PEPP: Collaborating to Improve Quality

by Laurie Poole

By collecting and analyzing information about Medicare payment errors, PEPP initiatives are making a contribution to healthcare quality efforts nationwide. Here's how one organization takes a collaborative approach to improving quality.

State Payment Error Prevention Programs (PEPPs) have a tall order to fill: collect and analyze information about Medicare payment errors and find and implement solutions. How are PEPPs making a contribution to healthcare quality efforts nationwide?

This article offers an overview of the PEPP initiative and a first-hand account of how a representative organization is making a difference.

A PROfessional Effort

The roots of the PEPP initiative stem from a 1998 report by the Office of Inspector General (OIG). The OIG conducted an audit of Medicare payments that revealed approximately $12.5 billion in improper payments. Approximately 25 percent of these payments were for inpatient prospective payment system (PPS) services. While most hospital providers document and bill correctly, improper claims are still a problem, for reasons ranging from coding errors to lack of complete documentation to support the medical necessity for the services provided.

Based on the OIG report, the Health Care Financing Administration (HCFA) initiated a broad-based effort to protect the Medicare trust fund. This effort-the Payment Error Prevention Program-is a national effort to reduce the overall payment error rate by implementing various quality improvement efforts.

HCFA is responsible for the administration of Medicare, the nation's largest health insurance program. Medicare provides coverage for more than 39 million Americans, primarily people who are 65 years of age or older, people with disabilities, and people who have permanent kidney failure.

Medicare has contracted with Peer Review Organizations (PROs) in each state to facilitate PEPP initiatives with acute care hospitals. The Iowa Foundation for Medical Care (IFMC) is the PRO for Iowa, Nebraska, and Illinois and is working with more than 350 acute care hospitals in its three-state region to reduce payment errors. Those hospitals designated as critical access are not required to participate in PEPP activities.

The scope of the Medicare program in these states is vast. There are more than 475,000 Medicare beneficiaries in Iowa, more than 250,000 beneficiaries in Nebraska, and more than 1.6 million beneficiaries in Illinois.

In recent years, PROs nationwide have developed collaborative relationships with hospitals and physicians to promote and expand clinical quality improvement activities. Healthcare quality improvement will continue to be the PROs' main activity, but now HCFA has also directed them to increase their focus on protecting the integrity of the Medicare program by ensuring that hospital inpatient claims are appropriately documented and billed. To accomplish this, HCFA has charged PROs nationwide with coordinating and assisting hospitals, providers, medical staff, compliance officers, state associations, and professional organizations with the implementation of PEPP.

On the Lookout for Errors

The primary goal of the PEPP program is to reduce the overall payment error rate on a statewide basis. PEPP is designed to be an educational rather than punitive program.

Nationwide implementation of PEPP occurred in three different phases. The first group of states began implementing the program in August 1999, the second group began implementation in November 1999, and the third group began implementation in February 2000.

The PEPP initiative has three components:

- to establish a baseline payment error rate in each state
- to collect data through the PRO processes and analyze it
- to implement quality improvement interventions as needed

To establish baseline payment error rates in each state, HCFA contracted with two independent review firms to perform data collection. The two review entities are called clinical data abstraction centers (CDACs). The CDACs performed data collection on approximately 1,100 randomly selected medical records per state.

Cases identified as having potential payment errors by the CDAC are sent to the PRO for confirmation. These cases are subject to the standard PRO case review process. If the PRO confirms a payment error, it forwards the error to a fiscal intermediary who makes the appropriate adjustment. These adjustments will correct both overpayments and underpayments made to hospitals by Medicare.

To identify potential problem areas that occur at the local level, PROs also analyze their own state-specific discharge data. Essentially, HCFA wants each PRO to have the autonomy and ability to determine what the problems are in its state or jurisdiction. For example, HCFA has observed some variance with respect to diagnosis-related group (DRG) use in different states. But a DRG code that might be identified as an area of focus in one state will not necessarily be a focus in other states.

Data Is the Cornerstone

According to Vicki Brandt, IFMC's PEPP director, the implementation effort has been grounded in a collaborative approach. This begins with the assumption that the majority of billing errors are unintentional and can be corrected through education and process improvement. "We have found quality improvement principles are key to helping hospital providers reduce payment errors," Brandt says. "Our role is to assist hospitals in identifying areas of potential improvement and then to provide the education and tools to help them in those efforts."

Data has been the cornerstone for all of IFMC's inpatient clinical topics targeted for quality improvement, and Brandt says that PEPP has also followed this approach. "Although HCFA has contracted with the CDACs to establish statewide baselines, we knew that additional data would need to be collected more expediently to develop the tools necessary to get the process started," Brandt says.

To quickly identify potential areas of improvement, IFMC conducted data collection on a statewide random sample of all Medicare discharges that occurred between July 1, 1998, and June 30, 1999, for Iowa and Nebraska. Discharges that occurred from January 1, 1999, to June 30, 1999, were selected from Illinois. From this data abstraction, IFMC established a baseline for payment errors related to admission necessity and DRG assignment that could have resulted in either overpayments or underpayments.

The diagnoses evaluated during this collection process were:

- congestive heart failure
- chronic obstructive pulmonary disease
- pneumonia
- gastroenteritis/esophagitis
- miscellaneous digestive disorders

Data collection on a second random sample was performed on all cases with the same diagnoses that were billed as one-day hospitalizations.

The next steps, Brandt says, were to provide all acute care hospitals in Iowa, Nebraska, and Illinois with the aggregate baseline data and to develop intervention tools to assist hospital utilization review and coding personnel.

"Although hospitals are not required to use our tools, all acute care hospitals who bill Medicare are expected to initiate some type of intervention to address payment errors related to medical necessity of admissions and DRG assignments," Brandt says. "Our tools are designed to assist hospitals to start looking at potential system changes to reduce payment errors."

IFMC modeled its PEPP approach after its other inpatient clinically focused quality improvement efforts. The organization has found that partnering with physicians, other providers, and healthcare professionals is an effective way to help implement system changes. It's also helped to improve quality in areas such as acute myocardial infarction, heart failure, TIA/ischemic stroke/atrial fibrillation, pneumonia (including influenza and pneumococcal immunizations), breast cancer, and diabetes.

Giving Providers Momentum

Studies have shown that system changes are the most effective method for improving quality. Along those lines, IFMC has learned that providing hospitals with quality improvement tools such as proposed standing orders, checklists, care pathways, reminder systems, physician pocket cards, utilization review checklists, coding checklists, and other educational materials are helpful when making such changes.

Brandt believes that these tools are beneficial in many ways. "Hospital staff are extremely busy," she says. "Although many providers are interested in quality improvement, it is very difficult for them to find the time to initiate quality improvement projects. We have found that providing them with materials gives them a place to start and some momentum."

Accordingly, IFMC also developed disease-specific utilization review (UR) tools to assist hospital nursing personnel in screening cases for medical necessity. Cases failing the screening criteria are sent to their UR physician reviewer for determination of medical necessity for acute hospitalization.

"Several hospitals have implemented our tools, and others have modified the tools to be more specific to their internal structure," Brandt says. In addition to using the tools, several hospitals are enhancing their peer review process to ensure consistency and monitor the validity of review decisions.

In Search of the Innovative Idea

Data is the key to many of IFMC's efforts. As the PRO for three states, Brandt says IFMC has the advantage of collecting large volumes of data for comparison purposes. "We are collecting a significant amount of data for the three states," Brandt says. "This will allow us to perform comparative analysis of the various interventions used in a three-state region and potentially identify the most efficient and effective process improvement methods." (Further information will be available when HCFA releases its compendium of comparative national baseline data, collected from each state. This collection is expected sometime this year.)

An essential component of IFMC's PEPP program is the on-site visit. IFMC provider liaisons provide support to hospitals through periodic visits to assess their progress in meeting the PEPP objectives, discuss intervention implementation ideas, and identify methods of performing facility-specific data collection and pattern analysis. These visits involve healthcare quality improvement project directors, PEPP directors, administrators, coding personnel, and HIM personnel.

Brandt says the visits have proven to be helpful for several reasons. "They allow us to work closely with the hospitals to assess current systems-what is working well and what doesn't work well," she says. "It also creates a climate of trust and collaboration. While on site, we assist hospital personnel in reviewing their process improvement plans and intervention strategies and discuss innovative ideas to address common barriers."

Communication, Education Are Key

While some PEPP efforts involve specific attention to areas such as UR and coding (see "UR, Coding in the Spotlight"), Brandt says that communication and education are key throughout the program. "We have found that quality improvement involves a multidisciplinary approach to ensure action and success," Brandt says. "Educating the staff about why certain steps

need to be followed helps encourage change. Change can be challenging for all of us, but if we understand why we need to do things differently, it is much easier to adjust."

The goal? When PEPP next measures payment error rates, Brandt expects to see improved payment rates and better data. "We anticipate that all facilities that implement interventions for PEPP will show significant improvement when a statewide remeasurement is conducted using data collected from medical records," she says. If improvement is not noted at remeasurement, IFMC will consider performing case review for problem topics, Brandt says.

It's all in the name of a better healthcare system, Brandt believes. She says that IFMC, like other PEPP participants, is committed to working together with hospitals using educational principles to meet its goals. "We believe a collaborative approach will help increase payment accuracy and help HCFA realize its goal of protecting the Medicare trust fund," she says. "We have found that hospitals want to reduce payment errors and appreciate the education and tools we are providing."

UR, Coding in the Spotlight

The PEPP program works to improve the quality of care through special attention to utilization review (UR) and coding quality.

Vicki Brandt says that IFMC is working with hospitals to compare their written UR plans to the Medicare Hospital Manual, found in the Code of Federal Regulations, Part 482, Section 482.30. Medicare requires that hospitals maintain an effective UR process to ensure the medical necessity of inpatient services and promote the most efficient use of available health services.

One condition of the regulations requires that hospitals have a UR committee and that at least two members of the committee are physicians. In addition, the physician committee members are prohibited from reviewing cases in which they were involved. In other words, if a physician on the UR committee took care of a patient whose case is undergoing review, that physician cannot be involved in the review.

In addition to evaluating UR plans, IFMC is asking hospitals to focus on their process for issuing a Hospital-issued Notice of Non-coverage (HINN). Provisions in the Medicare Hospital Manual allow a hospital to issue a notice to patients who have Medicare coverage if the hospital determines that the admission is not medically necessary. Hospital staff are encouraged to review the manual for specific instructions about processing HINNs.

In addition to the UR component of PEPP, IFMC is also working with coding personnel to improve coding accuracy. These efforts aim to ensure that complete and appropriate documentation exists in the record to support the DRG assignment. IFMC developed disease-specific DRG coding tools to assist hospitals with this effort, Brandt says. (Samples of the DRG coding tools have been sent to all state PROs and are available upon request from IFMC.)

The DRG coding tool prompts hospital personnel to consistently seek clarification when physician documentation is vague. During the collection of the baseline data, IFMC identified situations where coding was performed on incomplete medical records. For example, diagnostic documentation to support diagnoses such as pneumonia and heart failure was not always present in the medical record.

The DRG coding tool also provides guidance in coding co-morbid conditions. Conditions that have no bearing on the hospital stay should not be coded.

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