PEPPER

Inpatient Rehabilitation Facility Program for Evaluating Payment Patterns Electronic Report

User's Guide
Ninth Edition

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Program for Evaluating Payment Patterns Electronic Report User's Guide
Ninth Edition, effective with the Q4FY18 release

Introduction

What Is PEPPER?

The Office of Inspector General (OIG) encourages hospitals to develop and implement a compliance program to protect their operations from fraud and abuse.[1,2] As part of a compliance program, a hospital 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 hospital's auditing and monitoring activities.

PEPPER is a data report that contains a single hospital's claims data statistics (obtained from the UB-04 claim submitted to the Medicare Administrative Contractor (MAC)) for Case-Mix Groups (CMGs) and discharges that may be at risk for improper Medicare payment due to billing, coding and/or admission necessity issues. Each PEPPER contains statistics for each area at risk for improper payments (referred to in the report as "target areas"). Data in PEPPER are presented in tabular form, as well as in graphs that depict the hospital's target area percentages over time. PEPPER is developed and distributed by the RELI Group, along with its partners TMF Health Quality Institute and CGS, under contract with the Centers for Medicare & Medicaid Services (CMS).

All of the data tables, graphs and reports in PEPPER were designed to assist the hospital in identifying potentially improper payments.

PEPPER is available for inpatient rehabilitation facilities (IRFs), as well as critical access hospitals, short- and long-term acute care inpatient Prospective Payment System (PPS) hospitals, inpatient psychiatric facilities, hospices, partial hospitalization programs, skilled nursing facilities and home health agencies.

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

The inpatient rehabilitation facility (IRF) PEPPER is the version of PEPPER specifically for inpatient rehabilitation facilities and inpatient rehabilitation distinct part units of short-term acute care hospitals and critical access hospitals. **In PEPPER and throughout this guide, free-standing inpatient rehabilitation facilities and distinct part units of short-term acute care hospitals and critical access hospitals are grouped together and referred to collectively as IRFs.**

The IRF PEPPER for free-standing IRFs is available to the IRF's Chief Executive Officer, Administrator, President or Compliance Officer through a secure portal on the PEPPER.CBRPEPPER.org website. IRFs that are distinct part units of short-term acute care hospitals or critical access hospitals receive their

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[1] Department of Health and Human Services/Office of Inspector General. 1998. "Compliance Program Guidance for Hospitals," *Federal Register* 63, no. 35, February 23, 1998, 8987–8998. Available at: http://oig.hhs.gov/authorities/docs/cpghosp.pdf

[2] Department of Health and Human Services/Office of Inspector General. 2005. "Supplementing the Compliance Program Guidance for Hospitals," *Federal Register* 70, no. 19, January 31, 2005, 4858–4876. Available at: http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf

PEPPER electronically through a secure file exchange in QualityNet. The PEPPER files will be sent to the short-term acute care hospitals' QualityNet Administrators and to those who have QualityNet basic user accounts (PEPPER recipient role and File Exchange and Search role). Each IRF receives only its PEPPER. The PEPPER Team does not provide PEPPERs to other contractors, although the PEPPER Team does provide an Access database (the First-look Analysis Tool for Hospital Outlier Monitoring, or FATHOM) to MACs and Recovery Auditors. FATHOM can be used to produce a PEPPER.

IRFs, in general, are defined as hospitals that provide an intensive rehabilitation program. Patients who are admitted must be able to tolerate three hours of intense rehabilitation services per day. IRFs are reimbursed through the IRF prospective payment system (PPS).

Each IRF PEPPER summarizes claims data statistics (obtained from paid inpatient Medicare UB-04 claims) for the most recent twelve federal fiscal quarters, aggregated in three 12-month time periods. An IRF is compared to other IRFs in three comparison groups: nation, Medicare Administrative Contractor jurisdiction and state. These comparisons enable an IRF to determine if it is an outlier, differing from other IRFs.

PEPPER determines outliers 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 IRF PEPPER does not contain any coding-focused target areas; therefore, the IRF PEPPER draws attention to any findings that are at or above the upper control limit (national 80th percentile).

Note that in PEPPER, the term "outlier" is used when the IRF's target area percent is in the top twenty percent of all IRF target area percents in the respective comparison group (i.e. is at/above the 80th percentile). Formal tests of significance are not used to determine outlier status in PEPPER.

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

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Inpatient rehabilitation facilities or distinct part units of short-term acute care hospitals or critical access hospitals	Third through sixth positions of the CMS Certification Number are between "3025" and "3099" (for freestanding facilities) or third position = "T" (short-term) or "R" (critical access)
Services provided during the time periods included in the report	Claim "Through Date" (discharge date) falls within the three fiscal years included in the report.
Claim with valid medical record number	UB04 FL 03a or 03b is not null (blank)
Medicare claim payment amount greater than zero	The hospital received a payment amount greater than zero on the claim (*Note that Medicare Secondary Payer claims are included.*)
Final action claim	The patient was discharged; exclude claim status code "still a patient" (30) in UB04 FL 17
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Health Maintenance Organization
Exclude cancelled claims	Exclude claims cancelled by the Medicare Administrative Contractor

IRF PEPPER CMS Target Areas

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

TARGET AREA	TARGET AREA DEFINITION
Miscellaneous CMGs (Misc)	*Numerator (N):* count of discharges for Case-Mix Groups (CMGs) 2001 (Miscellaneous M>49.15), 2002 (Miscellaneous M>38.75 and M<49.15), 2003 (Miscellaneous M>27.85 and M<38.75) or 2004 (Miscellaneous M<27.85) *Denominator (D):* count of all discharges
CMGs at Risk for Unnecessary Admissions (CMGs)	*N:* count of discharges with no tier group assignment for CMGs 0101 (Stroke M>51.05), 0501 (Non-traumatic Spinal Cord Injury M>51.35), 0601 (Neurological M>47.75), 0801 (Replacement of Lower Extremity Joint M>49.55), 0802 (Replacement of Lower Extremity Joint M>37.05 and M<49.55), 0901 (Other Orthopedic M>44.75), 1401 (Cardiac M>48.85), or 1501 (Pulmonary M>49.25) *D:* count of all discharges
Outlier Payments (Outlier Pmts)	*N:* count of discharges with an outlier approved amount greater than $0 *D:* count of all discharges
STACH Admissions Following IRF Discharge (STACH Admiss)	*N:* count of discharges where the beneficiary (identified using the Health Insurance Claim number) was discharged from the IRF during the 12-month time period and admitted to a short-term acute care hospital within 30 days of discharge from the IRF; excluding transfers to a short-term acute care hospital, a long-term acute care hospital or an IRF within one day of discharge as evidenced by a subsequent claim; excluding patient discharge status codes 07 (left against medical advice), 20 (expired) *D*: count of all discharges excluding transfers to a short-term acute care hospital, long-term acute care hospital or IRF within one day of discharge as evidenced by a subsequent claim; and excluding patient discharge status codes 07, 20 (See Appendix 1 for how STACH admissions following IRF discharge are identified.)

These PEPPER target areas were approved by CMS because they have been identified as potentially prone to improper Medicare payments in IRFs.

Several Case-Mix Groups (CMGs) have been identified as potentially prone to unnecessary IRF admissions. These include the "Miscellaneous" CMGs and a number of CMGs with generally higher motor scores and no tier group assignment.

IRFs receive outlier payments for hospital stays that have extraordinarily high costs. A high percentage of outlier payments may represent improper utilization of Medicare resources.

Admissions to a short-term acute care hospital within 30 days of discharge from an IRF may be associated with premature discharge or incomplete care. They could also indicate that discharge planning or patient/family preparation for discharge could be improved.

How IRFs Can Use PEPPER Data

The IRF PEPPER allows IRFs to compare their billing statistics with national, jurisdiction and state percentile values for each target area with reportable data for the most recent three 12-month time periods included in PEPPER.

To calculate percentiles, the target area percents for all IRFs 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 IRFs' target area percents fall is identified as the 80th percentile. IRFs whose target percents are at or above the 80th percentile (i.e., in the top 20 percent) are considered at risk for improper Medicare payments. Percentiles are calculated for each of the three comparison groups (nation, jurisdiction and state).

> "Reportable data" in PEPPER means there are 11 or more numerator discharges for a given target area for a given time period. When there are fewer than 11 numerator discharges for a target area for a time period, statistics are not displayed in PEPPER due to CMS data restrictions.

The PEPPER Team has developed suggested interventions that IRFs may 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 cases for the time period, depending on the hospital's total discharges) to warrant a review of cases. If your facility always has a small volume of cases, numbers varying significantly from the norm could be important and warrant a review.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)
Miscellaneous CMGs (Misc)	This could indicate that there are unnecessary admissions for patients admitted in the "Miscellaneous" CMGs (2001 – 2004). A sample of medical records for these CMGs should be reviewed to determine if inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis or in another setting (e.g., skilled nursing facility or home with home health).
CMGs at Risk for Unnecessary Admissions (CMGs)	This could indicate that there are unnecessary admissions for patients admitted in CMGs 0101, 0501, 0601, 0801, 0802, 0901, 1401 or 1501 with no tier group assignment. A sample of medical records for these CMGs should be reviewed to determine if inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis or in another setting (e.g., skilled nursing facility or home with home health).
Outlier Payments (Outlier Pmts)	This indicates that the facility is submitting a high percentage of claims with outlier payments. Claims with outlier payments should be reviewed to ensure treatment provided was medically necessary. The facility may wish to ensure the "cost to charge" ratio as reported in their annual cost report is correct.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)
STACH Admissions Following IRF Discharge (STACH Admiss)	This could indicate that patients are not medically stable or prepared for discharge. The facility may wish to ensure that patient discharge planning is initiated early during patients' admission and that patients and their families are prepared to handle patient care following discharge; this may include following-up with patients/families after discharge to assess compliance with post-discharge care. IRF units of short-term acute care hospitals may wish to identify admissions to their short-term acute care hospital within 30 days of discharge and review medical records for those patients.

Comparative data for the three consecutive 12-month periods can be used to help identify whether the IRF'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, coding or billing practices, staff turnover or a change in medical staff.

Using PEPPER

Compare Targets Report

IRFs can use the Compare Targets Report to help prioritize areas for auditing and monitoring. The Compare Targets Report includes all target areas with reportable data for the most recent 12-month time period included in PEPPER. For each target area, the Compare Targets Report displays the IRF's number of target discharges; percent; IRF percentiles as compared to the nation, jurisdiction and state; and the "Sum of Payments."

Navigate through PEPPER by clicking on the worksheet tabs at the bottom of the screen. Each tab is labeled to identify the contents of each worksheet (e.g., Target Area Reports, Compare Targets Report).

IRF PEPPER identifies outliers as compared to all IRFs in the nation. The IRF's outlier status is indicated by the color of the target area percent on the Compare Targets Report. When the IRF is a high outlier for a target area, the IRF's percent is printed in **red bold**. When the IRF is not an outlier, the IRF's percent is printed in black.

The Compare Targets Report provides the IRF's percentile value for the nation, jurisdiction and state for all target areas with reportable data in the most recent 12-month time period. The percentile value allows an IRF to judge how its target area percent compares to all IRFs in each respective comparison group. (See "Percentile" in the Glossary, page 12.)

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

The IRF's jurisdiction percentile indicates the percentage of all other IRFs in the MAC jurisdiction that have a target area percent less than the IRF's target area percent. The jurisdiction percentile will be blank if there are fewer than 11 IRFs with reportable data for a target area in a jurisdiction.

The IRF's state percentile indicates the percentage of all other IRFs in the state that have a target area percent less than the IRF's target area percent. The state percentile will be blank if there are fewer than 11 IRFs with reportable data for a target area in a state.

For more on percents versus percentiles, see the "Frequently Asked Questions" section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

When interpreting the Compare Targets Report findings, IRFs should consider their target area percentile values for the nation, jurisdiction and state. Percentile values at or above the 80th percentile indicate that the IRF is an outlier. Outlier status should be evaluated in the priority order of 1) nation, 2) jurisdiction and 3) state. If an IRF is an outlier for nation (compared to all IRFs in the nation), this should be interpreted as the highest priority. If an IRF is an outlier for jurisdiction (compared to all IRFs in the jurisdiction), this is somewhat of a lower priority. Lastly, if an IRF is an outlier for the state (compared to all IRFs in the state), this would be the lowest priority, as the state has the smallest comparison group. The "Sum of Payments" can also be used to help prioritize areas for review. For example, the Compare Targets Report may show that the Outlier Payments target area has the highest "Sum of Payments," but the IRF's percent is at the 80th percentile as compared to the jurisdiction and at the 65th percentile as compared to the nation. The Miscellaneous CMGs target area may have a smaller "Sum of Payments" but is at the 80th percentile for jurisdiction and 90th percentile for nation. In this scenario, the Miscellaneous CMGs target area might be given priority.

Target Area Reports
PEPPER Target Area Reports display a variety of statistics for each target area summarized over three 12-month time periods. Each report includes a target area graph, a target area data table, comparative data, interpretive guidance and suggested interventions.

Target Area Graph
Each report includes a target area graph, which provides a visual representation of the IRF's target area percent over three 12-month time periods. The IRF's data is represented on the graph in bar format, with each bar representing a 12-month time period. IRFs can identify significant changes from one time period to the next, which could be a result of changes in the medical staff, coding staff, utilization review processes or hospital services. IRFs 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 (nation, jurisdiction and state) so the IRF can easily identify when it is an outlier as compared to any of these groups. A table of these percents ("Comparative Data") is included under the IRF's data table. For more information on percents versus percentiles, see the "Frequently Asked Questions" section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

An IRF'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 IRFs with reportable data for a target area in a state, there will not be a trend line for the state comparison group in the graph. If there are fewer than 11 IRFs with reportable data for a target area in a jurisdiction, there will not be a trend line for the jurisdiction comparison group in the graph.

Target Area Hospital Data Table

PEPPER Target Area Reports also include a hospital data table. Statistics in each data table include the total number of discharges for the target area (target area discharge count, which is the numerator), the denominator count of discharges, 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 IRF's percent will be shown in **red bold print** if it is at or above the national 80th percentile (high outlier). (See "Percentile" in the Glossary, page 12.) For each time period, an IRF'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 IRFs with reportable data for a target area in the state. Jurisdiction percentiles are zero when there are fewer than 11 IRFs with reportable data for a target area in the jurisdiction.

Interpretive Guidance and Suggested Interventions

Interpretive guidance is included on the target area report (to the left of the graph) to assist IRFs in considering whether they should audit a sample of records. Suggested interventions for outliers tailored to each target area are also included at the bottom of each target area report.

IRF Top CMGs Report

The IRF Top CMGs report lists the top CMGs by volume of discharges (including all tiers (A, B, C and D)) for your IRF in the most recent 12-month time period. It includes the total IRF discharges for each of the top CMGs listed, the proportion of discharges for each CMG to total discharges and the IRF's average length of stay for each CMG. Please note that this report is limited to the top CMGs (up to 20) for which there are a total of at least 11 discharges (for the respective CMG) during the most recent 12-month time period.

Jurisdiction-wide Top CMGs Report

The Jurisdiction-wide Top CMGs report lists the top CMGs by volume of discharges (includes all tiers (A, B, C and D)) for all IRFs in the MAC jurisdiction in the most recent fiscal year. It includes the total jurisdiction-wide discharges for each of the top CMGs listed, the proportion of discharges for each CMG to total discharges, the jurisdiction average length of stay (ALOS) for each CMG and the national ALOS for each CMG. Please note that this report is limited to displaying the top CMGs (up to 20) for which there are a total of at least 11 discharges during the most recent 12-month time period.

IRF ALOS by CMG Tier and Discharge Destination Report

The IRF ALOS by CMG Tier and Discharge Destination report identifies the number of discharges during the most recent 12-month period at the IRF for each of the four CMG tier levels:

1. Tier A, no comorbidity
2. Tier B, high comorbidity
3. Tier C, medium comorbidity
4. Tier D, low comorbidity

It also identifies the number of discharges during the most recent 12-month period at the IRF for five categories of discharge destination:

1. Home – patient discharge status codes
   - 01 (discharged to home/self-care)
   - 81 (discharged to home/self-care with a planned acute care hospital readmission)
2. Transfer to short-term or long-term acute care hospital – patient discharge status codes
   - 02 (discharged/transferred to a short-term acute care hospital)
   - 63 (discharged/transferred to a long-term acute care hospital)
   - 82 (discharged/transferred to a short-term acute care hospital with a planned acute care hospital readmission)
   - 91 (discharged/transferred to a long-term acute care hospital with a planned acute care hospital readmission)
3. Transfer to skilled nursing facility – patient discharge status codes
   - 03 (discharged/transferred to a skilled nursing facility)
   - 61 (discharged/transferred to a swing-bed)
   - 83 (discharged/transferred to a SNF with a planned acute care hospital readmission)
   - 89 (discharged to a swing bed with a planned acute care hospital readmission)
4. Home with home health – patient discharge status codes
   - 06 (discharged/transferred home with home health)
   - 86 (discharged/transferred home with home health with a planned acute care hospital readmission)
5. Other – all other patient discharge status codes

For each of these categories, the report identifies the total number of IRF discharges, the proportion of discharges to total discharges, the IRF's ALOS and the national ALOS. Please note that this report is limited to displaying CMG tier groups and discharge destinations for which there are a total of at least 11 discharges during the most recent 12-month time period.

Jurisdiction-wide ALOS by CMG Tier and Discharge Destination Report

The Jurisdiction-wide ALOS by CMG Tier and Discharge Destination report identifies the number of discharges during the most recent 12-month period in the jurisdiction for each of the four CMG tier levels (see above). It also identifies the number of discharges during the most recent 12-month period in the jurisdiction for the five categories of discharge destination (see above). For each of these categories, the

report identifies the total number of discharges in the jurisdiction, the proportion of discharges to total discharges, the jurisdiction ALOS and the national ALOS.

System Requirements, Customer Support and Technical Assistance

PEPPER is a Microsoft Excel workbook that can be opened and saved to a PC. It is not intended for use on a network but may be saved to as many PCs as necessary.

For help using PEPPER, please submit a request for assistance at PEPPER.CBRPEPPER.org by clicking on the "Help/Contact Us" tab. This website also contains many educational resources to assist IRFs with PEPPER in the Inpatient Rehabilitation Facility training and resources section.

Please do **not** contact your state Medicare Quality Improvement Organization or any other association 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 mean. It is computed by dividing the total number of hospital (or inpatient) days by the total number of discharges within the time period. For the STACH Admission Following IRF Discharge target area, the ALOS is calculated using the first (index) admission's length of stay, not the second (STACH) admission's length of stay.

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

Fiscal Year
For Medicare data, the fiscal year starts October 1 and ends September 30.

Graph
In PEPPER, a graph shows a hospital's percentages for three 12-month time periods. The hospital's percentages are compared to the 80th percentiles for the state, jurisdiction and nation for all target areas. See *Percentile*.

Length of Stay
The length of stay (LOS) for an individual discharge is determined by subtracting the date of admission (Admission Date) from the date of discharge (Through Date). If the dates of admission and discharge fall on the same day, the LOS equals one day.

Outlier Payment
An IRF discharge qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold amount.

PEPPER Outlier
In IRF PEPPER, an IRF is identified as an outlier if its target area percent is at or above the national 80th percentile (high outlier).

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

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

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

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 hospital (or inpatient) days by the total number of discharges within a given time period.
CMG	Case-Mix Group. A classification that groups inpatient rehabilitation patients who are expected to use similar resources. Rehabilitation Impairment Categories (RICs), functional status and age (as collected on the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)) determine the CMG. Each CMG has four payment tiers; a comorbidity that affects the cost of the rehabilitation admission is assigned to one of the tiers based on the cost of the resources necessary to treat the comorbidity.
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) compare providers in areas at risk for improper payment using Medicare administrative claims data. FATHOM produces PEPPER.
FY	Fiscal Year; the Medicare federal fiscal year begins October 1 and ends September 30.
PPS	Prospective Payment System
LOS	Length of Stay
MAC	The Medicare Administrative Contractor (MAC) is the contracting authority that replaced 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 an electronic data report in Microsoft Excel format that contains a single hospital's claims data statistics for DRGs and discharges at high risk for improper payments due to billing, coding and/or admission necessity issues.
ST	Short-term; refers to Short-term Acute Care Hospital
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 MAC.

Appendix 1: How STACH Admissions Following IRF Discharge Are Identified

This example is provided to assist in understanding how STACH admissions following IRF discharge are identified and counted in PEPPER. A STACH admission is considered a "STACH admission following IRF discharge" only for the IRF discharge immediately preceding the STACH admission (considering all claims for the beneficiary) if:

- The STACH admission occurs within 30 days of the IRF discharge date, and
- The beneficiary discharged from the IRF was not transferred to a short-term acute care hospital, a long-term acute care hospital or an IRF within one day of discharge as evidenced by a subsequent claim, and
- The IRF discharge does not have a patient discharge status code of "07" (left against medical advice) or "20" (expired).

Below is a table showing claims submitted for one beneficiary over a 30-day period. The claims are sorted in date order on the left side of the table. Each row includes two admissions: the "index admission" and the "next admission" which may be considered as a readmission. The "next admission" on one row becomes the "index admission" on the following row.

	Index Admission Provider	Index Admission Date	Discharge Date	Patient Discharge Status Code	Next Admission Provider	Next Admission Date	Discharge Date	Calendar Gap Days	Next Admission Counts as a Readmission against Index Admission?
1	IRF #1	1/20/11	2/1/11	01	STACH #1	2/5/11	2/10/11	4	Yes, to IRF #1
2	STACH #1	2/5/11	2/10/11	62	IRF #2	2/10/11	2/20/11	0	Not applicable as the index admission is not to an IRF
3	IRF #2	2/10/11	2/20/11	02	STACH #1	2/20/11	2/22/11	0	No
4	STACH #1	2/20/11	2/22/11	01	(no further admissions)				n/a

Detailed discussion:
- Row 1: The beneficiary was admitted to IRF #1 on 1/20/11 and was discharged home (patient discharge status code 01). The beneficiary was admitted to STACH #1 on 2/5/11. This STACH admission counts as a "STACH admission within 30 days of IRF discharge" for IRF #1 against the 1/20/11 index admission.
- Row 2: The beneficiary was admitted to STACH #1 on 2/5/11 and was transferred (patient discharge status code 62) to IRF #2 on 2/10/11. The index admission to STACH #1 is not considered; only index admissions to an IRF are considered for this measure.
- Row 3: The beneficiary was admitted to IRF #2 on 2/10/11 and was transferred (patient discharge status code 02) to STACH #1 on 2/20/11. This admission is not counted as a "STACH admission following IRF discharge" because the beneficiary was transferred to a short-term acute care hospital (patient discharge status code 02).
- Row 4: The beneficiary was admitted to STACH #1 on 2/20/11 and was discharged home (patient discharge status code 01) on 2/22/11.