodes with 20+ therapy visits paid to the HHA during the report period (first digit of HHRG equal to '5') $D$: count of episodes paid to the HHA during the report period</td>
</tr>
</tbody>
</table>

Short-term Acute Care Hospital Target Areas

- Stroke Intracranial Hemorrhage
- Respiratory Infections
- Simple Pneumonia
- Septicemia
- Unrelated OR Procedures
- Medical DRGs with CC or MCC
- Surgical DRGs with CC or MCC
- Single CC or MCC
- Excisional Debridement
- Ventilator Support
- Transient Ischemic Attack
- Chronic Obstructive Pulmonary Disease
- PTCA with Stent
- Syncope
- Other Circulatory System Diagnoses
- Other Digestive System Diagnoses
- Medical Back Problems
- Spinal Fusion
- 3-day SNF-qualifying Admissions
- 30-day Readmissions to Same Hospital or Elsewhere
- 30-day Readmissions to Same Hospital
- 2-DS Medical DRGs
- 2DS Surgical DRGs
- 1DS Medical DRGs
- 1DS Surgical DRGs
- Same-day Stays Medical DRGs
- Same-day Stays Surgical DRGs
Critical Access Hospital Target Areas

- Stroke Intracranial Hemorrhage
- Respiratory Infections
- Simple Pneumonia
- Septicemia
- Medical DRGs with CC or MCC
- Surgical DRGs with CC or MCC
- Single CC or MCC
- Chronic Obstructive Pulmonary Disease
- Syncope
- Medical Back Problems
- Swing Bed Transfers

- 3-day SNF-qualifying Admissions
- 30-day Readmissions to Same Hospital or Elsewhere
- 30-day Readmissions to Same Hospital
- 2DS Heart Failure and Shock
- 2DS Cardiac Arrhythmia
- 2DS Esophagitis Gastroenteritis
- 2DS Nutritional & Metabolic Disorders
- 2DS Kidney & UTI
- 1DS Excluding Transfers
- 1DS Medical DRGs

IPF and LT Target Areas

Inpatient Psychiatric Facility Target Areas:
- Outlier Payments
- 3- to 5-Day Readmissions
- 30-Day Readmissions
- Comorbidities

Long-term Acute Care Hospital Target Areas:
- Septicemia
- Excisional Debridement
- Short Stays
- Short Stays for Resp. Syst. Diagnoses
- Outlier Payments
- 30-Day Readmissions
- STACH Admissions following LT discharge
Partial Hospitalization Program Target Areas

- Days of Service with 4 Units Billed
- Group Therapy
- No Individual Psychotherapy
- 60+ Days of Service
- 30-day Readmissions

Questions?

- “Help/Contact Us” at PEPPERresources.org
Hospice PEPPER Reports and Your Compliance Program

Kathryn Krenz
Compliance Analyst

Agenda

- Medicare Hospice Benefit
- Why PEPPER for Hospice?
- What is Hospice PEPPER?
- Hospice PEPPER target areas
- Case Study
- Auditing and Monitoring Considerations
- Questions
Medicare Hospice Benefit

Overview

• Established in 1986 to provide palliative care and support to terminally ill patients and their families

• Is part of the Medicare Part A Hospital Benefit

• Paid on a per diem basis based on 4 levels of care
  – Routine home care
  – Respite care
  – Short-term general inpatient care
  – Continuous home care

Medicare Hospice Benefit

Eligibility

• Patient must be eligible for Medicare Part A

• Patient must be certified terminally ill by two physicians with life expectancy of 6 months or less if the illness runs its usual course

• Patient must elect hospice
  – Must be aware that care will be palliative vs. curative
  – Must understand that election waives rights to other Medicare benefits
Medicare Hospice Benefit
Covered Hospice Services

Includes coverage of
– nursing
– medical social services
– physician services
– counseling
– short-term general inpatient care
– medical appliances and supplies
– aide and homemaker services
– PT, OT, ST
– other services related to the palliation of the terminal illness

Why PEPPER for Hospice?

• The Government Accountability Office has designated the Medicare hospice benefit as a high risk program for fraud and abuse

• Supports CMS program integrity efforts

• It is an educational tool to help providers assess risk

• Trends over time have generated concern
  – Spending has increased by approximately $1 billion per year
  – Diagnoses have changed from cancer to non-cancer
  – Average length of stay has increased
What is Hospice PEPPER?

- Contains claims data statistics obtained from paid hospice Medicare claims for the most recent three federal fiscal years – Oct 1 through September 30
- Compares the provider’s hospice data to other hospices in three comparison groups
  - Nation
  - Medicare Administrative Contractor jurisdiction
  - State
- Identifies risk areas for improper Medicare payments based on preset upper control limit of the 80th percentile

What is Hospice PEPPER?

- Claims included must meet criteria
  - Must be a final action claim that was non-rejected and for which all adjustments and disputes have been resolved and payment made in an amount greater than zero
  - Services must have been provided during the time period used to create the episode of service – the beneficiary must have been discharged or did not return for care within 30 days for those claims to be included
  - Excludes claims submitted to a Medicare Advantage plan
  - Excludes cancelled claims
- Claims are collected for two years prior to each time period so that longer lengths of stay can be evaluated
What is Hospice PEPPER?

Has informational tabs in excel spreadsheet format

- Purpose tab – gives hospice identifier and general report information
- Definitions tab – explains how target area information for the hospice was generated
- Compare tab – compares individual hospice data to nation, MAC jurisdiction and state hospices
- Target areas tabs (currently Live Discharges and Long LOS tabs) – graphs out the agency related to nation, jurisdiction and state
- Hospice Top Terminal Conditions – lists provider top diagnoses for time period of report (must be at least 11 decedents)
- Jurisdiction Top Terminal Conditions – lists MAC top diagnoses for time period of report (must be at least 11 decedents)

PEPPER Hospice Target Areas

**Target Area**

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<tr>
<td><strong>Live Discharges</strong></td>
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<td>(Live Discharges)</td>
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For discharges prior to July 1, 2012:

Numerator (N): count of beneficiary episodes discharged alive by the hospice - patient discharge status code not equal to "40" (expired at home), "41" (expired in a medical facility) or "42" (expired place unknown) with occurrence code "42" (date of termination of hospice benefit)

Denominator (D): count of all beneficiary episodes discharged by death or alive by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)

For discharges beginning July 1, 2012:

Numerator (N): count of beneficiary episodes who were discharged alive by the hospice - patient discharge status code not equal to "40" (expired at home), "41" (expired in a medical facility) or "42" (expired place unknown), excluding:
- beneficiary transfers (patient discharge status code "50" or "51")
- beneficiary revocations (occurrence code "42")
- beneficiaries discharged for cause (condition code "H2")
- beneficiaries who moved out of the service area (condition code "52")

Denominator (D): count of all beneficiary episodes discharged by death or alive by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)
### PEPPER Hospice Target Areas-continued

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<td><strong>Long Length of Stay</strong></td>
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<tr>
<td>(Long LOS)</td>
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<td><strong>Continuous Home Care Provided in an Assisted Living Facility</strong></td>
<td><em>N:</em> count of beneficiary episodes discharged (by death or alive) by the hospice during the report period where at least eight hours of Continuous Home Care (revenue code = &quot;0652&quot;) were provided while the beneficiary resided in an Assisted Living Facility (HCPCS code = &quot;Q5002&quot;)</td>
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<td>(CHC in ALF)</td>
<td><em>D:</em> count of all beneficiary episodes ending in the report period that indicate the beneficiary resided in an assisted living facility (HCPCS code = &quot;Q5002&quot;) for any portion of the episode</td>
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</table>

*new as of the Q4FY14 release*
### Target Area Definition

#### Target Area
- **Routine Home Care Provided in an Assisted Living Facility (RHC in ALF)**
- *new as of the Q4FY14 release*

**N:** count of Routine Home Care days (revenue code = "0651") provided on claims ending in the report period that indicate the beneficiary resided in an assisted living facility (HCPCS code = “Q5002”)

**D:** count of all Routine Home Care days (revenue code = "0651") provided by the hospice on claims ending in the report period

#### Target Area
- **Routine Home Care Provided in a Nursing Facility (RHC in NF)**
- *new as of the Q4FY14 release*

**N:** count of Routine Home Care days (revenue code = "0651") provided on claims ending in the report period that indicate the beneficiary resided in a nursing facility (HCPCS code = “Q5003”)

**D:** count of all Routine Home Care days (revenue code = "0651") provided by the hospice on claims ending in the report period
### PEPPER Hospice Target Areas-continued

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<tr>
<td>Routine Home Care Provided in a Skilled Nursing Facility (RHC in SNF)</td>
<td><strong>N:</strong> count of Routine Home Care days (revenue code = “0651”) provided on claims ending in the report period that indicate the beneficiary resided in a skilled nursing facility (HCPCS code = “Q5004”)</td>
</tr>
<tr>
<td><em>new as of the Q4FY14 release</em></td>
<td><strong>D:</strong> count of all Routine Home Care days (revenue code = “0651”) provided by the hospice on claims ending in the report period</td>
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### Why New Hospice Target Areas?

**RAC (Recovery Audit Contractor) Improvements**
- Tasked with reviewing all provider types, including hospice
- First new contract awarded to Connolly for Region 5 on 12/30/2014 - currently under post-award protest

**OIG reports on Medicare hospices**
- July 2011 – hospices that focus on NF residents
- January 2015 – hospices have incentives to provide care in ALs
Case Study

Purpose of Hospice
Program for Evaluating Payment Patterns Electronic Report

PEPPER

Visit PEPPERresources.org

Data Report Through Q4 FY13

XXXXXX, Kenz Hospice

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) summarizes provider-specific data for Medicare services that may be at higher risk for improper Medicare payments.

Please refer to the Hospice PEPPER User’s Guide at PEPPERresources.org for guidance using the report. If you need assistance, please contact TMF by visiting PEPPERresources.org and clicking on the “Help/Contact Us” tab.

This is HSPC PEPPER version Q4 FY13
Jurisdiction: J15 OSIS Administrators

PEPPER was developed by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the Department of Health and Human Services (HHS).

TMF

Health Quality Institute

Purpose
Definitions
Compare
Live Discharges
Long LOS
Hospice Top Terminal Conditions
Jurisdiction Top Terminal Conditions

Enriching the lives of those we serve with compassion, respect, excellence and integrity.
Hospice PEPPEP Resources.org

Compare Targets Report, Four Quarters Ending Q4 FY 2013

XOOOOOX, Xenet Hospice

The Compare Targets Report displays statistics for target areas that have reportable data (11+ target count) in the most recent time period. Percentiles indicate how a hospice’s target area percent compares to the target area percent for all hospices in the respective comparison group. For example, if a hospice’s national percentile (see below) is 80.6, 80.6% of the hospices in the nation have a lower percent value than that hospice. The hospice’s state percentiles (if displayed) and the Medicare Administrative Contractor (MAC) jurisdiction percentile values should be interpreted in the same manner.

Percentiles at or above the 60th percentile for any target area indicate that the hospice may be at a higher risk for improper Medicare payments. The greater the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Target Count</th>
<th>Percent</th>
<th>Hospice National %ile</th>
<th>Hospice Jurisdiction %ile</th>
<th>Hospice State %ile</th>
<th>Sum of Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Discharges</td>
<td>Patients with benefit effective date before July 1, 2012 who died alive or were discharged alive, excluding patients who died in hospital or hospice inpatient unit, that were discharged alive, excluding patients who died in hospital or hospice inpatient unit.</td>
<td>11</td>
<td>8.1%</td>
<td>32.5</td>
<td>20.3</td>
<td>27.3</td>
<td>$273,298</td>
</tr>
<tr>
<td>Long LOS</td>
<td>Patients with benefit effective date before July 1, 2012 who died alive or were discharged alive, excluding patients who died in hospital or hospice inpatient unit.</td>
<td>30</td>
<td>22.3%</td>
<td>76.8</td>
<td>83.2</td>
<td>85.4</td>
<td>$1,427,999</td>
</tr>
</tbody>
</table>

**Purpose**: Define, compare, and analyze
targets for hospices.

**Definitions**:
- **Live Discharges**: Patients who died or were discharged alive, excluding patients who died in hospital or hospice inpatient unit.
- **Long LOS**: Patients who died or were discharged alive, excluding patients who died in hospital or hospice inpatient unit.

**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 greater risk of improper Medicare payments.
- Your Target Percent (first row in the table below) is above the national 90th percentile.

**YOUR HOSPICE**

<table>
<thead>
<tr>
<th>Target Area Percent</th>
<th>3/17/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

**Target Count**
- For discharges prior to July 1, 2012:
  - Numerator: Count of patients who died alive or were discharged alive, excluding patients who died in hospital or hospice inpatient unit, that were discharged alive, excluding patients who died in hospital or hospice inpatient unit.

<table>
<thead>
<tr>
<th>Target</th>
<th>3/17/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>114</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator Count</th>
<th>3/17/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>156</td>
</tr>
</tbody>
</table>

**Target (Numerators) Average Length of Stay**

<table>
<thead>
<tr>
<th>Target</th>
<th>3/17/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>84</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator Count</th>
<th>3/17/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>102</td>
</tr>
</tbody>
</table>

**Target (Differences) Average Payment**

<table>
<thead>
<tr>
<th>Target</th>
<th>3/17/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>244</td>
</tr>
</tbody>
</table>

**Total Number of Patients**

<table>
<thead>
<tr>
<th>Target</th>
<th>3/17/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>733</td>
</tr>
</tbody>
</table>
Hospice PEPER

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 greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile

![Graph showing Routine Home Care Provided in Asst. Living Facility](image)

<table>
<thead>
<tr>
<th>YOUR HOSPICE</th>
<th>10/1/11 – 9/30/12</th>
<th>10/1/12 – 9/30/13</th>
<th>10/1/13 – 9/30/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Area Percent</td>
<td>10.9%</td>
<td>12.9%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Target Count (Numerator: count of Routine Home Care days (Revenue code 05511) provided on claims ending in the report period)</td>
<td>17,656</td>
<td>713</td>
<td>688</td>
</tr>
<tr>
<td>Denominator Count (see Definitions worksheet for complete definition)</td>
<td>190,794</td>
<td>5,607</td>
<td>4,970</td>
</tr>
<tr>
<td>Target (Numerator) Average Length of Stay</td>
<td>21.4 days</td>
<td>1.0 day</td>
<td>1.0 day</td>
</tr>
<tr>
<td>Denominator Average Length of Stay</td>
<td>20.6 days</td>
<td>1.0 day</td>
<td>1.1 day</td>
</tr>
</tbody>
</table>

COMPARATIVE DATA

<table>
<thead>
<tr>
<th>National 80th Percentile</th>
<th>Jurisdiction 80th Percentile</th>
<th>State 80th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.9%</td>
<td>15.9%</td>
<td>15.5%</td>
</tr>
<tr>
<td>26.6%</td>
<td>19.4%</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

Note: If your hospice area does not have any provider data, the data is not available.

Hospice PEPER

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 greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile

![Graph showing Routine Home Care Provided in a Nursing Facility](image)

<table>
<thead>
<tr>
<th>YOUR HOSPICE</th>
<th>10/1/11 – 9/30/12</th>
<th>10/1/12 – 9/30/13</th>
<th>10/1/13 – 9/30/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Area Percent</td>
<td>66.4%</td>
<td>59.2%</td>
<td>32.9%</td>
</tr>
<tr>
<td>Target Count (Numerator: count of Routine Home Care days (Revenue code 05511) provided on claims ending in the report period)</td>
<td>110,097</td>
<td>3,302</td>
<td>2,628</td>
</tr>
<tr>
<td>Denominator Count (see Definitions worksheet for complete definition)</td>
<td>169,854</td>
<td>5,570</td>
<td>4,970</td>
</tr>
<tr>
<td>Target (Numerator) Average Length of Stay</td>
<td>21.4 days</td>
<td>1.0 day</td>
<td>1.0 day</td>
</tr>
<tr>
<td>Denominator Average Length of Stay</td>
<td>20.6 days</td>
<td>1.0 day</td>
<td>1.1 day</td>
</tr>
</tbody>
</table>

COMPARATIVE DATA

<table>
<thead>
<tr>
<th>National 80th Percentile</th>
<th>Jurisdiction 80th Percentile</th>
<th>State 80th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>47.3%</td>
<td>43.5%</td>
<td>41.5%</td>
</tr>
<tr>
<td>63.1%</td>
<td>59.2%</td>
<td>58.6%</td>
</tr>
<tr>
<td>74.1%</td>
<td>69.4%</td>
<td>66.6%</td>
</tr>
</tbody>
</table>

Note: If your hospice area does not have any provider data, the data is not available.
Auditing and Monitoring Considerations

- Review the PEPPER for trends that point to risk for a single year and for changes over time
- Review hospice eligibility and admission criteria for your agency and change processes as needed
- Audit for accurate documentation and billing of discharge type
- Audit for accurate documentation of place of service
- Monitor for accurate hospice diagnosis coding
- Review for education needs for patients/families
Auditing and Monitoring Considerations continued

• Audit medical records
  – Does documentation support terminal prognosis?
  
  – Watch for “cookie cutter” or conflicting documentation, particularly in electronic medical records
  
  – Monitor IDG notes for accuracy and completeness and agreement with the rest of the medical record

Use audit findings to determine training needs

Auditing and Monitoring Considerations continued

• Monitor contractor sites for changes in LCDs/review focus/denial information

• Watch CMS Hospice Center for changes and areas that CMS is concerned about

• Review the OIG work plan yearly and any other pertinent OIG reports for areas to focus on in your audit/monitoring
Questions?

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PEPPER & Data Analytics: SNF

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Vice President of Compliance & Clinical Services
Evergreen Rehabilitation
Louisville, KY

• 2010 OIG Report

• 2012 OIG Report: $1.5 billion
Continued Focus on SNFs

- 2015 OIG Work Plan
  - The OIG will describe changes in SNF billing practices from FYs 2011 to 2013
- RAC Review
  - FY2013 SNF recoveries $1.8 million (6%)
- MAC Review
- MedPAC Report
- MDS Focused Surveys
- CMS Monitoring of RUGs

Therapy in the News

- Nursing Home Operator to Pay $48 Million to Resolve Allegations that Six California Facilities Billed for Unnecessary Therapy
- Extendicare Health Services Inc. Agrees to Pay $38 Million to Settle False Claims Act Allegations Relating to the Provision of Substandard Nursing Care and Medically Unnecessary Rehabilitation Therapy
- $3.8 million settlement shows nursing homes must oversee their therapy providers, feds say
- $1.3 million settlement marks second recent deal over SNF supervision of therapy providers
Mitigating Audit Risk

Circle of Concern

Train & Educate

Continuous Audit Preparation

Audit & Monitor

Response

Therapy Oversight

Which Are You?

PEPPER

No PEPPER

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## SNF PEPPER Target Areas

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy RUGs with High ADL</td>
<td>$N$: count of days billed with RUG equal to RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB. $D$: count of days billed for all therapy RUGs</td>
</tr>
<tr>
<td>Nontherapy RUGs with High ADL</td>
<td>$N$: count of days billed with RUG equal to SSC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 in RUG III; HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1 in RUG IV. $D$: count of days billed for all nontherapy RUGs</td>
</tr>
<tr>
<td>Change of Therapy Assessment</td>
<td>$N$: count of assessments with AI second digit “D”. $D$: count of all assessments</td>
</tr>
</tbody>
</table>

## SNF PEPPER Target Areas, cont.

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrahigh Therapy RUGs</td>
<td>$N$: count of days billed with RUG equal to RUX, RUL, RUC, RUB, RUA. $D$: count of days billed for all therapy RUGs</td>
</tr>
<tr>
<td>Therapy RUGs</td>
<td></td>
</tr>
</tbody>
</table>

- $N$: count of days billed for all therapy RUGs
- $D$: count of days billed for all therapy and nontherapy RUGs

| 90+ Day Episodes of Care | $N$: count of episodes of care at the SNF with LOS 90+ days. $D$: count of all episodes of care at the SNF |
High ADLs (11-16)

- If at/above 80th percentile
  - This could indicate a risk of potential overcoding of beneficiaries’ activities of daily living (ADL) status.
  - The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.
  - Is the ADL score reported consistent with the intensity of therapy being provided

- If at/below 20th percentile
  - This could indicate a risk of potential undercoding of beneficiaries’ ADL status.
  - The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.
  - Is the ADL score reported consistent with the intensity of therapy being provided
### Coding Instructions for ADL Self Performance

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of Self Performance</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Independent</td>
<td>Resident completed activity with no help or oversight every time during the seven-day look-back period.</td>
</tr>
<tr>
<td>1</td>
<td>Supervision</td>
<td>Oversight, encouragement, or cueing was provided three or more times during the seven-day look-back period.</td>
</tr>
<tr>
<td>2</td>
<td>Limited Assistance</td>
<td>Resident was slightly involved in activity and required physical help in guiding manipulations of limbs or other non-weight bearing assistance on three or more times during the seven-day look-back period.</td>
</tr>
<tr>
<td>3</td>
<td>Extensive Assistance</td>
<td>Resident performed part of the activity over the seven-day look-back period, help of the following type was provided three or more times: weight-bearing support provided three or more times. Full staff performance of activity during part but not all of the seven-day look-back period.</td>
</tr>
<tr>
<td>4</td>
<td>Total Dependence</td>
<td>There was full staff performance of an activity with no participation by resident for any aspect of the ADL activity. The resident must be unwilling or unable to perform any part of the activity over the entire seven-day look-back period.</td>
</tr>
<tr>
<td>7</td>
<td>Activity Occurred Only Once or Twice</td>
<td>The activity occurred but not three or more times.</td>
</tr>
<tr>
<td>8</td>
<td>Activity Did Not Occur</td>
<td>The activity did not occur for any reason and/or non-facility staff provided care 100% of the time for that activity over the entire seven-day look-back period.</td>
</tr>
</tbody>
</table>

### Coding Instructions for ADL Support

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of Support</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Setup or Physical Assist</td>
<td>Resident completed activity with no help or oversight.</td>
</tr>
<tr>
<td>1</td>
<td>Setup Only</td>
<td>Resident is unable to lift materials or receive necessary to perform the ADL independently. This care includes giving or helping out an item rather than the resident taking from the caregiver.</td>
</tr>
<tr>
<td>2</td>
<td>One-Person Physical Assist</td>
<td>Resident was assisted by one staff person.</td>
</tr>
<tr>
<td>3</td>
<td>Two-Person Physical Assist</td>
<td>Resident was assisted by two or more staff persons.</td>
</tr>
</tbody>
</table>

ADL Activity Self Section: The activity did not occur for any reason and/or non-facility staff provided care 100% of the time during the entire period that activity over the entire seven-day look-back period.
**ADL Score Audit Tool**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>RUG</th>
<th>ADL Audit</th>
<th>Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, Patient</td>
<td>RUC</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>Smith, Jones</td>
<td>RHH</td>
<td>B</td>
<td>X</td>
</tr>
</tbody>
</table>
COT Considerations

- If at/above 80th percentile:
  - SNF may be experiencing challenges with delivering services to the beneficiary
  - Look at factors that lead to the need for the COT
    - Communication between disciplines
    - Missed therapy due to appointments, scheduling
    - Scheduling conflicts
    - Staffing Issues

- If at/below 20th percentile:
  - Review process in facility for IDT review of minutes
  - Process for Unscheduled Assessment Monitoring & Communication
  - Length of Stay?
Change of Therapy (COT) Assessment Audit Tool

<table>
<thead>
<tr>
<th>Patient Id</th>
<th>COT Check</th>
<th>COT Check</th>
<th>COT Check</th>
<th>COT Check</th>
<th>COT Check</th>
<th>COT Check</th>
<th>COT Check</th>
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<th>COT Check</th>
<th>COT Check</th>
<th>COT Check</th>
<th>COT Check</th>
<th>COT Check</th>
<th>COT Check</th>
<th>COT Check</th>
<th># Match</th>
<th>#COT Checks</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>RUG-bled</td>
<td>RU</td>
<td>RU</td>
<td>RU</td>
<td>RU</td>
<td>RU</td>
<td>RU</td>
<td>RU</td>
<td>RU</td>
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<td>RU</td>
<td>RU</td>
<td>RU</td>
<td>RU</td>
<td>RU</td>
<td>RU</td>
<td>4</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>RUG-bled</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>RV</td>
<td>8</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>
90+ Day Episode of Care

- If at/above 80th percentile:
  - Could indicate that the SNF is continuing treatment beyond point where services are medically necessary
- If at/below 20th percentile:
  - Review to assure that patients receive all necessary treatments prior to discharge = RISK MANAGEMENT

### Target Description

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Target Count</th>
<th>SNF National %ile</th>
<th>SNF Jurisd. %ile</th>
<th>SNF State %ile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy High ADL</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RUX, RUX, RHU, RHX, RMX, RMC, RLB, to days billed within episodes of care ending in the report period for all therapy RUGs</td>
<td>1,136</td>
<td>26.3%</td>
<td>34.3</td>
<td>41.7</td>
</tr>
<tr>
<td>Nontherapy High ADL</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to SSC, CC2, BB2, BB1, PE2, PE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1, to days billed within episodes of care ending in the report period for all nontherapy RUGs</td>
<td>33</td>
<td>9.1%</td>
<td>13.9</td>
<td>21.1</td>
</tr>
<tr>
<td>Change of Therapy Assessment</td>
<td>Proportion of assessments with AI second digit equal to H within episodes of care ending in the report period, to all assessments within episodes of care ending in the report period</td>
<td>28</td>
<td>6.3%</td>
<td>13.4</td>
<td>7.6</td>
</tr>
<tr>
<td>Ultrahigh Therapy RUGs</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RUX, RUX, RUX, RUX, to days billed within episodes of care ending in the report period for all therapy RUGs</td>
<td>2,525</td>
<td>58.5%</td>
<td>56.9</td>
<td>71.5</td>
</tr>
<tr>
<td>Therapy RUGs</td>
<td>Proportion of days billed within episodes of care ending in the report period for therapy RUGs, to days billed within episodes of care ending in the report period for all therapy and nontherapy RUGs</td>
<td>4,315</td>
<td>92.2%</td>
<td>45.2</td>
<td>46.0</td>
</tr>
<tr>
<td>90+ Day Episodes of Care</td>
<td>Proportion of episodes of care ending in the report period of the SNF with a length of stay of 90+ days, to all episodes of care ending in the report period at the SNF</td>
<td>26</td>
<td>30.2%</td>
<td>86.4</td>
<td>92.3</td>
</tr>
</tbody>
</table>
Ultra High Therapy RUGs / Therapy RUGs

- If at/above 80th percentile
  - Could indicate SNF is improperly billing for therapy services.
  - Is clinical intensity appropriate based on patient need?
- If at/below 20th percentile
  - Is clinical intensity appropriate based on patient need?
  - Is staffing appropriate?

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Target Count</th>
<th>Percent</th>
<th>SNF National %ile</th>
<th>SNF Jurisdiction %ile</th>
<th>SNF State %ile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy High ADL</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL, RUC, RUB, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs</td>
<td>15,003</td>
<td>43.0%</td>
<td>72.5</td>
<td>78.2</td>
<td>78.6</td>
</tr>
<tr>
<td>Nontherapy High ADL</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to SSC, CC2, CC1, BB2, BB1, PE2, PE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1, to days billed within episodes of care ending in the report period for all nontherapy RUGs</td>
<td>298</td>
<td>17.1%</td>
<td>38.0</td>
<td>33.4</td>
<td>33.6</td>
</tr>
<tr>
<td>Change of Therapy Assessment</td>
<td>Proportion of assessments with AI second digit equal to D within episodes of care ending in the report period, to all assessments within episodes of care ending in the report period</td>
<td>132</td>
<td>3.0%</td>
<td>3.1</td>
<td>6.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Ultrahigh Therapy RUGs</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL, RUC, RUB, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs</td>
<td>32,362</td>
<td>92.8%</td>
<td>99.1</td>
<td>97.0</td>
<td>97.1</td>
</tr>
<tr>
<td>Therapy RUGs</td>
<td>Proportion of episodes of care ending in the report period for therapy RUGs, to days billed within episodes of care ending in the report period for all therapy and nontherapy RUGs</td>
<td>34,885</td>
<td>95.4%</td>
<td>71.2</td>
<td>62.1</td>
<td>62.2</td>
</tr>
<tr>
<td>90+ Day Episodes of Care</td>
<td>Proportion of episodes of care ending in the report period of the SNF with a length of stay of 90+ days, to all episodes of care ending in the report period at the SNF</td>
<td>36</td>
<td>2.7%</td>
<td>1.9</td>
<td>3.4</td>
<td>3.4</td>
</tr>
</tbody>
</table>
Intensity & Duration Outlier Considerations

- Additional Data
  - Length of Stay
  - Community discharge %
  - Functional Outcomes
- Section O Accuracy
  - Scheduled Assessment ARD Communication
  - Unscheduled Assessment Communication
  - MDS Section O Verification
- RUG Level Setting Process
  - How would therapists respond to question from investigator "How amount/intensity of treatment is determined for their patient?"
- LOS Determination Process
  - How would facility staff respond to question from investigator related to pressure to keep on Part A
- Documentation Quality

Intensity & Duration Outlier Considerations

- Documentation Review Technical
  - Certifications
    - Signed and dated timely and legible
  - Technical Therapy Minute Recording
    - Non MDS: evaluation Time, non skilled Modality Time
    - MDS: Skilled Modality Minutes, Re-eval Minutes, Set-Up Minutes
    - Co-treat minutes
    - Mode of Treatment Accuracy: Individual, Concurrent, Group
- Claim—Triple Check
  - RUGs match MDS
    - Section O Verified
    - ADL Score Supported
  - Days match scheduled and unscheduled assessments completed
Intensity & Duration Outlier Considerations

• Documentation Review—Medical Necessity
  • Nursing Medical Necessity & Daily Skill
    • Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse.
    • ADL score consistent with Therapy RUG
  • Therapy Medical Necessity & Daily Skill
    • Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist.
      • Therapy Plans of Care are individual, pt. centered, and match patient clinical presentation
        • RUG Level (treatment intensity) and LOS (treatment duration)
          • # disciplines
          • d/c destination
          • Level (severity) of decline from PLOF
          • Diagnosis vs. Complexities/co-morbidities

Section O Audit Tool
## Section O Audit Tool

### Target Description

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Target Count</th>
<th>SNF National %ile</th>
<th>SNF Jurisd. %ile</th>
<th>SNF State %ile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapy High ADL</strong></td>
<td>Proportion of days billed within episodes of care ending in the report period for therapy RUGs, to days billed within episodes of care ending in the report period for all therapy RUGs</td>
<td>4,315</td>
<td>92.2%</td>
<td>40.2%</td>
<td>40.4%</td>
</tr>
<tr>
<td><strong>Ultrahigh Therapy RUGs</strong></td>
<td>Proportion of days billed within episodes of care ending in the report period for therapy RUGs with RUG equal to RUX, RUL, RUB, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs</td>
<td>2,520</td>
<td>56.5%</td>
<td>48.5%</td>
<td>48.0%</td>
</tr>
<tr>
<td><strong>90+ Day Episodes of Care</strong></td>
<td>Proportion of episodes of care ending in the report period at the SNF with a length of stay of 90+ days, to all episodes of care ending in the report period at the SNF</td>
<td>26</td>
<td>56.2%</td>
<td>86.4%</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

### Section O Audit Tool

|---------|------|--------|-------|-----|-----|--------|-------|-----|-----|----------|-----------|
### Target Description

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<th>SNF Jurisdiction %ile</th>
<th>SNF State %ile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy High ADL</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to RX, RIX, RIM, RUR, RUC, RUE, RUL, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs</td>
<td>15,303</td>
<td>43.0%</td>
<td>72.5</td>
<td>78.2</td>
<td>78.6</td>
</tr>
<tr>
<td>Nontherapy High ADL</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to SC, CIC, CRX, CBX, CB2, CB1, AS1, BB1, BB2, BB3, BB4, BB5 in RUG III; HE2, HE1, LE1, CE2, CE1, EB2, EB1, PE2, PE1 in RUG IV, to days billed within episodes of care ending in the report period for all nontherapy RUGs</td>
<td>298</td>
<td>17.7%</td>
<td>38.0</td>
<td>33.4</td>
<td>33.8</td>
</tr>
<tr>
<td>Change of Therapy Assessment</td>
<td>Proportion of assessments with AI second digit equal to D within episodes of care ending in the report period, to all assessments within episodes of care ending in the report period</td>
<td>132</td>
<td>3.0%</td>
<td>3.1</td>
<td>6.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Ultrahigh Therapy RUGs</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL, RUC, RUB, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs</td>
<td>32,082</td>
<td>92.0%</td>
<td>99.1</td>
<td>97.0</td>
<td>97.1</td>
</tr>
<tr>
<td>Therapy RUGs</td>
<td>Proportion of days billed within episodes of care ending in the report period for therapy RUGs, to days billed within episodes of care ending in the report period for all therapy and nontherapy RUGs</td>
<td>24,083</td>
<td>93.9%</td>
<td>91.2</td>
<td>82.1</td>
<td>82.2</td>
</tr>
<tr>
<td>90+ Day Episodes of Care</td>
<td>Proportion of episodes of care ending in the report period at the SNF, weighted according to the length of stay of 90+ days, to all episodes of care ending in the report period at the SNF</td>
<td>36</td>
<td>2.7%</td>
<td>1.6</td>
<td>3.4</td>
<td>3.4</td>
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**Part A Data Monitoring**

![Graph showing data monitoring](http://www.pepperresources.org/Data.aspx#SNF)

Source: PEPPER National Target Analysis; http://www.pepperresources.org/Data.aspx#SNF
Questions?

Shawn Halcsik
alcsik@evergreenrehab.com
877.471.7142

INTEGRATING THE PEPPER INTO YOUR IRF COMPLIANCE/QUALITY PROGRAM

T R A G E Y  N I X O N  C H C  -  S V P  /  C O M P L I A N C E  O F F I C E R

Reliant
COMPLIANCE OVERSIGHT

External Oversight

Corporate Internal Oversight

Leadership Governing Body

Internal Priority Structures

Hospital Services
ADD SOME FLAVOR TO YOUR COMPLIANCE PROGRAM

1. Compliance Infrastructure
2. Standards of Conduct
3. Education and Training
4. Process to Receive Reports of Non-Compliance
5. System to Respond to Allegations
6. Audits to Monitor Compliance
7. System to Investigate Problems
8. Program Effectiveness

INPATIENT REHABILITATION FACILITY COMPLIANCE PRIORITIES

- OIG target – Begin tracking adverse events in IRF’s for Medicare beneficiaries in 2015.
- Condition of Participation- 42 CFR 482.21(a)(2)- requires hospitals to track adverse patient events.
- RAC target- Medical necessity of patients at time of admission and throughout the patient’s stay.
- Operational Outcomes:
  - Comorbidity capture
  - 60% Compliance
  - Reduction in non-community transfers- ACT, SNF
- Patient Outcomes
  - Transition to community following IP stay.
  - LOS management
MANAGING RISK

ASSESS THE DATA

• An IRF’s target area % is compared to other IRFs’ 5 in the State, MAC jurisdiction and Nation.

• If the IRF’s target area percent is at/above the national 80th percentile or at/below the national 20th percentile, the IRF is identified as at risk for improper Medicare payments.

• Compare and target area reports:
  Red bold print- at or above the national 80th percentile for the target area.
EVALUATE RISK

- Determine how your facility compares to other IRFs
- If statistics are higher/lower than most other IRFs (“outlier”), ask “why?”
- Consider patient population and external factors
- Review documentation: does it support the CMG?
- If yes- note results of audit; reassess periodically; maintain documentation of audits
- If no- take necessary steps to address; reassess; continue to adjust if necessary.

PEPPER AS A TOOL TO EVALUATE/MONITOR RISK

- Coding
- Length of Stay Mgt.
- Medical Necessity of Admissions
- Discharge Planning
# IRF PEPPER TARGET AREAS

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
</table>
| Miscellaneous CMGs                | **N**: count of discharges for Case-Mix Groups (CMGs) 2001 (Miscellaneous M>49.15), 2002 (Miscellaneous M>38.75 and M<49.15), 2003 (Miscellaneous M>27.85 and M<38.75) or 2004 (Miscellaneous M<27.85)  
  **D**: count of all discharges |
| CMGs at Risk for Unnecessary Admissions | **N**: 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>48.85), or 1501 (Pulmonary M>49.25)  
  **D**: count of all discharges |
| Outlier Payments                  | **N**: count of discharges with an outlier approved amount greater than $0  
  **D**: count of all discharges |
| STACH Admissions following IRF Discharge | **N**: count of beneficiaries 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; excluding beneficiaries that were transferred to a STACH, LTCH or IRF within one day of discharge as evidenced by a subsequent claim; excluding patient discharge status codes 07 (left against medical advice), 20 (expired)  
  **D**: count of all discharges excluding beneficiaries that were transferred to a STACH, LTCH or IRF within one day of discharge as evidenced by a subsequent claim; and excluding patient discharge status codes 07, 20 |
WHAT ARE THE RISKS?

• Is Coding to the most specific level possible? *2015 60% Compliance methodology.
• Does documentation clearly support why the patient needed an acute level of care in an intensive rehabilitation environment?
• Could the patient have been treated at a lower level of care?
• Was admission criteria met?
IRF TARGET AREA - CMG AT RISK FOR UNNECESSARY ADMISSIONS

WHAT ARE THE RISKS?

- Are physicians and clinical screeners capturing all appropriate co-morbidities in their documentation?
- Are admit FIM scores accurately capturing the highest burden of care (lowest score)
IRF TARGET- OUTLIER PAYMENTS

WHAT ARE THE RISKS?

• What causes the overpayment?
• Long length of stay
• Medical complexity of patient
• Cost to charge ratio (CCR)
WHAT ARE THE RISKS?

- Was patient not medically stable or prepared at time of discharge?
- Includes patients that were discharged to SNF and then return to acute
- Not easily tracked by an IRF.
OPPORTUNITIES

- Discharge Planning- was there family involvement? Additional needs?
- Were patient goals met?
- Patient follow-up after discharge
- Strategic Partnerships

MANAGE THE RISK

- Build risk areas into performance improvement indicators
- Add targets to operational dashboards
- Internal Audits- Peer Audits
- Monitor targets in MEC and GB meetings so entire hospital/unit is monitoring on an ongoing basis.