

JULY/ AUGUST 2007

IPRO releases PEPPER supplementary readmission reports to assist NYS hospitals in their data review

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is an electronic data report developed under contract with the Centers for Medicare & Medicaid Services (CMS) by the Hospital Payment Monitoring Program (HPMP) Quality Improvement Organization Support Center (QIOSC), which is TMF Health Quality Institute (TMF). PEPPER contains hospital-specific, Medicare inpatient Prospective Payment System (PPS) discharge data for 14 target areas-specific Diagnosis Related Groups (DRGs) and discharges that have been identified as being at high risk for payment errors in the short-term acute care hospital setting.

In general, target areas are constructed such that the discharges in the numerator have been identified as problematic. These data are intended to assist hospitals in their HPMP efforts to identify and prevent payment errors. The overall goal of HPMP is to reduce the Medicare payment error rate within each state, as well as nationally. 1

Seven-day Readmission to the Same Facility or Elsewhere target area is identified as follows:

Numerator: Count of index (first) admissions for which a readmission occurred within seven days to the same hospital or to another short-term acute care PPS hospital for the same beneficiary (identified using the Health Insurance Claim number); patient status of the index admission is not equal to 02: discharged/transferred to a short-term general hospital for inpatient care.

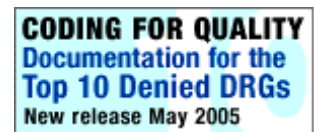
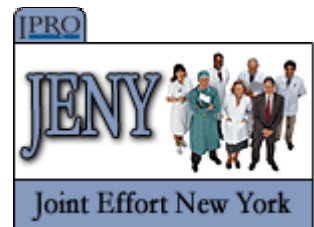
Denominator: Count of all discharges.

NYS hospitals currently have 7.2% of all discharges falling into the PEPPER readmission target area. NYS has displayed an increasing volume of readmission discharges, as shown in Table 1 below.

Fiscal Year	Percent
2004	6.4
2005	6.9
2006	7.1
2007	7.2

While further investigation of outlier status may reveal instances of readmissions in the PEPPER data that point to correct hospital care and discharge patterns, it is imperative that hospitals identified as outliers conduct root cause analysis as part of their hospital compliance-monitoring plan. For example, one NYS hospital noticed an increasingly high seven-day readmission rate in their Pepper report over an extended period of time, despite the fact that their internal records regularly show few readmissions to their own facility. Lacking any information about or control over patients admission patterns beyond their own facility, this hospital requested assistance from IPRO in gaining insight into the seven-day readmission rates contained in PEPPER.

IPRO' analysis of the seven-day readmission target area data for this hospital indicated that the PEPPER reported readmissions for this hospital were almost exclusively to facilities other than their own and occurred mostly on the same date as the date of discharge for the index admission. In addition, the index admission discharge disposition on these readmissions to other facilities indicated again almost exclusively that these patients were planned transfers to specialized hospitals for follow-up care rather



than discharges "to home" with subsequent readmissions to acute care hospitals, as seen in the traditional conceptualization of an inpatient readmission.

As a result of this hospital's request and its subsequent analysis of seven-day readmissions, IPRO identified a need within the acute care inpatient provider community to have more detailed information about this area. IPRO created a Seven-day Supplementary Report on Readmissions designed to assist hospitals in their review of readmissions within seven days as reflected in the Medicare data reported in Pepper for a specific period. Through careful review of the tables included in the report it is expected that hospitals with high seven-day readmission rates will gain insight into factors that have impacted their data.

Seven-day Supplementary Report on Readmissions (the details):

The IPRO created *Seven-day Supplementary Report on Readmissions* is meant to assist hospitals in their review of readmissions within seven days as reflected in their Medicare discharge data for a specific reporting period. The report contains summary information across several data categories relevant to patient readmissions. Through careful review of the tables included in the report it is expected that hospitals with high seven-day readmission rates will gain insight into factors that have impacted their data. It is hoped that the reports will enhance a hospitals ability to identify and prevent payment errors associated with readmissions.

The report provides acute care inpatient providers with data summarizing readmissions. Providers can expect to find the following data in their reports:

1. discharge disposition category of the index (first) admission;
2. DRG of the index admission;
3. location of the readmission (to the same or another provider); and,
4. whether or not the readmission occurred on the same day as the date of discharge of the index admission.

Summary analyses of the data elements above are provided at both the hospital and statewide levels to enable comparisons from specific providers to all NYS short-term acute care hospitals as a whole. **The distribution of these reports is scheduled for August 16 through August 20, 2007 via QualityNet Exchange.**

In review of readmission extension reports, hospitals should be cognizant of data that could indicate inappropriate admissions or discharges, quality of care issues, or billing errors. Reviewing a sample of readmission cases will help to identify appropriateness of admission, discharge, quality of care and DRG assignment and billing errors. Hospitals are also encouraged to generate data profiles for patients readmitted the same day or next day after discharge. Suggested data elements to include in these profiles are: patient identifier, date of admission, date of discharge, discharge destination code, principal and secondary diagnoses, procedure code(s) and DRG. Evaluate profiles for the following indications of potential payment errors:

- When patients are discharged to home or self care (routine discharge) - patient status code 01 and readmitted on the same or next day, this may indicate a potential premature discharge or incomplete care.
- When a patient is readmitted for the same principal diagnosis as for the first admission, this may indicate a potential premature discharge or incomplete care.
- Hospitals that have exempt units (i.e., swing beds, rehabilitation units, or psychiatric units) should take special note of patient status codes and same day readmissions. In these situations, the second admission is usually billed to an incorrect provider number, rather than a true readmission to the acute care PPS hospital. There is a very high probability of billing errors when the following patient status codes are billed on the first admission of a same-day readmission: 03 (discharged/transferred to SNF); 05 (discharged/transferred to another type of institution, including distinct parts); 61 (discharged/transferred within the institution to a hospital-based Medicare approved swing bed, effective 10-01-01); or 62 (discharged/transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital, effective 01-01-02).

IPRO will provide training in the coming months on reading and interpreting the readmission extension reports. Notification of the training will be provided in August with the data

dissemination. For difficulties with downloading the data in August, you may contact Karen Sharpe at 516-209-5562.

Reminder: New York State Fiscal Year 2005 Payment Error Cause Analysis (PECA)

The Centers for Medicare & Medicaid Services (CMS) pulls a random sample of claims from short-term, acute care, NYS hospitals each month to assess the Medicare fee-for-service payment error rate. The random sample is reviewed for admission necessity, DRG/coding accuracy and billing errors. Records that are not submitted for review are issued technical denials, resulting in full fiscal recoupment by CMS for a failure to provide the medical record. Each year, CMS provides aggregated national and NYS data, which details the causes of the payment errors.

The NYS PECA data was posted to your hospitals QualityNet Users inbox on or about Tuesday, June 19, 2007. If you have questions about the data please contact Dr. Kathy Terry at 516-209-5364. For difficulties with downloading the data you may contact Karen Sharpe at 516-209-5562.

¹ Excerpt from the PEPPER User's Guide; see www.hpmpresources.org for a full copy of the User's Guide.

HPMP Compliance Workbook: <http://providers.ipro.org/index/hpmp-compliance-workbook>

DRG Coding Corner: <http://providers.ipro.org/index/coding-corner>

JENY: <http://jeny.ipro.org/forumdisplay.php?f=25>

Top 10 denied DRGs: <http://providers.ipro.org/index/hpmp-top-ten-denied-drgs>

Top 7 DRGs: <http://providers.ipro.org/index/hpmp-top-seven-drgs>

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This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-NY-TSK3B-07-07