Home Health Agency Program for Evaluating Payment Patterns Electronic Report

User Guide

CY 2025 Release

August 2026

Table of Contents

List of Tables

What's new in this edition?

No changes to this edition.

1. What is PEPPER?

The Government Accountability Office has designated Medicare as a program at high risk for fraud, waste, and abuse. Medicare spending on home health care has increased dramatically in recent years and home health care has been identified as vulnerable to abuse. The Office of Inspector General (OIG) encourages home health agencies to develop and implement a compliance program to protect their operations from fraud and abuse.[1, 2] As part of its compliance program, a home health agency 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 home health agencies' auditing and monitoring activities.

PEPPER is an electronic data report that contains a single home health agency's claims data statistics in areas identified as at risk for improper Medicare payments due to billing, coding, or changes in admission or treatment practices. To develop the Home Health Agency PEPPER, Medicare claims data for all home health agencies nationwide (obtained from UB-04 claims submitted to the Medicare Administrative Contractor (MAC)) were analyzed to identify areas that could be at risk for improper Medicare payment. Each PEPPER contains statistics for the most recent calendar year for each area at risk for improper payments (referred to in the report as "target areas"). Data in PEPPER are presented in graphs and tables that depict the home health agency's target area percentages over time. PEPPER also includes reports on the home health agency's Top Clinical Groups. 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 the home health agency in identifying potential overpayments as well as potential underpayments.

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

PEPPER is available for Short-Term Acute Care Hospitals (STACH), Long-Term Acute Care Hospitals (LTACH), Critical Access Hospitals (CAHs), Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), Hospices, Partial Hospitalization Programs (PHPs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). The Home Health Agencies PEPPER (HHA PEPPER) is designed for HHAs and compares an individual HHA's results to other HHAs in three comparison groups: the nation, MAC jurisdictions, and the state in which the HHA operates. These comparisons enable an HHA to determine whether it is an outlier, differing from other HHAs.

---

[1] 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.

[2] 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.

PEPPER determines outliers based on preset control limits. The upper control limit for all target areas is the 80th percentile, while the lower control limit is the 20th percentile. PEPPER draws attention to any findings that are at or above the upper control limit (high outlier) or at or below the lower control limit.

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

Table 1: Eligible Claims Specifications for HHA PEPPER

Inclusion/Exclusion Criteria	Data Specifications
Claim facility type equal to "3"	UB-04 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 3 (Home Health Agency)
Include claim service classification type of "Home Health Visits"	UB-04 FL 04 Type of Bill, third digit (Bill Classification) = 2 (Home health visits under Part B) or 3 (Home health visits Part A)
Services provided during the time periods included in the report	Claim "Through Date" falls within the three calendar years included in the report.
Exclude non-payment and interim claims	UB-04 FL 04 Type of Bill, fourth digit (Frequency) ≠ 0 (Non-payment/zero claim) or 2 (Interim – first claim)
Final action claim	A final action claim is a non-rejected claim for which a payment has been made. All disputes and adjustments have been resolved and details clarified.
Medicare claim payment amount greater than zero	The home health agency received a payment amount greater than zero on the claim (Note that Medicare Secondary Payer claims are included).
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Advantage (MA) (Health Maintenance Organization) plan
Exclude cancelled claims	Exclude claims cancelled by the MAC

HHAs receive PEPPER files through a secure portal on the CMS CBR PEPPER website on a yearly basis.

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. After October 2000, HHAs were paid under the Home Health Prospective Payment System (HH PPS) for 60-day periods of care that included all covered home health services. The 60-day payment amount was adjusted for case-mix and area wage differences. The case-mix adjustment under this system included a clinical dimension, a functional dimension, and a service dimension, in which payment would increase if certain thresholds of therapy visits were met. If fewer than five visits were delivered during a 60-day period, the low-utilization payment adjustment (LUPA) rate was applied, and the HHA was paid per visit by visit type. The HH PPS included a partial episode payment (PEP) adjustment for situations in which a beneficiary elected to transfer to another HHA or when a beneficiary was discharged and readmitted to the same

HHA during the 60-day episode. Medicare also makes additional payments, known as outlier payments, to HHAs that provide services to beneficiaries who incur unusually high costs.

CMS finalized a new case-mix classification model, the Patient-Driven Groupings Model (PDGM), which took effect on January 1, 2020. The PDGM eliminates the use of therapy thresholds for case-mix adjustments and changes the 60-day unit of payment to a 30-day unit of payment. LUPA payments, partial payments, and outlier payments are included in the model. For more information on the PDGM, see Home Health PDGM and MLN SE20005, or visit the CMS HH PPS page on the CMS website.

A beneficiary can receive an unlimited number of periods as long as they meet the coverage criteria. For home health services, a period is represented by one claim submitted to the MAC for Medicare reimbursement. The PEPPER target areas are designed to report on beneficiary periods (i.e., claims) that begin during the respective calendar year.

1.1 HHA PEPPER Target Areas

In general, the target areas are constructed as ratios and expressed as percents (when the numerator and denominator are expressed as the same unit, such as periods) or as rates (when the numerator is expressed in a different unit than the denominator, such as beneficiaries and periods). Typically, the numerator represents periods that may be identified as problematic in terms of their risk for improper Medicare payment, while the denominator represents a larger comparison group.

Table 2 identifies the Calendar Year (CY) 2023 through CY 2025 definitions for the HHA PEPPER target areas.

Table 2: Target Area and Target Area Definitions

Target Area	Target Area Definition
Low Comorbidity	**Numerator**: Count of periods with a secondary diagnosis that qualifies as a low comorbidity adjustment (fourth position of Health Insurance Prospective Payment System (HIPPS) code equal to '2') paid to the HHA during the time frame. **Denominator**: Count of periods paid to the HHA during the time frame.
High Comorbidity	**Numerator**: Count of periods with two secondary diagnoses that qualify as a high comorbidity adjustment (fourth position of HIPPS code equal to '3'). **Denominator**: Count of periods paid to the HHA during the time frame.
Functional Impairment Medium	**Numerator**: Count of periods with a functional impairment level of medium (third position of HIPPS code equal to 'B') paid to the HHA during the time frame. **Denominator**: Count of periods paid to the HHA during the time frame.
Functional Impairment High	**Numerator**: Count of periods with a functional impairment level of high (third position of HIPPS code equal to 'C') paid to the HHA during the time frame. **Denominator**: Count of periods paid to the HHA during the time frame.

Target Area	Target Area Definition
Average Case Mix	**Numerator**: Sum of case mix weight for all periods paid to the HHA during the time frame. **Numerator Exclusions**: Exclude periods with HHA low-utilization payment adjustment (LUPA) codes. Exclude periods with a partial episode payment (PEP), identified by patient discharge status code 06. **Denominator**: Count of periods paid to the HHA during the time frame. **Denominator Exclusions**: Exclude periods with LUPA codes. Exclude periods with a PEP, identified by patient discharge status code 06. ***Note**: Reported as a rate, not a percent.*
Average Number of Periods	**Numerator**: Count of periods paid to the HHA during the time frame. **Denominator**: Count of unique beneficiaries served by the HHA during the time frame. ***Note**: Reported as a rate, not a percent.*
Periods With Low Visits	**Numerator**: Count of periods with the number of visits equal to the LUPA threshold or one visit more than the LUPA threshold, paid to the HHA during the time frame. **Denominator**: Count of periods paid to the HHA during the time frame.
Non-LUPA Payments	**Numerator**: Count of periods paid to the HHA that did not have a LUPA payment during the time frame. **Denominator**: Count of periods paid to the HHA during the time frame.
Outlier Payment	**Numerator**: Sum of dollar amount of outlier payments (identified by the amount where Value Code equal to '17') for periods paid to the HHA during the time frame. **Denominator**: Sum of dollar amount of total payments for periods paid to the HHA during the time frame.
Admission Source	**Numerator**: Count of periods where admission source is institutional (first position of HIPPS code equal to '2' or '4'). **Denominator**: Count of periods paid to the HHA during the time frame.

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

1.2 How HHAs Can Use PEPPER Data

HHA PEPPER provides HHAs with their national, jurisdiction, and state percentile values for each target area with reportable data for the most recent calendar-year included in PEPPER. "Reportable Data" in PEPPER means the numerator count is 11 or more for a given target area for a given time period, or the denominator count is 11 or more for the Average Case Mix and

Average Number of Periods target area. Due to CMS data restrictions, PEPPER does not display statistics when there are fewer than 11 numerator or denominator counts for a target area for a given time period.

Note: These are generalized suggestions and do not apply to all situations. For all areas, assess whether there is sufficient volume 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)
Low Comorbidity	This could indicate a risk of potential over-coding of secondary diagnoses. A review of medical records may be considered to determine if the coding of the diagnoses were substantiated by the medical record.	This could indicate a risk of potential under-coding of secondary diagnoses. A review of medical records may be considered to determine if all secondary diagnoses were appropriately captured from the medical record.
High Comorbidity	This could indicate a risk of potential over-coding of secondary diagnoses. A review of medical records may be considered to determine if the coding of the diagnoses were substantiated by the medical record.	This could indicate a risk of potential under-coding of secondary diagnoses. A review of medical records may be considered to determine if all secondary diagnoses were appropriately captured from the medical record.
Functional Impairment Medium	This could indicate over-representation of the functional impairment status on the Outcome and Assessment Information Set (OASIS) resulting in the assignment of medium functional impairment. A review of OASIS responses of functional impairment may be warranted to confirm the accuracy of the responses.	This could indicate under-representation of the functional impairment status on the OASIS. A review of OASIS responses of functional impairment may be warranted to confirm the accuracy of the responses.
Functional Impairment High	This could indicate over-representation of the functional impairment status on the OASIS resulting in the assignment of high functional impairment. A review of OASIS responses of functional impairment may be warranted to confirm the accuracy of the responses.	This could indicate under-representation of the functional impairment status on the OASIS. A review of OASIS responses of functional impairment may be warranted to confirm the accuracy of the responses.

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)
Average Case Mix	This could indicate a risk of potential over-coding of beneficiaries' clinical, functional, or comorbidity status. The HHA should determine whether beneficiaries' status as reported on the OASIS is supported and consistent with medical record documentation.	Not Applicable
Average Number of Periods	This could indicate that the HHA is continuing treatment beyond the point where services are necessary. The HHA should review documentation for beneficiaries with a high number of periods to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. If the individualized assessment of the patient does not demonstrate the need for skilled care, such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, these services are not covered under the home health benefit. The HHA should review plans of care for appropriateness and assess the appropriateness of discharge plans.	Not Applicable

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)
Periods With Low Visits	This could indicate that the HHA is considering the minimum number of visits to obtain an HHRG payment instead of a LUPA payment when there are fewer visits than the LUPA visit threshold. The HHA should review documentation for periods with a low number of visits to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. If the individualized assessment of the patient does not demonstrate the need for skilled care, such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, these services are not covered under the home health benefit. The HHA should review plans of care to ensure they are individualized and appropriate for the beneficiaries' condition.	Not Applicable

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)
Non-LUPA Payments	This could indicate that the HHA is considering the minimum number of visits to obtain an HHRG payment instead of a LUPA payment where there are fewer visits than the threshold. The HHA should review documentation to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. If the individualized assessment of the patient does not demonstrate the need for skilled care, such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, these services are not covered under the home health benefit. The HHA should review plans of care to ensure they are individualized and appropriate for the beneficiaries' condition.	Not Applicable
Outlier Payment	This could indicate a risk of potential over-coding of beneficiaries' clinical, functional, or comorbidity status. The HHA should determine whether beneficiaries' status, as reported on the OASIS, is supported and consistent with medical record documentation.	Not Applicable
Admission Source	This target area is provided for informational purposes; admission source is determined by submission of claims.	Not Applicable

Comparative data for three consecutive years can be used to help identify whether the HHA's target area percents or rates changed significantly in either direction from one year to the next. Such changes may indicate shifts in admission or treatment practices, staff turnover, changes in medical staff, or broader 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 on the worksheet tabs at the bottom of the screen. Each tab is

labeled to identify the contents of its worksheet (e.g., Definitions, Compare, Outlier Rank, and specific Target Area).

2.1 Compare Targets Report

HHAs can use the Compare Targets Report to help prioritize areas for auditing and monitoring. The Compare Targets Report includes all target areas with reportable data for the most recent year included in PEPPER. For each target area, the Compare Targets Report displays the HHA's numerator count, percent or rate, and percentile values, as compared to the nation, jurisdiction, state, and the "Sum of Payments" (where applicable).

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

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

The Compare Targets Report provides the HHA's percentile value for the nation, jurisdiction, and state for all target areas with reportable data in the most recent year. These percentile values allow an HHA to assess how its target area percent or rate compares to all HHAs in each respective comparison group.

The HHA's national percentile indicates the percentage of all other HHAs in the nation that have a target area percent or rate lower than the HHA's own target area percent or rate.

The HHA's jurisdiction percentile indicates the percentage of all other HHAs in the jurisdiction that have a target area percent or rate lower than the HHA's own target area percent or rate. The HHA's jurisdiction percentile for a target area is not calculated if fewer than 11 HHAs in the jurisdiction have reportable data for that target area.

The HHA's state percentile indicates the percentage of all other HHAs in the state that have a target area percent or rate lower than the HHA's own target area percent or rate. The HHA's state percentile for a target area is not calculated if fewer than 11 HHAs in the state have reportable data for that target area.

When interpreting the Compare Targets Report findings, HHAs 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 HHA is an outlier. Outlier status should be evaluated in the following priority order: (1) nation, (2) jurisdiction, and (3) state. The state should be the lowest priority because it represents the smallest comparison group.

HHAs can also use the "Sum of Payments" (available for target areas based on periods) and the "Numerator Count/Amount" to help prioritize areas for review. For example, the Compare Targets Report may show that the HHA is at the 85th national percentile for the High Comorbidity target area and at the 83rd national percentile for the Low Comorbidity target area. If the Low Comorbidity target area has a higher "Sum of Payments" and "Numerator Count/Amount" than the High Comorbidity target area, the Low Comorbidity target area may be given priority over the High Comorbidity target area.

2.2 Target Area Data Tables

PEPPER data tables display a variety of statistics for each target area summarized over the previous three years. Each data table includes the target (numerator) count for the target area, the denominator count, the proportion of the numerator and denominator (percent or rate), the average length of stay (ALOS) for the numerator and for the denominator (where available), and the average and sum of Medicare payment data (available for period-based target areas).

For the Average Case Mix target area, the numerator ALOS, average Medicare payments, and sum of Medicare payments cannot be calculated. This is because the numerator represents the sum of case-mix weights for periods paid to the HHA during the report period (excluding LUPAs and PEPs), rather than a count of periods or beneficiaries.

For the Average Number of Periods target area, the denominator ALOS cannot be calculated because the denominator represents the count of unique beneficiaries served by the HHA during the report period.

For the Outlier Payments target area, the average and sum of Medicare payments are not reported to avoid duplication in reporting these measures. Instead, the average outlier payment amount for each calendar year is calculated and reported.

The “Outlier Status” column identifies when the HHA is a high outlier, indicated by the percentile displayed in red bold text, meaning the HHA is at or above the national 80th percentile. The column also identifies when the HHA is a low outlier; in these cases, the HHA’s percent appears in green italics, indicating it is at or below the national 20th percentile. The “Outlier Status” column will display “Not an outlier” when the HHA is not an outlier for the target area and time period, and “No data” when the HHA 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’s numerator definition. The “Target Average Medicare Payment” column is determined by dividing the Target Sum Medicare Payments by the Target Count. Interpretive guidance is included on the data tables to help HHAs assess 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 HHA’s percentage for each target area over the previous three years. These graphs allow HHAs to identify significant year-to-year changes, which may result from shifts in medical staff, coding or billing staff, utilization review processes, documentation improvement efforts, or the types of services the HHA provides. External changes among health care providers in the community can also influence patient population and case mix, which may be reflected in PEPPER target area statistics. HHAs 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 the 20th percentile for coding-focused target areas) for the three comparison groups—nation, jurisdiction, and state—so the HHA can easily identify when it is an outlier relative to any of these groups. A table displaying these percentile values is included on each target area graph worksheet. State percentiles are shown as zero when fewer than 11 HHAs in the state have reportable data for the target area. Jurisdiction percentiles are shown as zero when fewer than 11 HHAs in the jurisdiction have reportable data for the target area. If no reportable data exist for a given year, the table will display #N/A in the corresponding cell.

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

2.3 HHA and Jurisdiction Top Clinical Groups Report

The HHA Top Clinical Groups Report lists the top clinical groups for periods at the HHA that began in the most recent calendar year. For each clinical group listed, the report provides the total number of periods with a principal diagnosis code that maps to that category, the proportion of those periods relative to all periods, the number of visits, and the average number of visits. This report is limited to displaying only those clinical groups for which at least 11 periods began in the most recent calendar year.

The Jurisdiction Wide Top Clinical Groups Report lists the top clinical groups for periods in the MAC jurisdiction that began in the most recent calendar year. For each clinical group listed, the report provides the total number of periods with a principal diagnosis code that maps to that category, the proportion of those periods relative to all periods, the number of visits, and the average number of visits. This report is limited to displaying only those clinical groups for which at least 11 periods began in the most recent calendar year.

2.4 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 through the CMS CBR PEPPER website by selecting the “Help/Contact Us” tab. The website also provides a variety of educational resources to assist HHAs in using PEPPER effectively.

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
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.
Calendar Year	CY	A CY is the standard 12-month period that begins on January 1 and ends on December 31. It consists of exactly 365 days, or 366 days during a leap year, and is distinct from a "rolling" year or an academic year.
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.
Critical Access Hospital	CAH	A CAH is a small, rural medical facility certified by CMS to provide 24/7 emergency care, short-term inpatient stays, and cost-based Medicare reimbursement.
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 Insurance Prospective Payment System	HIPPS	HIPPS use standardized codes to determine Medicare reimbursement rates for skilled nursing facilities (SNFs), home health agencies, and inpatient rehabilitation facilities based on patient characteristics and resource utilization. These five-digit codes (HIPPS codes) represent case-mix groups, such as clinical condition, functional level, and therapy needs. Code indicates referral source, timing, clinical grouping, and functional level.
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.
Home Health Resource Group	HHRG	HHRG is a classification of groups used by Medicare to determine payment rates for home health agencies under the Patient-Driven Groupings Model (PDGM). Based on OASIS assessments, HHRGs categorize patients into 432 distinct groups based on clinical condition, functional impairment, and comorbidities. These groups determine the case-mix adjusted payment, with 12 primary clinical categories ranging from neuro rehab to behavioral health.

Term	Abbreviation	Definition
Home Health Prospective Payment System	HH PPS	An HH PPS is a payment model for Medicare home health agencies that was established to reimburse providers based on a predetermined amount for services rendered. This tool allows providers to estimate their claims payment amount for Medicare Home Health services.
Hospice	NA	Hospice is specialized care for individuals with a terminal illness, focusing on comfort, pain management, and quality of life rather than finding a cure. It is typically utilized when a physician determines whether a patient has a life expectancy of six months or less and they choose to stop curative treatments.
Index Analytics	Index	Index provides data integration services, including data architecture, master data management, data quality, security, and data warehousing.
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.
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.
Long-Term Acute Care Hospital	LTACH	An LTACH is a specialized medical facility that provides round-the-clock, high-level hospital care for patients with complex illnesses who need an average stay of more than 25 days.
Low-Utilization Payment Adjustment	LUPA	A LUPA is a Medicare reimbursement mechanism in home health that reduces payment from a 30-day episodic rate to a standardized per-visit rate when the number of visits falls below a specific threshold (typically 2 to 6 visits, depending on the case-mix group). It applies when patient care requires fewer resources than initially projected.
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.
Medicare Administrative Contractor	MAC	A MAC is a private health insurance company that the federal government hires to manage the day-to-day operations of Original Medicare. They act as the middleman between healthcare providers and the government, processing medical claims, enforcing coverage rules, and issuing payments.
Medicare	NA	Medicare is the federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

Term	Abbreviation	Definition
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.
Outcome and Assessment Information Set	OASIS	OIG is a standardized assessment tool for adult patients (18+) receiving skilled Medicare/Medicaid home health services. It collects clinical, functional, and demographic data to plan care, measure quality, determine reimbursement, and monitor outcomes.
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.
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 Episode Payment	PEP	A PEP adjustment in Medicare is a prorated payment made to a home health agency when a patient transfers to another agency or is discharged and readmitted to the same agency before completing a full care period.
Partial Hospitalization Program	PHP	A PHP is a structured, daytime medical treatment plan for mental health or addiction. It provides intensive therapy and support—such as individual and group counseling, medical care, and medication management—for 4 to 8 hours a day, several days a week, without requiring an overnight stay in the hospital.
Patient-Driven Groupings Model	PDGM	PDGM is a Medicare payment system for home health services. It shifts payment from the volume of therapy visits to patient needs.
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.
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.

Term	Abbreviation	Definition
Recovery Auditor	RA	RAs, formerly referred to as RACs, are contracted entities that identify and recover improper Medicare payments made to healthcare providers, focusing on both overpayments and underpayments.
Short-Term Acute Care Hospital	STACH	A STACH is a medical center that provides rapid, active, and time-sensitive treatment for severe injuries, sudden illnesses, or surgical recovery.
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.
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.