

# MEDICARE COMPLIANCE

## PEPPER Compliance Tool Is Revised for Two-Midnight Rule in Time for June Release

In early June, hospitals will receive a revamped version of the Program for Evaluating Payment Patterns Electronic Report (PEPPER) that takes into account Medicare's two-midnight rule for inpatient admissions.

"PEPPER has been updated to give hospitals statistics so they can assess their length of stay given the two-midnight rule," says Kim Hrehor, project director for TMF Health Quality Institute, which generates PEPPERS for CMS. The two-midnight rule, adopted in the 2014 inpatient prospective payment system regulation, generally presumes that hospital stays crossing two midnights are properly billed as inpatient, while shorter stays are probably not, with a few exceptions, unless patients are admitted for inpatient-only procedures (*RMC 5/5/14, p. 1*).

The PEPPERS are free comparative electronic reports on billing rates in certain risk areas. They are provided quarterly by CMS to all short-term acute-care hospitals and annually to other types of facilities, such as critical access hospitals. The purpose of PEPPERS is to help hospitals point their compliance monitoring in more productive directions — toward outliers, which could mean overpayments and underpayments depending on the reason billing is outside the norm (*RMC 2/6/12, p. 1*).

The new PEPPER is somewhat of a different animal because of the two-midnight rule. "We wiped out all the [DRG-specific] target areas" for short-stay admissions, such as two-day stays for heart and renal failure, "and replaced them with six new target areas," Hrehor tells *RMC*. The other target areas, which address MS-DRG coding, unnecessary admissions and readmissions, are unchanged.

### PEPPER Is Revised for IPPS

The six new target areas are:

- ◆ Two-day stays for medical DRGs
- ◆ Two-day stays for surgical DRGs
- ◆ One-day stays for medical DRGs
- ◆ One-day stays for surgical DRGs
- ◆ Same-day stays for medical DRGs
- ◆ Same-day stays for surgical DRGs

Hrehor says each hospital will receive a PEPPER listing the total number of discharges in each of these six target areas that is not focused on individual MS-DRGs. The reports, as always, are hospital specific. They will show how each hospital compares to other hospitals in the nation and in their state and Medicare administrative contractor (MAC) jurisdiction.

An outlier hospital is at or above the 80th national percentile, which means it bills Medicare more often for that target area than 80% of all hospitals. PEPPERS make no value judgments; it's up to the hospital to review medical records and determine whether outliers indicate the hospital has a compliance problem or there's a reasonable explanation for the billing rate, Hrehor notes.

In terms of the two-midnight rule, Hrehor says that TMF separated short stays for medical and surgical DRGs because procedures on the inpatient-only list automatically qualify for Medicare reimbursement under Part A as long as the procedures themselves are medically necessary. Also, the two-midnight stay statistics may help hospitals evaluate the potential for gaming — delayed discharges to qualify for Part A payment — while same-day and one-day stays are at risk of routine claims denial by Medicare auditors. The PEPPER data on two-day stays don't reflect time spent in outpatient settings, even though Medicare auditors will take that into account under the two-midnight "benchmark," Hrehor says.

"The PEPPER is now looking at short stays from a higher level," she says. "What are hospital trends for two-day stays and for one-day and same-day stays and how are they changing over time? What are the DRGs the hospital is coding for the same-day and one-day stays?" Then hospitals can generate their own statistics and identify common factors driving potential errors, such as admitting physicians and the use of observation for same-day and one-day stays.

Hospitals may get a hand from the supplemental reports provided by TMF Health Quality Institute. Every hospital will get a list of its top medical and surgical DRGs for same- and one-day stays for the previous four quarters. Hospitals can use these data to identify danger zones in their medical necessity compliance.

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Ralph Wuebker, M.D., chief medical officer for Executive Health Resources in Newtown Square, Pa., says, “it’s great they are updating the PEPPER for the two-midnight rule,” but he notes there could be inconsistencies between how the PEPPER and hospitals collect and track the data. Hospitals should calculate length of stay as a date difference — admission date to discharge date — and then align it with the PEPPER’s one/two midnight metric. PEPPER also has limitations because it does not identify two-midnight stays where the first day was in observation or the emergency room, even though these cases could meet the two-midnight benchmark.

Still, the data could point hospitals in the direction of noncompliance, Wuebker says. If hospitals have a disproportionately high number of zero/one-midnight inpatient cases for surgical DRGs compared to their peers, they should check whether they are on the inpatient-only list. If not, “do a close review of documentation as these are likely to be a primary audit target,” he says.

Observation metrics also could identify overpayments and/or underpayments. Hospitals may feel like they are flying blind because the two-midnight rule is too new for industry-wide benchmarks, but they can start by monitoring their own data. Put overpayments in one group, which include one-midnight inpatient stays that aren’t exceptions (e.g., transfers, death) and therefore could be denied, Wuebker says. In the other group, put observation stays that cross two midnights but were not billed to Medicare Part A. Patients could get stuck in this limbo because the utilization review team didn’t review the case concurrently; the physician thought the patient would be in the hospital for only one midnight but something changed; there’s a delay in administering a test or procedure; or the patient is staying for convenience (e.g., the hospital can’t locate a family member), Wuebker says.

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