Hospice
Program for Evaluating Payment Patterns Electronic Report

User's Guide

First Edition

Prepared by

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Prepared by TMF Health Quality Institute

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Introduction

The Government Accountability Office has designated Medicare as a program at high risk for fraud, waste and abuse.[1] Medicare spending for hospice care has increased dramatically in recent years.[2] The Medicare Hospice Benefit has been identified as vulnerable to abuse; in 1999 the Office of Inspector General encouraged hospices to develop and implement a compliance program to protect their operations from fraud and abuse.[3] As part of a compliance program, a hospice should conduct regular audits to ensure charges for Medicare services are correctly documented and billed. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) can help guide the hospice's auditing and monitoring activities.

What Is PEPPER?

National hospice claims data were analyzed to identify areas within the hospice benefit which could be at risk for improper Medicare payment. These areas are referred to as "target areas." PEPPER is a data report that contains a single hospice's claims data statistics (obtained from the UB-04 claims submitted to the Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI)) for these target areas. Each hospice receives a PEPPER, which contains statistics for these target areas, regardless of whether the hospice's data are of concern. The report shows how a hospice's data compares to jurisdiction, state and national statistics. Data in PEPPER are presented in tabular form, as well as in graphs that depict the hospice's target area percentages over time. All of the data tables, graphs and reports in PEPPER were designed to assist the hospice in identifying potentially improper payments. PEPPER is developed and distributed by TMF Health Quality Institute, under contract with the Centers for Medicare & Medicaid Services (CMS).

Beginning in 2012, PEPPER is available for hospices and for partial hospitalization programs (PHPs). PEPPERs are also available for short- and long-term acute care inpatient Prospective Payment System (PPS) hospitals, critical access hospitals, inpatient psychiatric facilities and inpatient rehabilitation facilities (the format of the reports and the target areas are customized for each setting). The Hospice PEPPER is the version of PEPPER specifically developed for the hospice setting. The Hospice PEPPER will be distributed in hard copy format via Federal Express, addressed to the Hospice Administrator/Chief Executive Officer.

PEPPER does not identify the presence of improper payments, but it can be used as a guide for auditing and monitoring efforts. A hospice can use PEPPER to compare its claims data over time to identify areas of potential concern and to identify changes in billing practices.

[1] Government Accountability Office. "Medicare Fraud, Waste and Abuse: Challenges and Strategies for Preventing Improper Payments." June 15, 2012. Available at: http://www.gao.gov/new.items/d10844t.pdf.

[2] Medicare Payment Advisory Commission. "Report to the Congress: Medicare Payment Policy" March 2012. Chapter 11, 281-308. Available at: http://www.medpac.gov/chapters/Mar12_Ch11.pdf

[3] Department of Health and Human Services/Office of Inspector General. 1999. "Publication of the OIG Compliance Program, Guidance for Hospices," *Federal Register* 64, no. 192, October 5, 1999, 54031–54049. Available at: http://oig.hhs.gov/authorities/docs/hospicx.pdf

Each hospice receives only its PEPPER; PEPPERs are not available for public release. TMF does not provide PEPPERs to other contractors, although TMF does provide an Access database (the First-look Analysis Tool for Hospital Outlier Monitoring, or FATHOM) to MACs, FIs and Recovery Auditors. FATHOM can be used to produce a PEPPER.

Hospices provide palliative care and support services for terminally ill beneficiaries who have a life expectancy of six months or less if the terminal illness follows its normal course. Beneficiaries must elect the Medicare hospice benefit, and in doing so they agree to forgo Medicare coverage for curative treatment for the terminal illness.

Each Hospice PEPPER contains claims data statistics (obtained from paid hospice Medicare UB-04 claims) for the most recent three cap years (a cap year spans November 1 through October 31). A hospice is compared to other hospices in three comparison groups: state, Medicare Administrative Contractor/Fiscal Intermediary jurisdiction and nation. These comparisons enable a hospice to determine if its results differ from other hospices and if it is at risk for improper Medicare payments.

PEPPER identifies areas at risk for improper Medicare payments based on preset control limits. The upper control limit for all target areas is the national 80th percentile. Coding-focused target areas also have a lower control limit, which is the national 20th percentile. Note that the Hospice PEPPER does not contain any coding-focused target areas; therefore, the Hospice PEPPER draws attention to any findings that are at or above the national 80th percentile.

In order to be included in the Hospice PEPPER, claims must meet the specifications shown below.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Claim facility type equal to “8”	UB-04 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 8 (Special facility or ASC surgery)
Include claim service classification type of “Hospice”	UB-04 FL 04 Type of Bill, third digit (Bill Classification) = 1 (Hospice (non-hospital based)) or 2 (Hospice (hospital based))
Final action claim	A final action claim is a non-rejected claim for which a payment has been made. All disputes and adjustments have been resolved and details clarified.
Services provided during the specified time period; for hospice, the cap year is used as the reporting period	“Claim From” date is on or after the beginning of the reporting period (November 1st), and “Claim Through” date is on or before the end of the reporting period (October 31st).
Medicare claim payment amount greater than zero	The hospice received a payment amount greater than zero on the claim (*Note that Medicare Secondary Payer claims are included*).
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Advantage (Health Maintenance Organization) plan
Exclude cancelled claims	Exclude claims cancelled by the fiscal intermediary or Medicare Administrative Contractor

Hospice PEPPER CMS Target Areas

In general, the target areas are constructed as ratios and expressed as percents, with the numerator representing claims for service that may be identified as problematic, and the denominator representing claims for service of a larger comparison group. The Hospice PEPPER target areas are defined in the table below.

TARGET AREA	TARGET AREA DEFINITION
Live Discharges	*Numerator (N):* count of beneficiaries discharged alive with occurrence code "42" (date of termination of hospice benefit) and with a length of stay (LOS) < 25 days *Denominator (D):* count of all beneficiaries discharged (by death or alive) with a LOS < 25 days excluding discharge patient status code "30" (still a patient)
Long Length of Stay	*N:* count of beneficiaries receiving hospice services whose combined days of service at the hospice during the cap year (November 1 through October 31) is greater than 180 days (obtained by considering all claims billed for a beneficiary during the cap year) *D:* count of all beneficiaries receiving hospice services at the hospice at any point during the cap year (beneficiaries must have at least one claim for service from the hospice)

These PEPPER target areas were approved by CMS because they have been identified as being potentially at risk for improper Medicare payments. For example, hospices that discharge alive a high proportion of beneficiaries from the hospice benefit may be admitting beneficiaries who do not meet the hospice eligibility criteria. This may also be an indication of quality of care concerns. Analysis of national claims data indicates that 25% of beneficiaries discharged alive had a length of stay (LOS) of less than 25 days, which is the basis for the LOS criteria in this target area**. It is recognized that beneficiaries could be discharged alive due to the beneficiary requesting to revoke the hospice benefit, or the beneficiary moving out of the hospice service area.** Future reports will exclude these occurrences from the statistics for this target area.

Similarly, hospices that have a high proportion of beneficiaries with a long length of stay may be admitting beneficiaries who do not meet the hospice eligibility criteria. In addition, in its March 2012 Report to Congress, MedPAC raised concerns regarding longer lengths of stay and higher frequencies of patients being discharged alive in hospices.

How Hospices Can Use PEPPER Data

The Hospice PEPPER provides hospices with their jurisdiction, state and national percentile values for each target area with reportable data for the most recent three hospice cap years (November 1 through October 31) (see Compare Worksheet on page 7). “Reportable data” in PEPPER means there are 11 or more numerator claims for service for a given target area for a given time period. When there are fewer than 11 numerator claims for service for a target area for a time period, statistics are not displayed in PEPPER due to CMS data restrictions.

To calculate percentiles, the target area percents for all hospices with reportable data for each target area and each time period are ordered from highest to lowest. The target area percent below which 80 percent of all hospices' target area percents fall is identified as the 80th percentile. Hospices whose target percents are at or above the 80th percentile (i.e., the top 20 percent) are considered at risk for improper Medicare payments. Percentiles are calculated for each of the three comparison groups (state, MAC/FI jurisdiction and nation).

We have suggested some interventions that hospices could consider when assessing their risk for improper Medicare payments. Please note that these are generalized suggestions and will not apply to all situations. For all areas, assess whether there is sufficient volume (10 to 30 claims for the time period, depending on the hospice's total claims for service) to warrant a review. The following table can assist hospices with interpreting their percentile values which are indications of possible risk of improper Medicare payments.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HOSPICES AT RISK FOR IMPROPER PAYMENTS (IF AT/ABOVE 80TH PERCENTILE)
Live Discharges	This could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet the hospice eligibility criteria. Medical record documentation should be reviewed to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria. It is recognized that beneficiaries could be discharged alive due to the beneficiary requesting to revoke the hospice benefit, or the beneficiary moving out of the hospice service area.
Long Length of Stay	This could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet the hospice eligibility criteria. Medical record documentation should be reviewed to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria.

Comparative data for the three consecutive cap years can be used to help identify whether the hospice's target area percents changed significantly in either direction from one year to the next. This could be an indication of a procedural change in admitting practices, staff turnover or a change in medical staff.

Using PEPPER

Compare Worksheet

Hospices can use the Compare Worksheet to help prioritize areas for auditing and monitoring. The Compare Worksheet includes all target areas with reportable data for the most recent cap year included in PEPPER. For each target area, the Compare Worksheet displays the hospice's number of target claims; percent; hospice percentiles as compared to the nation, jurisdiction and state; and the "Sum of Payments."

The Hospice PEPPER identifies providers whose data results suggest they are at risk for improper Medicare payments as compared to all hospices in the nation. The hospice's risk status is indicated by the color of the target area percent on the Compare Worksheet. When the hospice's percent is at or above the national 80th percentile for a target area, the hospice's percent is printed in **red bold**. When the hospice's percent is below the national 80th percentile, the hospice's percent is printed in black.

The Compare Worksheet provides the hospice's percentile value for the nation, jurisdiction and state for all target areas with reportable data in the most recent cap year. The percentile value allows a hospice to judge how its target area percent compares to all hospices in each respective comparison group. (See "Percentile" in the Glossary, page 10.)

The national percentile indicates the percentage of all other hospices in the nation that have a target area percent less than the hospice's target area percent.

The state percentile indicates the percentage of all other hospices in the state within the MAC/FI jurisdiction that have a target area percent less than the hospice's target area percent. The state percentile will be blank if there are fewer than 11 hospices in a state within the MAC/FI jurisdiction.

The jurisdiction percentile indicates the percentage of all other hospices in the MAC/FI jurisdiction that have a target area percent less than the hospice's target area percent.

For more on percents versus percentiles, see the "Training and Resources" page in the Hospice section on PEPPERresources.org for a short slide presentation with visuals to assist in the understanding of these terms.

When interpreting the Compare Worksheet findings, hospices should consider their target area percentile values for the nation, jurisdiction and state. Percentile values at or above the 80th percentile indicate that the hospice is at risk for improper Medicare payments. Providers should place the highest priority with their national percentile, as this percentile represents how the hospice compares to all hospices in the nation.

Percentile values at or above the jurisdiction 80th percentile or state 80th percentile should be considered as well but with a lower priority. Jurisdiction and state are smaller comparison groups, and therefore the percentiles may be less meaningful. In addition, there may be regional differences in practice patterns reflected in jurisdiction and state percentiles.

The "Sum of Payments" and "Number of Target Claims" can also be used to help prioritize areas for review. Areas in which a provider is at/above the 80th percentile that have a high sum of payment and/or number of target claims may be given higher priority than target areas for which a provider is at/above the 80th percentile that have a lower sum of payments/number of target claims.

Target Area Worksheets

PEPPER Target Area Worksheets display a variety of statistics for each target area summarized over three cap years. Each worksheet includes a target area graph, a target area data table, comparative data, interpretive guidance and suggested interventions.

Target Area Graph

Each worksheet includes a target area graph, which provides a visual representation of the hospice's target area percent over three cap years. The hospice's data is represented on the graph in bar format, with each bar representing a cap year. Hospices can identify significant changes from one time period to the next, which could be a result of, for example, changes in medical staff or utilization review processes. Hospices are encouraged to identify root causes of major changes to ensure that improper payments are prevented.

The graph includes red trend lines for the percents that are at the 80th percentile for the three comparison groups (state, jurisdiction and nation) so the hospice can easily identify when its results suggest that it is at risk for improper Medicare payments when compared to any of these groups. A table of these percents ("Comparative Data") is included under the hospice's data table. For more information on percents versus percentiles, see the "Training and Resources" page in the Hospice section on PEPPERresources.org for a short slide presentation with visuals to assist in the understanding of these terms.

A hospice's data will not be displayed in the graph if the numerator count for the target area is less than 11 for any time period. This is due to data restrictions established by CMS. If there are fewer than 11 hospices in a state within the MAC/FI jurisdiction, there will not be a trend line for the state comparison group in the graph.

Target Area Hospice Data Table

PEPPER Target Area Worksheets also include a hospice data table. Statistics in each data table include the total number of claims for the target area (target area claim count, which is the numerator), the denominator count of claims for service, the proportion of the numerator and denominator (percent), average length of stay for the numerator and for the denominator, and the average and sum of Medicare payment data. The hospice's percent will be shown in **red bold print** if it is at or above the national 80th percentile (suggesting a risk of improper Medicare payments). (See "Percentile" in the Glossary, page 10.) For each time period, a hospice's data will not be displayed if the numerator for the target area is less than 11.

Comparative Data Table

The Comparative Data Table provides the target area percents that are at the 80th percentile for the three comparison groups of nation, jurisdiction and state. These are the percent values that are graphed as trend lines on the Target Area Graph. State percentiles are zero when there are fewer than 11 hospices in the jurisdiction's state or when there are no hospices with at least 11 target (numerator) claims.

Interpretive Guidance and Suggested Interventions

Interpretive guidance is included on the target area worksheet (to the left of the graph) to assist hospices in considering whether they should audit a sample of records. Suggested interventions for providers, whose results suggest a risk for improper Medicare payments, are tailored to each target area and are also included at the bottom of each worksheet.

Hospice Terminal Conditions Report

This report lists the top terminal conditions for hospice decedents (beneficiaries that died) for the most recent cap year (see Appendix 1 for a listing of terminal conditions and the diagnosis codes included in each condition). The report includes the total decedents for each of the top terminal conditions listed (as identified by the principal diagnosis code on the final claim for the decedent), the proportion of decedents for each terminal condition to total hospice decedents and the hospice's average length of stay for each terminal condition. Please note that this report is limited to the top terminal conditions (up to 10) for which there are a total of at least 11 decedents with the respective terminal condition during the most recent cap year.

Jurisdiction-wide Terminal Conditions Report

This report lists the top terminal conditions for hospice decedents for the most recent cap year. It includes the total jurisdiction-wide hospice decedents for each of the top terminal conditions listed (as identified by the principal diagnosis code on the final claim for the decedent), the proportion of decedents for each terminal condition to total decedents and the jurisdiction average length of stay for each terminal condition. Please note that this report is limited to displaying the top terminal conditions (up to 10) for which there are a total of at least 11 decedents with the respective terminal condition during the most recent cap year.

Customer Support and Technical Assistance

For help using PEPPER, please submit a request for assistance at PEPPERresources.org by clicking on the "Help/Contact Us" tab. This website also provides many educational resources to assist hospices with PEPPER.

Please do **not** contact your state Medicare Quality Improvement Organization for assistance with PEPPER, as these organizations are not involved in the production or distribution of PEPPER.

Glossary

Average Length of Stay The average length of stay (ALOS) is calculated as an arithmetic average, or mean. It is computed by dividing the total number of days beneficiaries received service from the hospice by the total number of beneficiaries receiving services from the hospice within a given time period.

Data Table The statistical findings for a hospice are presented in tabular form, labeled by time period and indicator.

Cap Year For Medicare data, the cap year starts November 1 and ends October 31.

Graph In PEPPER, a graph shows a hospice's percentages for three cap years. The hospice's percentages are compared to the 80th percentiles for the state, jurisdiction and nation for all target areas. See *Percentile*.

Percentile In PEPPER, percentile represents the percent of hospices in the comparison group below which a given hospice's percent value ranks. It is a number that corresponds to one of 100 equal divisions of a range of values in a group. In PEPPER, the percentile represents the hospice's position in the group compared to all other hospices in the comparison group for that target area. For example, suppose a hospice has a target area percent of 2.3 and 80 percent of the hospices in the comparison group have a percent for that target area that is less than 2.3. Then we can say the hospice is at the 80th percentile.

Percentiles in PEPPER are calculated from the hospices' percents so that each hospice percent can be compared to the statewide, jurisdiction-wide or nationwide distribution of hospice percents.

For more on percents versus percentiles, please see the "Training and Resources" page in the Hospice section on PEPPERresources.org for a short slide presentation with visuals to assist in the understanding of these terms.

Prioritize To arrange or sort items into an order according to some rule or characteristic to reflect importance or need. The Compare Worksheet was designed to assist hospices with prioritizing data findings.

Acronyms and Abbreviations

ACRONYM/ ABBREVIATION	ACRONYM/ABBREVIATION DEFINITION
ALOS	The average length of stay (ALOS) is calculated as an arithmetic average, or mean. It is computed by dividing the total number of days beneficiaries received service from the hospice by the total number of beneficiaries receiving services from the hospice within a given time period.
CMS	The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for oversight of Medicare and Medicaid. CMS is a division of the U.S. Department of Health and Human Services.
FATHOM	First-look Analysis Tool for Hospital Outlier Monitoring (FATHOM) is a Microsoft Access application. It was designed to help Medicare Administrative Contractors (MACs) and Fiscal Intermediaries (FIs) compare acute care prospective payment system (PPS) inpatient hospitals in areas at risk for improper payment using Medicare administrative claims data.
FI	The fiscal intermediary (FI) is being replaced by the Medicare Administrative Contractor (MAC) in performing Medicare Fee-For-Service, Part A claims processing activities.
MAC	The Medicare Administrative Contractor (MAC) is the contracting authority replacing the fiscal intermediary (FI) and carrier in performing Medicare Fee-For-Service claims processing activities.
PEPPER	Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a data report that contains a single hospice's claims data statistics for claims for service at risk for improper Medicare payments.
TMF	TMF Health Quality Institute (TMF) is under contract with the Centers for Medicare & Medicaid Services (CMS) to develop and distribute PEPPER to short-term and long-term acute care hospitals, critical access hospitals, inpatient psychiatric and rehabilitation facilities, hospices, partial hospitalization programs, and to develop and distribute FATHOM to CMS and MAC/FIs.
UB-04	Standard uniform bill used by health care providers to submit claims for services. Claims for Medicare reimbursement are submitted to the provider's Medicare Administrative Contractor or fiscal intermediary.

Appendix 1: Hospice Terminal Conditions by Diagnosis Code

Terminal Condition	ICD-9-CM Diagnosis Code(s)
Alzheimer's disease	331.0
Bladder Cancer	188.0 – 188.9
Blood/lymph Cancer	200.00 – 208.92
Brain Cancer	191.0 – 191.9
Breast Cancer	174.0 – 175.9
Congestive heart failure	428.0 – 428.9
Chronic kidney disease	585.1 – 587
Chronic liver disease	571.0 – 573.9
Colo-rectal Cancer	153.0 – 154.8
CVA/stroke	430 – 434.91, 436 – 438.9
Debility not otherwise specified	799.3
Failure to thrive (adult)	783.7
Liver Cancer	155.0 – 156.9
Lung and other chest cavity Cancer	162.0 – 165.9
Non-Alzheimer's dementia	290.0 – 290.9, 294.0 – 294.9, 331.11 – 331.9
Non-infectious respiratory	490 – 496
Other heart disease	390 – 398.99, 402.00 – 402.91, 404.00 – 404.93, 410.00-417.9, 420.0 – 427.9, 429.0 – 429.9
Ovarian Cancer	183.0
Pancreatic Cancer	157.0 – 157.9
Parkinson's and other degenerative diseases	332.0 – 335.9
Pneumonias and other infectious lung diseases	480.0 – 488.89, 510.0 – 519.9
Prostate Cancer	185