Inpatient Psychiatric Facility Program for Evaluating Payment Patterns Electronic Report

User Guide

FY 2025 Release

August 2026

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What's new in this edition?

The Fiscal Year (FY) 2025 Inpatient Psychiatric Facility (IPF) Program for Evaluating Payment Patterns Electronic Report (PEPPER) reflects updates associated with releasing PEPPERs via the new PEPPER portal. This edition does not include any significant changes to the target area definitions.

1. What is PEPPER?

The Office of Inspector General (OIG) encourages IPFs to develop and implement a compliance program to protect their operations from fraud and abuse.[1, 2] As part of its compliance program, an IPF should conduct regular audits to ensure charges for Medicare services are correctly documented and billed. PEPPER can help guide IPFs' auditing and monitoring activities.

PEPPER is an electronic data report that contains a single IPF'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 PEPPER are presented in graphs and tables that depict the IPF's target area percentages over time. 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 IPF 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****. An IPF 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 Inpatient Psychiatric Facilities (IPFs), Short-Term Acute Care Hospitals (STACH), Long-Term Acute Care Hospitals (LTACH), Critical Access Hospitals (CAHs), Inpatient Rehabilitation Facilities (IRFs), Hospices, Partial Hospitalization Programs (PHPs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

The IPF PEPPER is the version of PEPPER designed specifically for IPFs and for inpatient psychiatric distinct part units within acute care and critical access hospitals. Throughout PEPPER and this guide, free-standing IPFs and distinct part units of acute care and critical access hospitals are grouped together and referred to collectively as IPFs.

IPFs are generally defined as hospitals that provide psychiatric services for the diagnosis and treatment of patients with mental illness. IPFs are reimbursed through the IPF prospective payment system (PPS). Each IPF PEPPER summarizes statistics for the most recent twelve federal fiscal quarters, aggregated into three 12-month time periods. An IPF is compared to other IPFs across three comparison groups: the nation, Medicare Administrative Contractor

[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.

(MAC) jurisdiction, and state. These comparisons help an IPF determine whether it is an outlier, differing from other IPFs.

PEPPER identifies outliers using preset control limits. The upper control limit for all target areas is the national 80th percentile. Coding-focused target areas also include a lower control limit, set at the national 20th percentile. PEPPER flags any findings at or above the upper control limit or at or below the lower control limit.

In PEPPER, the term “outlier” refers to an IPF whose target area percent falls within the top 20 percent of all IPF target area percents in the respective comparison group (i.e., at or above the 80th percentile). For coding-focused target areas, an IPF may also be considered an outlier if its target area percent is in the bottom 20 percent (i.e., at or below the 20th percentile). PEPPER does not use formal statistical significance testing to determine outlier status.

Table 1 provides specifications for claims eligible for inclusion in IPF PEPPER.

Table 1: Eligible Claims Specifications for IPF PEPPER

Inclusion/Exclusion Criteria	Data Specifications
IPFs or distinct part units of STACHs or CAHs	Third through sixth positions of the CMS Certification Number (CCN) are between “4000” and “4499” (for freestanding facilities) or third position = “S” (short-term) or “M” (critical access).
Services provided during the time periods included in the report	Claim “Through Date” (discharge date) falls within the 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 that Medicare Secondary Payer claims are included).
Final action claim	The patient was discharged; exclude claim status code “still a patient” (30) in UB-04 FL 17.
Exclude Health Maintenance Organization (HMO) claims	Exclude claims submitted to a Medicare Advantage Plan.
Exclude cancelled claims	Exclude claims cancelled by the MAC.
Exclude cancelled claims	Exclude claims cancelled by the MAC.

Each IPF receives only its own PEPPER. The PEPPER Team does not provide PEPPERs to other contractors. IPFs access their PEPPER files through a secure portal on the CMS CBR PEPPER website on an annual basis.

1.1 IPF PEPPER Target Areas

In general, the target areas are constructed as ratios and expressed as percents; the numerator r In general, PEPPER target areas are constructed as ratios and expressed as percents. The numerator represents discharges identified as potentially problematic, while the denominator represents discharges from a broader comparison group. For admission-necessity target areas, the numerator typically includes discharges prone to unnecessary admissions, and the denominator generally includes all discharges. For coding-related target areas, the numerator includes discharges identified as prone to DRG coding errors, and the denominator includes

those discharges plus a larger comparison group. *Table 2* provides the definitions for the IPF PEPPER target areas for FY 2023 through FY 2025.

Table 2: Target Area and Target Area Definitions

Target Area	Target Area Definition
Comorbidities	**Numerator**: Count of discharges with at least one comorbidity on the claim. **Denominator**: Count of all discharges. **Note**: The IPF PPS Comorbidity Categories and associated International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes are available at: Classifications of Diseases, 10 Revision, Clinical Modification (ICD-10-CM). Select Inpatient Psychiatric Facilities PPS Files from the left column.
No Secondary Diagnoses	**Numerator**: Count of discharges with no secondary diagnosis codes. **Denominator**: Count of all discharges.
Outlier Payments	**Numerator**: Sum of outlier approved amounts (in dollars). **Denominator**: Sum of Medicare reimbursement for all discharges (in dollars).
3- to 5-Day Readmissions	**Numerator**: Count of index (first) admissions during the 12-month time period for which a readmission occurred within three to five calendar days (four to six consecutive days) to the same IPF or to another IPF for the same beneficiary (identified using the Health Insurance Claim number). Exclude claims for index admissions with patient discharge status code 20 (expired). **Denominator**: Count of all discharges. Exclude claims with patient discharge status code 20. (See *Appendix B* for how readmissions are identified.)
30-Day Readmission	**Numerator**: Count of index (first) admissions during the 12-month time period for which a readmission occurred within 30 days to the same IPF or to another IPF for the same beneficiary (identified using the Health Insurance Claim number). **Numerator Exclusion**: Exclude claims for index admissions with patient discharge status codes: • **07** (left against medical advice), • **20** (expired), • **65** (discharged/transferred to a psychiatric hospital or psychiatric distinct part unit), or • **93** (discharged/transferred to a psychiatric hospital/unit with a planned acute care hospital readmission). **Denominator**: Count of all discharges. **Denominator Exclusion**: Exclude claims with patient discharge status codes **07**, **20**, **65**, or **93**. (See *Appendix B* for how readmissions are identified.)

CMS approved these IPF PEPPER target areas because they have been identified as potentially 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) (now referred to as a Recovery Auditor or RA) Program has identified additional areas prone to improper payments https://www.federalregister.gov.

IPFs receive payment adjustments for a number of comorbid conditions. A high percentage of patients with comorbidities may indicate potential over-coding, while a very low percentage may suggest potential under-coding. Providers may reasonably expect a high or low percent in this target area depending on their patient population or on whether their billing system supports coding all comorbidities.

Claims should include the appropriate selection of the principal diagnosis as well as other additional and coexisting diagnoses. Coding guidelines specify that “all of a patient’s coexisting or additional diagnoses” should be reported on the claim to provide accurate information about the beneficiaries receiving services. If IPFs do not code secondary diagnoses on the claim, they may not be capturing comorbidities, which may affect reimbursement. To address this concern, one target area focuses on the percentage of claims for discharges with only one diagnosis coded.

IPFs receive outlier payments for hospital stays that incur extraordinarily high costs. When a patient is discharged from an IPF and readmitted to the same or another IPF before midnight of the third consecutive day (second calendar day) following discharge, the readmission is considered an interrupted stay and is treated as one discharge for payment purposes. If the patient is readmitted after midnight of the third consecutive day, the IPF receives two separate DRG payments. The 3- to 5-Day Readmissions target area assesses the possibility that IPFs may postpone readmissions until the third through fifth calendar days (fourth through sixth consecutive days) following discharge, which would result in two DRG payments. *Table 3* below provides examples illustrating how consecutive days and calendar days are applied when evaluating readmissions.

Table 3: Consecutive Days vs Calendar Days Example

Date of Discharge	January 1	January 1	January 1	January 1	January 1	January 1
Date of Readmission	January 1	January 2	January 3	January 4	January 5	January 6
Consecutive Day(s)	1	2	3	4	5	6
Calendar Day(s)	0	1	2	3	4	5

In general, readmissions to the same IPF may be associated with premature discharge or incomplete care. Both readmission-focused target areas can help IPFs assess this risk. Find additional information here: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf

1.2 Error! Reference source not found.How IPFs Can Use PEPPER Data

IPF PEPPER provides IPFs 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 PEPPER (refer to *Section 1.3*). "Reportable Data" in PEPPER means there are eleven or more numerator discharges for a given target area during a given time period. Due to CMS data restrictions, PEPPER does not display statistics when there are fewer than eleven numerator discharges for a target area in a time period.

Note: These are generalized suggestions and may not apply to all situations. For all target areas, assess whether there is sufficient volume (generally 10 to 30 cases per year, depending on the IPF's total annual discharges) to warrant a review of cases.

Table 4 provides suggested interventions for outliers by target area.

Table 4: 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)
Comorbidities	This could indicate potential over-coding. A sample of medical records with comorbidities coded should be reviewed to determine whether coding errors exist.	This could indicate that there are coding errors related to under-coding of comorbidities, or it could be related to under-coding of secondary diagnosis codes (i.e., comorbidities that occur subsequent to admission). A sample of medical records without comorbidities should be reviewed to determine whether coding errors exist. Remember to ensure that the documentation supports any comorbid conditions. A coder may need to seek clarification about the clinical significance of findings from the physician. Ensure that physicians are aware that they should document the complete clinical status of the patient, rather than just the clinical findings related to the patient's psychiatric care.

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)
No Secondary Diagnoses	This could indicate that secondary and/or comorbid conditions are not being coded. The IPF should review medical records for claims with no secondary diagnoses coded to ensure that all secondary and/or comorbid conditions that are substantiated by documentation in the medical record are correctly coded and included on the claim. Remember that in order for a diagnosis to be coded it must be substantiated by documentation. A coder should not code based on laboratory or radiological findings without seeking a physician's determination of the clinical significance of the abnormal finding. Consider whether the use of a physician query would have substantiated a secondary/comorbid condition.	Not applicable
Outlier Payments	This indicates that a higher percentage of the facility's Medicare reimbursement is due to outlier payments. Claims with a high outlier payment dollar amount should be reviewed to ensure treatment provided was medically necessary.	Not applicable; a low percentage of outlier payments is not a concern.
3- to 5-Day Readmissions	This could indicate a high rate of premature discharge, incomplete care, or readmission after the interrupted-stay threshold, resulting in separate DRG payments. Review a sample of readmission cases to identify the appropriateness of admission, discharge, quality of care, post-discharge care, DRG assignment, and billing accuracy. Facilities are encouraged to generate data profiles for readmissions occurring within three to five days (four to six consecutive days), using key data elements such as patient identifier, admission and discharge dates, discharge status code, principal and secondary	Not applicable; this is an admission-necessity focused 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)
	diagnoses, procedure code(s), and DRG. Patients discharged home (patient discharge status code 01) and readmitted may indicate a potential premature discharge or incomplete care. IPFs should compare their discharges that meet the target area numerator criteria and the number of readmissions for the same time period to determine the number of patients discharged and readmitted to a different IPF. If concerned with the number of patients readmitted to different IPFs, consider reviewing discharge planning processes, discharge plan documentation, and discharge status coding to ensure accuracy.	
30-Day Readmissions	This could indicate premature discharge or incomplete care. Review a sample of readmission cases to identify the appropriateness of admission, discharge, quality of care, post-discharge care, DRG assignment, and billing accuracy. Facilities are encouraged to generate data profiles for readmissions within 30 days, using key data elements such as patient identifier, admission and discharge dates, discharge status code, principal and secondary diagnoses, procedure code(s), and DRG(s). Patients discharged home (patient discharge status code 01) and readmitted within 30 days may indicate a potential premature discharge or incomplete care. IPFs should compare their discharges that meet the numerator criteria and the number of readmissions for the same time period to determine the number of patients discharged and readmitted to a different IPF. If concerned with the number of patients readmitted to different IPFs,	Not applicable; this is an admission-necessity focused 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)
	consider reviewing discharge planning processes, discharge plan documentation, and discharge status coding to ensure accuracy.	

Comparative data across several consecutive years can help identify whether an IPF's target area percents have changed significantly 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.

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

1.3 Compare Targets Report

IPFs can use the Compare Targets Report to help prioritize areas for auditing and monitoring. The 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 IPF's number of target discharges, percent, and percentile values, as compared to the nation, jurisdiction, state, and the "Sum of Payments."

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

An IPF's outlier status is indicated by the color formatting applied to the target area percent on the Compare Targets Report. When the IPF is a high outlier for a target area, the IPF's percentile is displayed in bold red text. When the IPF is a low outlier (for coding-focused target areas only), the IPF's percent is displayed in green italics. When the IPF is not an outlier, the IPF's percentile appears in black.

The Compare Targets Report provides the IPF'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 an IPF to assess how its target area percent compares to all IPFs within each respective comparison group.

The IPF's national percentile indicates the percentage of all other IPFs in the nation that have a target area percent lower than the IPF's own target area percent.

The IPF's jurisdiction percentile indicates the percentage of all other IPFs in the jurisdiction that have a target area percent lower than the IPF's own target area percent. A jurisdiction percentile is not calculated for a target area when fewer than eleven IPFs in the jurisdiction have reportable data for that target area.

The IPF's state percentile indicates the percentage of all other IPFs in the state that have a target area percent lower than the IPF's own target area percent. A state percentile is not calculated for a target area when fewer than eleven IPFs in the state have reportable data for that target area.

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

IPFs 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 Outlier Payments target area has the highest "Sum of Payments," but the IPF's percent is at the 80th percentile for its jurisdiction and the 65th percentile for the nation. The Comorbidities target area may have a smaller "Sum of Payments," yet still be at the 80th percentile for the jurisdiction and the 90th percentile for the nation. In this scenario, the Comorbidities target area may warrant higher priority for review.

1.4 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 IPF is a high outlier, indicated by the IPF's percentile displayed in bold red text, meaning it is at or above the national 80th percentile. Low outliers (for coding-focused target areas only) are shown in green italics. The "Outlier Status" column will display "Not an outlier" when the IPF is not an outlier for the target area and time period, and "No data" when the IPF does not have reportable data for that target area and time period.

The "Target Sum Medicare Payments" column reflects the total Medicare payments associated with all claims that meet the numerator definition for the target area. 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 on the data tables to assist IPFs in determining 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 IPF's percentage for each target area across three fiscal years. These graphs allow IPFs to identify significant year-to-year changes, which may result from shifts in medical staff, coding or billing personnel, utilization review processes, documentation improvement efforts, or changes in IPF services. External factors, such as changes in health care providers within the community, can also influence patient population and case mix, which may be reflected in PEPPER target area statistics. IPFs 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 only) for each of the three comparison groups (nation, jurisdiction, and state) so the IPF 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 eleven IPFs in the state have reportable data for the target area. Jurisdiction percentiles are shown as zero when fewer than eleven IPFs in the

jurisdiction have reportable data for the target area. If there is no reportable data for a given year, the table will display #N/A in the corresponding cell.

If there is no reportable data for the IPF for a given time period due to CMS data-use restrictions, no data point will appear on the graph for that time period. Likewise, if fewer than eleven IPFs 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.

1.4.1 IPF Top DRGs Reports

The IPF Top DRGs Report lists the top DRGs by discharge volume for the IPF in the most recent fiscal year. It includes the total number of IPF discharges for each listed DRG, the proportion of discharges for each DRG relative to total discharges, and the IPF's ALOS for each DRG. Please note that this report is limited to the top DRGs (up to 20), for which there are at least eleven discharges for the respective DRG during the most recent fiscal year.

The Jurisdiction-Wide Top DRGs Report lists the top DRGs by discharge volume for all IPFs within the MAC jurisdiction in the most recent fiscal year. It includes the total jurisdiction-wide discharges for each listed DRG, the proportion of discharges for each DRG relative to total discharges, the jurisdiction ALOS, and the national ALOS for each DRG. Please note that this report is limited to the top DRGs (up to 20), for which there are at least eleven discharges during the most recent fiscal year.

1.5 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 contains many educational resources to assist hospitals with 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 5 provides a list of terms, abbreviations, and definitions in this document.

Table 5: 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.
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.
CMS Certification Number	CCN	A CCN is a unique six-digit identification code given by the government to health groups like hospitals, nursing homes, and clinics.
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.
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.

Term	Abbreviation	Definition
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	Index	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.
Long-Term Acute Care Hospital	LTACH	An LTACH is a specialized medical facility providing round-the-clock, high-level care for patients with complex conditions who need an extended stay averaging more than 25 days.
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.

Term	Abbreviation	Definition
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.
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 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.
Procedure Coding System	PCS	PCS is a standardized set of codes used in healthcare to report medical procedures, services, and supplies for billing and record-keeping purposes.
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.
Short-Term Acute Care Hospital	STACH	A STACH is a medical center providing rapid, 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.

Term	Abbreviation	Definition
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: How Readmissions Are Identified

These examples have been developed to help users understand how readmissions are identified and counted in PEPPER's 3- to 5- Day Readmissions and 30-Day Readmission target areas. When reviewing these examples, keep in mind that:

3- to 5-Day Readmissions

- Readmissions are counted when the discharge from the index (first) IPF admission occurs during the 12-month period and the patient is readmitted to the same IPF or another IPF for the same beneficiary within three to five calendar days (four to six consecutive days) following the IPF discharge.
- Index admissions with a patient discharge status code of "20" (expired) are excluded from the numerator count and cannot be identified as index admissions.

30-Day Readmissions

- Readmissions are counted when the discharge from the index (first) IPF admission occurs during the 12-month period. Each IPF admission may serve as an index admission for determining whether a subsequent admission within 30 days of the IPF discharge date qualifies as a readmission.
- Each admission for a patient can be identified as a readmission only in relation to the IPF admission that immediately precedes it.
- Index admissions with a patient discharge status code of "20" (expired) or "65" (discharged or transferred to a psychiatric hospital or distinct part unit) are excluded from the numerator count and cannot be identified as index admissions.
- Any admission of a beneficiary to a short-term or long-term acute care hospital, a critical access hospital, or any other type of provider is not considered a readmission for this measure. Only admissions to inpatient psychiatric units or freestanding inpatient psychiatric hospitals can be considered as readmissions.

B.1 Example 1: Two IPF Stays, One Qualifying Readmission for the 3- to 5-Day Readmission Target Area

The following table displays claims submitted for one beneficiary. The claims are sorted in date order based on 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."), which may be considered a readmission. The next admission shown on one row becomes the index admission on the following row.

Table 6: Example 1

# (Index)	Index Adm. Provider	Index Adm. Date	Discharge Date	Patient Discharge Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Calendar Gap Days	Next Admission Counts as a Readmission Against Index Admission
1	IPF #1	11/20/2024	12/01/2024	01	2	IPF #2	12/05/2024	12/10/2024	4	Yes, to IPF #1
2	IPF #2	12/05/2024	12/10/2024	01	N/A	No further admissions	N/A	N/A	N/A	N/A

Detailed Discussion:

- **Row 1**: The beneficiary was admitted to IPF #1 on 11/20/2024 and discharge home (patient discharge status code 01) on 12/01/2024. The beneficiary was admitted to IPF #2 on 12/05/2024, which is four calendar days after being discharged from IPF #1. This admission counts as a 3- to 5-Day Readmission to IPF #1 against the 11/20/2024 index admission because it occurred within three to five calendar days after the beneficiary was discharged from IPF #1.
- **Row 2**: The beneficiary was admitted to IPF #2 on 12/05/2024 and discharged home on 12/10/2024.

B.1 Example 2: Five IPF Stays, Three Qualifying Readmissions for the 30 Day Readmission Target Area

The following table displays claims submitted for one beneficiary. The claims are sorted in date order based on 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.”), which may be considered a readmission. The next admission shown on one row becomes the index admission on the following row.

Table 7: Example 2

# (Index)	Index Adm. Provider	Index Adm. Date	Discharge Date	Patient Discharge Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Calendar Gap Days	Next Admission Counts as a Readmission Against Index Admission
1	**IPF #1**	11/20/2024	12/01/2024	01	**2**	IPF #2	12/05/2024	12/10/2024	4	Yes, to IPF #1
2	IPF #2	12/05/2024	12/10/2024	65	**3**	IPF #1	12/10/2024	12/14/2024	0	No
3	IPF #1	12/10/2024	12/14/2024	01	**4**	IPF #2	12/20/2024	12/22/2024	6	Yes, to IPF #1
4	IPF #2	12/20/2024	12/22/2024	01	**5**	IPF #3	12/25/2024	12/28/2024	3	Yes, to IPF #2
5	IPF #3	12/25/2024	12/28/2024	01	**N/A**	No further admissions	N/A	N/A	N/A	N/A

Detailed Discussion:

- **Row 1**: The beneficiary was admitted to IPF #1 on 11/20/2024 and discharged home (patient discharge status code 01) on 12/01/2024. The beneficiary was then admitted to IPF #2 on 12/05/2024. This admission counts as a readmission within 30 days for IPF #1, based on the 11/20/2024 index admission.

- **Row 2**: The beneficiary was admitted to IPF #2 on 12/05/2024 and discharged/transferred to IPF #1 (patient discharge status code 65) on 12/10/2024. The admission to IPF #1 does not count as a 30-Day Readmission for the IPF #2 index admission dated 12/05/2024 because the patient was discharged/transferred from IPF #2 to IPF #1 (status code 65).
- **Row 3**: The beneficiary was admitted to IPF #1 on 12/10/2024 and discharged home (patient discharge status code 01) on 12/14/2024. The beneficiary was then admitted to IPF #2 on 12/20/2024. This admission counts as a 30-Day Readmission for IPF #1, based on the 12/10/2024 index admission.
- **Row 4**: The beneficiary was admitted to IPF #2 on 12/20/2024 and discharged home (patient discharge status code 01) on 12/22/2024. The beneficiary was then admitted to IPF #3 on 12/25/2024. This admission counts as a 30-Day Readmission for IPF #2, based on the 12/20/2024 index admission.
- **Row 5**: The beneficiary was admitted to IPF #3 on 12/25/2024 and discharged home (patient discharge status code 01) on 12/28/2024.
- No further admissions occurred, so no additional readmissions are identified.