TMF Health Quality Institute

Q&A Session for Inpatient Psychiatric Facility PEPPER Training

Wednesday, June 29, 2011

Q: How do we get a copy of this presentation?

A: A PDF of the PowerPoint slides for the IPF PEPPER training session is available on PEPPERresources.org at:
http://www.pepperresources.org/TrainingResources/InpatientPsychiatricFacilities.aspx

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Q: Where can I access the IPF PEPPER User's Guide?

A: The IPF PEPPER User's Guide is available on PEPPERresources.org in the Inpatient Psychiatric Facilities section at:
http://www.pepperresources.org/LinkClick.aspx?fileticket=LDshIg9kJcU%3d&tabid=95

Q: When was the first IPF PEPPER distributed?

A: The first IPF PEPPER (version Q1FY11) was distributed via FedEx on June 22, 2011. The FedEx envelopes were addressed to the CEO, or for IPF units of hospitals, to the CEO: IPF Unit.

Q: How often will the IPF PEPPER be distributed? How would I know when it is distributed and to look for it?

A: The IPF PEPPER will be distributed annually. At this time, the future distribution schedule has not yet been set. TMF Health Quality Institute will send notices through a listserv to alert IPFs of future PEPPER distribution and training opportunities. Join the email list at PEPPERresources.org and click on the gray "Join our email list…" button. TMF will also coordinate with The Centers for Medicare & Medicaid Services (CMS) to share information with the provider community.

Q: Why is the PEPPER being reported annually rather than quarterly?

A: The IPF PEPPER contains the most recent 12 federal fiscal quarters of data, which are aggregated in three 12-month time periods. By aggregating the data into larger time periods, more IPFs will have at least 11 discharges in a time period and will therefore have reportable data (due to CMS data restrictions, we are unable to display statistics with a numerator or denominator less than 11).

PEPPER

Q: How can we determine to whom our IPF's PEPPER was sent on June 22? Can we request another copy of the report if we cannot locate it?

A: If you are unable to locate your IPF's PEPPER, you may submit a request for assistance through the Help Desk at PEPPERresources.org. We will be able to tell you who signed for the package and provide the FedEx tracking number. If you are unable to locate your PEPPER, we may be able to provide another copy.

Q: Acute Care PEPPERs are sent via secure QNET transmission. Why was this IPF PEPPER not sent that way?

A: Currently, My QualityNet accounts are only available to short-term and critical access hospitals. IPFs are not able to obtain My QualityNet accounts. Therefore, the IPF PEPPERs were distributed to IPFs in hard copy format via FedEx.

Q: We received our report as a PDF file and do not have it as Excel. How do we get this report for our hospital?

A: The IPF PEPPERs were distributed as a hard copy report via FedEx. They were not distributed as a PDF. It may be possible that someone within your facility scanned the document and sent it to you as a PDF.

Q: Can I get detailed patient information pertaining to the reported PEPPER statistics? The QIO used to be able to provide that for the short-term acute care hospital PEPPERs.

A: TMF is not able to provide detailed case listings of claims included in the numerator or denominator of PEPPER target area reports. IPFs should be able to generate these listings by following these steps:

1. Make sure you are using the claims inclusion criteria as found on page 4 of the IPF PEPPER User's Guide to make sure you are including the correct claims in your listing.
2. Refer to the "Definitions" page in your PEPPER or in the IPF User's Guide to make sure you are correctly identifying the numerator and denominator claims for the target area you are interested in.
3. Make sure you assess the claims by discharge date for the same time period as PEPPER.
4. Note that, due to late or corrected claims being filed, it is possible that there may be slight differences in the PEPPER statistics versus the counts you obtain. Remember the PEPPER statistics were downloaded approximately two months prior to report generation.

Please note that QIOs are no longer involved in the development, distribution or support of PEPPERs.

Q: Is IPF PEPPER applicable to a large psychiatric facility that is a department of a Med/Surg Hospital?

A: IPF PEPPER is applicable to all types of IPFs, whether distinct part units or free-standing. The comparison groups for nation, jurisdiction and state include all IPFs (free-standing and distinct part units). If you are interested in obtaining comparative national-level statistics for either free-standing IPFs or for IPF distinct part units, visit the "Data" section of PEPPERresources.org.

Q: Our psych unit is Medicare-exempt (i.e., not DRG). How does the PEPPER relate to a non-DRG payment system?

A: The IPF PEPPER only includes Medicare claims data statistics (see page 4 of the IPF PEPPER User's Guide for claims inclusion specifications). IPFs are reimbursed from Medicare through the IPF prospective payment system (PPS). For more on the IPF PPS, please see the following links:

http://www.cms.gov/InpatientPsychFacilPPS/01_overview.asp#TopOfPage

http://www.cms.gov/transmittals/downloads/R2220CP.pdf

Q: Does this include Medicare HMOs?

A: Medicare HMO claims are not included in IPF PEPPER. See page 4 of the IPF PEPPER User's Guide for claims inclusion specifications.

Q: Will there be any Medicare Audits by CMS contractors and recoupment down the road?

A: TMF is not aware of any audits; however, as efforts to recoup improper Medicare payments expand, they may begin focusing on IPFs at some point in the future.

Q: Can we obtain a listing of other IPFs within the MAC area to whom we are being compared?

A: TMF is not able to provide listings of IPFs within the MAC/FI jurisdiction; however, you may access a report identifying the number of IPFs in each jurisdiction by state and in total at PEPPERresources.org in the Inpatient Psychiatric Facility Training & Resources section.

Q: For the Compare Target Report, what time period is the Q1 FY 2011?

A: The Compare target report includes the most recent four federal fiscal quarters ending quarter 1, fiscal year 2011. This translates into statistics for discharges from January 1, 2010, through December 31, 2010. Note that the federal fiscal year begins October 1.

Q: When will the separate free-standing and distinct part unit reports be distributed?

A: There will not be separate free-standing and distinct part unit reports distributed; however, TMF has developed national-level reports that aggregate statistics for free-standing IPFs and for distinct part units. These are available on the "Data" page of PEPPERresources.org.

Q: Is PEPPER data available for IPF facilities which are not distinct part units?

A: IPF PEPPER is available for all IPFs (free-standing and distinct part units) that have at least 11 Medicare discharges in any time period for any target area.

Q: So what is the goal? Are we trying to be in the 20th percentile, 80th percentile or in the middle?

A: Keeping in mind that there will always be 20 percent of facilities at or above the 80th percentile, and there will always be 20 percent of facilities at or below the 20th percentile, the goal is for IPFs to take necessary steps to ensure that the patients they admit require an inpatient level of care, that the documentation within the medical record is complete and supports the inpatient admission and that diagnoses and procedures are clearly documented and correctly coded. The goal is for IPFs to receive accurate reimbursement for care that is necessary and provided in the correct setting/level of care.

Q: Can we get information on "best practice" IPFs to have a reference facility to network with?

A: At this point TMF does not have any contacts for "best practice" IPFs. If you are part of a multi-hospital network, you may be able to coordinate and work toward that goal. Another option would be to work with a state association to see if there are IPFs that would be interested in collaborating in this manner.

Q: The data in my report for "State %tile" appears unusual compared to the other comparison groups. You mentioned something about an FI transition to MAC jurisdictions and this could affect the state comparison group. Could this be reflected in this data element and could it look differently in a future report?

A: The state percentiles in PEPPER may look very different from the national and jurisdiction percentiles, especially if there are a small number of hospitals in the state comparison group. This is why we encourage hospitals to give a higher priority to national and jurisdiction percentiles. State percentiles will be calculated if there are at least 11 hospitals with reportable data in the state within the MAC/FI jurisdiction. As hospitals transition from the Part A legacy contractors/fiscal intermediaries to the Medicare Administrative Contractors, the state (and jurisdiction) comparison groups may change and thus the state (and jurisdiction) percentiles may change over time.

Q: Where can we get a list of comorbidities?

A: The IPF PEPPER User's Guide includes a listing in Appendix 1 of the included comorbidity categories and the respective codes contained within each. A complete listing of comorbidity categories can be accessed here:

http://www.cms.gov/InpatientPsychFacilPPS/Downloads/ipf_comorbidity_cat.pdf

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Q: Is there a list of top reported medical comorbidities?

A: TMF assessed the total count of claims for hospitals with reportable data for fiscal year 2009.

Comorbidity Category	Count
Infectious Disease	16,997
Renal Failure, Chronic	13,778
Developmental Disabilities	13,429
Drug and/or Alcohol Induced Mental Disorders	11,950
Uncontrolled Diabetes-Mellitus	5,519
Renal Failure, Acute	3,839
Eating and Conduct Disorders	2,987
Poisoning	2,334
Chronic Obstructive Pulmonary Disease	2,171
Severe Musculoskeletal and Connective Tissue Diseases	1,866
Artificial Openings - Digestive and Urinary	1,489
Severe Protein Calorie Malnutrition	896
Coagulation Factor Deficits	262
Tracheostomy	178
Cardiac Conditions	93
Gangrene	87
	77,875

Q: Do the PEPPERs include both stand-alone and hospital based IPFs? Would hospital-based units tend to have a higher comorbidity rate?

A: The IPF PEPPER comparison groups for nation, jurisdiction and state include all IPFs (free-standing and distinct part units). At a national level for the four quarters ending Q1FY11, IPF distinct part units have 17.7 percent of claims with at least one comorbidity, as compared to 15.8 percent for free-standing IPFs. To obtain comparative national-level statistics for either free-standing IPFs or for IPF distinct part units, visit the "Data" page of PEPPERresources.org.

Q: Are comorbid conditions on the target area qualifying comorbid conditions only or all comorbid conditions?

A: The comorbid conditions included in the "Comorbidities" target area are those listed in Appendix 1 of the IPF PEPPER User's Guide.

Q: Why are we not comparing similar data with regard to age, specialty and other demographics, especially when referring to comorbidities?

A: PEPPER is intended to assist with the identification of claims that may be at risk for improper Medicare payments, and therefore includes those Medicare claims that meet the claims inclusion criteria. Outlier status is based on comparison to all IPFs in the nation. While it is not intended to be used as a means for peer-grouping, TMF does recognize that there may be differences in patient populations and treatment patterns between free-standing and distinct part unit IPFs; therefore, we have provided comparative national-level statistics for free-standing IPFs and for IPF distinct part units, which are available on the "Data" page of PEPPERresources.org.

Q: If we are keeping our own stats on our own number of comorbidities and they differ from PEPPER, how do we challenge the difference?

A: If you generate your own statistics to compare to the statistics reflected in your PEPPER and find differences, we encourage you to:

1. Make sure you are using the claims inclusion criteria as found on page 4 of the IPF PEPPER User's Guide to make sure you are including the correct claims in your listing.
2. Refer to the "Definitions" page in your PEPPER or in the IPF User's Guide to make sure you are correctly identifying the numerator and denominator claims for the target area you are interested in (in particular for the comorbidities, take care to exclude from the numerator comorbidity diagnosis codes 1400 through 2399 with a radiation therapy code 92.21 – 92.29 or chemotherapy code 99.25 (see Appendix 1 in the IPF PEPPER User's Guide)).
3. Make sure you assess the claims by discharge date for the same time period as PEPPER.
4. Note that, due to late or corrected claims being filed, it is possible that there may be slight differences in the PEPPER statistics versus the counts you obtain. Remember the PEPPER statistics were downloaded approximately two months prior to report generation.

If, after ensuring all of the above have been followed, you find a difference, please visit the Help Desk at PEPPERresources.org and submit a request for assistance.

Q: If the hospital comorbidities is below the 20th percentile, does this mean it might not be capturing comorbidities?

A: If your hospital is a low outlier (at or below the national 20th percentile) it is possible that you may not be capturing comorbidities. A recommended course of action would be to select a sample of medical records that do not have a comorbidity coded and review the documentation within the medical record. Ensure that the documentation supports any comorbid conditions, and that physicians are aware they should document the patient's complete clinical status, not just findings related to the patient's psychiatric care/condition. Coders should query the physician for a more definitive diagnosis when necessary. In order to be coded, medical conditions must be under active treatment during the patient's admission. In addition, ensure that coders are coding all substantiated diagnoses and procedures.

Q: What effect does 1) charge structure, 2) co-morbidities and 3) length of stay have on outlier payments?

A: Please refer to the Inpatient Psychiatric Facility Prospective Payment System information available on the CMS website for specific information regarding calculation of outlier payments. This fact sheet may be a good starting point: http://www.cms.gov/MLNProducts/downloads/InpatientPsychFac.pdf.

Q: What is an outlier payment?

A: Please refer to the Inpatient Psychiatric Facility Prospective Payment System information available on the CMS website for specific information regarding calculation of outlier payments. This fact sheet may be a good starting point: http://www.cms.gov/MLNProducts/downloads/InpatientPsychFac.pdf.

Q: Is "Outlier Payments," as one of the target areas regarding those facilities, receiving an outlier payment?

A: The "Outlier Payments" target area reflects the percent of all Medicare discharges (meeting the claims inclusion criteria found on page 4 of the IPF PEPPER User's Guide) that have an outlier-approved amount greater than $0 on the claim. IPFs that have 11 or more claims with an outlier payment in a 12-month time period will have statistics included for this target area.

Q: Please elaborate on Readmission criteria difference between calendar 3-5 days and the consecutive days?

A: The difference between calendar days and consecutive days is described in the IPF PEPPER User's Guide pages 5-6 as follows:

When a patient is discharged from an IPF and readmitted to the same or another IPF before midnight of the third consecutive day (second calendar day) following discharge, the readmission is considered to be an interrupted stay and is treated as one discharge for the purposes of payment. If the patient is readmitted

after midnight of the third consecutive day the IPF receives two separate DRG payments. The 3- to 5-day readmissions target area measures the possibility of IPFs postponing readmissions to their facility until the third through fifth calendar days (fourth through sixth consecutive days) following discharge, thereby receiving two DRG payments. The table below provides examples of how consecutive days and calendar days are considered for readmissions (also see the IPF PEPPER User's Guide Glossary, page 12).

Date of discharge:	January 1	January 1	January 1	January 1	January 1	January 1
Date of readmission:	January 1	January 2	January 3	January 4	January 5	January 6
Consecutive day(s):	1	2	3	4	5	6
Calendar day(s):	0	1	2	3	4	5

Q: Some readmission for free-standing IPFs maybe transferred to a medical facility due to a serious medical condition and sent back once the acute condition has been treated. Are these taken into account on the report?

A: The "3- to 5-day Readmissions" target area does not exclude patients transferred to a short-term acute care hospital for treatment of a medical condition. This target area is designed to assess risk for circumvention of CMS' IPF PPS interrupted stay policy.

The "30-day Readmissions" target area excludes patients transferred to another IPF (patient discharge status code 65) from the numerator, but does not exclude patients transferred to a short-term acute care hospital for the treatment of a medical condition.

Q: Can you explain what an interrupted stay is?

A: Please see the following documents on the CMS website for more information on interrupted stays:

http://www.cms.gov/transmittals/downloads/R2083CP.pdf

http://www.cms.gov/MLNMattersArticles/downloads/MM7044.pdf

http://www.cms.gov/MLNProducts/downloads/InpatientPsychFac.pdf

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Q: We do not have a "30-day Readmission" report. Can you tell us why?

A: If there are no hospital statistics reported on any of the target area reports, this is an indication that there were less than 11 claims meeting inclusion criteria for the numerator and/or denominator during all 12-month time periods reported in the IPF PEPPER. Due to CMS data restrictions, we are unable to display statistics with a numerator or denominator less than 11 for any target area and for any time period.