Skilled Nursing Facility
Program for Evaluating Payment
Patterns Electronic Report

User's Guide

Eighth Edition

Skilled Nursing Facility
Program for Evaluating Payment Patterns Electronic Report User's Guide
Eighth Edition, effective with the Q4FY19 release

Introduction

The Government Accountability Office designated Medicare as a program at high risk for fraud, waste, and abuse.[1] Payments to skilled nursing facilities (SNFs) have been identified as vulnerable to abuse. In 2012, the Office of Inspector General (OIG) found that approximately 25% of SNF claims were billed in error.[2] The OIG encourages SNFs to develop and implement a compliance program to protect their operations from fraud and abuse.[3,4] Beginning in 2013, according to statutory language in "Section 6102" of the *Affordable Care Act*, SNFs are required to have a compliance program. As part of its compliance program, a SNF should conduct regular audits to ensure services provided are necessary and that charges for Medicare services are correctly documented and billed. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) can help guide SNFs' auditing and monitoring activities.

What Is PEPPER?

National SNF claims data was analyzed to identify areas within the SNF prospective payment system (PPS) that could be at risk for improper Medicare payment. These areas are referred to as "target areas." PEPPER is a data report that contains a single SNF's Medicare claims data statistics (obtained from the UB-04 claims submitted to the Medicare Administrative Contractor [MAC]) for these target areas. All SNFs that have sufficient data to generate a report receive a PEPPER, which contains statistics for these target areas. The report shows how a SNF's data compares to aggregate jurisdiction, state, and national statistics. Statistics in PEPPER are presented in tabular form and in graphs that depict the SNF's target area percentages over time. All of the data tables, graphs, and reports in PEPPER were designed to assist SNFs with the identification of potentially improper payments. 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).

PEPPER is available for SNFs. PEPPERs are also available for short- and long-term acute care inpatient prospective payment system (IPPS) hospitals, critical access hospitals (CAHs), inpatient psychiatric facilities, inpatient rehabilitation facilities, hospices, partial hospitalization programs, and home health agencies (the format of the reports and the target areas are customized for each type of provider).

SNFs are specially-qualified facilities that provide skilled nursing care, rehabilitation services, and other services to Medicare beneficiaries who meet certain conditions. A SNF may be free-standing or it may operate as a distinct part of a nursing home or hospital. In addition, short-term acute care hospitals

[1] Government Accountability Office. "Medicare Fraud, Waste and Abuse: Challenges and Strategies for Preventing Improper Payments." June 15, 2012. Available at: http://www.gao.gov/new.items/d10844t.pdf.
[2] Department of Health and Human Services/Office of Inspector General, 2012. "Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009." Nov. 9, 2012. Available at: https://oig.hhs.gov/oei/reports/oei-02-09-00200.asp
[3] Department of Health and Human Services/Office of Inspector General. 2000. "Compliance Program Guidance for Nursing Facilities," 65 Federal Register 14289, March 16, 2000. Available at: http://oig.hhs.gov/authorities/docs/cpgnf.pdf
[4] Department of Health and Human Services/Office of Inspector General. 2000. "Supplemental Compliance Program Guidance for Nursing Facilities," 73 *Federal Register* 56832, Sept. 30, 2008. Available at: http://oig.hhs.gov/compliance/compliance-guidance/docs/complianceguidance/nhg_fr.pdf

(STACH) in rural areas with fewer than 100 beds (CAH) may qualify to provide SNF services as swing bed facilities.

SNFs are reimbursed through the SNF PPS (Note: CAHs with swing-beds are exempt from the SNF PPS). A beneficiary may receive up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least three days. SNFs use the *Minimum Data Set (MDS)* to assess each beneficiary's clinical condition, functional status, and expected and actual use of services. Prior to Oct. 1, 2019, certain items on the MDS classified beneficiaries into case-mix categories called Resource Utilization Groups (RUGs). The RUG classification determined how much Medicare paid the SNF for each day the beneficiary received services; payments were based primarily on the amount of therapy services provided to beneficiaries.

On Oct. 1, 2019, CMS implemented the Patient Driven Payment Model (PDPM), which was designed to improve Medicare payments made under the SNF PPS by improving payment accuracy and appropriateness. To achieve this, the PDPM focuses on the patient, rather than the volume of services provided. The PDPM was also designed to reduce the administrative burden on providers. The PDPM consists of five case-mix adjusted components: physical therapy, occupational therapy, speech language pathology, nursing, and non-therapy ancillary. The PDPM also includes a variable per diem adjustment that adjusts the per diem rate over the course of a patient's SNF stay. For more information and additional resources related to the SNF PPS, visit the CMS Skilled Nursing Facility Patient Driven Payment Model page.

Note: The *SNF PEPPER* target areas and supplemental reports will be changing over time to provide information related to potential vulnerabilities of the PDPM, rather than those that were vulnerable under the RUG system.

The *SNF PEPPER* is the version of PEPPER specifically developed for SNFs reimbursed through the SNF PPS. **In PEPPER and throughout this guide, free-standing SNFs, distinct part unit SNFs, and swing bed SNFs are grouped together and referred to collectively as SNFs. CAHs with swing beds are not included; a *SNF PEPPER* is not available for CAH swing bed units.**

The *SNF PEPPER* for free-standing SNFs is available to the SNF'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. STACH swing beds receive their PEPPER electronically through a secure file exchange in QualityNet, which is a CMS-approved method to electronically distribute PEPPERs to providers. The PEPPER files will be sent to the STACHs' QualityNet Administrators and to those who have QualityNet basic user accounts (i.e., the PEPPER recipient role and File Exchange and Search role). Each SNF 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.

Each *SNF PEPPER* summarizes claims data statistics (obtained from paid SNF Medicare UB-04 claims) for SNF episodes of care that end in the most recent three federal fiscal years (the federal fiscal year spans Oct. 1 through Sept. 30). In *SNF PEPPER*, a SNF is compared to other SNFs in three comparison groups: the nation, MAC jurisdiction, and state. These comparisons enable a SNF to determine whether its individual results differ from other SNFs and whether it is at risk for improper Medicare payments (i.e., whether it is an outlier).

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

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

Note that, in PEPPER, the term "outlier" is used when a SNF's target area percent is in the top 20% of all SNF target area percents in the respective comparison group (i.e., is at/above the 80th percentile) or is in the bottom 20% of all SNF target area percents in the respective comparison group (i.e., is at/below the 20th percentile for areas at risk for under-coding). Formal tests of significance are not used to determine outlier status in PEPPER.

In order to be included in the *SNF PEPPER*, claims must meet the specifications shown below.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
SNFs or hospitals with swing beds	Third through sixth positions of the CMS Certification Number (CCN) are between "5000" and "6499" for SNFs or the third position of the CCN is 'U', 'W', or 'Y' for hospitals
Claim facility type of "SNF" or "hospital"	UB-04 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 2 (SNF) or 1 (Hospital)
SNF non-swing bed and SNF swing bed claims	National Claims History Claim Type Code = 20 (SNF Non-Swing Bed) or 30 (SNF Swing Bed)
Claim service classification type of "inpatient" or "swing beds"	UB-04 FL 04 Type of Bill, third digit (Bill Classification) = 1 (Inpatient Part A) or 8 (Swing beds)
Services provided during the time period used to create the episode of care	Claim "From Date" and claim "Through Date" fall within the three fiscal years included in the report. Additional claims for the last four months of the previous fiscal year will be included for episodes of care beginning prior to the reporting period. See below for more explanation of the episode of care.
Medicare claim payment amount greater than zero	The provider received a payment amount greater than zero on the claim (Note that Medicare Secondary Payer claims are included)
Final action claim	A final action claim is a non-rejected claim for which a payment has been made. All disputes and adjustments have been resolved and details clarified.
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Health Maintenance Organization
Exclude cancelled claims	Exclude claims cancelled by the MAC

The PEPPER target areas were designed to report on the services provided to a beneficiary whose SNF episode of care ends during the specified time period (the federal fiscal year). An episode of care is created from the claims submitted by a SNF for each beneficiary. Episodes of care are created as follows:

- All claims submitted by a SNF for a beneficiary are collected and sorted from the earliest "Claim From" date to the latest.
- If the patient discharge status code on the latest claim in a series indicates that the beneficiary was discharged or did not return for continued care, then that beneficiary's episode of care is included in the time/report period in which the latest "Through Date" falls.
- If the latest claim in the series ended in the last month of the time/report period (e.g., Sept. 1 – 30, 2019, for the Q4FY19 release) and indicates that the beneficiary was still a patient (patient discharge status code "30"), then that beneficiary's episode of care is not included.
- If there is a gap between one claim's "Through Date" to the next claim's "From Date" of more than 30 days, then that is considered the ending of one episode of care and the beginning of a new episode of care.
- Each episode of care is included in the time/report period in which the latest "Through Date" falls.
- Claims are collected for four months prior to each time period so that the longer lengths of stay (LOSs) may be evaluated.

SNF PEPPER CMS Target Areas

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

TARGET AREA Full and Abbreviated Title	TARGET AREA DEFINITION
Therapy RUGs with High ADL (Therapy Hi ADL)	*Numerator (N):* count of days billed within episodes of care ending in the report period with RUG equal to RUX (Rehabilitation ultra high & extensive services w/ Activities of Daily Living [ADL] 11-16), RVX (Rehabilitation very high & extensive services w/ ADL 11-16), RHX (Rehabilitation high & extensive services w/ ADL 11-16), RMX (Rehabilitation medium & extensive services w/ ADL 11-16), RUC (Rehabilitation ultra high w/ ADL 11-16), RVC (Rehabilitation very high w/ ADL 11-16), RHC (Rehabilitation high w/ ADL 11-16), RMC (Rehabilitation medium w/ ADL 11-16), RLB (Rehabilitation low with ADL 11-16) *Denominator (D):* count of days billed within episodes of care ending in the report period for all therapy RUGs (See Appendix 1) Note: An episode of care is defined as a series of claims from a SNF for a beneficiary where the difference between the "Through Date" of one claim and the "From Date" of the subsequent claim is less than or equal to thirty days. The "From" and "Through" dates in form locator 6 (statement covers period) on the claim identify the span of service dates included in a particular bill; the "From" date is the earliest date of service on the claim.
Nontherapy RUGs with High ADL	*N:* count of days billed within episodes of care ending in the report period with RUG equal to HE2 (Special care high w/ depression & ADL 15-16), HE1 (Special

TARGET AREA Full and Abbreviated Title	TARGET AREA DEFINITION
(Nontherapy Hi ADL)	care high w/o depression & ADL 15-16), LE2 (Special care low w/ depression & ADL 15-16), LE1 (Special care low w/o depression & ADL 15-16), CE2 (Clinically complex w/ depression & ADL 15-16), CE1 (Clinically complex w/o depression & ADL 15-16), BB2 (Behavior/cognitive w/ 2+ restorative nursing & ADL 2-5), BB1 (Behavior/cognitive w/ <=1 restorative nursing & ADL 2-5), PE2 (Physical function w/ 2+ restorative nursing & ADL 15-16), PE1 (Physical function w/ <=1 restorative nursing & ADL 15-16) *D:* count of days billed within episodes of care ending in the report period for all nontherapy RUGs (See Appendix 2)
Change of Therapy Assessment (COT Assmnt)	*N:* count of assessments with AI second digit equal to "D" within episodes of care ending in the report period *D:* count of all assessments within episodes of care ending in the report period
Ultrahigh Therapy RUGs (Ultrahigh)	*N*: count of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL (Rehabilitation ultrahigh & extensive services w/ ADL 2-10), RUC, RUB (Rehabilitation ultrahigh w/ ADL 6-10), RUA (Rehabilitation ultrahigh w/ ADL 0-5) *D*: count of days billed within episodes of care ending in the report period for all therapy RUGs (See Appendix 1)
20-Day Episodes of Care (20 Days)	*N:* count of episodes of care ending in the report period with a LOS of 20 days *D*: count of all episodes of care ending in the report period
90+ Day Episodes of Care (90+ Days)	*N:* count of episodes of care ending in the report period with a LOS of 90+ days *D*: count of all episodes of care ending in the report period
3- to 5-Day Readmissions **(3-5 Day Readm)** **new as of the Q4FY19 release*	*N:* count of readmissions within three to five calendar days (four to six consecutive days) to the same SNF for the same beneficiary (identified using the Health Insurance Claim number) during an episode that ends during the report period *D:* count of all claims associated with SNF episodes ending during the report period, excluding patient discharge status code 20 (expired) (See Appendix 3)

These PEPPER target areas were identified by CMS as being potentially at risk for improper Medicare payments. For example, under the RUG system, SNFs that have a high proportion of RUGs with high ADL may report on the MDS that beneficiaries need more assistance than was actually needed. Conversely, SNFs that have a low proportion of RUGs with high ADL may report on the MDS that beneficiaries need less assistance than was actually needed. A high target area percent does not necessarily indicate the presence of improper payment or that the provider is doing anything wrong; however, under these circumstances, providers may wish to review their medical record documentation to ensure that the services their beneficiaries receive are appropriate and necessary, as well as to ensure that the documentation in the medical record supports the level of care and services for which they have received Medicare reimbursement.

Under the RUG system, SNFs must complete a "change of therapy" assessment when the amount of therapy provided no longer reflects the RUG. SNFs that have a high proportion of "change of therapy" (COT) assessments should investigate whether there are barriers preventing the provision of anticipated services for beneficiaries, care planning, or other issues that result in a high rate of COT assessments.

Medicare payment rates for therapy RUGs are typically higher than those for nontherapy RUGs. In addition, Medicare typically pays more for higher levels of therapy, and it generally pays the most for ultrahigh therapy. SNFs that have high proportions of ultrahigh RUGs should ensure that the amount of therapy beneficiaries receive is appropriate and necessary, and SNFs should also ensure that their documentation in the medical record supports the level of care and services provided.

The SNF benefit provides 20 days of 100% Medicare coverage, after which the coverage drops to 80%. SNFs have a financial incentive to keep patients for 20 days, even though beneficiaries may no longer require skilled care. SNFs that have high proportions of 20-day episodes should ensure that beneficiaries require a skilled level of care for the entire duration of their SNF stay.

Medicare reimburses up to 100 days of skilled care per beneficiary's spell of illness. SNFs that have a high proportion of episodes of care with 90 or more days should ensure that beneficiaries are receiving services that are necessary. The SNF should also ensure that beneficiaries receive skilled care the entire duration of their SNF stay.

Under the PDPM, there is a potential incentive for providers to discharge SNF patients from a covered Part A stay and then readmit the patient in order to reset the variable per diem schedule. To mitigate this potential incentive, PDPM includes an interrupted stay policy, which combines multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within a prescribed window. If a patient is discharged from a SNF and readmitted to the same SNF no more than three consecutive calendar days after discharge, then the subsequent stay is considered a continuation of the previous stay, and the variable per diem schedule continues from the point just prior to discharge. If the patient is discharged from a SNF and then readmitted more than three consecutive calendar days after discharge or admitted to a different SNF, then the subsequent stay is considered a new stay, and the variable per diem schedule resets to day one.

How SNFs Can Use PEPPER Data

The *SNF PEPPER* allows SNFs to compare their billing statistics with national, jurisdiction, and state percentile values for each target area with reportable data for the most recent three fiscal years (Oct. 1 through Sept. 30) included in PEPPER.

To calculate percentiles, the target area percents for all SNFs 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 SNFs' target area percents fall is identified as the 80th percentile. SNFs whose target area percents are at or above the 80th percentile (i.e., in the top

"Reportable data" in PEPPER means the target (numerator) count is 11 or more for a given target area for a given time period. When the target (numerator) count is less than 11 for a target area for a time period, statistics are not displayed in PEPPER due to CMS data restrictions.

20%) are considered at risk for improper Medicare payments. Similarly, for areas at risk for under-coding, SNFs whose target percents are at or below the 20th percentile (i.e., in the bottom 20%) 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 SNFs may consider when assessing their risk for improper Medicare payments. Please note that these are generalized suggestions and will not apply to all situations. Prior to submitting claims for reimbursement, SNFs may consider scheduling regular meetings that are attended by the director of nursing, MDS coordinator, therapy director, business office manager, and other appropriate team members to verify that all aspects of care, documentation, and/or billing meet all Medicare regulations. For all areas, assess whether there is sufficient volume (i.e., the numerator count is 10 to 30 for the time period, depending on the SNF's total claims for service) to warrant a review. The following table can assist SNFs with interpreting their percentile values, which are indications of possible risk of improper Medicare payments.

TARGET AREA	SUGGESTED INTERVENTIONS IF AT/ABOVE 80TH PERCENTILE	SUGGESTED INTERVENTIONS IF AT/BELOW 20TH PERCENTILE
Therapy RUGs with High ADL ***Nontherapy RUGs with High ADL***	This could indicate a risk of potential overcoding of beneficiaries' ADL status. The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.	This could indicate a risk of potential under-coding of beneficiaries' ADL status. The SNF should determine whether the amount of assistance beneficiaries need with ADL, as reported on the MDS, is supported and consistent with medical record documentation.
Change of Therapy Assessment	This could indicate that the SNF is experiencing challenges with delivering services to the beneficiary as anticipated. The SNF may look into factors that lead to the need for the COT assessment (e.g., Can care planning be improved? Are there issues with completing therapy as scheduled?)	Not applicable.
Ultrahigh Therapy RUGs	This could indicate that the SNF is improperly billing for therapy services. The SNF should determine whether therapy provided was reasonable and medically necessary, and the SNF should also determine whether the amount of therapy reported on the MDS is supported by documentation in the medical record.	Not applicable.

TARGET AREA	SUGGESTED INTERVENTIONS IF AT/ABOVE 80TH PERCENTILE	SUGGESTED INTERVENTIONS IF AT/BELOW 20TH PERCENTILE
20-Day Episodes of Care	This could indicate that the SNF is continuing treatment beyond the point where services are necessary. The SNF should review documentation for beneficiary episodes of care with a LOS of 20 days to ensure that beneficiaries' continued care was appropriate and that they received a skilled level of care. The SNF should review the appropriateness of plans of care and discharge planning.	Not applicable.
90+ Day Episodes of Care	This could indicate that the SNF is continuing treatment beyond the point where those services are necessary. The SNF should review documentation for beneficiary episodes of care with a LOS of 90+ days to ensure that beneficiaries' continued care was appropriate and that they received a skilled level of care. The SNF should review appropriateness of plans of care and discharge planning.	Not applicable.
3- to 5-Day Readmissions	This could indicate that patients are being discharged prematurely or that patients are being readmitted after the interrupted stay threshold, thereby resetting the variable per diem adjustment. A sample of readmission cases should be reviewed to identify the appropriateness of admission, discharge, quality of care, post-discharge care, and billing errors. The facility is encouraged to generate data profiles for readmissions to its facility within three to five consecutive calendar days. Suggested data elements to include in these profiles are as follows: patient identifier, date of admission, date of discharge, patient discharge status code, and principal and secondary diagnoses.	Not applicable.

Comparative data for the three consecutive years can be used to help identify whether the SNF's target area percents changed significantly in either direction from one year to the next. This could be an indication of changes in admission or assessment procedures, staff turnover, or changes in patient case mix.

Using PEPPER

Compare Targets Report

SNFs 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 year included in PEPPER. For each target area, the Compare Targets Report displays the SNF's number of target (numerator) count, the target area percent, and the SNF's percentiles, as compared to the nation, jurisdiction, and state comparison groups.

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).

The *SNF PEPPER* identifies providers whose data results suggest they are at risk for improper Medicare payments as compared to all SNFs in the nation. The SNF's risk status is indicated by the color of the target area percent on the Compare Targets Report. When the SNF's percent is at or above the national 80th percentile for a target area, the SNF's percent is printed in **red bold**. When the SNF is a low outlier (for areas at risk for under-coding only), the SNF's percent is printed in *green italics*. When the SNF is not an outlier, the SNF's percent is printed in black.

The Compare Targets Report provides the SNF's percentile value for the nation, jurisdiction, and state for all target areas with reportable data in the most recent year. The percentile value allows a SNF to assess how its target area percent compares to all SNFs in each respective comparison group. (See "Percentile" in the Glossary, page 15.)

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

The SNF's jurisdiction percentile indicates the percentage of all other SNFs in the MAC jurisdiction that have a target area percent less than the SNF's target area percent. The SNF's jurisdiction percentile for a target area is not calculated (it will be blank) if there are fewer than 11 SNFs with reportable data for the target area in the jurisdiction.

The SNF's state percentile indicates the percentage of all other SNFs in the state within the MAC jurisdiction that have a target area percent less than the SNF's target area percent. The SNF's state percentile for a target area is not calculated (it will be blank) if there are fewer than 11 SNFs with reportable data for the target area in the state.

For more information about how percents differ from percentiles, see the "Training and Resources" page in the SNF 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, SNFs should consider their target area percentile values in order of nation, jurisdiction, and state. Percentile values at or above the 80th percentile indicate that the SNF is at risk for improper Medicare payments. Providers should place the highest priority with their national percentile, as this percentile represents how the SNF compares to all SNFs in the nation.

Percentile values at or above the jurisdiction's 80th percentile or state's 80th percentile should be considered as well, though they should be considered as a lower priority. Jurisdiction and state are smaller comparison groups; therefore, the percentiles for these groups may be less meaningful. In addition, there may be regional differences in practice patterns reflected in jurisdiction and state percentiles.

The "Target Count" can also be used to help prioritize areas for review. Areas in which a provider is at/above the 80th percentile that have a large target count may be given higher priority than target areas for which a provider is at/above the 80th percentile that have a smaller target count.

Target Area Reports

PEPPER Target Area Reports display a variety of statistics for each target area summarized over three years. 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 SNF's target area percent over three years. The SNF's data is represented on the graph in bar format; each bar represents a fiscal year. SNFs can identify significant changes from one time period to the next. SNFs are encouraged to consider the root causes of major changes and strive to prevent improper Medicare payments.

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 SNF can easily identify when it may be at higher risk for improper Medicare payments when compared to any of the comparison groups. A table of these percents called "Comparative Data" is included under the SNF's data table. For more information about how percents differ from percentiles, see the "Training and Resources" page in the SNF section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

A SNF'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 SNFs 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 SNFs 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 SNF Data Table

PEPPER Target Area Reports also include a SNF data table. Statistics in each data table include the total numerator count of episodes of care for the target area (target area count), the denominator count of episodes of care, the proportion of the numerator and denominator (percent), average length of stay (ALOS) for the numerator and for the denominator (where available), and the average and sum of Medicare payment data (where available).

The calculation of SNF payments for the individual RUGs included in the numerator of the following target areas is not available: *Therapy RUGs with High ADL, Nontherapy RUGs with High ADL,* and *Ultrahigh Therapy RUGs*. SNF claims include the total SNF payments per claim, which can include any number of RUGs. RUG-specific reimbursement information is not available on the SNF claim. Therefore, the average and sum of payments are only available for the *90+ Day Episodes of Care* target area. Neither the ALOS nor payment statistics are applicable to the *Change of Therapy Assessment* target area; therefore, these statistics are not reported.

In the data table, the SNF's percent will be shown in **red bold print** if it is at or above the national 80th percentile (high outlier); for areas at risk for under-coding, the SNF's percent will be shown in *green italics* if it is at or below the national 20th percentile (low outlier). (See "Percentile" in the Glossary, page 15.) For each time period, a SNF's data will not be displayed if the numerator count for the target area is less than 11.

Comparative Data Table

The comparative data table identifies the target area percents that are at the 80th and 20th percentiles (for areas at risk for under-coding only) 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 SNFs with reportable data for the target area in the state. Jurisdiction percentiles are zero when there are fewer than 11 SNFs with reportable data for the target area in the jurisdiction.

Interpretive Guidance and Suggested Interventions

Interpretive guidance is included on the Target Area Report (to the left of the graph) to assist SNFs in considering whether they should audit a sample of records. Suggested interventions for providers whose results suggest a risk for improper Medicare payments are tailored to each target area and are included at the bottom of each Target Area Report.

SNF Top RUGs Reports

The SNF Top RUGs Reports list the top RUGs by number of days for the SNF for episodes of care ending in the most recent fiscal year. There are two reports: one includes the top RUGs for all episodes of care, and the other includes the top RUGs for episodes of care with 90+ days. Both reports include the following:

- Total episodes of care in the report period (in the report heading, must be 11+ to display)
- RUG code and description
- Number of RUG days billed
- Percent of RUG days to total days
- Percent of episodes of care with the RUG billed total episodes of care
- Average number of days per RUG

Note that these reports are limited to the top RUGs (up to 20) for which there are a total of at least 11 days billed to the respective RUG during the most recent fiscal year and where there are at least 11 episodes ending in the most recent fiscal year.

Jurisdiction-Wide Top RUGs Reports

The Jurisdiction-Wide Top RUGs Reports list the top RUGs by number of days for the jurisdiction for episodes of care ending in the most recent fiscal year. There are two reports: one includes the top RUGs in the jurisdiction for all episodes of care, and the other includes the top RUGs in the jurisdiction for episodes of care with 90+ days. They include the same statistics as the SNF-specific reports (See above). Please note that these reports are limited to the top RUGs (up to 20) for which there are a total of at least 11 days billed to the respective RUG during the most recent fiscal year.

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 provides many educational resources to assist SNFs with PEPPER in the SNF "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 "Cost Report Days" billed by the total number of episodes of care that meet the target definition, ending during the time period.
Data Table	The statistical findings for a SNF are presented in tabular form, labeled by time period and indicator.
Episode of Care	An episode of care is created using claims submitted by a SNF. To create an episode of care: All claims submitted by a SNF for a beneficiary are collected and sorted from the earliest "Claim From" date to the latest. If the patient discharge status code on the latest claim in a series indicates that the beneficiary was discharged or did not return for continued care, then that beneficiary's episode of care is included in the time/report period in which the latest "Through Date" falls. If the latest claim in the series ended in the last month of the time/report period (e.g., Sept. 1 – 30, 2019, for the Q4FY19 release) and indicates that the beneficiary was still a patient (patient discharge status code "30"), then that beneficiary's episode of care is not included. If there is a gap between one claim's "Through Date" to the next claim's "From Date" of more than 30 days, then that is considered the ending of one episode of care and the beginning of a new episode of care. Each episode of care is included in the time/report period in which the latest "Through Date" falls. Claims are collected for four months prior to each time period so that the longer LOSs may be evaluated.
Fiscal Year	For Medicare data, the fiscal year starts on Oct. 1 and ends on Sept. 30.
Graph	In PEPPER, a graph shows a SNF's percentages for three years. The SNF's percentages are compared to the 80th percentiles for the state, jurisdiction, and nation for all target areas. See *Percentile*.
Length of Stay	The length of stay (LOS) is the total number of days represented by the series of claims submitted for a beneficiary as the result of a SNF stay. It is computed by taking the sum of "Cost Report Days" for each RUG (from the claim) for the series of claims submitted for a beneficiary.

TERM	DESCRIPTION
Percentile	In PEPPER, percentile represents the percent of SNFs in the comparison group below which a given SNF'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 a SNF's position in the group compared to all other SNFs in the comparison group for that target area. For example, suppose a SNF has a target area percent of 47.7 and 80% of the SNFs in the comparison group have a percent for that target area that is less than 47.7. Then we can say the SNF is at the 80th percentile. Percentiles in PEPPER are calculated from the SNFs' percents so that each SNF percent can be compared to the statewide, jurisdiction-wide, or nationwide distribution of SNF percents. For more information about how percents differ from percentiles, please see the "Training and Resources" page in the SNF section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

Acronyms and Abbreviations

ACRONYM/ ABBREVIATION	ACRONYM/ABBREVIATION DEFINITION
ADL	Activities of daily living (ADL)
ALOS	The average length of stay (ALOS) is calculated as an arithmetic average or mean. It is computed by dividing the total number of "Cost Report Days" billed by the total number of episodes of care that meet the target definition, ending during the time period.
CAH	Critical access hospitals (CAHs)
CCN	CMS Certification Number (CCN)
CMS	The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for oversight of Medicare and Medicaid. CMS is a division of the U.S. Department of Health and Human Services.
FATHOM	First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) is a Microsoft Access application. It was designed to help MACs compare providers in areas at risk for improper payment using Medicare administrative claims data. FATHOM produces PEPPER.
FI	Fiscal intermediary (FI)
FY	Fiscal year (FY)
IPPS	Inpatient prospective payment system (IPPS)
LOS	Length of stay (LOS)
MAC	The Medicare Administrative Contractor (MAC) is the contracting authority that replaced the FI and carrier in performing Medicare Fee-for-Service claims processing activities.
OIG	The Office of Inspector General (OIG)
PEPPER	Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a data report that contains a single SNF's claims data statistics for claims for service that are at risk for improper Medicare payments.
PDPM	Patient Driven Payment Model (PDPM)
PPS	Prospective payment system (PPS)
RUG	Resource Utilization Group (RUG)
SNF	Skilled nursing facility (SNF)
STACH	Short-term acute care hospital (STACH)
UB-04	Standard uniform bill used by health care providers to submit claims for services. Claims for Medicare reimbursement are submitted to the provider's MAC.

Appendix 1: Therapy RUGs

Includes RUG categories of "Rehabilitation" and "Rehabilitation Plus Extensive Services."

RUG-IV (beginning Fiscal Year 2011)

RUG Code	RUG Description
RUX	Rehabilitation Ultra High And Extensive Services with ADL 11 – 16
RUL	Rehabilitation Ultra High And Extensive Services with ADL 2 – 10
RVX	Rehabilitation Very High And Extensive Services with ADL 11 – 16
RVL	Rehabilitation Very High And Extensive Services with ADL 2 – 10
RHX	Rehabilitation High And Extensive Services with ADL 11 – 16
RHL	Rehabilitation High And Extensive Services with ADL 2 – 10
RMX	Rehabilitation Medium And Extensive Services with ADL 11 – 16
RML	Rehabilitation Medium And Extensive Services with ADL 2 – 10
RLX	Rehabilitation Low And Extensive Services with ADL 2 – 16
RUC	Rehabilitation Ultra High with ADL 11 – 16
RUB	Rehabilitation Ultra High with ADL 6 – 10
RUA	Rehabilitation Ultra High with ADL 0 – 5
RVC	Rehabilitation Very High with ADL 11 – 16
RVB	Rehabilitation Very High with ADL 6 - 10
RVA	Rehabilitation Very High with ADL 0 – 5
RHC	Rehabilitation High with ADL 11 – 16
RHB	Rehabilitation High with ADL 6 – 10
RHA	Rehabilitation High with ADL 0 – 5
RMC	Rehabilitation Medium with ADL 11 – 16
RMB	Rehabilitation Medium with ADL 6 – 10
RMA	Rehabilitation Medium with ADL 0 – 5
RLB	Rehabilitation Low with ADL 11 – 16
RLA	Rehabilitation Low with ADL 0 – 10

Appendix 2: Nontherapy RUGs

Includes RUGs in categories "Extensive Services," "Special Care High," "Special Care Low," "Clinically Complex," "Reduced Physical Function," and "Behavioral Systems and Cognitive Performance."

RUG-IV (beginning Fiscal Year 2011)

RUG Code	RUG Description
ES3	Extensive Services Tracheostomy Care and Ventilator/respirator and ADL 2 - 16
ES2	Extensive Services Tracheostomy Care or Ventilator/respirator and ADL 2 - 16
ES1	Extensive Services Infection Isolation without Tracheostomy Care or Ventilator/respirator and ADL 2 – 16
HE2	Special Care High with Depression and ADL 15 – 16
HE1	Special Care High with No Depression and ADL 15 – 16
HD2	Special Care High with Depression and ADL 11 – 14
HD1	Special Care High with No Depression and ADL 11 – 14
HC2	Special Care High with Depression and ADL 6 – 10
HC1	Special Care High with No Depression and ADL 6 – 10
HB2	Special Care High with Depression and ADL 2 – 5
HB1	Special Care High with No Depression and ADL 2 – 5
LE2	Special Care Low with Depression and ADL 15 – 16
LE1	Special Care Low with No Depression and ADL 15 – 16
LD2	Special Care Low with Depression and ADL 11 – 14
LD1	Special Care Low with No Depression and ADL 11 – 14
LC2	Special Care Low with Depression and ADL 6 – 10
LC1	Special Care Low with No Depression and ADL 6 – 10
LB2	Special Care Low with Depression and ADL 2 – 5
LB1	Special Care Low with No Depression and ADL 2 – 5
CE2	Clinically Complex with Depression and ADL 15 – 16
CE1	Clinically Complex with No Depression and ADL 15 – 16
CD2	Clinically Complex with Depression and ADL 11 – 14
CD1	Clinically Complex with No Depression and ADL 11 – 14
CC2	Clinically Complex with Depression and ADL 6 – 10
CC1	Clinically Complex with No Depression and ADL 6 – 10
CB2	Clinically Complex with Depression and ADL 2 – 5
CB1	Clinically Complex with No Depression and ADL 2 – 5
CA2	Clinically Complex with Depression and ADL 0 – 1
CA1	Clinically Complex with No Depression and ADL 0 – 1
BB2	Behavior/Cognitive with ≥2 Restorative Nursing and ADL 2 – 5
BB1	Behavior/Cognitive with ≤1 Restorative Nursing and ADL 2 – 5

RUG Code	RUG Description
BA2	Behavior/Cognitive with ≥2 Restorative Nursing and ADL 0 – 1
BA1	Behavior/Cognitive with ≤1 Restorative Nursing and ADL 0 – 1
PE2	Physical Function with ≥2 Restorative Nursing and ADL 15 – 16
PE1	Physical Function with ≤1 Restorative Nursing and ADL 15 – 16
PD2	Physical Function with ≥2 Restorative Nursing and ADL 11 – 14
PD1	Physical Function with ≤1 Restorative Nursing and ADL 11 – 14
PC2	Physical Function with ≥2 Restorative Nursing and ADL 6 – 10
PC1	Physical Function with ≤1 Restorative Nursing and ADL 6 – 10
PB2	Physical Function with ≥2 Restorative Nursing and ADL 2 – 5
PB1	Physical Function with ≤1 Restorative Nursing and ADL 2 – 5
PA2	Physical Function with ≥2 Restorative Nursing and ADL 0 – 1
PA1	Physical Function with ≤1 Restorative Nursing and ADL 0 – 1
AAA	Default RUG Code (unassigned)

Appendix 3: How Readmissions Are Identified

These example scenarios are included to help providers understand how readmissions are identified and counted in PEPPER.

Scenario 1: A beneficiary returns to the SNF after three complete non-covered SNF Medicare Part A days. This scenario **would** be counted as a *3- to 5-Day Readmission* in PEPPER.

- 2/1/20: Admitted to SNF for Medicare Part A care.
- 2/8/20: Discharged from SNF and admitted to a hospital (anytime between midnight and 11:59 p.m.). This is the first non-covered day.
- 2/9/20: Remains in hospital. This is the second non-covered day.
- 2/10/20: Remains in hospital. This is the third non-covered day.
- 2/11/20: Readmitted to SNF for Medicare Part A care (anytime between midnight and 11:59 p.m.). This is the first day outside the three-day interruption window. The SNF PPS treats this as a new stay with a required five-day PPS assessment; the variable payment rate schedule starts on day 1.

Scenario 2: A beneficiary returns to the SNF during the third non-covered SNF day. This scenario **would not** be counted as a *3- to 5-Day Readmission* in PEPPER.

- 2/1/20: Admitted to SNF for Medicare Part A care.
- 2/8/20: Discharged from SNF and admitted to a hospital (anytime between midnight and 11:59 p.m.). This is the first non-covered day.
- 2/9/20: Remains in hospital. This is the second non-covered day.
- 2/10/20: Readmitted to SNF for Medicare Part A care (anytime between midnight and 11:59 p.m.). This is the last day of the three-day period that begins on the first non-covered day following a SNF stay covered by Medicare Part A. The SNF PPS would treat this as an interrupted stay; this day would be considered covered because there is not a complete period of three consecutive non-covered days.