Catching Up with PEPP

by Gloryanne Bryant, RHIT, CCS, and Robin Fletcher, RN, MPH

A year ago, the *Journal of AHIMA* reported on the newly created Payment Error Prevention Program (PEPP), which went into effect in August 1999. What has happened since then?

Best Billing Practices

PEPP was created to reduce Medicare prospective payment system (PPS) inpatient hospital payment errors at the national and state levels. PEPP will initially focus on several areas that contribute to payment errors:

- medically unnecessary admissions/procedures
- prevalent DRGs (coding errors and DRG upcoding)
- readmissions due to incomplete care or premature discharge
- inappropriate transfers
- other billing errors that affect payment (e.g., billing to the wrong provider number)

The program sprang from the 1997 Office of the Inspector General (OIG) financial statement, which indicated that the Medicare program had paid out more than $20 billion in incorrect payments, including $4 billion from the hospital inpatient PPS. To stem the tide of erroneous payments, the Health Care Financing Administration (HCFA) directed state peer review organizations (PROs) to initiate programs to work with hospitals to reduce these payment errors.

PROfessional Help

Under PEPP, PROs collaborate with hospitals to improve hospital structures and processes that contribute to payment errors. The PEPP initiative will involve several stages.

Since 1995, HCFA has used two specialized contractors called clinical data abstraction centers (CDACs). Under PEPP, the CDACs screen a random sample of records from each state on a monthly basis for medical necessity and DRG validation and forward problem cases to the PRO for review.

PROs conduct a full case review on all records that fail the initial CDAC review and notify the fiscal intermediary (FI) of the need for an adjustment for confirmed errors. HCFA calculates a baseline and later surveillance payment error rates for each state and nationally.

To determine problem areas at the local level, PROs will also analyze their own state-specific discharge data and conduct PEPP projects. PROs will be responsible for:

- profiling discharge data to identify potential patterns in payment errors
- selecting medical records for data collection/case review to confirm suspected payment errors
- requesting improvement plans from hospitals when patterns are identified
- providing education
- monitoring the success of interventions through profiling and additional review as appropriate

Because PEPP focuses on inpatient billing, certain single DRGs and DRG pairs, as well as utilization issues, are often targeted. Each state chooses DRGs and issues to focus on based on its data. Samples of problem DRGs might include 014/015, 079/089, 087/127, 416/320, and 475/127. (Other DRGs targeted by state PROs include 130/128, 132/140, and 483.) Examples of problematic utilization issues might be one to two-day admission, three-day admission with discharge to SNF,

weekend admission, or same-day readmissions to same PPS facility. The PEPP efforts of the PROs will not be duplicating the role of the OIG, Department of Justice, or Program Safeguard Contractors (PSCs).

Intervention successes and lessons learned through PRO/hospital collaborative projects will be shared between PROs via a management information system to encourage similar improvements nationwide. HCFA will evaluate the effectiveness of PEPP through remeasurement of the payment error rate and comparison to baseline data both nationally and for each state. This will occur at specific intervals throughout the PRO's contract. PRO performance will be assessed based on reduction of payment errors (both overpayments and underpayments), not dollars saved. All PROs have implemented DRG and/or medical necessity projects, and it is anticipated by HCFA that PROs will complete the PEPP baseline review by September.

California PRO launches PEPP efforts

by Gloryanne Bryant

The state of California PRO, California Medical Review, Inc. (CMRI), launched its PEPP activities by examining 18 months' worth of national billing data from January 1998 to June 1999 for many of the target DRGs. It compared the national percentile of billings within the specific DRGs and then calculated a state-specific percentage.

This process identified hospitals whose percentages were significantly above or below the state mean. Hospitals that had billed more than 15 cases of a target DRG were sent a notification letter alerting them to the potential concern, including a list of cases that had the potential for errors.

Criteria for hospital responses to the self-audit included:

- list the steps taken in response in a notification letter of potential outlier
- describe the results of self-audit/reviews
- describe how many cases were coded correctly
- describe how many were coded incorrectly
- prepare a quality improvement plan for educational intervention activities and continuing internal monitoring of cases, including a hospital timeline

Other activities CMPI has completed include:

- a letter to hospitals with an alert for potential errors and quality improvement plan form, highlighting:
  —DRG 014 (Specific Cerebrovascular Disorders except TIA) (November 1999, 106 hospitals)
  —DRG 079 (Complicated Pneumonia) (November 1999, 62 hospitals) —one-day admission/utilization (December 1999, 168 hospitals)
  —DRG 087 (Pulmonary Edema and Respiratory Failure) (January 2000, 128 hospitals)
  —DRG 475 (Respiratory System Diagnosis with Ventilator Support) (January 2000, 188 hospitals, a combination of both high and low-risk hospitals)
  —Same-day readmissions to same PPS hospital/utilization (February 2000, 59 hospitals)
- a PEPP letter with "Tools to help hospitals with PEPP activities" and a white paper that included a Q&A sheet, a request information form, and tip sheets for the above DRGs and other problem areas
- newsletters and letters to the media
- second letters sent to those hospitals whose recent data indicated potential problems, asking for chart reviews to be performed. Review volumes were lower than the previous utilization review activity

A unique part of the CMRI PEPP agenda of activities was the formation of a statewide PEPP task force. This group was made up of PRO physicians, administrative staff, and representatives from the California Hospital Association (CHA), California Medical Association (CMA), and the California Health Information Association (CHIA).

One particular issue of interest has been poor physician documentation. As a result, the methodology used for coding and classification has been discussed with physician representatives, and the need for ongoing, continuous physician education on documentation improvement was clearly identified. The efforts of this group have demonstrated that fostering understanding

of documentation issues and creating stronger compliance efforts requires the partnership of many players in various areas of healthcare, as represented by these associations.

PEPSPRO makes progress nationally

by Robin Fletcher

The Texas Medical Foundation (TMF), the Medicare PRO for the state of Texas, is the Payment Error Prevention Support Peer Review Organization (PEPSPRO) for PEPP. It is responsible for providing program support to HCFA and all PROs in the United States in implementing PEPP. It also is responsible for activities that facilitate effective implementation, monitoring, and evaluation of PEPP. These include:

- developing a management information system (MIS) that will track PEPP outcomes
- analyzing the payment error rate and best practices related to medical necessity and DRG interventions and reporting findings to HCFA and PROs
- developing a compendium of intervention best practices
- serving as a consultant to PROs on data issues and maintaining a library of successful analytical approaches
- developing healthcare compliance guidelines/training and disseminating this information to PROs
- conducting PRO coding conferences to address DRG and ICD-9-CM coding issues
- developing methods for PEPP information dissemination between HCFA and the PROs, such as meeting networks, electronic newsletters, and Web sites

The PEPSPRO has completed developing the specifications for the MIS, payment error rate calculation, and certain reports that will provide information regarding PEPP outcomes to HCFA and the PROs. HCFA anticipates that initial analysis of payment error rate data will occur in the fall of this year.

The PEPSPRO also completed development of a PEPP toolkit in March 2000. The toolkit, containing a PEPP/ compliance workbook, two PEPP videotapes, and documentation prompter cards and posters, was disseminated by HCFA to all PROs in the nation. The decision of a PRO to disseminate the toolkit to hospitals is voluntary.

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Article Citation:

Bryant, Gloryanne and Robin Fletcher. "Catching Up with PEPP." *Journal of AHIMA* 71, no. 8 (2000): 20-21.