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Evaluating Medicare Fee-For-Service payment patterns for post-acute care

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In 2018, the Centers for Medicare & Medicaid Services (CMS) projected that improper payment for post-acute care (PAC) services provided through the Medicare Fee-for-Service program totaled $8.3 billion, with home health services accounting for more than 30% of these payments.[1] Submitting insufficient documentation or failing to adequately document medical necessity are the main reasons for these improper payments. To help address this problem, CMS provides free provider-level reports comparing service use and billing to state-level, jurisdiction-level, and national aggregate data through the Program for Evaluating Payment Patterns Electronic Report (PEPPER). PEPPERs summarize Medicare claims data across areas prone to improper payment. CMS distributes these reports to short-term acute care providers once every quarter and to other types of hospitals and PAC providers once every year. Providers can use PEPPERs to inform their compliance programs; for example, providers can use this information to prioritize areas for auditing and to review their billing practices for Medicare services. These reports also support PAC providers in their participation in Medicare's new Prospective Payment Systems (PPSs) for PAC.