



Critical Access Hospital
Program for Evaluating Payment
Patterns Electronic Report

User's Guide
Twelfth Edition

**Critical Access Hospital
Program for Evaluating Payment Patterns Electronic Report User’s Guide**
Twelfth Edition, effective with the Q4FY22 release

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What's new in this edition?

- One target area has been removed:
 - *Chronic Obstructive Pulmonary Disease*

Introduction

What Is PEPPER?

The Office of Inspector General (OIG) encourages hospitals to develop and implement a compliance program to protect their operations from fraud and abuse.^{1,2} As part of 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 an electronic data report that contains a single hospital's claims data statistics for Medicare-Severity Diagnosis-Related Groups (MS-DRGs) and discharges at high risk for improper 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 also includes reports on the hospital's top DRGs by volume of discharges. PEPPER is developed and distributed by the RELI Group, along with its partners TMF® Health Quality Institute and CGS, under contract with the CMS.

All of the data tables, graphs, and reports in PEPPER were designed to assist hospitals with the identification of potential overpayments and underpayments.

PEPPER is available for critical access hospitals (CAHs). PEPPERs are also available for short- and long-term acute care inpatient prospective payment system (IPPS) hospitals, inpatient psychiatric facilities,

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:

- Significant changes in billing practices
- Possible over- or under-coding
- Increasing length of stays (LOSs)

inpatient rehabilitation facilities, hospices, partial hospitalization programs, skilled nursing facilities (SNFs), and home health agencies. The *CAH PEPPER* is the version of PEPPER specifically for CAHs.

CAHs, in general, are defined as hospitals that are located in a rural area, maintain no more than 25 inpatient beds, and maintain an annual average length of stay (ALOS) of 96 hours per patient for acute inpatient care. Although CAHs are reimbursed through a different payment

methodology (based on cost rather than DRG) than short-term acute care hospitals, they provide many of the same services; therefore, the PEPPER for CAHs has many of the same target areas as the PEPPER for short-term acute care hospitals. Based on ongoing analysis, these target areas may change over time.

Each *CAH PEPPER* summarizes statistics for the most recent twelve federal fiscal quarters, aggregated in three fiscal years. A CAH is compared to other CAHs in three comparison groups: the nation, Medicare

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>

Administrative Contractor (MAC) jurisdiction, and state. These comparisons enable a hospital to determine whether it is an outlier, differing from other CAHs.

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. PEPPER draws attention to any findings that are at or above the upper control limit or at or below the lower control limit.

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 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 included in *CAH PEPPER* are shown in the table below.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
CAH providers only Claim with valid medical record number Services provided during the time periods included in the report	Third and fourth positions of the CMS Certification Number = “13” UB-04 FL 03a or 03b is not null (blank) Claim “Through Date” (discharge date) falls within the three fiscal years included in the report
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 *CAH PEPPER* is available to the CAH’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 CAH 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.

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CAH 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 DRG(s) that have been identified as prone to unnecessary admissions, and the denominator generally includes all discharges for the DRG(s) (i.e., 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 CAH PEPPER target areas are defined in the table on the following pages.

TARGET AREA	TARGET AREA DEFINITION
<p><i>Stroke Intracranial Hemorrhage</i></p>	<p><i>Numerator (N):</i> count of discharges for DRGs 061 (acute ischemic stroke with use of thrombolytic agent with major complication or comorbidity [MCC]), 062 (acute ischemic stroke with use of thrombolytic agent with complication or comorbidity [CC]), 063 (acute ischemic stroke with use of thrombolytic agent without CC/MCC), 064 (intracranial hemorrhage or cerebral infarction with MCC), 065 (intracranial hemorrhage or cerebral infarction with CC or tPA in 24 hours), 066 (intracranial hemorrhage or cerebral infarction without CC/MCC)</p> <p><i>Denominator (D):</i> count of discharges for DRGs 061, 062, or 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)</p>
<p><i>Respiratory Infections</i></p>	<p><i>N:</i> count of discharges for DRGs 177 (respiratory infections and inflammations with MCC), 178 (respiratory infections and inflammations with CC)</p> <p><i>D:</i> 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)</p> <p>Note: As of the release of the Q4FY18 PEPPER, some hospitals may see increases in the numerator and denominator counts for <i>Simple Pneumonia</i> and in the denominator counts for <i>Respiratory Infection</i>, due to a coding guideline change that came into effect for discharges on 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 FY2018) (I.A.17).</p>

TARGET AREA	TARGET AREA DEFINITION
<p>Simple Pneumonia</p>	<p><i>N</i>: count of discharges for DRGs 193, 194</p> <p><i>D</i>: 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</p> <p>Note: As of the release of the Q4FY18 PEPPER, some hospitals may see increases in the numerator and denominator counts for Simple Pneumonia and in the denominator counts for Respiratory Infection, due to a coding guideline change that came into effect for discharges on 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 FY2018) (I.A.17).</p>
<p>Septicemia</p>	<p><i>N</i>: 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)</p> <p><i>D</i>: 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</p>
<p>Medical DRGs with CC or MCC</p>	<p><i>N</i>: 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.], 291 [heart failure & shock w MCC or peripheral extracorporeal membrane oxygenation (ECMO)], 296 [cardiac arrest, unexplained w MCC or ECMO], 838 [chemo with acute leukemia as SDX with CC or high dose chemo agent].</p> <p><i>D</i>: 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, 291, 296, 838</p>

TARGET AREA	TARGET AREA DEFINITION
<p><i>Surgical DRGs with CC or MCC</i></p>	<p><i>N</i>: 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], 129 [major head and neck procedures with CC/MCC or major device], 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])</p> <p><i>D</i>: 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, 129, 246, 248, 469, 518)</p>
<p><i>Single CC or MCC</i></p>	<p><i>N</i>: 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</p> <p><i>D</i>: 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</p>
<p><i>Three-Day Skilled Nursing Facility-Qualifying Admissions</i></p>	<p><i>N</i>: count of discharges to a SNF with a three-day LOS</p> <p><i>D</i>: 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 readmission], 61 [discharged or transferred to a swing bed], or 89 [discharged or transferred to a swing bed with a planned acute care hospital inpatient readmission])</p>
<p><i>Swing Bed Transfers</i></p>	<p><i>N</i>: count of discharges with a LOS equal to three or four days with patient discharge status code 61 or 89</p> <p><i>D</i>: count of discharges with a LOS equal to three or four days</p>

TARGET AREA	TARGET AREA DEFINITION
30-Day Readmissions to Same Hospital or Elsewhere	<p><i>N</i>: count of index (first) admissions during the 12-month time period for which a readmission occurred within 30 days to the same CAH, to another CAH 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 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 1)</p> <p><i>D</i>: count of all discharges excluding patient discharge status codes 02, 82, 07, 20 and excluding rehabilitation and primary psychiatric CCS diagnosis categories</p>
30-Day Readmissions to Same Hospital	<p><i>N</i>: count of index (first) admissions during the 12-month time period for which a readmission occurred within 30 days to the same CAH for the same beneficiary (identified using the Health Insurance Claim number); patient discharge status of the index admission is not equal to 02, 82, 07; excluding rehabilitation and primary psychiatric CCS diagnosis categories (see Appendix 1)</p> <p><i>D</i>: count of all discharges excluding patient discharge status codes 02, 82, 07, 20 and excluding rehabilitation and primary psychiatric CCS diagnosis categories</p>
Two-Day Stays for Medical DRGs	<p><i>N</i>: count of discharges for medical DRGs with a LOS equal to two days (“through” date minus “admission” date = 2 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</p> <p><i>D</i>: 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</p>
Two-Day Stays for Surgical DRGs	<p><i>N</i>: count of discharges for surgical DRGs with a LOS equal to two days (“through” date minus “admission” date = 2 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</p> <p><i>D</i>: 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</p>

³ ICD-10 diagnoses and procedures have been collapsed into general categories using CCS. More information on CCS can be found at <http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp>.

TARGET AREA	TARGET AREA DEFINITION
<i>One-Day Stays for Medical DRGs</i>	<p><i>N</i>: count of discharges for medical DRGs with a LOS equal to one day (“through” date minus “admission” date = 1 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</p> <p><i>D</i>: 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</p>
<i>One-Day Stays for Surgical DRGs</i>	<p><i>N</i>: count of discharges for surgical DRGs with a LOS equal to one day (“through” date minus “admission” date = 1 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</p> <p><i>D</i>: 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</p>

These PEPPER target areas were approved by CMS because they have been identified as prone to improper Medicare payments in short-term acute care hospitals. Historically, many of these target areas were the focus of OIG audits, while others were identified through the former Payment Error Prevention Program and former Hospital Payment Monitoring Program, which were implemented by state Medicare Quality Improvement Organizations in 1999 through 2008. The Recovery Audit Contractor (RAC) demonstration project and the RAC permanent program have identified additional areas prone to improper payments.

Although it is recognized that CAHs are limited to lengths of stay of 96 hours, short inpatient hospital admissions — one- and two-day stays, in particular — have had high rates of unnecessary admissions. Several target areas in PEPPER focus on one- and two-day stays. These target areas can assist hospitals with focusing on potentially unnecessary admissions.

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 includes statistics for patients who were readmitted to the same CAH, to another CAH, or to a short-term acute care PPS hospital, and the other includes statistics for patients who were readmitted to the same CAH.

Three-day SNF-qualifying admissions have been found to be problematic in terms of admission necessity, and historical data indicate that three-day SNF-qualifying admissions have a higher incidence of unnecessary admissions than other three-day admissions (in the short-term acute care setting). Two target areas (*Three-Day Skilled Nursing Facility-Qualifying Admissions* and *Swing Bed Transfers*) are included to focus on this issue.

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 was not substantiated by documentation in the medical record. The target areas relating to medical and surgical DRGs with a CC or MCC focus on this issue.

Please note there are changes in DRGs and DRG definitions from one fiscal year (FY) to the next that should be considered. Refer to the Federal Register for specific details.

How Hospitals Can Use PEPPER Data

The *CAH PEPPER* allows CAHs 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 included in PEPPER.

To calculate percentiles, the target area percents for all CAHs 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 CAHs' target area percents fall is identified as the 80th percentile. CAHs whose target percents are at or above the 80th percentile (i.e., in the top 20%) are considered at risk for improper Medicare payments. Similarly, for areas at risk for under-coding, CAHs 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).

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

The PEPPER Team has developed suggested interventions in the following table for CAHs to 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 fiscal year, depending on the hospital’s total discharges for the fiscal year) to warrant a review of cases. The following table can assist CAHs with interpreting their percentile values, which are indications of possible risk of improper Medicare payments.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80 TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20 TH PERCENTILE)
<i>Stroke Intracranial Hemorrhage</i>	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.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80 TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20 TH PERCENTILE)
<i>Respiratory Infections</i>	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 507.x (aspiration pneumonia), 482.83 (pneumonia due to other gram negative pneumonia), or 482.89 (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.
<i>Simple Pneumonia</i>	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.
<i>Septicemia</i>	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 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.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80 TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20 TH PERCENTILE)
<p>Medical DRGs with CC or MCC</p> <p>Surgical DRGs with CC or MCC</p> <p>Single CC or MCC</p>	<p>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 should be reviewed to determine whether coding errors exist. Hospitals may generate data profiles to identify proportions of their CCs or MCCs to determine if 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. Note: As of Oct. 1, 2015, a principal diagnosis can also be a CC or MCC. Principal and secondary diagnosis codes should be reviewed to determine whether they are a CC/MCC.</p>	<p>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. Note: As of Oct. 1, 2015, a principal diagnosis can also be a CC or MCC. Principal and secondary diagnosis codes should be reviewed to determine whether they are a CC/MCC.</p>
<p>Three-Day Skilled Nursing Facility-Qualifying Admissions</p>	<p>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.</p>	<p>Not applicable; this is an admission-necessity focused target area.</p>
<p>Swing Bed Transfers</p>	<p>This could indicate there are admission necessity issues related to unnecessary admissions to qualify patients for a swing bed admission. A sample of medical records with three- or four-day lengths of stay and patient discharge status code of “61” or “89” should be reviewed to determine whether the admission was necessary.</p>	<p>Not applicable; this is an admission-necessity focused target area.</p>

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80 TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20 TH PERCENTILE)
<p><i>30-Day Readmissions to Same Hospital or Elsewhere</i></p> <p><i>30-Day Readmissions to Same Hospital</i></p>	<p>A sample of readmission cases should be reviewed to identify appropriateness of admission, discharge, quality of care, DRG assignment, or identify 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 as follows: 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:</p> <ul style="list-style-type: none"> • 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. <p>Hospitals that have exempt units (i.e., swing beds, rehabilitation units, or psychiatric 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 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.</p>	<p>Not applicable; these are admission-necessity focused target areas.</p>

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80 TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20 TH PERCENTILE)
<p><i>Both two-day stay target areas:</i></p> <p><i>Two-Day Stays for Medical DRGs</i></p> <p><i>Two-Day Stays for Surgical DRGs</i></p>	<p>This could indicate that there are unnecessary admissions related to inappropriate use of admission screening criteria or outpatient observation. 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 identification of any patterns related to increasing two-day stays.</p>	<p>Not applicable; these are admission-necessity focused target areas.</p>
<p><i>Both one-day stay target areas:</i></p> <p><i>One-Day Stays for Medical DRGs</i></p> <p><i>One-Day Stays for Surgical DRGs</i></p>	<p>This could indicate that there are unnecessary admissions related to 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 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.”</p>	<p>Not applicable; these are admission-necessity focused target areas.</p>

Comparative data for several consecutive fiscal years can be used to help identify whether the hospital’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

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 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 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. *CAH PEPPER* identifies outliers as compared to all hospitals in the nation.

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 year. 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 jurisdiction percentile will be blank if there are fewer than 11 hospitals with reportable data for the target area in the 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 state percentile will be blank if there are fewer than 11 hospitals with reportable data for the target area in the state.

For more information about how percents differ from percentiles, see the CAH "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, 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. If a hospital is an outlier for the nation (i.e., as compared to all hospitals in the nation), this should be interpreted as the highest priority. If a hospital is an outlier for its jurisdiction (i.e., as compared to all CAHs in its jurisdiction), this is somewhat of a lower priority. Lastly, if a hospital is an outlier for its state (i.e., as compared to all CAHs 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 *Septicemia* target area has the highest "Sum of Payments," but the hospital's percent is at the 80th percentile as compared to the jurisdiction and at the 65th percentile as compared to the nation. The *Swing Bed Transfers* 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 *Swing Bed Transfers* 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 fiscal 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 hospital's target area percent over three fiscal years. The hospital's data is represented on the graph in bar format; each bar represents a fiscal year. Hospitals can identify significant changes from one year to the next, which could be a result of changes in the medical staff, coding staff, utilization review processes, or hospital services. Hospitals are encouraged to identify root causes of major changes to ensure that improper payments are prevented.

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 graph includes 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 it is an outlier as compared to any of these comparison groups. A table of these percents called "Comparative Data" is included under the hospital's data table. For more information about how percents differ from percentiles, see the CAH "Training and Resources" section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

For each time period, a hospital's data will not be displayed in the graph if the numerator for the target area is less than 11. This is due to data use restrictions established by CMS, which came into effect with the January 2010 release of PEPPER. If there are fewer than 11 hospitals with reportable data in a state, there will not be a trend line for the state comparison group in the graph. If there are fewer than 11 hospitals with reportable data in a jurisdiction, there will not be a trend line for the jurisdiction comparison group in the graph.

Target Area Data Table

PEPPER Target Area Reports also include a 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 ALOS, and Medicare payment data. The hospital's percent will be shown in **red bold print** if it is at or above the national 80th percentile (high outlier); for coding-focused target areas, it will be shown in *green italics* if it is at or below the national 20th percentile (low outlier) (see "Percentile" in the Glossary, page 18). For each time period, a hospital'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 and 20th percentiles (for coding-focused areas 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 hospitals with reportable data in the state. Jurisdiction percentiles are zero when there are fewer than 11 hospitals with reportable data in the jurisdiction.

Interpretive Guidance and Suggested Interventions

Interpretive guidance is included on the Target Area Report (below the graph) to assist hospitals in considering whether they should audit a sample of records. Suggested interventions tailored to each target area are also included at the bottom of each Target Area Report.

Hospital Top DRGs Report

The Hospital Top DRGs Report lists the top DRGs by volume of discharges for your hospital in the most recent fiscal year. It includes the total hospital discharges for each of the top DRGs listed, the proportion of discharges for each DRG 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 discharges (for the respective DRG) during the most recent fiscal year.

Jurisdiction-Wide Top DRGs Report

The Jurisdiction-Wide Top DRGs Report lists the top DRGs by volume of discharges for all hospitals in the jurisdiction in the most recent fiscal year. It includes the total jurisdiction-wide discharges for each of the top DRGs listed, the proportion of discharges for each DRG to total discharges, the jurisdiction ALOS for each DRG, and the national ALOS for each DRG. Please note that this report is limited to displaying the top DRGs (up to 20) for which there are a total of at least 11 discharges 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 contains many educational resources to assist hospitals with PEPPER in the CAH “Training and Resources” section.

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.

Glossary

TERM	DESCRIPTION
Average Length of Stay	The average length of stay (ALOS) is calculated as an arithmetic mean. It is computed by dividing the total number of hospital (or inpatient) days by the total number of discharges within the time period. For the <i>30-Day Readmissions to Same Hospital or Elsewhere</i> and the <i>30-Day Readmissions to Same Hospital</i> target areas, the ALOS is calculated using the first (index) admission’s LOS, not the second (readmission) admission’s LOS.
Data Table	The statistical findings for a hospital are presented in tabular form, labeled by time period and indicator.
Fiscal Year	For Medicare data, the fiscal year starts on Oct. 1 and ends on Sept. 30.
Graph	In PEPPER, a graph shows a hospital’s percentages for the previous three years. The hospital’s percentages are compared to the 80 th percentiles for the nation, jurisdiction, and state or all target areas, in addition to the 20 th percentiles for the nation, jurisdiction, and state for coding-focused target areas. <i>See 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	In <i>CAH PEPPER</i> , hospitals are identified as an outlier if their target area percent is at or above the national 80 th percentile (high outlier) or at or below the national 20 th percentile (low outlier) for coding-focused target areas.
Percentile	<p>In PEPPER, the percentile represents the percent of hospitals in the comparison group below which a given hospital’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 hospital’s position in the group compared to all other hospitals in the comparison group for that target area and time period. For example, suppose a hospital has a target area percent of 2.3 and 80% of the hospitals in the comparison group have a percent for that target area that is less than 2.3. Then we can say the hospital is at the 80th percentile.</p> <p>Percentiles in PEPPER are calculated from the hospitals’ percents so that each hospital percent can be compared to the statewide, jurisdiction-wide, or nationwide distribution of hospital percents.</p> <p>For more information about how percents differ from percentiles, please see the CAH “Training and Resources” page 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 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.
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.
CCS	Clinical Classification Software (CCS)
CVA	Cerebrovascular accident (CVA)
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.
DS	Used in conjunction with <i>CAH PEPPER</i> one- and two-day stay (DS) target areas.
ECMO	Extracorporeal membrane oxygenation (ECMO)
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). The Medicare federal fiscal year begins on Oct. 1 and ends on Sept. 30.
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
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.
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.

ACRONYM/ ABBREVIATION	ACRONYM/ABBREVIATION DEFINITION
MCC	Major complication or comorbidity (MCC): Before the introduction of 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 re-defined and replaced with a new standard CC list and a new MCC list.
MS-DRG	Medicare-Severity Diagnosis-Related Groups (MS-DRGs)
OIG	Office of Inspector General (OIG)
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)
RAC	Recovery Audit Contractor (RAC)
SNF	Skilled nursing facility (SNF)
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: Rehabilitation and Primary Psychiatric CCS Diagnosis Categories

<u>CCS</u>	<u>Description</u>
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