



**Critical Access Hospital (CAH)  
Program for Evaluating Payment  
Patterns Electronic Report  
(PEPPER)**

**User Guide**

**FY 2025 Release**

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## What's new in this edition?

The existing Surgical Complication and Comorbidity (CC)/Major Complication and Comorbidity (MCC) target area was modified as of Quarter 1 (Q1) of Fiscal Year (FY) 2024 (Q1FY2024) to remove Diagnosis Related Group (DRG) codes 246 and 248 and replace them with DRG 321 (Percutaneous cardiovascular procedures with intraluminal device with MCC or 4+ Arteries/Intraluminal Devices) and DRG 322 (Percutaneous cardiovascular procedures with intraluminal device without MCC). Refer to the Surgical DRGs with CC or MCC row in *Table 2*.

There has been an update to the Single CC or MCC target area calculations. As a result, users will see a decrease in the number of claims included in the numerator for these target areas compared with PEPPERs issued prior to FY 2022. The underlying target area definitions remain unchanged.

# 1. 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.<sup>1, 2</sup> 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 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 (referred to in the report as "target areas"). Data in PEPPERs are presented in graphs and tables that depict the hospital's target area percentages over time. PEPPER also includes reports on the hospital's top DRGs by volume of discharges. Index Analytics (IA), along with its partners Integrity Management Services, Inc. (IntegrityM) and GovCon Growth Solutions, LLC, develops and distributes PEPPER under contract with the Centers for Medicare & Medicaid Services (CMS).

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

***PEPPER does not identify the presence of payment errors, but it can be used as a guide for auditing and monitoring efforts. A hospital can use PEPPER to compare its claims data over time to identify potential areas of concern, including significant changes in billing practices; possible over- or under-coding, and changes in length of stay.***

PEPPER is available for Critical Access Hospitals (CAHs), Short-Term (ST) Acute Care Hospitals, Long-Term (LT) Acute Care Hospitals, Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), Hospices, Partial Hospitalization Programs (PHPs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

CAHs are generally defined as hospitals located in rural areas that 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 (cost-based rather than DRG-based) they provide many of the same services as short-term acute care hospitals. As a result, the PEPPER for CAHs includes 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 Critical Access Hospital PEPPER (CAH PEPPER) summarizes statistics for the most recent twelve federal fiscal quarters, aggregated into three fiscal years. The CAH PEPPER is designed for critical access hospitals and compares each hospital's results with those of other critical access hospitals across three comparison groups: the nation, the Medicare Administrative Contractor (MAC) jurisdiction, and the state in which the hospital operates. These comparisons enable a hospital to determine whether it is an outlier compared with other CAHs. PEPPER determines outliers based on preset control limits. The upper control limit for all target

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<sup>1</sup> Refer to [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.](#)

<sup>2</sup> Refer to [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.](#)

areas is the 80th percentile, while the lower control limit is the 20th percentile. PEPPER highlights any findings at or above the upper control limit (high outlier) or at or below the lower control limit.

In PEPPER, the term “outlier” refers to a hospital whose target area percent falls within the top 20 percent of all hospital target area percents in the comparison group (i.e., at or above the 80th percentile) or within the bottom 20 percent of all hospital target area percents in the comparison group (i.e., at or below the 20th percentile for coding-focused target areas). Formal tests of significance are not used to determine outlier status in PEPPER.

*Table 1* provides specifications for claims eligible for inclusion in CAH PEPPER.

**Table 1: Eligible Claims Specifications for CAH PEPPER**

Inclusion/Exclusion Criteria	Data Specifications
CAH providers only	Third and fourth positions of the CMS Certification Number = “13”.
Services provided during the time periods included in the report	Claim “Through Date” (discharge date) falls within the three fiscal years included in the report.
Claim with a valid medical record number	UB-04 FL 03a or 03b is not null (blank).
Medicare claim payment amount greater than zero	The hospital received a payment amount greater than zero on the claim (Note: 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 (HMO) claims	Exclude claims submitted to a Medicare Advantage Plan.
Exclude cancelled claims	Exclude claims cancelled by the MAC.

## 1.1 CAH PEPPER Target Areas

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

*Table 2* identifies the FY 2025 definitions for the CAH PEPPER target areas. Definitions for FY 2023 and FY 2024 are provided in *Appendix B*.

**Table 2: Target Area and Target Area Definitions**

Target Area	Target Area Definition
<b>Stroke Intracranial Hemorrhage</b>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>061</b> (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with major complication or comorbidity [MCC]),</li> <li>• <b>062</b> (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with complication or comorbidity [CC]),</li> <li>• <b>063</b> (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent without CC/MCC),</li> <li>• <b>064</b> (intracranial hemorrhage or cerebral infarction with MCC),</li> <li>• <b>065</b> (intracranial hemorrhage or cerebral infarction with CC or tissue plasminogen activator [tPA] in 24 hours),</li> <li>• <b>066</b> (intracranial hemorrhage or cerebral infarction without CC/MCC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>061, 062, 063, 064, 065, 066,</b></li> <li>• <b>067</b> (nonspecific cerebral vascular accident [CVA] and precerebral occlusion without infarction with MCC),</li> <li>• <b>068</b> (nonspecific CVA and precerebral occlusion without infarction without MCC),</li> <li>• <b>069</b> (transient ischemia without thrombolytic).</li> </ul>
<b>Respiratory Infection</b>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>177</b> (respiratory infections and inflammations with MCC),</li> <li>• <b>178</b> (respiratory infections and inflammations with CC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>177, 178,</b></li> <li>• <b>179</b> (respiratory infections and inflammations w/o CC/MCC),</li> <li>• <b>193</b> (simple pneumonia and pleurisy with MCC),</li> <li>• <b>194</b> (simple pneumonia and pleurisy with CC),</li> <li>• <b>195</b> (simple pneumonia and pleurisy without CC/MCC).</li> </ul>
<b>Simple Pneumonia</b>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>193</b> (simple pneumonia and pleurisy with MCC),</li> <li>• <b>194</b> (simple pneumonia and pleurisy with CC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>190</b> (chronic obstructive pulmonary disease with MCC),</li> <li>• <b>191</b> (chronic obstructive pulmonary disease with CC),</li> <li>• <b>192</b> (chronic obstructive pulmonary disease without CC/MCC),</li> <li>• <b>193, 194,</b></li> <li>• <b>195</b> (simple pneumonia and pleurisy without CC/MCC).</li> </ul>

Target Area	Target Area Definition
<b>Septicemia</b>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>870</b> (septicemia or severe sepsis with mechanical ventilation &gt;96 hours),</li> <li>• <b>871</b> (septicemia or severe sepsis without mechanical ventilation &gt;96 hours with MCC), and</li> <li>• <b>872</b> (septicemia or severe sepsis without mechanical ventilation &gt;96 hours without MCC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>193</b> (simple pneumonia and pleurisy with MCC),</li> <li>• <b>194</b> (simple pneumonia and pleurisy with CC),</li> <li>• <b>195</b> (simple pneumonia and pleurisy without CC/MCC),</li> <li>• <b>207</b> (respiratory system diagnosis with ventilator support &gt;96 hours),</li> <li>• <b>208</b> (respiratory system diagnosis with ventilator support ≤ 96 hours),</li> <li>• <b>689</b> (kidney and urinary tract infections with MCC),</li> <li>• <b>690</b> (kidney and urinary tract infections without MCC), and</li> <li>• <b>870, 871, or 872.</b></li> </ul>
<b>Medical DRGs with CC or MCC</b>	<p><b>Numerator:</b> Count of discharges for medical DRGs with "w CC", "w MCC," or "w CC/MCC" in DRG description.</p> <p><b>Numerator Exclusions:</b> Exclude DRGs that can be assigned on the basis of a CC, MCC, or medication administration. For FY 2025, this includes the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>065</b> (intracranial hemorrhage or cerebral infarction with CC or tPA in 24 hours),</li> <li>• <b>124</b> (other disorders of the eye with mcc or thrombolytic agent), and</li> <li>• <b>838</b> (chemo with acute leukemia as secondary diagnosis (SDX) with CC or high dose chemo agent).</li> </ul> <p><b>Denominator:</b> 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.</p> <p><b>Denominator Exclusions:</b> Exclude DRGs that can be assigned on the basis of a CC, MCC, or medication administration. For FY 2025, this includes DRGs <b>065, 124,</b> and <b>838.</b></p>

Target Area	Target Area Definition
<b>Surgical DRGs with CC or MCC</b>	<p><b>Numerator:</b> Count of discharges for surgical DRGs with "w CC", "w MCC," or "w CC/MCC" in DRG description.</p> <p><b>Numerator Exclusions:</b> Exclude DRGs that can be assigned on the basis of a CC, MCC, or a procedure. For Fiscal Year 2025, this includes the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>005</b> (liver transplant with MCC or intestinal transplant),</li> <li>• <b>023</b> (craniotomy with major device implant or acute complex CNS principal diagnosis with MCC or chemotherapy implant or epilepsy with neurostimulator),</li> <li>• <b>029</b> (spinal procedures with CC or spinal neurostimulators),</li> <li>• <b>041</b> (peripheral, cranial nerve and other nervous system procedures with CC or peripheral neurostimulator),</li> <li>• <b>276</b> (cardiac defibrillator implant with MCC or carotid sinus neurostimulator),</li> <li>• <b>321</b> (percutaneous cardiovascular procedures with intraluminal device with MCC or 4+ arteries/intraluminal devices),</li> <li>• <b>426</b> (multiple level combined anterior and posterior spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device),</li> <li>• <b>447</b> (multiple level spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device),</li> <li>• <b>450</b> (single level spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device),</li> <li>• <b>469</b> (major hip and knee joint replacement or reattachment of lower extremity with MCC or total ankle replacement), and</li> <li>• <b>518</b> (back and neck procedures except spinal fusion with MCC or disc device or neurostimulator).</li> </ul> <p><b>Denominator:</b> 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.</p> <p><b>Denominator Exclusions:</b> Exclude DRGs that can be assigned on the basis of a CC, MCC, or a procedure. For FY 2025, this includes DRGs <b>005, 023, 029, 041, 276, 321, 426, 447, 450, 469, or 518.</b></p>
<b>Single CC or MCC</b>	<p><b>Numerator:</b> Count of discharges for DRGs assigned on the basis of a CC or MCC with only one CC or MCC coded on the claim.</p> <p><b>Numerator Exclusions:</b> Exclude DRGs that can be assigned on the basis of a CC, MCC, or a procedure.</p> <p><b>Denominator:</b> Count of discharges for DRGs assigned on the basis of a CC or MCC.</p> <p><b>Denominator Exclusions:</b> Exclude DRGs that can be assigned on the basis of a CC, MCC, or a procedure.</p>

Target Area	Target Area Definition
<b>3-Day Skilled Nursing Facility (SNF)-Qualifying Admissions</b>	<p><b>Numerator:</b> Count of discharges to an SNF with a 3-day length of stay (LOS). Discharges to an SNF are identified by the following patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>03</b> (discharged or transferred to an SNF),</li> <li>• <b>61</b> (discharged or transferred to a swing bed),</li> <li>• <b>83</b> (discharged or transferred to an SNF with a planned acute care hospital inpatient admission), and</li> <li>• <b>89</b> (discharged or transferred to a swing bed with a planned acute care hospital inpatient admission).</li> </ul> <p><b>Denominator:</b> Count of all discharges to an SNF, identified by the following patient discharge status codes: <b>03, 61, 83, or 89.</b></p>
<b>Swing Bed Transfers</b>	<p><b>Numerator:</b> Count of discharges with a LOS equal to three or four days with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>61</b> (discharged or transferred to a swing Bed), or</li> <li>• <b>89</b> (discharged or transferred to a swing bed with a planned acute care hospital inpatient readmission).</li> </ul> <p><b>Denominator:</b> Count of discharges with a LOS equal to three or four days.</p>
<b>30-Day Readmissions to Same Hospital or Elsewhere</b>	<p><b>Numerator:</b> 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).</p> <p><b>Numerator Exclusions:</b> Exclude index admission claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged/transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), or</li> <li>• <b>82</b> (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software Refined (CCSR) diagnosis categories.</p> <p><b>Denominator:</b> Count of all discharges.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status codes: <b>02, 07, 20, or 82.</b></p> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCSR diagnosis categories.</p> <p>(Refer to <i>Appendix B</i> for more specifics regarding how readmissions are identified.)</p>

Target Area	Target Area Definition
<b>30-Day Readmissions to Same Hospital</b>	<p><b>Numerator:</b> 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).</p> <p><b>Numerator Exclusions:</b> Exclude index admission claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged/transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), or</li> <li>• <b>82</b> (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software Refined (CCSR) diagnosis categories.</p> <p><b>Denominator:</b> Count of all discharges.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status codes: <b>02, 07, 20, or 82.</b></p> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCSR diagnosis categories.</p> <p>(Refer to <i>Appendix B</i> for more specifics regarding how readmissions are identified.)</p>
<b>2-Day Stays for Medical DRGs</b>	<p><b>Numerator:</b> Count of discharges for medical DRGs with a LOS equal to 2 days (through date minus admission date = 2 days).</p> <p><b>Numerator Exclusions:</b> Exclude claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), or</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for medical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, or 82.</b></p> <p>Exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>

Target Area	Target Area Definition
<b>2-Day Stays for Surgical DRGs</b>	<p><b>Numerator:</b> Count of discharges for surgical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days).</p> <p><b>Numerator Exclusions:</b> Exclude claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), or</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for surgical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, or 82.</b></p> <p>Exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>
<b>1-Day Stays for Medical DRGs</b>	<p><b>Numerator:</b> Count of discharges for medical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day).</p> <p><b>Numerator Exclusions:</b> Claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), or</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for medical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, or 82.</b></p> <p>Exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>

Target Area	Target Area Definition
<b>1-Day Stays for Surgical DRGs</b>	<p><b>Numerator:</b> Count of discharges for surgical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day).</p> <p><b>Numerator Exclusions:</b> Exclude claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), or</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>And exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for surgical DRGs</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, or 82.</b></p> <p>And exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>

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

**Note:** There are changes in DRGs and DRG definitions from one fiscal year to the next that should be considered. Refer to the [Federal Register](#) for details. A full list of Medical and Surgical DRGs, including those with CC, MCC, and CC/MCC, and those without CC, MCC, and CC/MCC in the description, are available in the CMS MS-DRG Definitions Manual available on the CMS website: [ICD-10-CM/PCS MS-DRG Definitions Manual](#). A list of the target area definitions for FY 2023 and FY 2024 is provided in *Appendix B*.

Although CAHs are limited to a 96-hour length of stay, short inpatient hospital admissions — particularly one- and two-day stays — 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 identify potentially unnecessary admissions.

Hospitals can examine their statistics for these target areas to assess their risk for unnecessary admissions and to monitor changes in admission practices over time.

Readmissions have been associated with billing errors, premature discharge, incomplete care, and inappropriate readmission. There are two target areas related to readmissions within 30 days of discharge. One includes statistics for patients readmitted to the same CAH, to another CAH, or to a short-term acute care PPS hospital. The other includes statistics for patients readmitted to the same CAH. The PEPPER readmission statistics do not incorporate risk adjustment or exclude planned readmissions due to the significant complexity and processing time required to generate statistics for inclusion in the PEPPER.

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

Three-day SNF-qualifying admissions have been found to be problematic in terms of admission necessity, and historical data show that these admissions have a higher incidence of unnecessary admissions than other three-day admissions. Two target areas, Three-Day Skilled Nursing Facility-Qualifying Admissions and Swing Bed Transfers, are included to address this issue.

The coding of CCs and, more recently, MCCs has been found to be problematic. Oversight agencies have identified coding errors in which a CC or MCC was added without supporting documentation in the medical record. The target areas relating to medical and surgical DRGs with a CC or MCC, as well as discharges with a single CC or MCC, focus on this issue.

## 1.2 How Hospitals Can Use PEPPER Data

CAH PEPPER provides critical access hospitals with their national, jurisdiction, and state percentile values for each target area with reportable data for the most recent three fiscal years (October 1 through September 30) included in the report (Refer to *Section 2.1*). “Reportable Data” in PEPPER means there are 11 or more numerator discharges for a given target area during a specific time period. Due to CMS data restrictions, PEPPER does not display statistics when a target area has fewer than 11 numerator discharges for that period.

**Note:** These are generalized suggestions and do not apply to all situations. For all areas, assess whether there is sufficient volume (i.e., 10 to 30 discharges for the year, depending on the hospital’s total annual discharges) to warrant a review of cases.

*Table 3* provides suggested interventions for outliers by target area.

**Table 3: Suggested Interventions for Outliers by Target Area**

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
<b>Stroke Intracranial Hemorrhage</b>	<ul style="list-style-type: none"> <li>This could indicate potential coding or billing errors related to over-coding of DRGs <b>061, 062, 063, 064, 065, and 066</b>.</li> <li>Review a sample of medical records for these DRGs to determine whether coding errors exist.</li> </ul>	<ul style="list-style-type: none"> <li>This could indicate coding or billing errors related to under-coding of DRGs <b>061, 062, 063, 064, 065, and 066</b>.</li> <li>Review a sample of medical records for other DRGs, such as DRGs <b>067, 068, and 069</b>, to determine whether coding errors exist.</li> <li>Remember to ensure that the documentation supports the principal diagnosis.</li> <li>A coder should not code based on radiological findings without seeking clarification from the physician.</li> </ul>

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
<b>Respiratory Infections</b>	<ul style="list-style-type: none"> <li>• This could indicate potential coding or billing errors related to over-coding for DRGs <b>177</b> or <b>178</b>.</li> <li>• Review a sample of medical records for these DRGs to determine whether coding errors exist.</li> <li>• To ensure documentation supports the principal diagnosis, hospitals may generate data profiles to identify cases with the following principal diagnosis codes:               <ul style="list-style-type: none"> <li>• International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code <b>J69.0</b> (pneumonitis due to inhalation of food or vomit)</li> <li>• ICD-10-CM code <b>J15.69</b> (Pneumonia due to other Gram-negative bacteria)</li> <li>• ICD-10-CM code <b>J15.8</b> (pneumonia due to other specified bacteria)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• This could indicate coding or billing errors related to under-coding for DRGs <b>177</b> or <b>178</b>.</li> <li>• Review a sample of medical records for other DRGs such as DRGs <b>179</b>, <b>193</b>, <b>194</b>, or <b>195</b> to determine whether coding errors exist.</li> <li>• Only a physician can determine a diagnosis of pneumonia. A coder should not code based on laboratory or radiological findings without seeking clarification from the physician.</li> </ul>
<b>Simple Pneumonia</b>	<ul style="list-style-type: none"> <li>• This could indicate potential coding or billing errors related to over-coding of DRGs <b>193</b> or <b>194</b>.</li> <li>• Review a sample of medical records for these DRGs to determine whether coding errors exist.</li> <li>• Remember to ensure that the documentation supports the principal diagnosis.</li> </ul>	<ul style="list-style-type: none"> <li>• This could indicate coding or billing errors related to under-coding for DRGs <b>193</b> or <b>194</b>.</li> <li>• Review a sample of medical records for other DRGs such as DRGs <b>190</b>, <b>191</b>, <b>192</b>, and <b>195</b> to determine whether coding errors exist.</li> <li>• Only a physician can determine a diagnosis of pneumonia.</li> <li>• A coder should not code based on laboratory or radiological findings without seeking clarification from the physician.</li> </ul>

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
<b>Septicemia</b>	<ul style="list-style-type: none"> <li>• This could indicate coding or billing errors related to over-coding of DRGs <b>870, 871, or 872</b>.</li> <li>• Review a sample of medical records for these DRGs to determine whether coding errors exist.</li> <li>• To ensure documentation supports the principal diagnosis, hospitals may generate data profiles to identify cases with a principal diagnosis code of ICD-10-CM code <b>A41.9</b> (Sepsis, unspecified organism).</li> </ul>	<ul style="list-style-type: none"> <li>• This could indicate coding or billing errors related to under-coding of DRGs <b>870, 871, or 872</b>.</li> <li>• Review a sample of medical records for other DRGs such as DRGs <b>689, 690, 193, 194, 195, 207, and 208</b> to determine whether coding errors exist.</li> <li>• Only a physician can determine a diagnosis of septicemia/sepsis. A coder should not code based on laboratory or radiological findings without seeking clarification from the physician.</li> </ul> <p><b>Note:</b> There is no ICD-10-CM code for urosepsis.</p>
<b>Medical CC/MCC</b>	<ul style="list-style-type: none"> <li>• This could indicate that there are coding or billing errors related to over-coding due to unsubstantiated CCs or MCCs.</li> <li>• A sample of medical records for medical DRGs with CCs or MCCs should be reviewed to determine whether coding errors exist.</li> <li>• Hospitals may generate data profiles to identify proportions of their CCs or MCCs to determine whether there are any particular medical DRGs on which to focus.</li> <li>• Remember that a diagnosis of a CC or MCC must be determined by the physician.</li> <li>• A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding.</li> <li>• If particular diagnoses are found to be problematic, provide education.</li> </ul>	<ul style="list-style-type: none"> <li>• This could indicate that there are coding or billing errors related to under-coding for CCs or MCCs.</li> <li>• A sample of medical records for medical DRGs without a CC or MCC should be reviewed to determine whether coding errors exist.</li> <li>• Remember that in order for a diagnosis to be coded as a CC or MCC, it must be substantiated by documentation.</li> <li>• A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding.</li> <li>• Consider whether the use of a physician query would have substantiated a CC or MCC.</li> </ul>

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
<b>Surgical CC/MCC</b>	<ul style="list-style-type: none"> <li>• This could indicate that there are coding or billing errors related to over-coding due to unsubstantiated CCs or MCCs.</li> <li>• A sample of medical records for surgical DRGs with CCs or MCCs should be reviewed to determine whether coding errors exist.</li> <li>• Hospitals may generate data profiles to identify proportions of their CCs or MCCs to determine whether there are any particular surgical DRGs on which to focus.</li> <li>• Remember that a diagnosis of a CC or MCC must be determined by the physician.</li> <li>• A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding.</li> <li>• If particular diagnoses are found to be problematic, provide education.</li> </ul>	<ul style="list-style-type: none"> <li>• This could indicate that there are coding or billing errors related to under-coding for CCs or MCCs.</li> <li>• A sample of medical records for surgical DRGs without a CC or MCC should be reviewed to determine whether coding errors exist.</li> <li>• Remember that in order for a diagnosis to be coded as a CC or MCC, it must be substantiated by documentation.</li> <li>• A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding.</li> <li>• Consider whether the use of a physician query would have substantiated a CC or MCC.</li> </ul>
<b>Single CC or MCC</b>	<ul style="list-style-type: none"> <li>• This could indicate that there are coding or billing errors related to over-coding due to unsubstantiated CCs or MCCs.</li> <li>• A sample of medical records for a single CC or MCC should be reviewed to determine whether coding errors exist. Hospitals may generate data profiles to identify proportions of their CCs or MCCs to determine whether there are any particular medical and/or surgical DRGs on which to focus.</li> <li>• If particular diagnoses are found to be problematic, provide education.</li> </ul>	<ul style="list-style-type: none"> <li>• This could indicate that there are coding or billing errors related to under-coding for CCs or MCCs.</li> <li>• 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.</li> <li>• Remember that in order for a diagnosis to be coded as a CC or MCC, it must be substantiated by documentation.</li> <li>• 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.</li> </ul>

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
<b>3-Day Skilled Nursing Facility-Qualifying Admissions</b>	<ul style="list-style-type: none"> <li>This could indicate that there are unnecessary admissions related to the inadequate use of medical necessity to qualify patients for an SNF admission.</li> <li>A sample of medical records with 3-day lengths of stay and patient discharge status codes of <b>03, 61, 83</b> or <b>89</b> should be reviewed to determine whether the admission was necessary.</li> </ul>	Not applicable, as this is an admission-necessity focused target area.
<b>Swing Bed Transfers</b>	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 <b>61</b> or <b>89</b> should be reviewed to determine whether the admission was necessary.	Not applicable; this is an admission-necessity focused target area.
<b>30-Day Readmissions to the Same Hospital or Elsewhere and 30-Day Readmissions to the Same Hospital</b>	<ul style="list-style-type: none"> <li>A sample of readmission cases should be reviewed to identify appropriateness of admission, discharge, quality of care, DRG assignment, and billing errors.</li> <li>Hospitals may generate data profiles for readmissions, such as patients readmitted the same day or next day after discharge.</li> <li>Hospitals may use patient identifier, date of admission, date of discharge, patient discharge status code, principal and secondary diagnoses, procedure code(s), and DRG to profile these admissions and identify patterns.</li> </ul>	Not applicable, as these are admission-necessity focused target areas.

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
<b>2-Day Stay Medical DRGs and 2-Day Stay Surgical DRGs</b>	<ul style="list-style-type: none"> <li>• This could indicate that there are unnecessary admissions related to the inappropriate use of admission screening criteria or outpatient observation.</li> <li>• A sample of medical records with two-day length of stay 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 2-day stays sorted by DRG, physician, or admission source to assist in the identification of any patterns related to increasing two-day stays.</li> </ul>	Not applicable, as these are admission-necessity focused target areas.
<b>1-Day Stay Medical DRGs and 1-Day Stay Surgical DRGs</b>	<ul style="list-style-type: none"> <li>• This could indicate that there are unnecessary admissions related to the inappropriate use of admission screening criteria or outpatient observation.</li> <li>• A sample of medical records with 1-day length of 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).</li> <li>• Hospitals may generate data profiles to identify 1-day stays sorted by DRG, physician, or admission source to assist in the identification of any patterns related to 1-day stays.</li> <li>• Hospitals may also wish to identify whether patients admitted for 1-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 1-day stays that are associated with procedures designated by CMS as “inpatient only.”</li> </ul>	Not applicable, as these are admission-necessity focused target areas.

Comparative data across several consecutive years can be used to help identify whether the hospital's target area percents have changed significantly in either direction from one year to the next. Such shifts may indicate a procedural change in admitting, coding, or billing practices, staff turnover, or changes in the medical staff. It could also reflect changing business practices (e.g., new lines of service) or changes in the external healthcare environment.

## 2. Using PEPPER

PEPPER is a Microsoft Excel workbook that contains numerous worksheets. Users navigate through PEPPER by clicking the worksheet tabs at the bottom of the screen. Each tab is labeled to identify the content of the worksheet (e.g., Definitions, Compare, or a specific Target Area).

### 2.1 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, and percentiles, as compared to the nation, jurisdiction, state, and the "Sum of Payments."

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

The hospital's outlier status is indicated by the color of the target area percent on the Compare Targets Report. When the hospital is a high outlier for a target area, the hospital percentile is printed in red bold. When the hospital is a low outlier, the hospital percentile is printed in green italics. When the hospital is not an outlier, the hospital's percentile is printed in black.

The Compare Targets Report provides the hospital's percentile values for the nation, jurisdiction, and state for all target areas with reportable data in the most recent fiscal year. These percentile values allow a hospital to assess how its target area percents compare with those of all hospitals in each comparison group.

The hospital's national percentile indicates the percentage of all other hospitals in the nation that have a target area percent lower 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 lower than the hospital's target area percent. The jurisdiction percentile for a target area is not calculated when fewer than 11 hospitals in the jurisdiction have reportable data for that target area.

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

When interpreting the Compare Targets Report, hospitals should consider their target area percentile values for the nation, jurisdiction, and state. Percentile values at or above the 80th percentile (for all target areas) or at or below the 20th percentile (for coding-focused target areas) indicate that the hospital is an outlier. Outlier status should be evaluated in the following priority order: 1) nation, 2) jurisdiction, and 3) state. The state should have the last priority because it has the smallest comparison group.

Hospitals can also use the "Sum of Payments" and "Number of Target Discharges" 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,” yet the hospital’s percent is at the 80th percentile compared to the jurisdiction and at the 65th percentile 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 the 90th percentile for the nation. In this scenario, the Swing Bed Transfers target area might be given priority.

## 2.2 Target Area Data Tables

PEPPER data tables display a variety of statistics for each target area summarized over three fiscal years. These statistics include the proportion of numerator and denominator discharges (percent), the total numerator count of discharges for the target area (target area discharge count), the denominator count of discharges, average length of stay (ALOS), and Medicare payment data.

The “Outlier Status” column identifies when the hospital is a high outlier. In these cases, the hospital’s percentile is displayed in bold red print, indicating that it is at or above the national 80th percentile. The “Outlier Status” column also identifies when the hospital is a low outlier. In these cases, the hospital’s percentile is displayed in green italics, indicating that it is at or below the national 20th percentile. The “Outlier Status” column will display “Not an outlier” when the hospital is not an outlier for the target area and time period. It will display “No data” when the hospital does not have reportable data for that target area and time period.

The “Target Sum Medicare Payments” column is calculated by adding the claim payment amounts for all claims that meet the target area numerator definition. The “Target Average Medicare Payment” column is calculated by dividing the Target Sum Medicare Payments by the Target Area Discharge Count. Interpretive guidance is included in the data tables to help hospitals determine whether they should audit a sample of records. Suggested interventions tailored to each target area are also provided on each data table.

Below the data tables are graphs that provide a visual representation of the hospital’s percentage for each target area over three fiscal years. Hospitals can identify significant year-to-year changes, which may result from shifts in medical staff, coding or billing staff, utilization review processes, documentation improvement, or hospital services. External changes in health care providers in the community can also affect patient population and case mix, which may be reflected in PEPPER target area statistics. Hospitals are encouraged to identify the root causes of major changes to help ensure that improper payments are prevented.

The graphs include trend lines for the percents at the 80th percentile (and at the 20th percentile for coding-focused target areas) for the three comparison groups (nation, jurisdiction, and state) so the hospital can easily identify when it is an outlier as compared to any of these groups. A table of these percents is included on each target area graph worksheet. State percentiles are zero when fewer than 11 hospitals have reportable data for the target area in the state. Jurisdiction percentiles are zero when fewer than 11 hospitals have reportable data for the target area in the jurisdiction. If there is no reportable data for the time period, the table will display #N/A in the cell.

If there is no reportable data for the hospital for a given time period due to CMS data use restrictions, there will be no data point on the graph for that time period. If fewer than 11 hospitals have reportable data for a target area in a state or jurisdiction for one or more time periods, the graph will not display a data point or trend line for the state or jurisdiction comparison group.

### 2.2.1 Hospital and Jurisdiction Top DRGs

The Hospital Top DRGs table lists the top DRGs for your hospital in the most recent fiscal year. It also includes the total hospital discharges for each of the top DRGs listed, the proportion of discharges for each DRG relative to total discharges, and the average hospital LOS for each DRG. The Jurisdiction Top DRGs table lists the top DRGs by volume for all hospitals in your jurisdiction in the most recent fiscal year. It also includes the total jurisdiction-wide discharges for each of the top DRGs listed, the proportion of discharges for each DRG relative to total discharges, the jurisdiction ALOS for each DRG, and the national ALOS for each DRG.

Please note that these reports display only the top 20 ranked DRGs, for which at least 11 discharges occurred during the most recent fiscal year. If multiple DRGs share the same rank, all tied DRGs will be displayed. If no DRGs have at least 11 total discharges during the most recent fiscal year, no data will appear in the table.

## 2.3 System Requirements, Customer Support, and Technical Assistance

PEPPER is a Microsoft Excel spreadsheet, developed in Excel 2016, that can be opened and saved to a personal computer (PC). It is not intended for use on a network, but it may be saved to as many PCs as needed.

For help using PEPPER, submit a request for assistance on the [CMS CBR PEPPER website](#) by selecting the “Help/Contact Us” tab. The website also provides numerous educational resources to support hospitals in using PEPPER.

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.

## Appendix A: Terms and Abbreviations

Table 4 provides a list of terms, abbreviations, and definitions in this document.

**Table 4: Terms and Abbreviations**

Term	Abbreviation	Definition
Agency for Healthcare Research and Quality	AHRQ	AHRQ is the lead federal agency charged with improving the quality, safety, efficiency, and effectiveness of healthcare for all Americans.
Average Length of Stay	ALOS	ALOS refers to the average number of days a patient stays in a hospital, calculated by dividing the total number of inpatient hospital days by the total number of discharges within a given period.
Centers for Medicare & Medicaid Services	CMS	CMS is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program, and health insurance portability standards.
Cerebrovascular Accident	CVA	Commonly known as a stroke, a CVA is a medical condition where blood flow to the brain is interrupted, leading to brain damage or death.
Clinical Classifications Software Refined	CCSR	CCSR is used to analyze costs, usage, and outcomes associated with patient diagnoses and procedures.
Comparative Billing Report	CBR	A CBR provides comparative data on Medicare billing trends, allowing an individual health care provider to compare their billing practices to peers in the same state and across the nation by specialty.
Complication or Comorbidity	CC	A CC is a condition that, while not the primary reason for hospitalization, can increase length of stay, resource utilization, or treatment complexity.
Critical Access Hospital	CAH	CAH is a designation CMS gives to a small, rural hospital that provides limited inpatient care, 24-hour emergency services, and is located far from other hospitals, allowing it to receive cost-based Medicare reimbursements to help maintain services in underserved areas.
Diagnosis-Related Group	DRG	DRG is a system developed for Medicare in 1980, becoming effective in 1983, as a part of the PPS to classify hospital cases expected to have similar hospital resource use.
Fiscal Year	FY	For CMS, the FY is the 12-month period used for calculating annual fiscal spending, running from October 1 of the previous year to September 30 of the calendar year for which the FY is numbered.

Term	Abbreviation	Definition
GovCon Growth Solutions, LLC	NA	GovCon Growth Solutions is a company that helps government contractors grow their business through services like market research, strategic planning, proposal development, and business development.
Health Maintenance Organization	HMO	An HMO is a type of Medicare managed care plan where a group of doctors, hospitals, and other healthcare providers agree to give healthcare to Medicare beneficiaries for a set amount of money from Medicare every month.
Home Health Agency	HHA	An HHA is a public agency or private organization, or sub-division of such agency or organization that provides skilled nursing services and at least one other therapeutic service in the residence of the client.
Hospice	NA	Hospice is inpatient or outpatient supportive care given to a terminally ill client and the family. The focus of this care is to enable the client to remain in the familiar surroundings of their home for as long as they can.
Index Analytics	IA	Index provides data integration services, including data architecture, master data management, data quality, security, and data warehousing.
Inpatient Prospective Payment System	IPPS	IPPS (or PPS) refers to Section 1886(d) of the Social Security Act that sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.
Inpatient Psychiatric Facility	IPF	An IPF is a facility that provides intensive, 24-hour psychiatric care for individuals who cannot be safely or adequately managed at a lower level of care and is certified under Medicare as an inpatient psychiatric hospital.
Inpatient Rehabilitation Facility	IRF	An IRF is a hospital or specialized unit within a hospital that provides intensive, specialized rehabilitation services to patients who require a high level of care and therapy after an illness, surgery, or injury.
International Classification of Diseases, 10th Revision, Procedure Coding System	ICD-10-PCS	ICD-10-PCS is a U.S.-specific coding system used in hospital inpatient settings to classify medical procedures.
Integrity Management Services, Inc.	IntegrityM	IntegrityM is a women-owned small business empowering Federal Government, State agencies, and private sector organizations to make more informed decisions.
Length of Stay	LOS	LOS refers to the duration of time a patient spends in a healthcare facility, measured from admissions to discharge, and is a key metric for evaluating hospital efficiency and resource utilization.
Long-Term	LT	LT refers to long-term acute care hospitals.

Term	Abbreviation	Definition
Major Complication or Comorbidity	MCC	MCC refers to a secondary diagnosis that significantly complicates a patient's primary condition and increases the resources needed for their care, impacting treatment, prognosis, and resource utilization.
Medicare	NA	Medicare is the federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.
Medicare Administrative Contractor	MAC	The MAC is the contracting authority replacing the fiscal intermediary and carrier in performing Medicare Fee-for-Service claims processing activities.
Medicare Advantage	MA	MA Plans, also known as Part C Plans, are healthcare plans offered by private companies approved by Medicare.
Medicare Part A	NA	Medicare Part A is the part of Medicare that covers hospice care, home healthcare, skilled nursing facilities, and inpatient hospital stays.
Medicare Part B	NA	Medicare Part B is the part of Medicare that covers doctor services, outpatient hospital care, and other medical services that Part A does not cover such as physical and occupational therapy, X-rays, medical equipment, or limited ambulance service.
Medicare Severity Diagnosis Related Group	MS-DRG	MS-DRG refers to the system CMS uses for inpatient hospital reimbursement. This system classifies patients into groups based on their principal diagnosis, secondary diagnoses, procedures, sex, and discharge status, to better reflect the severity of their illness and resource utilization.
Not Applicable	NA	Not applicable
Office of Inspector General	OIG	The OIG is an HHS agency that protects the integrity of HHS programs as well as the health and welfare of the beneficiaries of those programs.
Operating Room	OR	An OR is a designated area within a hospital or healthcare facility specifically equipped to perform surgical procedures.
Outlier Status	NA	Outlier status refers to percentiles at or above the 80th percentile for any target areas or at or below the 20th percentile for coding-focused target areas.
Partial Hospitalization Program	PHP	PHP refers to an intensive outpatient psychiatric treatment program.
Personal Computer	PC	A PC is a general-purpose computer designed for individual use, distinguishing it from larger, multi-user systems like mainframes or supercomputers.

Term	Abbreviation	Definition
Program for Evaluating Payment Patterns Electronic Report	PEPPER	PEPPER is an electronic data report in Microsoft Excel format that contains a single hospital's claims data statistics for diagnosis-related groups (DRGs) and discharges at high risk for improper payments due to billing, coding, and/or admission necessity issues.
Prospective Payment System	PPS	PPS (or IPPS) refers to Section 1886(d) of the Social Security Act (the Act) that sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.
Recovery Audit Contractor	RAC	RACs are responsible for identifying improper Medicare payments made to healthcare providers that existing program integrity efforts did not detect.
Recovery Auditor	RA	RAs, formerly referred to as Recovery Audit Contractors (RACs), are contracted entities that identify and recover improper Medicare payments made to healthcare providers, focusing on both overpayments and underpayments.
Secondary Diagnosis	SDX	SDX is any medical condition that coexists with the primary reason for a patient's admission or treatment.
Short-Term	ST	A short-term hospital stay is an inpatient admission typically lasting between a few hours to roughly 72 hours.
Short-Term Acute Care Hospital	STACH	STACH refers to Short-Term Acute Care Hospital.
Skilled Nursing Facility	SNF	An SNF is a facility that provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but do not require the level of care provided in a hospital.
Tissue Plasminogen Activator	tPA	tPA is a protein that acts as a "clot buster" to dissolve blood clots.
UB-04	NA	Institutional healthcare providers, such as hospitals and rehabilitation facilities, use the UB-04 standardized claim form (also known as CMS-1450), to submit billing information to insurance companies, including Medicare and Medicaid.

## Appendix B: Historical Target Area Definitions for FY 2023 and 2024

Table 5: Historical Target Area Definitions for FY 2023 and 2024

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>Stroke Intracranial Hemorrhage</b>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>061</b> (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with major complication or comorbidity [MCC]),</li> <li>• <b>062</b> (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with complication or comorbidity [CC]),</li> <li>• <b>063</b> (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent without CC/MCC),</li> <li>• <b>064</b> (intracranial hemorrhage or cerebral infarction with MCC),</li> <li>• <b>065</b> (intracranial hemorrhage or cerebral infarction with CC or tissue plasminogen activator [tPA] in 24 hours), and</li> <li>• <b>066</b> (intracranial hemorrhage or cerebral infarction without CC/MCC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>061, 062, 063, 064, 065, 066, and 067</b> (nonspecific CVA and precerebral occlusion without infarction with MCC),</li> <li>• <b>068</b> (nonspecific CVA and precerebral occlusion without infarction without MCC), and</li> <li>• <b>069</b> (transient ischemia without thrombolytic).</li> </ul>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>061</b> (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with major complication or comorbidity [MCC]),</li> <li>• <b>062</b> (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with complication or comorbidity [CC]),</li> <li>• <b>063</b> (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent without CC/MCC),</li> <li>• <b>064</b> (intracranial hemorrhage or cerebral infarction with MCC),</li> <li>• <b>065</b> (intracranial hemorrhage or cerebral infarction with CC or tissue plasminogen activator [tPA] in 24 hours), and</li> <li>• <b>066</b> (intracranial hemorrhage or cerebral infarction without CC/MCC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>061, 062, 063, 064, 065, 066, 067</b> (nonspecific CVA and precerebral occlusion without infarction with MCC),</li> <li>• <b>068</b> (nonspecific CVA and precerebral occlusion without infarction without MCC), and</li> <li>• <b>069</b> (transient ischemia without thrombolytic).</li> </ul>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>Respiratory Infection</b>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>177</b> (respiratory infections and inflammations with MCC), and</li> <li>• <b>178</b> (respiratory infections and inflammations with CC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>177, 178, 179</b> (respiratory infections and inflammations w/o CC/MCC),</li> <li>• <b>193</b> (simple pneumonia and pleurisy with MCC),</li> <li>• <b>194</b> (simple pneumonia and pleurisy with CC), and</li> <li>• <b>195</b> (simple pneumonia and pleurisy without CC/MCC).</li> </ul>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>177</b> (respiratory infections and inflammations with MCC), and</li> <li>• <b>178</b> (respiratory infections and inflammations with CC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>177, 178, 179</b> (respiratory infections and inflammations w/o CC/MCC),</li> <li>• <b>193</b> (simple pneumonia and pleurisy with MCC),</li> <li>• <b>194</b> (simple pneumonia and pleurisy with CC), and</li> <li>• <b>195</b> (simple pneumonia and pleurisy without CC/MCC).</li> </ul>
<b>Simple Pneumonia</b>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>193</b> (simple pneumonia and pleurisy with MCC), and</li> <li>• <b>194</b> (simple pneumonia and pleurisy with CC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>190</b> (chronic obstructive pulmonary disease with MCC),</li> <li>• <b>191</b> (chronic obstructive pulmonary disease with CC),</li> <li>• <b>192</b> (chronic obstructive pulmonary disease without CC/MCC),</li> <li>• <b>193, 194,</b> and</li> <li>• <b>195</b> (simple pneumonia and pleurisy without CC/MCC).</li> </ul>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>193</b> (simple pneumonia and pleurisy with MCC), and</li> <li>• <b>194</b> (simple pneumonia and pleurisy with CC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>190</b> (chronic obstructive pulmonary disease with MCC),</li> <li>• <b>191</b> (chronic obstructive pulmonary disease with CC),</li> <li>• <b>192</b> (chronic obstructive pulmonary disease without CC/MCC),</li> <li>• <b>193, 194,</b> and</li> <li>• <b>195</b> (simple pneumonia and pleurisy without CC/MCC).</li> </ul>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>Septicemia</b>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>870</b> (septicemia or severe sepsis with mechanical ventilation &gt;96 hours),</li> <li>• <b>871</b> (septicemia or severe sepsis without mechanical ventilation &gt;96 hours with MCC), and</li> <li>• <b>872</b> (septicemia or severe sepsis without mechanical ventilation &gt;96 hours without MCC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>193</b> (simple pneumonia and pleurisy with MCC),</li> <li>• <b>194</b> (simple pneumonia and pleurisy with CC),</li> <li>• <b>195</b> (simple pneumonia and pleurisy without CC/MCC),</li> <li>• <b>207</b> (respiratory system diagnosis with ventilator support &gt;96 hours),</li> <li>• <b>208</b> (respiratory system diagnosis with ventilator support ≤ 96 hours),</li> <li>• <b>689</b> (kidney and urinary tract infections with MCC),</li> <li>• <b>690</b> (kidney and urinary tract infections without MCC), and</li> <li>• <b>870, 871, 872.</b></li> </ul>	<p><b>Numerator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>870</b> (septicemia or severe sepsis with mechanical ventilation &gt;96 hours),</li> <li>• <b>871</b> (septicemia or severe sepsis without mechanical ventilation &gt;96 hours with MCC), and</li> <li>• <b>872</b> (septicemia or severe sepsis without mechanical ventilation &gt;96 hours without MCC).</li> </ul> <p><b>Denominator:</b> Count of discharges for the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>193</b> (simple pneumonia and pleurisy with MCC),</li> <li>• <b>194</b> (simple pneumonia and pleurisy with CC),</li> <li>• <b>195</b> (simple pneumonia and pleurisy without CC/MCC),</li> <li>• <b>207</b> (respiratory system diagnosis with ventilator support &gt;96 hours),</li> <li>• <b>208</b> (respiratory system diagnosis with ventilator support ≤ 96 hours),</li> <li>• <b>689</b> (kidney and urinary tract infections with MCC),</li> <li>• <b>690</b> (kidney and urinary tract infections without MCC), and</li> <li>• <b>870, 871, 872.</b></li> </ul>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>Medical DRGs with CC or MCC</b>	<p><b>Numerator:</b> Count of discharges for medical DRGs with "w CC," "w MCC," or "w CC/MCC" in the DRG description.</p> <p><b>Numerator Exclusions:</b> Exclude DRGs that can be assigned on the basis of a CC, MCC, or medication administration. For FY 2023, this includes the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>065</b> (intracranial hemorrhage or cerebral infarction with CC or tPA in 24 hours), and</li> <li>• <b>838</b> (chemo with acute leukemia as secondary diagnosis (SDX) with CC or high dose chemo agent).</li> </ul> <p><b>Denominator:</b> 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.</p> <p><b>Denominator Exclusions:</b> Exclude DRGs <b>065</b> and <b>838</b>.</p>	<p><b>Numerator:</b> Count of discharges for medical DRGs with "w CC," "w MCC," or "w CC/MCC" in the DRG description.</p> <p><b>Numerator Exclusions:</b> Exclude DRGs that can be assigned on the basis of a CC, MCC, or medication administration. For FY 2024, this includes the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>065</b> (intracranial hemorrhage or cerebral infarction with CC or tPA in 24 hours),</li> <li>• <b>124</b> (other disorders of the eye with mcc or thrombolytic agent), and</li> <li>• <b>838</b> (chemo with acute leukemia as secondary diagnosis (SDX) with CC or high dose chemo agent).</li> </ul> <p><b>Denominator:</b> 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.</p> <p><b>Denominator Exclusions:</b> Exclude DRGs <b>065</b>, <b>124</b>, and <b>838</b>.</p>
<b>Surgical DRGs with CC or MCC</b>	<p><b>Numerator:</b> Count of discharges for surgical DRGs with "w CC," "w MCC," or "w CC/MCC" in the DRG description.</p> <p><b>Numerator Exclusions:</b> DRGs that can be assigned on the basis of a CC, MCC, or a procedure. For Fiscal Year 2023, this includes the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>005</b> (liver transplant with MCC or intestinal transplant),</li> <li>• <b>023</b> (craniotomy with major device implant or acute complex CNS principal diagnosis with MCC or chemotherapy implant or epilepsy with neurostimulator),</li> <li>• <b>029</b> (spinal procedures with CC or spinal neurostimulators),</li> <li>• <b>041</b> (peripheral, cranial nerve and other nervous system procedures with CC or peripheral neurostimulator),</li> </ul>	<p><b>Numerator:</b> Count of discharges for surgical DRGs with "w CC," "w MCC," or "w CC/MCC" in the DRG description.</p> <p><b>Numerator Exclusions:</b> DRGs that can be assigned on the basis of a CC, MCC, or a procedure. For Fiscal Year 2024, this includes the following DRGs:</p> <ul style="list-style-type: none"> <li>• <b>005</b> (liver transplant with MCC or intestinal transplant),</li> <li>• <b>023</b> (craniotomy with major device implant or acute complex CNS principal diagnosis with MCC or chemotherapy implant or epilepsy with neurostimulator),</li> <li>• <b>029</b> (spinal procedures with CC or spinal neurostimulators),</li> <li>• <b>041</b> (peripheral, cranial nerve and other nervous system procedures with CC or peripheral neurostimulator),</li> </ul>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>Surgical DRGs with CC or MCC (Continued)</b>	<ul style="list-style-type: none"> <li>• <b>246</b> (percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries or stents),</li> <li>• <b>248</b> (percutaneous cardiovascular procedures with non-drug-eluting stent with MCC or 4+ arteries or stents),</li> <li>• <b>469</b> (major hip and knee joint replacement or reattachment of lower extremity with MCC or total ankle replacement), and</li> <li>• <b>518</b> (back and neck procedures except spinal fusion with MCC or disc device or neurostimulator).</li> </ul> <p><b>Denominator:</b> 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.</p> <p><b>Denominator Exclusions:</b> Exclude DRGs <b>005, 023, 029, 041, 246, 248, 469,</b> and <b>518</b>.</p>	<ul style="list-style-type: none"> <li>• <b>321</b> (percutaneous cardiovascular procedures with intraluminal device with MCC or 4+ arteries/intraluminal devices),</li> <li>• <b>469</b> (major hip and knee joint replacement or reattachment of lower extremity with MCC or total ankle replacement), and</li> <li>• <b>518</b> (back and neck procedures except spinal fusion with MCC or disc device or neurostimulator).</li> </ul> <p><b>Denominator:</b> 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.</p> <p><b>Denominator Exclusions:</b> Exclude DRGs <b>005, 023, 029, 041, 321, 469,</b> and <b>518</b>.</p>
<b>Single CC or MCC</b>	<p><b>Numerator:</b> Count of discharges for DRGs assigned on the basis of a CC or MCC with only one CC or MCC coded on the claim.</p> <p><b>Numerator Exclusions:</b> DRGs that can be assigned on the basis of a CC, MCC, or a procedure.</p> <p><b>Denominator:</b> Count of discharges for DRGs assigned on the basis of a CC or MCC.</p> <p><b>Denominator Exclusions:</b> DRGs that can be assigned on the basis of a CC, MCC, or a procedure.</p>	<p><b>Numerator:</b> Count of discharges for DRGs assigned on the basis of a CC or MCC with only one CC or MCC coded on the claim.</p> <p><b>Numerator Exclusions:</b> DRGs that can be assigned on the basis of a CC, MCC, or a procedure.</p> <p><b>Denominator:</b> Count of discharges for DRGs assigned on the basis of a CC or MCC.</p> <p><b>Denominator Exclusions:</b> DRGs that can be assigned on the basis of a CC, MCC, or a procedure.</p>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>3-Day Skilled Nursing Facility (SNF)-Qualifying Admissions</b>	<p><b>Numerator:</b> Count of discharges to an SNF with a 3-day LOS. Discharges to an SNF are identified by the following patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>03</b> (discharged or transferred to an SNF),</li> <li>• <b>61</b> (discharged or transferred to a swing bed),</li> <li>• <b>83</b> (discharged or transferred to an SNF with a planned acute care hospital inpatient admission), and</li> <li>• <b>89</b> (discharged or transferred to a swing bed with a planned acute care hospital inpatient admission).</li> </ul> <p><b>Denominator:</b> Count of all discharges to an SNF, identified by the following patient discharge status codes: <b>03, 61, 83,</b> and <b>89</b>.</p>	<p><b>Numerator:</b> Count of discharges to an SNF with a 3-day LOS. Discharges to an SNF are identified by the following patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>03</b> (discharged or transferred to an SNF),</li> <li>• <b>61</b> (discharged or transferred to a swing bed),</li> <li>• <b>83</b> (discharged or transferred to an SNF with a planned acute care hospital inpatient admission), and</li> <li>• <b>89</b> (discharged or transferred to a swing bed with a planned acute care hospital inpatient admission).</li> </ul> <p><b>Denominator:</b> Count of all discharges to an SNF, identified by the following patient discharge status codes: <b>03, 61, 83,</b> and <b>89</b>.</p>
<b>Swing Bed Transfers</b>	<p><b>Numerator:</b> Count of discharges with a LOS equal to three or four days with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>61</b> (discharged or transferred to a swing bed)</li> <li>• <b>89</b> (discharged or transferred to a swing bed with a planned acute care hospital inpatient admission).</li> </ul> <p><b>Denominator:</b> Count of discharges with a LOS equal to three or four days.</p>	<p><b>Numerator:</b> Count of discharges with a LOS equal to three or four days with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>61</b> (discharged or transferred to a swing bed)</li> <li>• <b>89</b> (discharged or transferred to a swing bed with a planned acute care hospital inpatient admission).</li> </ul> <p><b>Denominator:</b> Count of discharges with a LOS equal to three or four days.</p>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<p><b>30-Day Readmissions to the Same Hospital or Elsewhere</b></p>	<p><b>Numerator:</b> 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).</p> <p><b>Numerator Exclusions:</b> Exclude index admission claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged/transferred),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), or</li> <li>• <b>82</b> (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software Refined (CCSR) diagnosis categories.</p> <p><b>Denominator:</b> Count of all discharges.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status codes: <b>02, 07, 20, or 82.</b></p> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by CCSR diagnosis categories.</p>	<p><b>Numerator:</b> 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).</p> <p><b>Numerator Exclusions:</b> Exclude index admission claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged/transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), or</li> <li>• <b>82</b> (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software Refined (CCSR) diagnosis categories.</p> <p><b>Denominator:</b> Count of all discharges.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status codes: <b>02, 07, 20, or 82.</b></p> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by CCSR diagnosis categories.</p>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>30-Day Readmissions to the Same Hospital</b>	<p><b>Numerator:</b> 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).</p> <p><b>Numerator Exclusions:</b> Exclude index admission claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged/transferred),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), or</li> <li>• <b>82</b> (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software Refined (CCSR) diagnosis categories.</p> <p><b>Denominator:</b> Count of all discharges.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status codes: <b>02, 07, 20, or 82.</b></p> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by CCSR diagnosis categories.</p>	<p><b>Numerator:</b> 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).</p> <p><b>Numerator Exclusions:</b> Exclude index admission claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged/transferred),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), or</li> <li>• <b>82</b> (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software Refined (CCSR) diagnosis categories.</p> <p><b>Denominator:</b> Count of all discharges.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status codes: <b>02, 07, 20, or 82.</b></p> <p>Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by CCSR diagnosis categories.</p>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>2-Day Stays for Medical DRGs</b>	<p><b>Numerator:</b> Count of discharges for medical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days).</p> <p><b>Numerator Exclusions:</b> Claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), and</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for medical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status codes: <b>02, 07, 20, or 82</b>.</p> <p>Exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>	<p><b>Numerator:</b> Count of discharges for medical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days).</p> <p><b>Numerator Exclusions:</b> Claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), and</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for medical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, and 82</b>, and exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>2-Day Stays for Surgical DRGs</b>	<p><b>Numerator:</b> Count of discharges for surgical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days).</p> <p><b>Numerator Exclusions:</b> Claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), and</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for surgical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, and 82</b>, and exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>	<p><b>Numerator:</b> Count of discharges for surgical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days).</p> <p><b>Numerator Exclusions:</b> Claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), and</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for surgical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, and 82</b>, and exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>1-Day Stays for Medical DRGs</b>	<p><b>Numerator:</b> Count of discharges for medical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day).</p> <p><b>Numerator Exclusions:</b> Claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), and</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for medical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, and 82</b>, and exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>	<p><b>Numerator:</b> Count of discharges for medical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day).</p> <p><b>Numerator Exclusions:</b> Claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), and</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for medical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, and 82</b>, and exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
<b>1-Day Stays for Surgical DRGs</b>	<p><b>Numerator:</b> Count of discharges for surgical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day).</p> <p><b>Numerator Exclusions:</b> Claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), and</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for surgical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, and 82</b>, and exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>	<p><b>Numerator:</b> Count of discharges for surgical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day).</p> <p><b>Numerator Exclusions:</b> Claims with patient discharge status codes:</p> <ul style="list-style-type: none"> <li>• <b>02</b> (discharged or transferred to a short-term general hospital for inpatient care),</li> <li>• <b>07</b> (left against medical advice),</li> <li>• <b>20</b> (expired), and</li> <li>• <b>82</b> (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission).</li> </ul> <p>Exclude claims with occurrence span code <b>72</b> (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission.</p> <p><b>Denominator:</b> Count of discharges for surgical DRGs.</p> <p><b>Denominator Exclusions:</b> Exclude claims with patient discharge status code <b>02, 07, 20, and 82</b>, and exclude claims with occurrence span <b>72</b> with the through date on or the day prior to the inpatient admission.</p>

## Appendix C: Rehabilitation and Primary Psychiatric CCSR Diagnosis Categories

Both Readmission measures, *30-Day Readmissions to the Same Hospital* and *30-Day Readmissions to the Same Hospital or Elsewhere*, exclude claims for patients with primary diagnoses related to rehabilitation or primary psychiatric conditions, as these diagnoses often result in frequent admissions that are unrelated to the level of care provided by the facility. These exclusions rely on the Clinical Classification Software Refined (CCSR) categories, which assign specific ICD-10 codes to diagnosis categories. The CCSR categories selected for Rehabilitation and Primary Psychiatric diagnoses for the CAH PEPPER Readmissions target areas are listed in *Table 6* below.

For more information on the CCSR and the diagnosis codes captured in each CCSR category, please refer to the Agency for Healthcare Research and Quality (AHRQ) website: [https://hcup-us.ahrq.gov/toolssoftware/ccsr/ccs\\_refined.jsp](https://hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp).

**Table 6: Rehabilitation and Primary Psychiatric CCSR Diagnosis Categories**

CCSR Category	CCSR Category Description
FAC009	Implant, device or graft related encounter
INJ021	Effect of other external causes, initial encounter
INJ022	Poisoning by drugs, initial encounter
MBD001	Schizophrenia spectrum and other psychotic disorders
MBD002	Depressive disorders
MBD003	Bipolar and related disorders
MBD004	Other specified and unspecified mood disorders
MBD005	Anxiety and fear-related disorders
MBD006	Obsessive-compulsive and related disorders
MBD007	Trauma- and stressor-related disorders
MBD008	Disruptive, impulse-control and conduct disorders
MBD009	Personality disorders
MBD010	Feeding and eating disorders
MBD011	Somatic disorders
MBD012	Suicidal ideation/attempt/intentional self-harm
MBD013	Miscellaneous mental and behavioral disorders/conditions
MBD014	Neurodevelopmental disorders
MBD018	Opioid-related disorders
MBD019	Cannabis-related disorders
MBD020	Sedative-related disorders
MBD021	Stimulant-related disorders
MBD022	Hallucinogen-related disorders
MBD023	Inhalant-related disorders
MBD026	Mental and substance use disorders in remission
MBD027	Suicide attempt/intentional self-harm; subsequent encounter
MBD034	Mental and substance use disorders; sequela

## Appendix D: How Readmissions Are Identified

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

- Readmissions are counted in the 12-month time period in which the discharge date of the index (first) admission occurs. Each admission for a patient may serve as an index admission for a subsequent admission to a short-term acute care hospital or a critical access hospital (CAH) if it occurs within 30 days of the discharge date of the index admission.
- Each admission for a patient can be identified as a readmission only for the CAH admission that immediately precedes it in time. Index admissions with a patient discharge status code of "02" (discharged/transferred to a short-term acute care hospital), "07" (left against medical advice), "20" (expired), or "82" (discharged/transferred to a short-term acute care hospital for inpatient care with a planned acute care hospital inpatient readmission) are excluded from the numerator count and cannot be identified as an index admission for both readmission target areas.
- Any admissions of beneficiaries to other settings, such as skilled nursing facility, swing bed, inpatient rehabilitation facility, inpatient psychiatric facility, or any other type of provider, are not considered for this measure. Only admissions to CAHs and short-term acute care hospitals are considered. Common billing errors that may result in claims being identified as readmissions include the following:
  - Billing an admission to a distinct part unit of your CAH (e.g., inpatient rehabilitation or inpatient psychiatric facility unit) to the provider number for the CAH, instead of the provider number for the unit.
  - Incorrect coding of the patient discharge status code when the patient is discharged/transferred to another CAH or short-term acute care hospital. As noted above, index admissions with a patient discharge status code of 02, 07, 20, or 82 are excluded from the numerator count and cannot be identified as an index admission.

## D.1 Example 1 - Three Hospital Stays, One Qualifying Readmission for Readmission Same and Readmission Same or Elsewhere Target Areas

The following table displays claims submitted for one beneficiary. The table sorts the claims in date order from the first column. Each row includes two admissions: the “Index Admission” (shortened to “Index Adm.” in the table header) and the “Next Admission” (shortened to “Next Adm.” in the table header), which may be considered as a readmission. The next admission on one row becomes the index admission on the following row.

**Table 7: Example 1**

# (Index)	Index Adm. Provider	Index Adm. Date	Discharge Date	Patient Discharge Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Next Adm. Counts as 30-Day Readm. to Same?	Next Adm. Counts as 30-Day Readm. to Same or Elsewhere?
1	CAH #1	03/25/2024	03/29/2024	01	2	CAH #1	04/15/2024	04/17/2024	Yes to CAH #1	Yes to CAH #1
2	CAH #1	04/15/2024	04/17/2024	02	3	Short Term Acute Care Hospital #1	04/17/2024	04/20/2024	No	No
3	Short Term Acute Care Hospital (STACH) #1	04/17/2024	04/20/2024	01	NA	No further admissions	No further admissions	No further discharge dates	NA	NA

### Detailed Discussion:

- Row 1:** The beneficiary was admitted to CAH #1 on March 25, 2024, and discharged home (patient discharge status code 01) on March 29, 2024. The beneficiary was then admitted to CAH #1 again on April 15, 2024. The April 15, 2024 admission counts as a *30-Day Readmission to Same* and a *30-Day Readmission to Same or Elsewhere* for CAH #1 because it occurred within 30 days of the March 25, 2024 index admission’s discharge date of March 29, 2024.
- Row 2:** The beneficiary was admitted to CAH #1 on April 15, 2024, and was transferred (patient discharge status code 02) to STACH #3 on April 17, 2024. The April 17, 2024 admission does not count as a *30-Day Readmission to Same or Elsewhere* for

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CAH #1 against the April 15, 2024 index admission because the April 15, 2024 index admission had a discharge status code of 02.

- **Row 3:** The beneficiary was admitted to STACH #1 on April 17, 2024, and discharged home (patient discharge status code 01) on April 20, 2024.

## D.2 Example 2 - Four Hospital Stays, One Qualifying Readmissions for Readmission Same and Readmission Same or Elsewhere Target Areas

The following table displays claims submitted for one beneficiary. The table sorts the claims in date order from the first column. Each row includes two admissions: the “Index Admission” (shortened to “Index Adm.” in the table header) and the “Next Admission” (shortened to “Next Adm.” in the table header), which may be considered as a readmission. The next admission on one row becomes the index admission on the following row.

**Table 8: Example 2**

# (Index)	Index Adm. Provider	Index Adm. Date	Discharge Date	Patient Discharge Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Next Adm. Counts as 30-Day Readm. to Same?	Next Adm. Counts as 30-Day Readm. to Same or Elsewhere?
1	CAH #1	04/05/2024	04/07/2024	01	2	CAH #1	04/12/2024	04/16/2024	Yes, to CAH #1	Yes, to CAH #1
2	CAH #1	04/12/2024	04/16/2024	07	3	CAH #2	04/21/2024	04/24/2024	No	No
3	CAH #2	04/21/2024	04/24/2024	02	NA	STACH	04/24/2024	05/02/2024	No	No
4	STACH	04/24/2024	05/02/2024	01	NA	No further admissions	No further admissions	No further discharge dates	NA	NA

### Detailed Discussion:

- Row 1:** The beneficiary was admitted to CAH #1 on April 05, 2024, and was discharged home (patient discharge status code 01) on April 07, 2024. The beneficiary was then admitted to CAH #1 again on April 12, 2024. The April 12, 2024 admission counts as a *30-Day Readmission to Same* and a *30-Day Readmission to Same or Elsewhere* for CAH #1 because it occurred within 30 days of the April 05, 2024 index admission’s discharge date of April 07, 2024.
- Row 2:** The beneficiary was admitted to CAH #1 on April 12, 2024, and left against medical advice (discharge status code 07) on April 16, 2024. This admission does not count as a *30-Day Readmission to Same* or as a *30-Day Readmission to Same or Elsewhere* index admission for CAH #1 because the patient left against medical advice.

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- **Row 3:** The beneficiary was admitted to CAH #2 on April 21, 2024, and was transferred to STACH #1 (patient discharge status code 02) on April 24, 2024. The April 24, 2024 admission to STACH #1 does not count as a *30-Day Readmission to Same* or as a *30-Day Readmission to Same or Elsewhere* for CAH #2 because the patient was transferred to a short term acute care hospital (discharge status code 02).
  - **Row 4:** The beneficiary was admitted to STACH #1 on April 24, 2024, and was discharged home (patient discharge status code 01) on May 2, 2024.

### D.3 Example 3 - Two Hospital Stays, One Qualifying Readmission for Readmission Same or Elsewhere Target Area

The following table displays claims submitted for one beneficiary. The table sorts the claims in date order from the first column. Each row includes two admissions: the “Index Admission” (shortened to “Index Adm. in the table header) and the “Next Admission” (shortened to “Next Adm.” in the table header), which may be considered as a readmission. The next admission on one row becomes the index admission on the following row.

**Table 9: Example 3**

# (Index)	Index Adm. Provider	Index Adm. Date	Discharge Date	Patient Discharge Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Next Adm. Counts as 30-Day Readm. to Same?	Next Adm. Counts as 30-Day Readm. to Same or Elsewhere?
1	CAH #1	10/10/2024	10/17/2024	01	2	CAH #2	11/02/2024	11/12/2024	No	Yes, to CAH #1
2	CAH #2	11/02/2024	11/12/2024	01	NA	No further admissions	No further admissions	No further discharge dates	NA	NA

#### Detailed Discussion:

- Row 1:** The beneficiary was admitted to CAH #1 on October 10, 2024, and was discharged home (patient discharge status code 01) on October 17, 2024. The beneficiary was then admitted to CAH #2 on November 02, 2024.
  - The November 02, 2024, admission to CAH #2 does not count as a *30-Day Readmission to Same*.
  - The November 02, 2024, admission to CAH #2 counts as a *30-Day Readmission to Same or Elsewhere* against the October 10, 2024 index admission for CAH #1 because the beneficiary was readmitted to CAH #2 within 30 days of the October 17, 2024 discharge date from index admission.
- Row 2:** The beneficiary was admitted to CAH #2 on November 02, 2024, and was discharged home (patient discharge status code 01) on November 12, 2024.