PEPPER

Short-Term Acute Care
Program for Evaluating Payment
Patterns Electronic Report

User's Guide
Thirty-Fifth Edition

Short-Term Acute Care
Program for Evaluating Payment Patterns Electronic Report User's Guide
Thirty-Fifth Edition, effective with the Q1FY22 release

What's new in this edition?

- Deleted the following Appendices, as they appeared in the Q3FY21 *Short-Term (ST) Acute Care Program for Evaluating Payment Patterns Electronic Report (PEPPER)*:
  - DRG Listing for the *Medical DRGs with CC or MCC* Target Area (FY 2021)
  - DRG Listing for the *Surgical DRGs with CC or MCC* Target Area (FY 2021)
  - Excisional Debridement ICD-10-PCS Procedure Codes
  - Percutaneous Cardiac Procedure Denominator CPT® and HCPCS Codes
  - Total Knee Replacement ICD-10-PCS Procedure Codes
  - Spinal Fusion Target Area Numerator and Denominator Procedure Codes
- Added a note about the inclusion of outpatient claims in the *Emergency Department Evaluation and Management Visits* target area Introduction

What Is PEPPER?

The Office of Inspector General encourages hospitals to develop and implement a compliance program to protect their operations from fraud and abuse.[1,2] As part of its compliance program, a hospital should conduct regular audits to ensure charges for Medicare services are correctly documented and billed. The PEPPER can help guide hospitals' auditing and monitoring activities.

PEPPER is an electronic data report that contains a single hospital's claims data statistics for Medicare-Severity Diagnosis-Related Groups (MS-DRGs) and discharges at risk for improper payment due to billing, coding, and/or admission necessity issues. Each PEPPER contains statistics for the most recent 12 federal fiscal quarters for each area at risk for improper payments (referred to in the report as "target areas"). Data in PEPPER is presented in tabular form, as well as in graphs that depict the hospital's target area percentages over time. PEPPER also includes reports on the hospital's top medical and surgical DRGs for one-day stays. 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 potential overpayments as well as potential underpayments.

PEPPER is available for short- and long-term acute care hospitals, critical access hospitals, and inpatient psychiatric facilities, inpatient rehabilitation facilities, hospices, partial hospitalization programs, skilled nursing facilities, and home health agencies. The *ST PEPPER* is the version of PEPPER designed specifically for short-term acute care hospitals. In *ST PEPPER*, a hospital is compared to other short-term acute care hospitals in three comparison groups: the nation, Medicare Administrative Contractor (MAC) jurisdictions, and the state in which the hospital operates. These comparisons enable a hospital to determine whether it is an outlier, differing from other short-term acute care hospitals.

> **PEPPER does not identify the presence of payment errors, 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:
> - Significant changes in billing practices
> - Possible over- or under-coding
> - Changes in lengths of stay

PEPPER determines outliers based on preset control limits. The upper control limit for all target areas is the 80th percentile. Coding-focused target areas also have a lower control limit, which is the 20th percentile. PEPPER draws attention to any findings that are at or above the upper control limit (high outlier) or at or below the lower control limit (low outliers for coding-focused areas only).

Note that in PEPPER, the term "outlier" is used when a hospital's target area percent is in the top 20% of all hospital target area percents in the respective comparison group (i.e., is at/above the 80th percentile) or is in the bottom 20% of all hospital target area percents in the respective comparison group (i.e., is

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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, Feb. 23, 1998, 8987–8998. Available at: https://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, Jan. 31, 2005, 4858–4876. Available at: https://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf

at/below the 20th percentile for coding-focused target areas). Formal tests of significance are not used to determine outlier status in PEPPER.

Specifications for claims eligible for inclusion in *ST PEPPER* are shown in the table below.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Acute care providers only	Third position of the CMS Certification Number = "0"
Services provided during the time periods included in the report	Claim "Through Date" (discharge date) falls within the 12 fiscal quarters included in the report
Claim with valid medical record number	UB-04 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 UB-04 FL 17
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Health Maintenance Organization
Exclude cancelled claims	Exclude claims cancelled by the MAC

Effective with this release, short-term acute care hospitals receive PEPPER files through a secure portal at PEPPER.CBRPEPPER.org on a quarterly basis.

ST PEPPER CMS Target Areas

In general, the target areas are constructed as ratios and expressed as percents; the numerator represents discharges that have been identified as problematic, and the denominator represents discharges of a larger comparison group. For example, admission necessity-focused target areas generally include in the numerator the discharges or DRG(s) that have been identified as prone to unnecessary admissions, and the denominator generally includes all discharges for the DRG(s) or all discharges. Target areas related to DRG coding generally include in the numerator the DRG(s) that have been identified as prone to DRG coding errors, and the denominator includes these DRGs in addition to the DRGs to which the original DRG is frequently changed.

The *ST PEPPER* target areas are defined in the table on the following pages.

TARGET AREA	TARGET AREA DEFINITION
Stroke Intracranial Hemorrhage	*Numerator (N):* count of discharges for DRGs 061 (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with major complication or comorbidity [MCC]), 062 (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with complication or comorbidity [CC]), 063 (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent without CC/MCC), 064 (intracranial hemorrhage or cerebral infarction with MCC), 065 (intracranial hemorrhage or cerebral infarction with CC or tissue plasminogen activator [tPA] in 24 hours), 066 (intracranial hemorrhage or cerebral infarction without CC/MCC) *Denominator (D):* count of discharges for DRGs 061, 062, 063, 064, 065, 066, 067 (nonspecific cerebrovascular accident [CVA] and precerebral occlusion without infarct with MCC), 068 (nonspecific CVA and precerebral occlusion without infarct without MCC), 069 (transient ischemia without thrombolytic)
Respiratory Infections	*N:* count of discharges for DRGs 177 (respiratory infections and inflammations with MCC), 178 (respiratory infections and inflammations with CC) *D:* count of discharges for DRGs 177, 178, 179 (respiratory infections and inflammations w/o CC/MCC), 193 (simple pneumonia and pleurisy with MCC), 194 (simple pneumonia and pleurisy with CC), 195 (simple pneumonia and pleurisy without CC/MCC) Note: Beginning with the Q1FY18 PEPPER, some hospitals may see increases in the numerator and denominator counts for *Simple Pneumonia* and in the denominator counts for *Respiratory Infections*, due to a coding guideline change effective for discharges after Oct. 1, 2017. The note associated with International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code J44.0 (chronic obstructive pulmonary disease with acute lower respiratory infection) changed from a "Use additional code" note to a "Code also" note, meaning there is no sequencing mandated, allowing coders to assign the principal diagnosis based on the circumstances of the admission (reference *ICD-10-CM Official Guidelines for Coding and Reporting*) (I.A.17).
Simple Pneumonia	*N:* count of discharges for DRGs 193, 194 *D:* count of discharges for DRGs 190 (chronic obstructive pulmonary disease with MCC), 191 (chronic obstructive pulmonary disease with CC), 192 (chronic obstructive pulmonary disease without CC/MCC), 193, 194, 195 Note: Beginning with the Q1FY18 PEPPER, some hospitals may see increases in the numerator and denominator counts for *Simple Pneumonia* and in the denominator counts for *Respiratory Infections*, due to a coding guideline change effective for discharges after Oct. 1, 2017. The note associated with ICD-10-CM code J44.0 (chronic obstructive pulmonary disease with acute lower respiratory infection) changed from a "Use additional code" note to a "Code also" note, meaning there is no sequencing mandated, allowing coders to assign the principal diagnosis based on the circumstances of the admission (reference *ICD-10-CM Official Guidelines for Coding and Reporting*) (I.A.17).

TARGET AREA	TARGET AREA DEFINITION
Septicemia	*N:* count of discharges for DRGs 870 (septicemia or severe sepsis with mechanical ventilation >96 hours), 871 (septicemia or severe sepsis without mechanical ventilation >96 hours with MCC), 872 (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC)
	D: count of discharges for DRGs 193 (simple pneumonia and pleurisy with MCC), 194 (simple pneumonia and pleurisy with CC), 195 (simple pneumonia and pleurisy without CC/MCC), 207 (respiratory system diagnosis with ventilator support >96 hours), 208 (respiratory system diagnosis with ventilator support < 96 hours), 689 (kidney and urinary tract infections with MCC), 690 (kidney and urinary tract infections without MCC), 870, 871, 872
Unrelated OR Procedure	*N*: count of discharges for DRGs 981 (extensive operating room [OR] procedure unrelated to principal diagnosis with MCC), 982 (extensive OR procedure unrelated to principal diagnosis with CC), 983 (extensive OR procedure unrelated to principal diagnosis without CC/MCC), 987 (non-extensive OR procedure unrelated to principal diagnosis with MCC), 988 (non-extensive OR procedure unrelated to principal diagnosis with CC), 989 (non-extensive OR procedure unrelated to principal diagnosis without CC/MCC)
	D: count of all discharges for surgical DRGs
Medical DRGs with CC or MCC	*N:* count of discharges for medical DRGs with "w CC," "w MCC," or "w CC/MCC" in the DRG description, excluding those DRGs that can be assigned on the basis of a CC, MCC, or medication administration (DRGs 065 [intracranial hemorrhage or cerebral infarction with CC or tPA in 24 hrs.], 838 [chemo with acute leukemia as secondary diagnosis (SDX) with CC or high dose chemo agent])
	D: count of discharges for medical DRGs with "w CC," "w MCC," "w CC/MCC," "wo CC," "wo MCC," or "wo CC/MCC" in the DRG description, excluding those DRGs that can be assigned on the basis of a CC, MCC, or medication administration (DRGs 065, 838)
Surgical DRGs with CC or MCC	*N:* count of discharges for surgical DRGs with "w CC," "w MCC," or "w CC/MCC" in the DRG description, excluding those DRGs that can be assigned on the basis of a CC, MCC, or a procedure (DRGs 005 [liver transplant with MCC or intestinal implant], 016 [autologous bone marrow transplant w CC/MCC or t-cell immunotherapy], 023 [craniotomy with major device implant or acute complex central nervous system (CNS) principal diagnosis with MCC or chemo implant or epilepsy with neurostimulator], 029 [spinal procedures with CC or spinal neurostimulators], 041 [peripheral/cranial nerve and other nervous system procedure with CC or peripheral neurostimulator], 246 [percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries/stents], 248 [percutaneous cardiovascular procedures with non-drug-eluting stent with MCC or 4+ arteries/stents], 469 [major hip and knee joint replacement or reattachment of lower extremity w MCC or total ankle replacement], 518 [Back and neck procedures except spinal fusion with MCC or disc/neurostimulator])
	D: count of discharges for surgical DRGs with "w CC," "w MCC," "w CC/MCC," "wo CC," "wo MCC," or "wo CC/MCC" in the DRG description, excluding those DRGs that can be assigned on the basis of a CC, MCC, or a procedure (DRGs 005, 016, 023, 029, 041, 246, 248, 469, 518)

TARGET AREA	TARGET AREA DEFINITION
Single CC or MCC	*N:* count of discharges for DRGs assigned on the basis of a CC or MCC with only one CC or MCC coded on the claim, excluding DRGs that can be assigned on the basis of a CC, MCC, or a procedure *D:* count of discharges for DRGs assigned on the basis of a CC or MCC, excluding DRGs that can be assigned on the basis of a CC, MCC, or a procedure
Severe Malnutrition *new as of the Q3FY21 release*	*N:* count of discharges for DRGs assigned on the basis of an MCC with one of the severe malnutrition codes (i.e., E40, E41, E42, or E43) as the only MCC *D:* count of discharges for DRGs assigned on the basis of an MCC when one or more MCCs includes severe malnutrition
Excisional Debridement	*N:* count of discharges for DRGs affected by International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) procedure codes for excisional debridement (see Appendix 1) that have an excisional debridement procedure code on the claim *D:* count of discharges for the DRGs Note: Based on changes related to ICD-10, Appendices 3 and 4 have been updated
Ventilator Support	*N*: count of discharges for DRGs 003 (extracorporeal membrane oxygenation or tracheostomy with mechanical ventilation >96 hours or principal diagnosis except face, mouth and neck with major OR procedure), 004 (tracheostomy with mechanical ventilation >96 hours or principal diagnosis except face, mouth and neck without major OR procedure), 207 (respiratory system diagnosis with ventilator support >96 hours), 870 (septicemia or severe sepsis with mechanical ventilation >96 hours), 927 (extensive burns or full thickness burns with mechanical ventilation >96 hours with skin graft), 933 (extensive burns or full thickness burns with mechanical ventilation >96 hours without skin graft), with ICD-10-PCS procedure code 5A1955Z (ventilator support >96 consecutive hours) on the claim *D*: count of discharges for DRGs 003, 004, 207, 208 (respiratory system diagnosis with ventilator support < 96 hours), 870, 871 (septicemia or severe sepsis without mechanical ventilation >96 hours with MCC), 872 (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC), 927, 928 (full thickness burns with skin graft or inhalation injury with CC or MCC), 929 (full thickness burns with skin graft or inhalation injury without CC or MCC), 933, 934 (full thickness burn without skin graft or inhalation injury)
Emergency Department Evaluation and Management Visits	*N*: count of emergency department (ED) evaluation and management (E&M) visits, highest severity (Current Procedural Terminology® [CPT®] = 99285, highest level code) *D*: count of all ED E&M visits (CPT® = 99281, 99282, 99283, 99284, 99285) Note: The numerator and denominator are derived solely from outpatient claims.
Chronic Obstructive Pulmonary Disease	*N*: count of discharges for DRGs 190 (chronic obstructive pulmonary disease with MCC) 191 (chronic obstructive pulmonary disease with CC), 192 (chronic obstructive pulmonary disease without CC/MCC) *D*: count of all discharges for medical DRGs in Major Diagnostic Category (MDC) 04 (respiratory system)

TARGET AREA	TARGET AREA DEFINITION
Percutaneous Cardiovascular Procedures	*N:* count of discharges for DRGs 246 (percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries/stents), 247 (percutaneous cardiovascular procedure with drug-eluting stent without MCC), 248 (percutaneous cardiovascular procedures with non-drug eluting stent with MCC or 4+ arteries/stents), 249 (percutaneous cardiovascular procedure with non-drug-eluting stent without MCC) *D:* count of discharges for DRGs 246, 247, 248, 249 plus outpatient claims with CPT® codes 92928, 92933, 92937, 92941, 92943 or with Healthcare Common Procedure Coding System (HCPCS) codes C9600, C9602, C9604, C9606, C9607
Total Knee Replacement *new as of the Q3FY20 release*	*N:* count of discharges with at least one of the ICD-10-PCS knee replacement procedure codes *D:* count of discharges with at least one of the ICD-10-PCS knee replacement procedure codes plus outpatient claims with CPT® code 27447
Syncope	N: count of discharges for DRG 312 (syncope and collapse) D: count of discharges for medical DRGs in MDC 05 (circulatory system)
Other Circulatory System Diagnoses	N: count of discharges for DRGs 314 (other circulatory system diagnoses with MCC), 315 (other circulatory system diagnoses with CC), 316 (other circulatory system diagnoses without CC/MCC) D: count of discharges for medical DRGs in MDC 05 (circulatory system)
Other Digestive System Diagnoses	N: count of discharges for DRGs 393 (other digestive system diagnoses with MCC), 394 (other digestive system diagnoses with CC), 395 (other digestive system diagnoses without CC/MCC) D: count of discharges for medical DRGs in MDC 06 (digestive system)
Medical Back Problems	*N:* count of discharges for DRGs 551 (medical back problems with MCC), 552 (medical back problems without MCC) *D:* count of all discharges for medical DRGs in MDC 08 (Musculoskeletal System and Connective Tissue)
Spinal Fusion	*N:* count of discharges that have spinal fusion procedure codes on the claim *D:* count of discharges that have spinal procedure codes on the claim
Three-Day Skilled Nursing Facility-Qualifying Admissions	*N:* count of discharges to a skilled nursing facility (SNF) with a three-day length of stay (LOS) *D:* count of all discharges to a SNF (identified by patient discharge status code of 03 [discharged or transferred to a SNF], 83 [discharged or transferred to a SNF with a planned acute care hospital inpatient admission], 61 [discharged or transferred to a swing bed], 89 [discharged or transferred to a swing bed with a planned acute care hospital inpatient admission])

TARGET AREA	TARGET AREA DEFINITION
30-Day Readmissions to Same Hospital or Elsewhere	*N:* count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the same hospital or to another short-term acute care prospective payment system (PPS) hospital for the same beneficiary (identified using the Health Insurance Claim number); patient discharge status of the index admission or the readmission is not equal to 02 (discharged/transferred to a short-term general hospital for inpatient care), 82 (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission), 07 (left against medical advice); excluding rehabilitation and primary psychiatric Clinical Classification Software (CCS)[3] diagnosis categories (see Appendix 2) *D*: count of all discharges excluding patient discharge status codes 02, 82, 07, 20 and excluding rehabilitation and primary psychiatric CCS diagnosis categories (See Appendix 3 for more specifics regarding how readmissions are identified)
30-Day Readmissions to Same Hospital	*N:* count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the same hospital for the same beneficiary (identified using the Health Insurance Claim number); patient discharge status of the index admission or the readmission is not equal to 02, 82, 07; excluding rehabilitation and primary psychiatric CCS diagnosis categories (see Appendix 2) *D*: count of all discharges excluding patient discharge status codes 02, 82, 07, 20; excluding rehabilitation and primary psychiatric CCS diagnosis categories (See Appendix 3 for more specifics regarding how readmissions are identified)
Two-Day Stays for Medical DRGs	*N*: count of discharges for medical DRGs with a LOS equal to two days ("through" date minus "admission" date = two days), excluding patient discharge status codes 02, 82, 07, 20, excluding claims with occurrence span code 72 (identifying outpatient time associated with an inpatient admission) with "through" date on or day prior to inpatient admission *D*: count of discharges for medical DRGs, excluding claims with patient discharge status codes 02, 82, 07, 20; excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission
Two-Day Stays for Surgical DRGs	*N*: count of discharges for surgical DRGs with a LOS equal to two days ("through" date minus "admission" date = two days), excluding patient discharge status codes 02, 82, 07, 20, excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission *D*: count of discharges for surgical DRGs, excluding claims with patient discharge status codes 02, 82, 07, 20; excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission

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[3] ICD-10 diagnoses and procedures have been collapsed into general categories using Clinical Classification Software (CCS). More information on CCS can be found at http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp

TARGET AREA	TARGET AREA DEFINITION
One-Day Stays for Medical DRGs	*N*: count of discharges for medical DRGs with a LOS equal to one day ("through" date minus "admission" date = one day, or "admission" date equal to "through" date), excluding patient discharge status codes 02, 82, 07, 20, excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission
	D: count of discharges for medical DRGs excluding claims with patient discharge status codes 02, 82, 07, 20; excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission
One-Day Stays for Surgical DRGs	*N*: count of discharges for surgical DRGs with a LOS equal to one day ("through" date minus "admission" date = one day, or "admission" date equal to "through" date), excluding patient discharge status codes 02, 82, 07, 20, excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission
	D: count of discharges for surgical DRGs, excluding claims with patient discharge status codes 02, 82, 07, 20; excluding claims with occurrence span code 72 with "through" date on or day prior to inpatient admission

CMS approved these *ST PEPPER* target areas because they have been identified as prone to improper Medicare payments. Historically, many of these target areas were the focus of Office of Inspector General audits, while others were identified through the former Payment Error Prevention Program and Hospital Payment Monitoring Program, which were implemented by state Medicare Quality Improvement Organizations from 1999 through 2008. More recently, the Recovery Audit Contractor (RAC) (now referred to as a Recovery Auditor or RA) program has identified additional areas prone to improper payments.

The Office of Inspector General (OIG) found widespread miscoding of severe malnutrition in instances where hospitals should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all.[4] Four ICD-10 diagnosis codes — E40, E41, E42, and E43 — qualify as an MCC and can raise the payment for a claim if included as a secondary diagnosis.

There are five levels of ED E&M codes. There are significant differences in payment levels for these services; the highest level code has much higher reimbursement than the other codes. Concerns with overuse/misuse of higher level E&M codes have been prevalent for several years. The Office of Inspector General identified increasing trends of E&M coding for higher-level services[4] as well as improper payments associated with E&M coding errors.[5]

Effective Jan. 1, 2018, total knee replacement procedures were removed from CMS' inpatient only list, allowing these procedures to be performed on an inpatient or outpatient basis. CMS maintains that the

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[4] Department of Health and Human Services/Office of Inspector General. 2020. *Hospitals Overbilled Medicare $1 Billion by Incorrectly Assigning Severe Malnutrition Diagnosis Codes to Inpatient Hospital Claims,* July 2020. Available at: https://oig.hhs.gov/oas/reports/region3/31700010.pdf

Department of Health and Human Services/Office of Inspector General. 2012. *Coding Trends of Medicare Evaluation and Management Services*, May 2012. Available at: https://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf

[5] Department of Health and Human Services/Office of Inspector General. 2014. *Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010*, May 2014. Available at: https://oig.hhs.gov/oei/reports/oei-04-10-00181.pdf

decision to admit a patient as an inpatient is a complex medical decision, based on the physician's clinical expectation of how long hospital care is anticipated to be necessary and the individual beneficiary's unique clinical circumstances. Analysis of claims data for calendar year 2019 indicates that approximately 30% of hospitals perform all total knee replacement procedures as inpatient. Short inpatient hospital admissions, in particular one-day stays, have had high rates of unnecessary admissions historically. CMS reported an improper payment rate of 36% in 2012 for inpatient stays lasting one night or less.[6] The Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) Final Rule changed admission and medical review criteria that CMS contractors (i.e., MACs and RAs) use to review inpatient hospital admissions for payment purposes. Generally, inpatient hospital admission is considered appropriate if the physician expects the beneficiary to require a stay that crosses two midnights and admits the beneficiary based on that expectation.[7]

To assist hospitals with monitoring short stays, several target areas in PEPPER focus on one- and two-day stays. Under the new CMS admission and medical review criteria, one-day stays may not be appropriate inpatient admissions, and two-day stays may be appropriate admissions. Hospitals can examine their statistics for these target areas to help them assess their risk for unnecessary admissions and to monitor changes in admission practices over time.

Readmissions have been associated with billing errors, premature discharge, incomplete care, and inappropriate readmission. There are two target areas relating to readmissions within 30 days of discharge: one including statistics for patients who were readmitted to either the same hospital or to another short-term acute care hospital, and the other including statistics for patients who were readmitted to the same hospital.

The *ST PEPPER* has included target areas pertaining to hospital readmissions since its initiation, before readmissions were added to the Hospital Inpatient Quality Reporting Program. As CMS began to calculate hospital readmission rates and report them publicly on Hospital Compare, the PEPPER Team has strived to calculate the PEPPER readmission statistics using a methodology that matches as closely as possible (but does not replicate) CMS' methodology. <u>Hospitals should expect the readmission statistics in their *ST PEPPER* to differ from those calculated by CMS and available on Hospital Compare.</u> The table below shows the differences between the readmission target areas included in the *ST PEPPER* and the readmissions measures calculated by CMS.

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[6] Department of Health and Human Services/Centers for Medicare & Medicaid Services. 2013. "Proposed Inpatient Admission Guidelines," *Federal Register* 78, no. 91, May. 10, 2013, 27647. Available at: https://www.govinfo.gov/content/pkg/FR-2013-05-10/pdf/2013-10234.pdf

[7] Department of Health and Human Services/Centers for Medicare & Medicaid Services. 2013. *Federal Register* 78, no. 160, Aug. 19, 2013. Available at: https://www.govinfo.gov/content/pkg/FR-2013-08-19/pdf/2013-18956.pdf

Differences Between PEPPER and Inpatient Quality Reporting

	ST PEPPER	CMS' Inpatient Quality Reporting
Use/Purpose	Measure hospital performance over time for quality improvement project monitoring; support efforts to prevent improper Medicare payments that result from billing errors or quality of care issues	Profile hospital performance for public reporting
Measures	Two measures: • 30-day readmissions to same hospital (all DRGs) • 30-day readmissions to same hospital or another short-term acute care hospital (all DRGs)	Seven measures: • 30-day readmission for acute myocardial infarction patients • 30-day readmission for heart failure patients • 30-day readmission for pneumonia patients • 30-day readmission for hip/knee replacement patients • 30-day readmission for coronary artery bypass graft patients • 30-day readmission for chronic obstructive pulmonary disease patients • 30-day overall rate of unplanned readmission after discharge from the hospital (hospital-wide readmission). (Note: This measure includes patients admitted for internal medicine, surgery/gynecology, cardiorespiratory, cardiovascular and neurology services. It is not a composite measure.)
Risk adjustment	No risk adjustment	Hospital-level 30-day all-cause risk standardized readmission measures
Planned readmissions	Planned readmissions not excluded	Planned readmissions excluded
Age requirements	Includes all Medicare beneficiaries regardless of age	Excludes Medicare beneficiaries under the age of 65
Coverage requirements	No coverage requirements	Medicare beneficiary must have 12 months of Part A coverage prior to the index admission and up to 30 days after discharge.
Readmission definition	Every readmission is counted within a 30 day period of a hospital discharge. Each subsequent readmission is also counted as an index admission.	The condition-specific readmission measures assign readmission status as a dichotomous "yes/no" value regardless of the number of times the patient was readmitted during the 30-day post-discharge time period. For hospital-wide readmission measures, readmission is also eligible to be counted as a new index admission if it meets all other eligibility criteria.
Data timeframe	Index admissions are identified as those with a discharge date that falls within the quarter. The timeframe is extended 30 days beyond the end of the quarter to capture readmissions.	For condition-specific measures, index hospitalizations are identified using three years of data; hospital-wide readmission measures use one year of data. Three years of data are required to obtain sufficient precision of the estimate for condition-specific measures.

	ST PEPPER	CMS' Inpatient Quality Reporting
Frequency of updates	Quarterly	Annually

The different purposes of the measures in the two programs impact the measures' design. While factors related to the risk-adjustment of patients are essential for measures that are publicly reported, they add significant complexity and processing time to generating statistics for inclusion in the PEPPER. A similar layer of increased complexity would be required to exclude planned readmissions. Therefore, the PEPPER readmission statistics do not incorporate risk adjustment or exclude planned readmissions.

Some hospitals have indicated they would like condition-specific readmission reports (analogous to the Inpatient Quality Reporting measures). These readmissions do not occur frequently enough during a quarter for most hospitals to have sufficient data to report.

In addition, some hospitals have requested patient-level data for their readmissions. Due to patient privacy regulations, the PEPPER Team cannot disclose to providers any information that would identify when a beneficiary was admitted to another provider.

Three-day SNF-qualifying admissions have been found to be problematic in terms of admission necessity, and historical data indicates that three-day SNF-qualifying admissions have a higher incidence of unnecessary admissions than other three-day admissions.

The coding of CCs and more recently MCCs has been found to be problematic. Oversight agencies have identified coding errors related to the addition of a CC or MCC that were not substantiated by documentation in the medical record. The target areas relating to medical and surgical DRGs with a CC or MCC and to discharges with a single CC or MCC focus on this issue. Note that as of Oct. 1, 2015, a principal diagnosis may also be a CC or MCC.

Please note there are changes in DRGs and DRG definitions from one fiscal year to the next that should be considered:

- Changes for FY 2020 are documented in the *Federal Register*, Volume 84, number 159, Aug. 16, 2019, pages 42044-42701.
- Changes for FY 2019 are documented in the *Federal Register*, Volume 83, number 160, Aug. 16, 2018, pages 41144-41784.
- Changes for FY 2018 are documented in the *Federal Register*, Volume 82, number 155, Aug. 14, 2017, pages 37990-38589.

How Hospitals Can Use PEPPER Data

For Medicare data, the fiscal year runs Oct. 1 through Sept. 30:
Quarter 1 = October – December
Quarter 2 = January – March
Quarter 3 = April – June
Quarter 4 = July – September

ST PEPPER provides short-term acute care hospitals with their national, jurisdiction, and state percentile values for each target area with reportable data for the most recent fiscal year quarter included in PEPPER (see Compare Targets Report on page 23). "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 following table can assist hospitals with interpreting these values.

Please note that these are generalized suggestions and will not apply to all situations. For all areas, assess whether there is sufficient volume (i.e., 10 to 30 discharges for the year, depending on the hospital's total discharges for the year) to warrant a review of cases.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Stroke Intracranial Hemorrhage	This could indicate potential over-coding. A sample of medical records for DRGs 061, 062, 063, 064, 065, and 066 should be reviewed to determine whether coding errors exist.	This could indicate that there are coding or billing errors related to under-coding of DRGs 061, 062, 063, 064, 065, and 066. A sample of medical records for other DRGs, such as DRGs 067, 068, and 069 should be reviewed to determine whether coding errors exist. Remember to ensure that the documentation supports the principal diagnosis. A coder should not code based on radiological findings without seeking clarification from the physician.
Respiratory Infections	This could indicate that there are coding or billing errors related to over-coding for DRGs 177 or 178. A sample of medical records for these DRGs should be reviewed to determine whether coding errors exist. Hospitals may generate data profiles to identify cases with principal diagnosis codes of ICD-10-PCS code J69.0 (pneumonitis due to inhalation of food or vomit), ICD-10-PCS code J15.64 (pneumonia due to other (aerobic) gram negative pneumonia), or ICD-10-PCS code J15.8 (pneumonia due to other specified bacteria) to ensure that documentation supports the principal diagnosis.	This could indicate that there are coding or billing errors related to under-coding for DRGs 177 or 178. A sample of medical records for other DRGs, such as DRGs 179, 193, 194, or 195 should be reviewed to determine whether coding errors exist. Remember that a diagnosis of pneumonia must be determined by the physician. A coder should not code based on a laboratory or radiological finding without seeking clarification from the physician.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Simple Pneumonia	This could indicate that there are coding or billing errors related to DRGs 193 or 194. A sample of medical records for these DRGs should be reviewed to determine whether coding errors exist. Hospitals should ensure documentation supports the principal diagnosis.	This could indicate that there are coding or billing errors related to under-coding for DRGs 193 or 194. A sample of medical records for other DRGs, such as DRGs 177, 178, and 189 (pulmonary edema and respiratory failure), should be reviewed to determine whether coding errors exist. Remember that a diagnosis of pneumonia must be determined by the physician. A coder should not code based on a laboratory or radiological finding without seeking clarification from the physician.
Septicemia	This could indicate that there are coding or billing errors related to over-coding of DRGs 870, 871, or 872. A sample of medical records for these DRGs should be reviewed to determine whether coding errors exist. Hospitals may generate data profiles to identify cases with a principal diagnosis code of ICD-10-CM code A41.9 (unspecified septicemia) to ensure documentation supports the principal diagnosis.	This could indicate that there are coding or billing errors related to under-coding of DRGs 870, 871, or 872. A sample of medical records for other DRGs, such as DRGs 689, 690, 193, 194, 195, 207, and 208 should be reviewed to determine whether coding errors exist. Remember that a diagnosis of septicemia/sepsis must be determined by the physician. A coder should not code based on a laboratory finding without seeking clarification from the physician. Note: There is no ICD-10-CM code for urosepsis.
Unrelated OR Procedure	This could indicate that there are coding or billing errors related to over-coding of DRGs 981, 982, 983, 987, 988, or 989. A sample of medical records for these DRGs should be reviewed to determine whether the principal diagnosis and principal procedure are correct.	This could indicate that the principal diagnosis is being billed with the related procedures. No intervention is necessary.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Medical DRGs with CC or MCC *Surgical DRGs with CC or MCC* *Single CC or MCC*	This could indicate that there are coding or billing errors related to over-coding due to unsubstantiated CCs or MCCs. A sample of medical records for medical and/or surgical DRGs with CCs or MCCs (a single CC or MCC for the *Single CC or MCC* target area) should be reviewed to determine whether coding errors exist. Hospitals may generate data profiles to identify proportions of their CCs or MCCs to determine whether there are any particular medical and/or surgical DRGs on which to focus. Remember that a diagnosis of a CC or MCC must be determined by the physician. A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. If particular diagnoses are found to be problematic, provide education.	This could indicate that there are coding or billing errors related to under-coding for CCs or MCCs. A sample of medical records for medical and/or surgical DRGs without a CC or MCC should be reviewed to determine whether coding errors exist. Remember that in order for a diagnosis to be coded as a CC or MCC, it must be substantiated by documentation. A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. Consider whether the use of a physician query would have substantiated a CC or MCC.
Severe Malnutrition **new as of the Q3FY21 release*	This could indicate that there are coding errors related to unsubstantiated coding of one of the severe malnutrition codes (i.e., E40, E41, E42, or E43) as the only MCC. A sample of medical records with a severe malnutrition code as the only MCC should be reviewed to determine whether coding errors exist. A diagnosis of severe malnutrition must be determined by the physician. A coder should not code based on laboratory findings or nutritional consultation without seeking physician determination of the clinical significance of the abnormal findings.	This could indicate that there are coding errors related to potential under-coding of severe malnutrition codes (i.e., E40, E41, E42, or E43). A sample of medical records should be reviewed to determine whether coding errors exist. A diagnosis of severe malnutrition must be determined by the physician. A coder should not code based on laboratory findings or nutritional consultation without seeking physician determination of the clinical significance of the abnormal findings.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Excisional Debridement	This could indicate that there are coding or billing errors related to the coding of excisional debridement. A sample of medical records including excisional debridement procedure codes should be reviewed to ensure that the coding is supported by the documentation. Refer to *Coding Clinic* for specific guidelines regarding the coding of excisional debridement.	If your facility does not perform excisional debridement, low numbers in this target area would be expected. If the excisional debridement number is lower than expected, this could indicate that there are coding or billing errors related to under-coding for excisional debridement. A sample of medical records involving debridement should be reviewed to ensure that the coding is supported by the documentation. Refer to *Coding Clinic* for specific guidelines regarding coding for debridement.
Ventilator Support	This could indicate that there are coding or billing errors related to over-coding of DRGs 003, 004, 207, 870, 927, or 933. A sample of medical records for these DRGs should be reviewed to determine whether the type of tracheostomy and mechanical ventilation were coded correctly. Verify that the number of continuous invasive mechanical ventilation hours was coded accurately.	This could indicate under-coding related to incorrect computation of the number of hours the patient was receiving continuous invasive mechanical ventilation. Review cases with ICD-10-PCS procedure codes 5A1935Z (mechanical ventilation less than 24 consecutive hours) and 5A1945Z (mechanical ventilation 24-96 consecutive hours) to verify that the number of continuous invasive mechanical ventilation hours was coded accurately.
Emergency Department Evaluation and Management Visits	This could indicate that there are coding or billing errors related to over-coding of CPT® code 99285. A sample of medical records for visits coded with 99285 should be reviewed to ensure that the coding is supported by the documentation. Refer to the current CPT® coding book and to CPT® Assistant, which is the official source for CPT® coding guidance.	This could indicate that there are coding errors related to under-coding of CPT® code 99285. A sample of medical records for visits coded with 99281, 99282, 99283, or 99284 should be reviewed to ensure that the coding is supported by the documentation. Refer to the current CPT® coding book and to CPT® Assistant, which is the official source for CPT® coding guidance.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Chronic Obstructive Pulmonary Disease	This could indicate that there are unnecessary admissions related to the failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRGs 190, 191, or 192. A sample of medical records for these DRGs should be reviewed to determine whether inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). Note: These DRGs are also vulnerable to coding errors.	Not applicable, as this is an admission-necessity focused target area.
Percutaneous Cardiovascular Procedures	This could indicate that there are unnecessary admissions related to the use of outpatient observation or inappropriate use of admission screening criteria associated with DRGs 246, 247, 248, or 249. A sample of medical records for these DRGs should be reviewed to determine whether care could have been provided more efficiently on an outpatient basis. Documentation should support the need for an inpatient admission.	Not applicable, as this is an admission-necessity focused target area.
Total Knee Replacement *new as of the Q3FY20 release*	This could indicate that there are unnecessary admissions related to the inappropriate use of admission screening criteria associated with total knee replacement procedures. A sample of medical records for these procedures should be reviewed to determine whether care could have been provided more efficiently on an outpatient basis. Documentation should support the need for an inpatient admission.	Not applicable, as this is an admission-necessity focused target area.
Syncope	This could indicate that there are unnecessary admissions related to the failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRG 312. A sample of medical records for DRG 312 should be reviewed to determine whether care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). Note: Code to the underlying cause of syncope if known.	Not applicable, as this is an admission-necessity focused target area.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Other Circulatory System Diagnoses	This could indicate that there are unnecessary admissions related to the failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRGs 314, 315, or 316. A sample of medical records for these DRGs should be reviewed to determine whether care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation).	Not applicable, as this is an admission-necessity focused target area.
Other Digestive System Diagnoses	This could indicate that there are unnecessary admissions related to the failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRGs 393, 394, and 395. A sample of medical records for these DRGs should be reviewed to determine whether care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation).	Not applicable, as this is an admission-necessity focused target area.
Medical Back Problems	This could indicate unnecessary admissions related to the failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRGs 551 and 552. A sample of medical records for these DRGs should be reviewed to determine whether inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation).	Not applicable, as this is an admission-necessity focused target area.
Spinal Fusion	This could indicate that there are unnecessary admissions related to the performance of unnecessary spinal fusion procedures. A sample of medical records for spinal fusion cases should be reviewed to validate the medical necessity of the procedure. Medical record documentation of 1) previous non-surgical treatment, 2) physical examination clearly documenting the progression of neurological deficits, extremity strength, activity modification, and pain levels, 3) diagnostic test results and interpretation, and 4) adequate history of the presenting illness, may help substantiate the necessity of the procedure.	Not applicable, as this is an admission-necessity focused target area.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Three-Day Skilled Nursing Facility-Qualifying Admissions	This could indicate that there are admission necessity issues related to unnecessary admissions to qualify patients for a SNF admission. A sample of medical records with three-day lengths of stay and patient discharge status codes of 03, 83, 61, or 89 should be reviewed to determine whether the admission was necessary.	Not applicable, as this is an admission-necessity focused target area.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
30-Day Readmissions to Same Hospital or Elsewhere *30-Day Readmissions to Same Hospital*	A sample of readmission cases should be reviewed to identify appropriateness of admission, discharge, quality of care, DRG assignment, and billing errors. The hospital is encouraged to generate data profiles for readmissions, such as 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, patient discharge status code, principal and secondary diagnoses, procedure code(s), and DRG. Evaluate these profiles for the following indications of potential improper payments: • Patients discharged home (patient discharge status code 01) and readmitted the same or next day may indicate a potential premature discharge or incomplete care. • Patients readmitted for the same principal diagnosis as the first admission may indicate a potential premature discharge or incomplete care. Same-day readmissions for related medical conditions are combined by the MAC, and the hospital is reimbursed for one admission. Hospitals should utilize condition code B4 when a patient is readmitted on the same day to treat a condition that was not related to the first admission. • Hospitals that have swing bed exempt units should verify that the correct provider number was billed (exempt unit number vs. acute care number) for same-day readmissions. The second admission to an exempt swing bed unit should be billed to the exempt unit number, whereas a readmission for acute care should be billed to the acute care number. There is a high probability of billing error when the following patient discharge status codes are billed on the first admission of a same-day readmission to the same hospital: 03, 83, 61, or 89.	Not applicable, as these are admission-necessity focused target areas.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Both one-day stay target areas: **One-Day Stays for Medical DRGs** **One-Day Stays for Surgical DRGs**	This could indicate that there are unnecessary admissions related to the inappropriate use of admission screening criteria or outpatient observation. A sample of one-day stay cases should be reviewed to determine whether inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). Hospitals may generate data profiles to identify one-day stays sorted by DRG, physician, or admission source to assist in the identification of any patterns related to one-day stays. Hospitals may also wish to identify whether patients admitted for one-day stays were treated in outpatient, outpatient observation, or the emergency department for one or more nights prior to the inpatient admission. Hospitals should not review one-day stays that are associated with procedures designated by CMS as "inpatient only."	Not applicable, as these are admission-necessity focused target areas.
Both two-day stay target areas: **Two-Day Stays for Medical DRGs** **Two-Day Stays for Surgical DRGs**	This could indicate that there are unnecessary admissions related to the inappropriate use of admission screening criteria or outpatient observation, in particular if the two-day stay rate has increased after the first quarter of fiscal year 2014 (Oct. 1, 2013). A sample of two-day stay cases should be reviewed to determine whether inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). Hospitals may generate data profiles to identify two-day stays sorted by DRG, physician, or admission source to assist in the identification of any patterns related to increasing two-day stays.	Not applicable, as these are admission-necessity focused target areas.

Comparative data for several consecutive quarters can be used to help identify whether the hospital's target area percents changed significantly in either direction from one quarter 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. It could also reflect changing business practices (e.g., new lines of service) or changes in the external health care environment.

Using PEPPER

PEPPER is a Microsoft Excel workbook that contains numerous worksheets. Users 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., Compare Targets Report, target area data tables, target area graphs).

Compare Targets Report

Hospitals 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 fiscal year quarter included in PEPPER. For each target area, the Compare Targets Report displays the hospital's number of target discharges, percent, percentiles as compared to the nation, jurisdiction, and state, and the "Sum of Payments."

> The Compare Targets Report is the only report in PEPPER that allows hospitals to assess high and low outlier status for all target areas simultaneously.

The hospital's outlier status is indicated by the color of the target area percent on the Compare Targets Report. When the hospital is a high outlier for a target area, the hospital percent is printed in **red bold**. When the hospital is a low outlier (for coding-focused target areas only), the hospital percent is printed in *green italics*. When the hospital is not an outlier, the hospital's percent is printed in black.

The Compare Targets Report provides the hospital's percentile value for the nation, jurisdiction, and state for all target areas with reportable data in the most recent quarter. The percentile value allows a hospital to judge how its target area percent compares to all hospitals in each respective comparison group.

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

The hospital's jurisdiction percentile indicates the percentage of all other hospitals in the jurisdiction that have a target area percent less than the hospital's target area percent. The hospital's jurisdiction percentile for a target area is not calculated if there are fewer than 11 hospitals with reportable data for the target area in a jurisdiction.

The hospital's state percentile indicates the percentage of all other hospitals in the state that have a target area percent less than the hospital's target area percent. The hospital's state percentile for a target area is not calculated if there are fewer than 11 hospitals with reportable data for the target area in the state.

To learn more about how percents differ from percentiles, please see the "Frequently Asked Questions" section or the "Training and Resources" section for short-term acute care hospitals at 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, hospitals should consider their target area percentile values for the nation, jurisdiction, and state. Percentile values at or above the 80th percentile (for all target areas) or at or below the 20th percentile (for coding-focused target areas) indicate that the hospital is an outlier. Outlier status should be evaluated in the following priority order: 1) nation, 2) jurisdiction, and 3) state. The state should have the last priority because it has the smallest comparison group.

The "Sum of Payments" and "Number of Target Discharges" can also be used to help prioritize areas for review. For example, the Compare Targets Report may show that the hospital is at the 85th national percentile for *Septicemia* target area and at the 83rd national percentile for the *Single CC or MCC* target

area. The *Single CC or MCC* target area has a higher "Sum of Payments" and "Number of Target Discharges" than the *Septicemia* target area. In this scenario, the *Single CC or MCC* target area might be given priority over the *Septicemia* target area.

National High Outlier Ranking Report

The National High Outlier Ranking Report provides a comparison of a hospital to all other short-term acute care hospitals in the nation in terms of high outlier status (at or above the national 80th percentile), and it also ranks a hospital based on the total number of target areas and time periods for which it is a

> **Outlier status in the National High Outlier Ranking Report is determined using the national percentile.**

high outlier. The hospital's national percentile is used to determine high outlier status. Note that a hospital may be identified as an outlier as compared to the nation but not as compared to its jurisdiction and/or state, and vice versa.

The report displays all target areas and 12 time periods in a grid format. For each target area and time period, the respective cell will contain a black "0" if the hospital is a low outlier or is not an outlier, a red "1" if the hospital is a high outlier, or "n/a" if the hospital does not have reportable data for that target area and time period. All quarters for which a hospital is at or above the national 80th percentile are added up for the target areas and are summed to provide the total number of high outliers. All hospitals in the nation are ranked by the total number of high outliers. The hospital with the greatest total number of high outliers is assigned a rank of "1," the hospital with the second greatest number of high outliers is assigned a rank of "2," and so on.

Because this report focuses on high outliers, it does not consider low outlier status for the coding-focused target areas. Hospitals may use the National High Outlier Ranking Report to:
- Assess risk for improper payments;
- Trend high outlier status across target areas;
- Compare outlier status among target areas; or
- Provide a high-level overview to leadership.

Target Area Data Tables

PEPPER data tables display a variety of statistics for each target area summarized over the previous 12 fiscal quarters. Statistics in each data table include the proportion of the numerator and denominator discharges (percent), the total numerator count of discharges for the target area (target area discharge count), the denominator count of discharges, average length of stay (ALOS), and Medicare payment data. The "Outlier Status" column identifies when the hospital is a high outlier — the hospital's percent will be shown in **red bold print** — indicating that it is at or above the national 80th percentile. The "Outlier Status" column also identifies when the hospital is a low outlier, which is a status that is applicable for coding-focused target areas; if identified as a low outlier, the hospital's percent will be shown in *green italics*, indicating that it is at or below the national 20th percentile. The "Outlier Status" column will display "Not an outlier" when the hospital is not an outlier for the target area and time period, and it will display "No data" when the hospital does not have reportable data for the target area and time period. Interpretive guidance is included on the data tables to assist hospitals in considering whether they should audit a sample of records. Suggested interventions tailored to each target area are also included on each data table.

Target Area Graphs

The PEPPER graphs provide a visual representation of the hospital's percent for each target area over the previous 12 fiscal quarters. Hospitals can identify significant changes from one quarter to the next, which could be a result of changes in the medical staff, coding or billing staff, utilization review processes, documentation improvement, or hospital services. External changes in health care providers in the community can also impact patient population/case mix, which may be reflected in PEPPER target area statistics. Hospitals are encouraged to identify root causes of major changes to ensure that improper payments are prevented.

The graphs include trend lines for the percents that are at the 80th percentile (and the 20th percentile for coding-focused target areas) for the three comparison groups (i.e., nation, jurisdiction, and state) so the hospital can easily identify when they are an outlier as compared to any of these groups. A table of these percents is included on each target area graph worksheet. State percentiles are zero when there are fewer than 11 hospitals with reportable data for the target area in the state. Jurisdiction percentiles are zero when there are fewer than 11 hospitals with reportable data for the target area in the jurisdiction. To learn more about how percents differ from percentiles, please see the "Frequently Asked Questions" section or the "Training and Resources" section for each respective setting on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

If there is no reportable data for the hospital for a given time period due to CMS data use restrictions (see "Target Area Data Tables" above), there will not be a data point on the graph for that respective time period. If there are fewer than 11 hospitals with reportable data for a target area in a state for one or more time periods, there will not be a data point/trend line for the state comparison group in the graph. If there are fewer than 11 hospitals with reportable data for a target area in a jurisdiction for one or more time periods, there will not be a data point/trend line for the jurisdiction comparison group in the graph.

Hospital Top Medical DRGs for Same- and One-Day Stay Discharges Report

This report lists the top medical DRGs for same- and one-day stays for your hospital in the most recent four fiscal quarters (excluding patient discharge status codes 02, 07, 20, and 82, along with claims with occurrence span code 72 with "through" date on or day prior to inpatient admission). It also includes the total hospital discharges for each of the top DRGs listed, the proportion of same- and one-day stays to total discharges and the average hospital LOS for each DRG. Please note that this report is limited to the top DRGs (up to 20) for which there are a total of at least 11 same- and one-day stays (for the respective DRG) during the most recent four fiscal quarters.

Hospital Top Surgical DRGs for Same- and One-Day Stay Discharges Report

This report lists the top surgical DRGs for same- and one-day stays for your hospital in the most recent four fiscal quarters (excluding patient discharge status codes 02, 07, 20, and 82, along with claims with occurrence span code 72 with "through" date on or day prior to inpatient admission). It also includes the total hospital discharges for each of the top DRGs listed, the proportion of same- and one-day stays to total discharges and the average hospital LOS for each DRG. Please note that this report is limited to the top DRGs (up to 20) for which there are a total of at least 11 same- and one-day stays (for the respective DRG) during the most recent four fiscal quarters.

Jurisdiction Top Medical DRGs for Same- and One-Day Stay Discharges Report

This report lists the top medical DRGs for same- and one-day stays for all hospitals in your jurisdiction in the most recent four fiscal quarters (excluding patient discharge status codes 02, 07, 20, and 82, along with claims with occurrence span code 72 with a "through" date on or the day prior to an inpatient admission). It also includes the total jurisdiction-wide discharges for each of the top DRGs listed, the proportion of same- and one-day stays to total discharges, and the ALOS for each DRG. Please note that this report is limited to displaying the top medical DRGs (up to 20) for which there are a total of at least 11 same- and one-day stays during the most recent four fiscal quarters.

Jurisdiction Top Surgical DRGs for Same- and One-Day Stay Discharges Report

This report lists the top surgical DRGs for same- and one-day stays for all hospitals in your jurisdiction in the most recent four fiscal quarters (excluding patient discharge status codes 02, 07, 20, and 82, along with claims with occurrence span code 72 with a "through" date on or the day prior to an inpatient admission). It also includes the total jurisdiction-wide discharges for each of the top DRGs listed, the proportion of same- and one-day stays to total discharges, and the ALOS for each DRG. Please note that this report is limited to displaying the top medical DRGs (up to 20) for which there are a total of at least 11 same- and one-day stays during the most recent four fiscal quarters.

Medicare Spending per Beneficiary by Claim Type Report

Hospital-level Medicare Spending per Beneficiary (MSPB) is calculated and reported annually to support the Hospital Value-Based Purchasing Program. Hospital-level statistics are available on the Hospital Compare website at https://www.medicare.gov/hospitalcompare/Data/spending-per-hospital-patient.html. These statistics can be valuable to hospitals to inform them on the total cost of care; however, the existing format of the data is not easily digestible. This report is intended to give hospitals a quick look at where their costs are higher or lower than the national median hospital.

The MSPB measure evaluates hospitals' efficiency, as reflected by Medicare payments made during an MSPB episode, relative to the efficiency of the median hospital in the nation. Each episode includes all Medicare Part A and Part B claims with a start date falling during the period from three days prior to a hospital admission (i.e., index admission) through 30 days after discharge from the hospital. Medicare payment amounts are risk-adjusted and price-standardized.

The MSPB Report tab contains the most current data available at the time of each PEPPER release. Please note that this report is populated for hospitals that have more than 25 episodes in the calendar year. The MSPB calculations do not include the following episodes:

- Episodes where at any time 90 days before or during the episode the beneficiary was enrolled in a Medicare Advantage plan or Medicare was the secondary payer.
- Episodes where the beneficiary becomes deceased during the episode.
- Episodes in which the index admission inpatient claim had $0 actual payment or a $0 standardized payment.
- Acute-to-acute transfers (where a transfer is defined based on the claim discharge code) are not considered index admissions. In other words, these cases do not generate new MSPB episodes; neither the hospital that transfers a patient to another subsection (d) hospital nor the receiving subsection (d) hospital will have an index admission or associated MSPB episode attributed to them.

- Admissions to hospitals that Medicare does not reimburse through the IPPS system (e.g., cancer hospitals, critical access hospitals [CAHs], hospitals in Maryland) are not considered index admissions and are therefore not eligible to begin an MSPB episode. If an acute-to-acute hospital transfer or a hospitalization in a PPS-exempt hospital type happens during the 30-day window following an included index admission; however, it will be counted in the measure.

Regarding beneficiaries whose primary insurance becomes Medicaid during an episode due to exhaustion of Medicare Part A benefits, Medicaid payments made for services rendered to these beneficiaries are excluded; however, all Medicare Part A payments made before benefits are exhausted and all Medicare Part B payments made during the episode are included. For more information on the MSPB, please see the following resources:

- More Information: https://data.cms.gov/provider-data/dataset/nrth-mfg3
- Measure Methodology: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350

System Requirements, Customer Support, and Technical Assistance

PEPPER is a Microsoft Excel spreadsheet, which was developed in Excel 2016, that can be opened and saved to a PC. It is not intended for use on a network, but it 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 hospitals with PEPPER in the "Training and Resources" section for short-term acute care hospitals.

Please do **not** contact your 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.

PEPPER

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.
CAH	Critical access hospital (CAH)
CC	Complication or comorbidity (CC). Patients who are more seriously ill tend to require more hospital resources than patients who are less seriously ill, even though they are admitted to the hospital for the same reason. Recognizing this, the DRG manual splits certain DRGs based on the presence of secondary diagnoses for specific complications or comorbidities.
CCS	Clinical Classification Software (CCS)
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.
CNS	Central nervous system (CNS)
CPT®	Current Procedural Terminology® (CPT®)
CVA	Cerebrovascular accident (CVA)
DRG	The diagnosis-related group (DRG) is a system that was developed for Medicare in 1980, becoming effective in 1983, as a part of the PPS to classify hospital cases expected to have similar hospital resource use.
DS	Used in conjunction with *ST PEPPER* one- and two-day stay (DS) target areas.
ED	Emergency department (ED)
E&M	Evaluation and management (E&M)
FATHOM	First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) is a Microsoft Access application. It was designed to help MACs compare ST and long-term (LT) acute care PPS inpatient hospitals, CAHs, inpatient rehabilitation facilities (IRFs), hospices, partial hospitalization programs (PHPs), SNFs, and home health agencies (HHAs) in areas at risk for improper payment using Medicare administrative paid claims data.
FY	Fiscal year (FY). The Medicare federal fiscal year begins Oct. 1 and ends Sept. 30. For example, Q2FY10 (or Q2FY2010) refers to the second quarter of federal fiscal year 2010, which began on Jan. 1, 2010, and ended on March 31, 2010.
HCPCS	Healthcare Common Procedure Coding System (HCPCS)
HHA	Home health agency (HHA)
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)
IPF	Inpatient psychiatric facility (IPF)

Acronym/ Abbreviation	Acronym/Abbreviation Definition
IPPS	The inpatient prospective payment system (IPPS) sets forth a system of reimbursement for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.
IRF	Inpatient rehabilitation facility (IRF)
LOS	Length of stay (LOS)
LT	Long-term (LT) refers to long-term acute care hospitals.
MAC	The Medicare Administrative Contractor (MAC) is the contracting authority replacing the fiscal intermediary and carrier in performing Medicare Fee-for-Service claims processing activities.
MCC	Major complication or comorbidity (MCC). Before the introduction of Medicare-Severity Diagnosis-Related Group (MS-DRG) system version 25, many CMS-DRG classifications were "paired" to reflect the presence of CCs. A significant refinement of version 25 was to replace this pairing, in many instances, with a design that created a tiered system of the absence of CCs, the presence of CCs, and a higher level of presence of MCCs. As a result of this change, the historical list of diagnoses that qualified for membership on the CC list was substantially redefined and replaced with a new standard CC list and a new MCC list.
MDC	Major Diagnostic Category (MDC)
MSPB	Medicare Spending per Beneficiary (MSPB)
MS-DRG	Medicare-Severity Diagnosis-Related Group (MS-DRG)
OR	Operating room (OR)
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.
PHP	Partial hospitalization program (PHP) refers to an intensive outpatient psychiatric treatment program.
RA	Recovery auditor (RA), formerly referred to as a Recovery Audit Contractor (RAC)
SDX	Secondary diagnosis (SDX)
SNF	Skilled nursing facility (SNF). One of the *ST PEPPER* target areas is the *Three-Day Skilled Nursing Facility-Qualifying Admissions.*
ST	Short-term (ST) refers to short-term acute care hospital.
tPA	Tissue plasminogen activator (tPA)
UB-04	The UB-04 is a 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: DRGs Affected by *Excisional Debridement* Procedure Codes

DRG	Description
003	ECMO or trach w mv >96 hrs or PDx exc face, mouth & neck w maj OR
040	Periph/cranial nerve & other nerv syst proc w MCC
041	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim
042	Periph/cranial nerve & other nerv syst proc w/o CC/MCC
115	Extraocular procedures except orbit
133	Other ear, nose, mouth & throat OR procedures w CC/MCC
134	Other ear, nose, mouth & throat OR procedures w/o CC/MCC
166	Other resp system OR procedures w MCC
167	Other resp system OR procedures w CC
168	Other resp system OR procedures w/o CC/MCC
264	Other circulatory system OR procedures
356	Other digestive system OR procedures w MCC
357	Other digestive system OR procedures w CC
358	Other digestive system OR procedures w/o CC/MCC
423	Other hepatobiliary or pancreas OR procedures w MCC
424	Other hepatobiliary or pancreas OR procedures w CC
425	Other hepatobiliary or pancreas OR procedures w/o CC/MCC
463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC
464	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC
570	Skin debridement w MCC
571	Skin debridement w CC
572	Skin debridement w/o CC/MCC
579	Other skin, subcut tiss & breast proc w MCC
580	Other skin, subcut tiss & breast proc w CC
581	Other skin, subcut tiss & breast proc w/o CC/MCC
622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC
623	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC
673	Other kidney & urinary tract procedures w MCC
674	Other kidney & urinary tract procedures w CC
675	Other kidney & urinary tract procedures w/o CC/MCC
715	Other male reproductive system OR proc for malignancy w CC/MCC
716	Other male reproductive system OR proc for malignancy w/o CC/MCC
717	Other male reproductive system OR proc exc malignancy w CC/MCC
718	Other male reproductive system OR proc exc malignancy w/o CC/MCC
749	Other female reproductive system OR procedures w CC/MCC
750	Other female reproductive system OR procedures w/o CC/MCC
802	Other OR proc of the blood & blood forming organs w MCC
803	Other OR proc of the blood & blood forming organs w CC
804	Other OR proc of the blood & blood forming organs w/o CC/MCC
823	Lymphoma & non-acute leukemia w other proc w MCC
824	Lymphoma & non-acute leukemia w other proc w CC
825	Lymphoma & non-acute leukemia w other proc w/o CC/MCC
853	Infectious & parasitic diseases w OR procedure w MCC
854	Infectious & parasitic diseases w OR procedure w CC

DRG	Description
855	Infectious & parasitic diseases w OR procedure w/o CC/MCC
856	Postoperative or post-traumatic infections w OR proc w MCC
857	Postoperative or post-traumatic infections w OR proc w CC
858	Postoperative or post-traumatic infections w OR proc w/o CC/MCC
876	OR procedure w principal diagnoses of mental illness
901	Wound debridements for injuries w MCC
902	Wound debridements for injuries w CC
903	Wound debridements for injuries w/o CC/MCC
906	Hand procedures for injuries
927	Extensive burns or full thickness burns w mv >96 hrs w skin graft
928	Full thickness burn w skin graft or inhal inj w CC/MCC
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC
939	OR proc w diagnoses of other contact w health services w MCC
940	OR proc w diagnoses of other contact w health services w CC
941	OR proc w diagnoses of other contact w health services w/o CC/MCC
957	Other OR procedures for multiple significant trauma w MCC
958	Other OR procedures for multiple significant trauma w CC
959	Other OR procedures for multiple significant trauma w/o CC/MCC
969	HIV w extensive OR procedure w MCC
970	HIV w extensive OR procedure w/o MCC
981	Extensive OR procedure unrelated to principal diagnosis w MCC
982	Extensive OR procedure unrelated to principal diagnosis w CC
983	Extensive OR procedure unrelated to principal diagnosis w/o CC/MCC
987	Non-extensive OR proc unrelated to principal diagnosis w MCC
988	Non-extensive OR proc unrelated to principal diagnosis w CC
989	Non-extensive OR proc unrelated to principal diagnosis w/o CC/MCC

Appendix 2: Rehabilitation and Primary Psychiatric CCS Diagnosis Categories

CCS	Description
254	Rehabilitation
650	Adjustment disorders
651	Anxiety disorders
652	Attention-deficit, conduct, and disruptive behavior disorders
654	Developmental disorders
655	Disorders usually diagnosed in infancy, childhood, or adolescence
656	Impulse control disorders, not elsewhere classified
657	Mood disorders
658	Personality disorders
659	Schizophrenia and other psychotic disorders
662	Suicide and intentional self-inflicted injury
670	Miscellaneous disorders

Appendix 3: How Readmissions Are Identified

These examples have been developed to assist users in understanding how readmissions are identified and counted in PEPPER's *30-Day Readmissions to Same* and *30-Day Readmissions to Same or Elsewhere* target areas. When reviewing these examples, remember that:

1. Readmissions are counted in the federal fiscal quarter during which the discharge date of the index (first) admission occurs. If the discharge date of the index admission occurs between:
   - Oct. 1 and Dec. 31, the readmission would be counted in Quarter 1of the respective fiscal year.
   - Jan. 1 and March 31, the readmission would be counted in Quarter 2 of the respective fiscal year.
   - April 1 and June 30, the readmission would be counted in Quarter 3 of the respective fiscal year.
   - July 1 and Sept. 30, the readmission would be counted in Quarter 4 of the respective fiscal year.
2. Each admission of a patient could serve as an index admission for a subsequent admission to short-term acute care hospitals if it occurs within 30 days of the discharge date of the index admission.
3. Each admission of a patient could be identified as a readmission only for the short-term acute care hospital admission directly preceding it in time (see Example 1, Row 2).
4. Index admissions with a patient discharge status code of "02" (discharged/transferred to a short-term acute care hospital), "07" (left against medical advice) or "82" (discharged/transferred to a short-term acute care hospital for inpatient care with a planned acute care hospital inpatient readmission) are excluded from the numerator count and cannot be identified as an index admission for both readmission target areas.
5. Any admissions of beneficiaries to other settings, such as skilled nursing facility, swing bed, inpatient rehabilitation facility, inpatient psychiatric facility, critical access hospital, or any other type of provider are not considered for this measure. Only admissions to short-term acute care hospitals are considered.
6. Common billing errors that may result in claims being identified as readmissions include the following:
   - Billing an admission to a distinct part unit of your short-term acute care hospital (e.g., inpatient rehabilitation or inpatient psychiatric facility unit) to the provider number for the short-term acute care hospital, instead of the provider number for the unit.
   - Incorrect coding of the patient discharge status code when the patient is discharged/transferred to another short-term acute care hospital. As noted in #4 above, index admissions with a patient discharge status code of 02, 07, or 82 are excluded from the numerator count and cannot be identified as an index admission.

Example 1
Below is a table showing claims submitted for one beneficiary. 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	Next Admission Counts as *30-Day Readm to Same?*	Next Admission Counts as *30-Day Readm to Same or Elsewhere?*
1	Hospital #1	3/25/13	3/29/13	01	Hospital #1	4/15/13	4/17/13	Yes, to Hospital #1 in Q2FY13	Yes, to Hospital #1 in Q2FY13
2	Hospital #1	4/15/13	4/17/13	02	Hospital #2	4/17/13	4/20/13	No	No
3	Hospital #2	4/17/13	4/20/13	01	(no further admissions)			n/a	n/a

Detailed discussion:
- Row 1: The beneficiary was admitted to Hospital #1 on 3/25/13 and discharged home (patient discharge status code 01) on 3/29/13. The beneficiary was admitted to Hospital #1 on 4/15/13. The 4/15/13 admission to Hospital #1 counts as a *30-Day Readmission to Same* and as a *30-Day Readmission to Same or Elsewhere* to Hospital #1 against the 3/25/13 index admission, because it occurred within 30 days of the 3/25/13 index admission discharge date of 3/29/13.
- Row 2: The beneficiary was admitted to Hospital #1 on 4/15/13 and was transferred (patient discharge status code 02) to Hospital #2 on 4/17/13.
  - The 4/17/13 admission to Hospital #2 does not count as a *30-Day Readmission to Same or Elsewhere* against the 4/15/13 index admission for Hospital #1 because the 4/15/13 index admission had a patient discharge status code "02."
  - The 4/17/13 admission to Hospital #2 does not count as a *30-Day Readmission to Same or Elsewhere* against the 3/25/13 index admission for Hospital #1 because there was an intervening short-term acute care hospital admission (4/15/13 admission to Hospital #1) that directly preceded the 4/17/13 admission to Hospital #2.
- Row 3: The beneficiary was admitted to Hospital #2 on 4/17/13 and discharged home (patient discharge status code 01) on 4/20/13.

Example 2

Below is a table showing claims submitted for one beneficiary. 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	Next Admission Counts as *30-Day Readm to Same?*	Next Admission Counts as *30-Day Readm to Same or Elsewhere?*
1	Hospital #1	4/5/13	4/7/13	01	Hospital #1	5/1/13	5/3/13	Yes, to Hospital #1 in Q3FY13	Yes, to Hospital #1 in Q3FY13
2	Hospital #1	5/1/13	5/3/13	62	IRF #1	5/3/13	5/15/13	No	No
3	IRF #1	5/3/13	5/15/13	02	Hospital #1	5/15/13	5/17/13	Yes, to Hospital #1 in Q3FY13	Yes, to Hospital #1 in Q3FY13
4	Hospital #1	5/15/13	5/17/13	01	(no further admissions)			n/a	n/a

Detailed discussion:

- Row 1: The beneficiary was admitted to Hospital #1 on 4/5/13 and was discharged home (patient discharge status code 01) on 4/7/13. The beneficiary was admitted to Hospital #1 on 5/1/13. The 5/1/13 admission to Hospital #1 counts as a *30-Day Readmission to Same* and as a *30-Day Readmission to Same or Elsewhere* for Hospital #1 against the 4/5/13 index admission, because the beneficiary was readmitted to Hospital #1 within 30 days of discharge from the 4/5/13 index admission discharge date of 4/7/13.
- Row 2: The beneficiary was admitted 5/1/13 to Hospital #1 and was transferred to IRF #1 (patient discharge status code 62) on 5/3/13. The admission to IRF #1 does not count as a *30-Day Readmission to Same* or as a *30-Day Readmission to Same or Elsewhere* against the 4/5/13 index admission for Hospital #1 because the patient was transferred to an IRF. Only admissions to short-term acute care hospitals can be considered as a readmission.
- Row 3: The beneficiary was admitted to IRF #1 on 5/3/13 and was transferred to Hospital #1 (patient discharge status code 02) on 5/15/13. The 5/15/13 admission to Hospital #1 counts as a *30-Day Readmission to Same* and as a *30-Day Readmission to Same or Elsewhere* to

Hospital #1 against the 5/1/13 index admission, as the beneficiary was readmitted to Hospital #1 on 5/13/13 which is within 30 days of discharge from the 5/1/13 index admission discharge date of 5/3/13.

- Row 4: The beneficiary was admitted to Hospital #1 on 5/15/13 and was discharged home (patient discharge status code 01) on 5/17/13.

Example 3

Below is a table showing claims submitted for one beneficiary. 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	Next Admission Counts as *30-Day Readm to Same?*	Next Admission Counts as *30-Day Readm to Same or Elsewhere?*
1	Hospital #1	10/10/13	10/17/13	01	Hospital #2	11/2/13	11/12/13	No	Yes, to Hospital #1 in Q1FY14
2	Hospital #2	11/2/13	11/12/13	01	(no further admissions)			n/a	n/a

Detailed discussion:

- Row 1: The beneficiary was admitted to Hospital #1 on 10/10/13 and was discharged home (patient discharge status code 01) on 10/17/13. The beneficiary was admitted to Hospital #2 on 11/2/13.
  - o The 11/2/13 admission to Hospital #2 does not count as a *30-Day Readmission to Same*.
  - o The 11/2/13 admission to Hospital #2 counts as a *30-Day Readmission to Same or Elsewhere* against the 10/10/13 index admission for Hospital #1 because the beneficiary was readmitted to Hospital #2 within 30 days of discharge from the index admission discharge date of 10/17/13.
- Row 2: The beneficiary was admitted to Hospital #2 on 11/2/13 and was discharged home (patient discharge status code 01) on 11/12/13.