What Happened to PEPP?: QIOs Plan for Hospital Payment Monitoring Program

by Renato Estrella, MS, RHIA

Efforts to boost the quality of care provided to Medicare patients aren't new, but CMS' latest plan will require additional efforts from hospitals. Learn more about the Hospital Payment Monitoring Program and how Quality Improvement Organizations are here to help.

Wondering what happened to PEPP, the 6th Scope of Work Payment Error Prevention Program? It's become the 7th Scope of Work (SOW), which encompasses the Medicare Beneficiary Protection Program/Hospital Payment Monitoring Program (HPMP). In the meantime, Peer Review Organizations (PROs) have become Quality Improvement Organization (QIOs), a name more applicable to their efforts to monitor and improve the quality of care delivered to Medicare beneficiaries.[1] In this article, we'll take a closer look at the mandates of the 7th SOW and how hospitals can prepare for HPMP.

CMS' Task List

The 7th SOW is based on Title XI of the Social Security Act, Part B, as amended by the Peer Review Improvement Act of 1982. Start dates for the 7th SOW, a three-year contract cycle with the Centers for Medicare & Medicaid Services (CMS), vary from August 2003 to February 2003, according to state groups. PEPP's evolution to HPMP is similar to the changes that occurred in the Healthcare Quality Improvement Program (HCQIP); that is, a move from state-specific to nationally focused issues.[2]

The 7th SOW provides many opportunities to further QIO work in ensuring quality of care to Medicare beneficiaries.[3] In this contract cycle, QIOs are expanding work into alternate care settings, taking on the task of educating the public about quality data, and collaborating with their colleagues.

QIOs Pinpoint Local Issues

Under the 6th SOW, the QIOs were mandated by CMS to reduce the occurrence of payment errors for inpatient prospective payment services (PPS) provided to Medicare beneficiaries (see "Changes in Scope of Work Structure," below). QIOs in each state were given the ability and autonomy to determine the types of payment errors that were significant to each state and were charged to reduce statewide payment error rates by reducing coding errors and decreasing unnecessary admissions.

A payment error results when the medical record does not support the necessity of a service, when the service should have taken place in a setting other than an acute care facility/hospital, or when the assignment of ICD-9-CM codes is not supported by medical record documentation resulting in incorrect DRG assignment. PEPP collaborates with hospitals to improve hospital structure and processes and to provide education.

As part of the new SOW, HPMP involves review and abstraction of hospital medical records. The program will use the First Look Analysis Tool for Hospital Outlier Monitoring (FATHOM), a modeling tool that allows QIOs to compare hospitals at risk for payment issues and permits the querying of hospital claims data to identify hospitals that are potential outliers due to length of stay, DRG ratios, or other factors. QIOs will use FATHOM data to look for patterns in focus areas, identify most significant outliers in the current year and patterns over time, compare case review findings, and perform case review/abstraction.

QIOs will continue to monitor state hospital admission and coding patterns by conducting profiling and trend monitoring/target identification activities. CMS may also delegate projects designed to reduce payment error in specific areas to individual QIOs.

However, individual payment error improvement projects will not be initiated without CMS approval. QIOs may be asked to participate in national projects based on CMS claims data analysis of target areas. For approved projects, the QIO will be required to monitor the effects of its interventions, determine whether the interventions had the desired effects, and respond appropriately.

CMS encourages QIOs to continue working with hospitals on their payment monitoring activities, such as internal auditing and monitoring. Hospitals should continue to monitor areas that historically have been identified by CMS and OIG as at risk for payment errors, including:

- DRG 416: Septicemia
- DRG 079: Respiratory Infections and Inflammations
- DRG 475: Respiratory System Diagnosis with Ventilator Support
- DRG 296: Nutritional and Miscellaneous Metabolic Disorders
- DRG 174/182: GI Hemorrhage with CC/Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders
- DRG 14/15: Intracranial Hemorrhage and Stroke with Infarction/Nonspecific Cerebrovascular and Precerebral Occlusion without Infarction
- One-day Stays
- Same-day Readmissions
- Discharges with patient status code as left “Against Medical Advice”

Keep in mind that it’s critical that hospitals focus on all areas, not just those areas identified above by OIG or CMS. Hospitals should also identify payment errors beyond those DRGs and those with admission necessity questions as part of their ongoing compliance activities and data quality responsibilities.

CART Can Help

One resource available to help hospitals in the 7th SOW is the CMS Abstraction and Reporting Tool (CART), a free application for the collection and analysis of quality improvement data. All QIOs throughout the country are required by CMS to support and promote the use of CART, which was designed by CMS with assistance from the Joint Commission and QIOs. Hospitals and other organizations should use CART to collect, analyze, and report data on CMS national quality indicators for the 7th SOW on the following clinical areas:

- acute myocardial infarction
- heart failure
- pneumonia
- surgical infection prevention

Using CART, hospitals can submit their inpatient care data to the QIO clinical warehouse through QualityNet Exchange (www.qnetexchange.org). CART enables a hospital to analyze its data internally and assess progress in quality improvement by comparing its data with internal baselines and state, regional, and national benchmarks and results.

The data obtained using CART are valuable for assessing the progress of the existing systems and assisting hospitals in identifying areas requiring system changes and selecting the most appropriate changes to the system. Through data collection, CART can assist hospitals in performing real-time reporting and obtaining up-to-date snapshots and retrospective analyses that are critical to the success of managing, analyzing, and evaluating quality improvement efforts.6

How Can Hospitals Prepare for HPMP?

There are several steps hospitals can take to plan for HPMP:

Capitalize on the Lessons Learned from PEPP

1. Link HPMP with compliance:

    - Create communication strategies for sharing and disseminating information such as educational programs, newsletters, committee meetings, and administrative memos

- Develop a formalized tracking system to monitor the sharing of HPMP/compliance material with all staff
- Schedule face-to-face meetings about HPMP issues to foster interaction among key staff members
- Strengthen and cultivate the compliance department and case management staff by integrating HPMP ongoing process improvement activities

2. Strengthen case management/utilization processes:

- Implement or energize a concurrent documentation improvement team to improve physician documentation and accurate assignment of ICD-9-CM codes
- Continue to foster a partnership between physicians/ case management staff and coding specialists
- Begin or strengthen the integration of utilization review and case management processes to meet patient needs from admission to post discharge
- Identify internal issues that contribute to payer denials
- Analyze instances of increased length of stay and lack of medical necessity for inpatient admission
- Prepare and distribute reports on physicians' specific denial rate data
- Make daily rounds using multidisciplinary teams
- Evaluate and refine data collection and analysis of data to identify trends and patterns and share severity of illness and acuity data with physicians, administration, and staff

3. Obtain executive support:

- Assess organizational philosophy on quality improvement initiatives; a high-level organizational commitment to the process is a necessity
- Evaluate the support and understanding of administration concerning the importance of proper documentation to patient and billing and the penalties for failure to comply

4. Step up monitoring and auditing programs:

- Incorporate HPMP information, project results, tools, and educational programs into ongoing internal auditing and monitoring and modify them based on your facility's needs, structure, and staff
- Monitor hospital billing patterns on a regular basis and use MEDPAR data to monitor the percentage of DRG pairs
- Compare hospital data using national, state, and peer group averages and take necessary actions
- Analyze your own facility data; through abstracting data, facilities can identify areas of potential risks that may require closer attention
- Examine the facility's case mix and monitor DRGs that are high in volume and reimbursement; look for variations over time and the causes of those variations
- Review all cases; do not limit reviews to only those identified as high risk by OIG and CMS. Other cases may identify payment issues of equal importance in reducing errors
- Create and implement an ongoing internal quality control program to monitor the accuracy of code assignments and the completeness of documentation
- Create a corrective action plan to improve deficiencies in documentation and coding. Include a methodology for measuring the plan, then show documented evidence that the improvement has been achieved or progress made. Determine the process or measurement you can use to ensure sustained improvement
- Summarize your payment monitoring activity findings and present them to the executive officers/CEO, medical director, HIM director, UR/QI/PI staff, compliance officer, and other appropriate parties

Provide Education and Training

1. Use education to reach physicians:

- Educate physicians and staff to prevent future errors, unnecessary admissions, and inappropriate DRGs resulting from code assignment errors
- Evaluate physician documentation and work with physicians to improve documentation, which will affect reimbursement and patient care

- Educate faculty and resident physicians on CMS documentation and coding guidelines and their relationship to coding and reimbursement
- Create a partnership between physicians, case managers, and HIM professionals so physicians see themselves as citizens of a larger community working together to reduce payment errors and improve patient care data management
- Create a process that mandates complete and timely documentation of medical records to support accurate assignment of diagnosis and procedure codes

2. Focus on coding staff education:

- Conduct initial training and continuing education sessions with coding staff at orientation on the application of coding guidelines; training should be provided on ICD-9-CM, CPT, and HCPCS coding and DRG updates annually or more often as indicated by coding accuracy assessments
- Educate all coding staff on appropriate medical record documentation and coding policies and procedures to support the accuracy of coding assignment; determine steps to take when documentation is unclear or incomplete
- Evaluate and refine the communication process between coders and physicians for answering documentation questions; avoid leading questions in physician queries
- Purchase new coding resources when needed to optimize knowledge and application of regulatory requirements, reporting instructions, and coding guidelines; coding managers should ensure that all staff are using coding resources and applying coding guidelines consistently

The change from PEPP to HPMP and PROs to QIOs is a clear message that continuous quality improvement using data management tools and process evaluation is here to stay. Stay in touch with your QIO for more details about benchmarking with CART and additional quality improvement programs underway as a part of these new initiatives.

The 7th SOW's Task List

The 7th SOW has three goals:[4]

- Improve the quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of healthcare
- Protect the integrity of the Medicare Trust Fund by ensuring Medicare only pays for services and items that are reasonable, medically necessary, and provided in the most appropriate setting
- Protect beneficiaries by expeditiously addressing individual cases such as beneficiary complaints, hospital-issued notices of non-coverage (HINNs), Emergency Medical Treatment and Active Labor Act (EMTALA) violations, and other statutory responsibilities

Specific tasks that will be undertaken by QIOs for the 7th SOW are:[5]

Task 1: Improving the beneficiary safety and health through clinical quality improvement:

A. Nursing home quality improvement
B. Home health quality improvement
C. Hospital quality improvement
D. Physician office quality improvement
E. Underserved and rural beneficiaries quality improvement
F. Medicare + Choice quality improvement

Task 2: Improving beneficiary safety and health through information and communications:

A. Promoting the use of performance data
B. Transitioning into hospital-generated data
C. Other mandated communication activities

Task 3: Improving Medicare beneficiary protection program:

A. Beneficiary complaint response program
B. HPMP
C. All other beneficiary protection activities:

- Hospital-issued Notices of Noncoverage (HINNs)
- Notice of Discharge and Medicare Appeal Rights Review (NODMAR)
- Emergency Medical Treatment and Active Labor Act (EMTALA)

Task 4: Improving beneficiary safety and health through developmental activities (Special Studies)

Changes in Scope of Work Structure

6th Scope of Work	7th Scope of Work
Quality improvement partnerships to develop and share best practices with providers and practitioner	Clinical quality improvement program
Health Care Quality Improvement Program (HCQIP)	Clinical information and communications
PEPP	Medicare beneficiary protection program; beneficiary complaint program; and HPMP
Mandatory reviews	Other beneficiary protection activities
Individual PEPP projects	Special studies on best practices and reproducible criteria for admission for high-variability conditions

Notes

1. For more information about QIO programs or to find the organization assigned to your state, go to the Medicare Quality Improvement Committee at www.medqic.org.

2. Will, Theodore O. "An Introduction to the 7th SOW Hospital Payment Monitoring Program." IPRO Hospital Payment Monitoring Program Administrative Memo (December 12, 2002). Available online at http://projects.ipro.org/index/admin_memos_hpmp_2002/id.119.

3. Will, Theodore O. "Medicare 7th Scope of Work-Overview." IPRO Hospital Payment Monitoring Program Administrative Memos (November 1, 2002). Available online at http://projects.ipro.org/index/admin_memos_ hpmp_2002/id.119.

4. Quality Improvement Organizations Statement of Work. Available online at http://cms.hhs.gov/qio/2.asp.

5. Ibid., Section C.

6. "What is CART?" Available at QualityNet Exchange, www.qnetexchange.org.

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