In 2015, Comprehensive Error Rate Testing (CERT) by the Centers for Medicare and Medicaid Services (CMS) found improper payments in 59% of Medicare home health claims, up from 51% in 2014. That represented about $10 billion in overpayment to home health agencies. This dramatic upsurge turned up the heat on Medicare Integrity Contractors (MICs) to root out fraud and abuse in home health. The MICs use historical billing data that shows statistical indicators of potentially fraudulent billing. Now CMS’ new home health Conditions of Participation, effective July 2017, give MICs even more opportunity to root out guilty agencies by exploiting enhanced communication with state survey agencies.

What hidden red flags could attract such scrutiny to your agency? Wouldn’t you like to uncover them in advance so that you can correct potential problems before external auditors find them?

The Home Health PEPPER (Program for Evaluating Payment Patterns Electronic Report) is available to help you at PEPPERresources.org. Armed with knowledge of your agency’s target area “outlier” rates, you can tailor QAPI (Quality Assurance Performance Improvement) activities to avoid even the appearance of fraud.

Outlier status in any given PEPPER target area does not indicate that the agency is guilty of wrongdoing. Rather, it shows how the agency’s billing statistics compare with those of other providers in its state, payer jurisdiction, and in the nation. An agency is an outlier in a target area when its data scores at or above the national 80th percentile, increasing the chance that MICs will scrutinize the agency’s records for improper billing.

Anyone can look at national and state statistics for home health. But only agencies can see their own and their MAC’s reports.

The Home Health PEPPER updates annually with data from the preceding three complete years. The target areas published in April 2016 are:

- Average Case Mix
- Average Number of Episodes
- Episodes with Five or Six Visits
- Non-LUPA (Low-Utilization Payment Adjustment) Payments
- High Therapy Utilization Episodes
- Outlier Payments

The PEPPER Target Areas

PEPPER Target Areas
The unique equation that creates your specific agency’s score in each target area, along with definitions of specific numerators and denominators, will appear in both the PEPPER Excel workbook your agency downloads and in the Home Health PEPPER User’s Guide.

**Home Health PEPPER User’s Guide**

You can find free training on how to access your agency’s individual PEPPER at pepperresources.org. While you’re there, be sure to download the Home Health PEPPER User’s Guide for more detailed guidance on how to use PEPPER and how to interpret PEPPER findings.

**The Compare Targets Report**

The Compare Targets Report lists agency outlier scores in **red and bold** with associated costs. Agencies can then prioritize their QAPI auditing and monitoring activities to address the highest-percentile and highest-cost target areas to ensure that all Medicare services are accurately documented as reasonable and necessary, and that all are correctly billed.

If you see a big change in your statistics over time, that should alert you to consider what caused the change. It will be necessary to review patient records to be sure nothing improper is happening or to identify and correct any errant activity or processes.

**Average Case Mix Target Area**

Outlier status in the Average Case Mix Target Area means your agency’s OASIS item responses may bring higher payments than your agency should receive. For example, OASIS scoring may present the patient as more functionally and clinically impaired than is warranted.

To remedy outlier status in average case mix, the Home Health PEPPER User’s Guide counsels agencies to audit for consistency between OASIS responses and other medical record documentation.

Remember, each target area report shows your agency’s trends over three years in that area.

**Average Number of Episodes Target Area**

A score in the 80th percentile or higher in the Average Number of Episodes Target Area should cue your home health agency to make sure it is not continuing treatment beyond the point where services are necessary.

The Home Health PEPPER User’s Guide recommends auditing patient records that have multiple episodes for documentation that “clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient’s illness or injury within the context of the patient’s unique medical condition.”
The User's Guide also reminds agencies that in "instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, such services are not covered under the home health benefit," and the guide counsels agencies to "review plans of care for appropriateness and assess appropriateness of discharge plans."

**Episodes With 5 or 6 Visits | Non-LUPA Payments Target Areas**

These two target areas reveal whether your agency is appropriately billing when patient care hovers around the minimum threshold of five visits to receive full Prospective Payment System (PPS) reimbursement rather than the Low-Utilization Payment Adjustment (LUPA) per-visit payment, which is allowed when an episode contains four visits or fewer.

The Home Health PEPPER User’s Guide conveys CMS’ belief that both episodes with five or six visits, and agencies with no LUPA payments may be evidence of an agency’s errant practice of performing at least five visits to obtain an HHRG payment instead of a LUPA payment, regardless of medical necessity.

The User Guide’s recommendation should sound familiar. It advises agencies to review for documentation that “clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient’s illness or injury within the context of the patient’s unique medical condition. If the individualized assessment of the patient does not demonstrate the need for skilled care – such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers – such services are not covered under the home health benefit. The [agency] should review plans of care to ensure they are individualized and appropriate for the beneficiaries’ condition.”

**High Therapy Utilization Target Area**

CMS suspects that some agencies that bill for more therapy visits than usual are doing so to capture more payment rather than for patient-specific, medically necessary services to prevent deterioration and/or to preserve the beneficiary’s existing capabilities.

The Home Health PEPPER User’s Guide recommends auditing episodes that include more than 19 therapy visits to ensure that documentation clearly substantiates that all provided skilled therapy services were reasonable and necessary, and that the visits required the specialized judgment, knowledge, and skills of a qualified therapist to prevent deterioration and/or to preserve the beneficiary’s existing capabilities. Be aware that, although the User’s Guide doesn’t mention it, Chapter 7 of the Medicare Benefit Policy Manual also includes coverage for medically necessary therapy to treat a patient’s illness or injury to restore function.

Note that PEPPER provides peer group bar charts, in addition to the graphs and tables, to allow your agency to see and use your data in multiple ways.

**Outlier Payments Target Area**

CMS defines outlier episodes as those with higher cost than what are allowed through PPS. These episodes are paid at a higher rate to compensate for the additional cost.

For example, an insulin-dependent beneficiary who is unable to self-administer insulin, and who has no one willing and available to do so, may require daily – or even more frequent – visits at a cost above the patient’s PPS calculation per episode.
The Home Health PEPPER User’s Guide recommends that agencies review medical records with focus on harmony between OASIS item responses about patients’ clinical and functional status and what is documented in the medical record. Both must support that the higher-than-predicted PPS cost is medically necessary.

Other Helpful Data in PEPPER
The PEPPER also provides diagnosis-related information to help agencies benchmark their own patients’ diagnoses against industry-wide trends, including related costs and therapy utilization.

Click here to discover what PEPPER says about your agency.


About the author
Beth Noyce, RN, BsjMC, HCS-D, COS-C, HCS-H provides consulting, education, and auditing services to hospice and home health agencies at noyczConsulting.com. She has presented at UHPCO, NAHC, UAHC, DecisionHealth’s Coding Summit and many other seminars. She has served as a MAC medical reviewer. Her work with DecisionHealth includes publishing in Diagnosis Coding Pro, authoring multiple ICD-10 courses, editing updates for the HCS-H credential study guide and more.