



Inpatient Rehabilitation Facility
Program for Evaluating Payment
Patterns Electronic Report

User's Guide
Eleventh Edition



**Inpatient Rehabilitation Facility
Program for Evaluating Payment Patterns Electronic Report User’s Guide**
Eleventh Edition, effective with the Q4FY20 release

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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 Program for Evaluating Payment Patterns Electronic Report (PEPPER) can help guide hospitals' 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, which are referred to in the report as target areas. Data in PEPPER is presented in tabular form and 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 hospitals with the identification of potentially improper payments.

PEPPER is available for inpatient rehabilitation facilities (IRFs), as well as critical access hospitals (CAHs), short- and long-term acute care inpatient prospective payment system (IPPS) hospitals, inpatient psychiatric facilities, hospices, partial hospitalization programs, skilled nursing facilities (SNFs), and home health agencies. The *IRF PEPPER* is specifically created for IRFs and inpatient rehabilitation distinct part units of short-term acute care hospitals (ST or STACHs) and CAHs. **In PEPPER and throughout this guide, free-standing IRFs and distinct part units of STACHs and CAHs are grouped together and referred to collectively as IRFs.**

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.

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).

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: <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, Jan. 31, 2005, 4858–4876. Available at: <http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf>

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. In *IRF PEPPER*, an IRF is compared to other IRFs in three comparison groups: the nation, MAC jurisdiction, and state. These comparisons enable an IRF to determine whether 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 (i.e., the national 80th percentile).

Note that, in PEPPER, the term “outlier” is used when an IRF’s target area percent is in the top 20% 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
IRFs or distinct part units of STACHs or CAHs	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	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

The IRF PEPPER is available to the IRF’s Chief Executive Officer, Administrator, President, Quality Assurance and Performance Improvement Officer, or Compliance Officer through a secure portal on the PEPPER.CBRPEPPER.org website. Each IRF receives only its PEPPER. The PEPPER Team does not provide PEPPERS to other contractors, although the PEPPER Team does provide a Microsoft Access database (the First-Look Analysis Tool for Hospital Outlier Monitoring [FATHOM]) to MACs and Recovery Auditors. FATHOM can be used to produce a PEPPER.

IRF PEPPER CMS Target Areas

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

TARGET AREA	TARGET AREA DEFINITION
Miscellaneous CMGs	<i>Numerator (N):</i> count of discharges for 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)
CMGs at Risk for Unnecessary Admissions	<i>Denominator (D):</i> count of all discharges <i>N:</i> 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)
Outlier Payments	<i>D:</i> count of all discharges <i>N:</i> count of discharges with an outlier approved amount greater than \$0
STACH Admissions Following IRF Discharge	<i>D:</i> count of all discharges <i>N:</i> 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 STACH within 30 days of discharge from the IRF; excluding transfers to a STACH, a long-term acute care hospital (LTCH), 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) <i>D:</i> count of all discharges excluding transfers to a STACH, LTCH, 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.)
3- to 5-Day Readmissions <i>*new as of the Q4FY19 release</i>	<i>N:</i> count of index (first) admissions during the 12-month time period for which a readmission occurred within three to five calendar days (four to six consecutive days) to the same IRF for the same beneficiary (identified using the Health Insurance Claim number) <i>D:</i> count of all discharges excluding patient discharge status code 20 (expired) (See Appendix 2 for how readmissions are identified.)
Short Stays <i>*new as of the Q4FY19 release</i>	<i>N:</i> count of discharges with a length of stay (LOS) less than or equal to three days, excluding discharge status code “20” (expired) <i>D:</i> count of all IRF discharges excluding discharge status code of “20” (expired)

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

Several 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 STACH within 30 days of a discharge from an IRF may be associated with premature discharge or incomplete care. Such an admission may also indicate that an IRF's discharge planning or patient/family preparation for discharge could be improved.

IRF readmissions following a three- to five-day gap may identify the potential for circumvention of the interrupted stay policy.

Regarding short stays, in "[Chapter 1, Section 110.1.2](#)" of the *Medicare Benefit Policy Manual*, CMS says the following:

[T]he preadmission screening and the post-admission physician evaluation could differ in rare cases when a patient's preadmission screening indicates that the patient is an appropriate candidate for IRF care but this turns out not to be the case, either, for example, due to a marked improvement in the patient's functional ability since the time of the preadmission screening or an inability to meet the demands of the IRF rehabilitation program. If this occurs, the IRF must immediately begin the process of discharging the patient to another setting of care. It might take a day or more for the IRF to find placement for the patient in another setting of care. A/B Medicare Administrative Contractors (MACs) (A) will therefore allow the patient to continue to receive treatment in the IRF until placement in another setting can be found. However, in these particular cases, any IRF services provided after the third day following the patient's admission to the IRF (considering the day of admission to be the first day) are not considered reasonable and necessary. In these particular cases, instead of denying the entire IRF claim for not meeting the criteria in section 110.2 of this chapter, Medicare authorizes its A/B MACs (A) to permit the IRF claim to be paid at the appropriate case mix group (CMG) for IRF patient stays of 3 days or less.

The PEPPER Team found that approximately 3% of IRF claims were for an LOS of three or fewer days; the average payment for a short LOS was somewhere between \$2,000 and \$4,000, and the overall average payments were between \$15,000 and \$30,000. Two-thirds of the short LOS claims were transferred to a STACH (discharge status = 02), while only 7% of the claims with an LOS that exceeded three days were transferred to a STACH.

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.

"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.

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% 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 (i.e., nation, jurisdiction, and state).

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 (i.e., 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 that vary significantly from the norm could be important and warrant a review.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80 TH PERCENTILE)
<i>Miscellaneous CMGs</i>	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., SNF or home with home health).
<i>CMGs at Risk for Unnecessary Admissions</i>	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., SNF or home with home health).
<i>Outlier Payments</i>	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.
<i>STACH Admissions Following IRF Discharge</i>	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 STACHs may wish to identify admissions to their STACH within 30 days of discharge and review medical records for those patients.
<i>3- to 5-Day Readmissions</i>	This could indicate that patients are being discharged prematurely or that patients are being readmitted after the interrupted stay threshold, thereby qualifying for two separate CMG payments. A sample of readmission cases should be reviewed to identify appropriateness of admission, discharge, quality of care, post discharge care, and CMG assignment and billing errors. The facility is encouraged to generate data profiles for readmissions to their facility within three to five consecutive days. Suggested data elements to include in these profiles are as follows: patient identifier, date of admission, date of discharge, patient discharge status code, principal and secondary diagnoses, procedure code(s), and CMG. Patients discharged home (patient discharge status code 01) and readmitted may indicate a potential premature discharge or incomplete care.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80 TH PERCENTILE)
<i>Short Stays</i>	This could indicate opportunities for improvement in the preadmission screening process. A sample of medical records for short stays may be reviewed to evaluate the appropriateness of the admission and whether the preadmission process could be improved/strengthened.

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 13.)

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 the 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 the state.

For more information about how percents differ from percentiles, see the IRF “Training and Resources” 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 following priority order: 1) nation, 2) jurisdiction, and 3) state. If an IRF is an outlier for the nation (i.e., as compared to all IRFs in the nation), this should be interpreted as the highest priority. If an IRF is an outlier for its jurisdiction (i.e., as compared to all IRFs in its jurisdiction), this is somewhat of a lower priority. Lastly, if an IRF is an outlier for its state (i.e., as compared to all IRFs in its state), this would be the lowest priority; 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 its jurisdiction and at the 65th percentile as compared to the nation. The *Miscellaneous CMGs* target area may have a smaller “Sum of Payments,” but it could still be at the 80th percentile for the jurisdiction and 90th percentile for the 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; each bar represents 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 (i.e., nation, jurisdiction, and state) so the IRF can easily identify when it is an outlier as compared to any of the comparison groups. A table of these percents called “Comparative Data” is included under the IRF’s data table. For more information about how percents differ from 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 numerator count of discharges for the target area (target area discharge count), the denominator count of discharges, the proportion of the numerator and denominator (percent), the average length of stay (ALOS) 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 13.) 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: the 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 (below 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 the 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 ALOS 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 (including 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 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 STACH)
 - 63 (discharged/transferred to an LTCH)
 - 82 (discharged/transferred to a STACH with a planned acute care hospital readmission)
 - 91 (discharged/transferred to an LTCH with a planned acute care hospital readmission)
3. Transfer to SNF — Patient discharge status codes
 - 03 (discharged/transferred to a SNF)
 - 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 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 IRFs with PEPPER in the IRF “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

TERM	DESCRIPTION
Average Length of Stay	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 the time period. For the <i>STACH Admissions Following IRF Discharge</i> target area, the ALOS is calculated using the first (index) admission’s length of stay, not the second (STACH) admission’s LOS.
Data Table	The statistical findings for hospitals presented in tabular form, labeled by time period and measures.
Fiscal Year	For Medicare data, the fiscal year starts Oct. 1 and ends Sept. 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 80 th percentiles for the state, jurisdiction, and nation for all target areas. See <i>Percentile</i> .
Length of Stay	The length of stay (LOS) for an individual discharge is determined by subtracting the date of admission (i.e., admission date) from the date of discharge (i.e., 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 <i>IRF PEPPER</i> , an IRF is identified as an outlier if its target area percent is at or above the national 80 th percentile (high outlier).
Percentile	<p>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% 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.</p> <p>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.</p> <p>For more information about how percents differ from percentiles, please see the “Training and Resources” page in the IRF section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.</p>

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 hospitals (CAHs)
CMG	Case-mix group (CMG). 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.
DRG	The diagnosis-related group (DRG) is a system that was developed for Medicare in 1980 (it became effective in 1983) as part of the PPS to classify hospital cases expected to have similar hospital resource use.
FATHOM	First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) is a Microsoft Access application. It was designed to help MACs compare providers in areas at risk for improper payment using Medicare administrative claims data. FATHOM produces PEPPER.
FY	Fiscal year (FY). The Medicare federal fiscal year begins on Oct. 1 and ends on Sept. 30.
IRF	Inpatient rehabilitation facility (IRF)
IRF-PAI	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
IPPS	Inpatient prospective payment system (IPPS)
PPS	Prospective payment system (PPS)
LOS	Length of stay (LOS)
LTCH	Long-term acute care hospital (LTCH)
MAC	The Medicare Administrative Contractor (MAC) is the contracting authority that replaced the fiscal intermediary 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 that are at high risk for improper payments due to billing, coding, and/or admission necessity issues.
PPS	Prospective payment system (PPS)
RICs	Rehabilitation Impairment Categories (RICs)
SNF	Skilled nursing facility (SNF)

ACRONYM/ ABBREVIATION	ACRONYM/ABBREVIATION DEFINITION
ST	Short-term (ST), refers to STCHs or to reports pertaining to STCHs
STACH	Short-Term Acute Care Hospital (STACH)
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: How STACH Admissions Following IRF Discharge Are Identified

This example is provided to help providers understand how STACH admissions following IRF discharges are identified and counted in PEPPER. A STACH admission is considered a *STACH Admissions Following IRF Discharge* only for IRF discharges that immediately precedes a STACH admission (considering all claims for the beneficiary) if:

- The STACH admission occurred within 30 days of the IRF discharge date, and
- The beneficiary discharged from the IRF was not transferred to a STACH, an LTCH, 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 by date 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 Following IRF Discharge* “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 STACH (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.

Appendix 2: How Readmissions Are Identified

This example is provided to help providers understand how readmissions are identified and counted in PEPPER.

Example: 3- to 5-Day Readmissions

The target area numerator definition is the count of index (first) admissions during the 12-month time period for which a readmission occurred within three to five calendar days (four to six consecutive days) to the same IRF for the same beneficiary (identified using the Health Insurance Claim number). The target area denominator definition is the count of all discharges excluding patient discharge status code 20 (expired).

Below is a table showing two claims for one beneficiary submitted by an IRF. The claims are sorted by date 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	11/20/10	12/1/10	01	IRF #1	12/5/10	12/10/10	4	Yes, to IRF #1
2	IRF #1	12/5/10	12/10/10	01	(no further admissions)				n/a

Detailed discussion:

- Row 1: The beneficiary was admitted to IRF #1 on 11/20/10 and discharged home (patient discharge status code 01) on 12/1/10. The beneficiary was readmitted to IRF #1 on 12/5/10, which is four calendar days after being discharged from IRF #1. This admission counts as a 3- to 5-Day Readmission to IRF #1 against the 11/20/10 index admission because it occurred within three to five calendar days after the beneficiary was discharged from IRF #1.
- Row 2: The beneficiary was admitted to IRF #1 on 12/5/10 and discharged home (patient discharge status code 01) on 12/10/10 with no additional claims during the fiscal year period.

Note: For the 3- to 5-Day Readmissions target area, the patient discharge status code of the index admission is not considered.