Inpatient Rehabilitation Facility Program for Evaluating Payment Patterns Electronic Report

User Guide

FY 2025 Release

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What's new in this edition?

1. What is PEPPER?

The Office of Inspector General (OIG) encourages Inpatient Rehabilitation Facilities (IRFs) to establish and maintain a compliance program to safeguard their operations against fraud and abuse. As part of this program, IRFs should conduct regular audits to ensure Medicare service charges are accurately documented and billed. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) supports IRFs in guiding their auditing and monitoring activities.

PEPPER is an electronic data report that provides an individual IRF's claims-based statistics for Case-Mix Groups (CMGs) and discharges at risk for improper payment due to billing, coding, or admission-necessity issues. Each PEPPER includes statistics for the most recent federal fiscal year across defined "target areas" associated with potential improper payments. Data are displayed in graphs and tables showing the IRF's target-area percentages over time. PEPPER also provides information on the IRF's top CMGs by discharge volume, average length of stay (ALOS) by CMG tier level, and discharge destination. Index Analytics (IA), in partnership with 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 data tables, graphs, and reports in PEPPER are designed to help IRFs identify potential overpayments as well as potential underpayments.

> ***PEPPER does not identify the presence of payment errors, but it can be used as a guide for auditing and monitoring efforts****. An IRF 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 Rehabilitation Facilities (IRFs), Short-Term (ST) Acute Care Hospitals (STACH), Long-Term (LT) Acute Care Hospitals (LTACH), Critical Access Hospitals (CAHs), Inpatient Psychiatric Facilities (IPFs), Hospices, Partial Hospitalization Programs (PHPs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

IRFs are generally defined as facilities that provide an intensive rehabilitation program. Patients admitted to an IRF must be able to tolerate three hours of intensive rehabilitation services per day. IRFs are reimbursed through the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). In PEPPER and throughout this guide, free-standing IRFs and distinct part units of STACHs and CAHs are grouped together and referred to collectively as IRFs. Target areas may be updated over time as analysis continues. Each IRF PEPPER summarizes statistics for the most recent twelve federal fiscal quarters, aggregated into three fiscal years. The IRF PEPPER is designed specifically for IRFs and compares the facility's results to three comparison groups: the nation, Medicare Administrative Contractor (MAC) jurisdictions, and the state in which the facility operates. These comparisons enable a facility to determine whether it is an outlier relative to other IRFs. PEPPER identifies outliers using preset control limits: the upper control limit is the 80th percentile for all target areas, and the lower control limit is the 20th percentile. PEPPER highlights any findings at or above the upper control limit (high outliers) or at or below the lower control limit. Note that the IRF PEPPER does not contain any coding-focused target areas; therefore, it highlights findings that are at or above the upper control limit (i.e., the national 80th percentile).

In PEPPER, the term “outlier” refers to an IRF whose target-area percent falls within the top 20 percent of all IRFs in the respective comparison group (i.e., at or above the 80th percentile). Formal tests of statistical significance are not used to determine outlier status in PEPPER.

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

Table 1: Eligible Claims Specifications for IRF PEPPER

Inclusion/Exclusion Criteria	Data Specifications
IRFs or distinct part units of STACHs or CAHs	Third through sixth positions of the CMS Certification Number (CCN) are between “3025” and “3099” (for freestanding facilities) or third position = “T” (short-term) or “R” (critical access).
Services provided during the time periods included in the report	Claim “Through Date” (discharge date) falls within the fiscal quarters 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.

Each IRF receives only its own PEPPER. IRFs access PEPPER files through a secure portal on the CMS CBR PEPPER website on an annual basis.

1.1 IRF PEPPER Target Areas

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

Table 2 identifies the fiscal year (FY) 2025 definitions for the IRF PEPPER target areas. Definitions for FY 2023 and FY 2024 are available in *Appendix B*.

Table 2: Target Area and Target Area Definitions

Target Area	Target Area Definition
Miscellaneous CMGs	**Numerator**: Count of discharges for CMGs: • **2001** (Miscellaneous M>=66.5), • **2002** (Miscellaneous M >=55.50 and M <66.50), • **2003** (Miscellaneous M >=46.50 and M <55.50), • **2004** (Miscellaneous M <46.50 and A >=77.50), or • **2005** (Miscellaneous M <46.50 and A <77.50). **Denominator**: Count of all discharges.
CMGs at Risk for Unnecessary Admissions	**Numerator**: Count of discharges with no tier group assignment for CMGs: • **0101** (Stroke M >=72.50), • **0501** (Non-Traumatic Spinal Cord Injury M >=60.50), • **0601** (Neurological M>=64.50), • **0801** (Replacement of Lower Extremity Joint M >=63.50), • **0802** (Replacement of Lower Extremity Joint M >=57.50 and M <63.50), • **0901** (Other Orthopedic M >=63.50), • **1401** (Cardiac M >=68.50), or • **1501** (Pulmonary M >=68.50). **Denominator**: Count of all discharges.
Outlier Payments	**Numerator**: Count of discharges with an outlier approved amount greater than $0. **Denominator**: Count of all discharges.
STACH Admissions Following IRF Discharge	**Numerator**: Count of discharges where the beneficiary (identified using the Health Insurance Claim number) was discharged from the IRF during the 12-month time period and admitted to a STACH within 30 days of discharge from the IRF. **Numerator Exclusion**: Exclude transfers to a STACH, an LTACH, or an IRF within one day of discharge as evidenced by a subsequent claim. **Numerator Exclusions**: Excluding patient discharge status codes: • **07** (left against medical advice), or • **20** (expired). **Denominator**: Count of all discharges. Exclude transfers to a STACH, LTACH, or IRF within one day of discharge as evidenced by a subsequent claim. **Denominator Exclusions**: Exclude patient discharge status codes: **07** or **20**. (See *Appendix C* for information on how STACH admissions following IRF discharges are identified.)

Target Area	Target Area Definition
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 IRF for the same beneficiary (identified using the Health Insurance Claim number). **Denominator**: Count of all discharges. **Denominator Exclusions**: Exclude patient discharge status code **20** (expired). (See *Appendix C* for information on how STACH admissions following IRF discharges are identified.)
Short Stays	**Numerator**: Count of discharges with a length of stay (LOS) less than or equal to three days. **Numerator Exclusion**: Exclude patient discharge status code **20** (expired). **Denominator**: Count of all IRF discharges. **Denominator Exclusions**: Exclude patient discharge status code **20**.

Note: CMGs and CMG definitions may change from one fiscal year to the next. Refer to the Federal Register for details. Definitions for the FY 2023 and FY 2024 target areas are listed in *Appendix B*.

CMS approved these IRF 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), now referred to as a Recovery Auditor (RA), Program has identified additional areas prone to improper payments.

Several CMGs have been identified as potentially prone to unnecessary IRF admissions. This group includes the “Miscellaneous” CMGs as well as CMGs with higher motor scores that do not receive a tier assignment.

IRFs receive outlier payments for facility stays that incur extraordinarily high costs. A high percentage of outlier payments may indicate improper utilization of Medicare resources.

Admissions to a STACH within 30 days of an IRF discharge may be associated with premature discharge or incomplete care. Such admissions may also suggest opportunities to strengthen an IRF’s discharge planning or patient and family preparation for discharge.

IRF readmissions occurring after a three- to five-day gap may indicate potential circumvention of the interrupted stay policy.

Regarding short stays, the IRF PPS established a separate CMG 5001 for cases with a length of stay of three days or less, without regard to the patient’s clinical characteristics. The Short Stays target area may identify cases in which the stay did not meet the definition of a transfer.[1]

[1] CMS Medicare Benefit Policy Manual, Chapter 3, Section 140.2.4: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf

In addition, some IRFs 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.

1.2 How IRFs Can Use PEPPER Data

IRF PEPPER provides each IRF with its national, jurisdiction, and state percentile values for every target area with reportable data for the three most recent 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 given time period. Due to CMS data-use restrictions, PEPPER does not display statistics when fewer than 11 numerator discharges are present.

Note: These are general suggestions and may not apply to all situations. For each area, determine whether the case volume is sufficient, typically 10 to 30 cases per year, depending on the IRF's total annual discharges, to warrant a review.

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)
Miscellaneous CMGs	This could indicate that there are unnecessary admissions for patients admitted in the "Miscellaneous" CMGs (2001 – 2004). A sample of medical records for these CMGs should be reviewed to determine if inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis or in another setting (e.g., SNF or home with home health).	NA
CMGs at Risk for Unnecessary Admissions	This could indicate that there are unnecessary admissions for patients admitted in CMGs 0101, 0501, 0601, 0801, 0802, 0901, 1401, or 1501 with no tier group assignment. A sample of medical records for these CMGs should be reviewed to determine if inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis or in another setting (e.g., SNF or home with home health).	NA

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)
Outlier Payments	This indicates that the facility is submitting a high percentage of claims with outlier payments. Claims with outlier payments should be reviewed to ensure treatment provided was medically necessary. The facility may wish to ensure the cost-to-charge ratio as reported in their annual cost report is correct.	NA
STACH Admissions Following IRF Discharge	This could indicate that patients are not medically stable or prepared for discharge. The facility may wish to ensure that patient discharge planning is initiated early during patients' admission and that patients and their families are prepared to handle patient care following discharge; this may include following up with patients/families after discharge to assess compliance with post-discharge care. IRF units of STACHs may wish to identify admissions to their STACH within 30 days of discharge and review medical records for those patients.	NA

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)
3- to 5-Day Readmissions	This could indicate that patients are being discharged prematurely or that patients are being readmitted after the interrupted stay threshold, thereby qualifying for two separate CMG payments. A sample of readmission cases should be reviewed to identify appropriateness of admission, discharge, quality of care, post discharge care, and CMG assignment and billing errors. The facility is encouraged to generate data profiles for readmissions to their facility within three to five consecutive days. Suggested data elements to include in these profiles are as follows: patient identifier, date of admission, date of discharge, patient discharge status code, principal and secondary diagnoses, procedure code(s), and CMG. Patients discharged home (patient discharge status code 01) and readmitted may indicate a potential premature discharge or incomplete care.	NA
Short Stays	This could indicate opportunities for improvement in the preadmission screening process. A sample of medical records for short stays may be reviewed to evaluate the appropriateness of the admission and whether the preadmission process could be improved/strengthened.	NA

Comparative data across several consecutive years can help identify whether an IRF's target area percents have changed significantly in either direction from one year to the next. Such changes may indicate a shift in admitting, coding, or billing practices, staff turnover, or changes in medical staff. They may also reflect evolving business practices (e.g., new service lines) or broader changes in the external healthcare environment.

2. Using PEPPER

PEPPER is a Microsoft Excel workbook containing multiple worksheets. Users navigate through PEPPER by selecting the worksheet tabs at the bottom of the screen. Each tab is labeled to indicate the contents of the worksheet (e.g., Definitions, Compare, or a specific Target Area).

2.1 Compare Targets Report

IRFs 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 IRF's number of target discharges, percent, and percentile values, compared with the nation, jurisdiction, state, and the "Sum of Payments."

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

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

The Compare Targets Report provides the IRF'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 IRF to assess how its target area percent compares with all IRFs in each respective comparison group.

The IRF's national percentile indicates the percentage of IRFs nationwide that have a target area percent less than the IRF's own target area percent.

The IRF's jurisdiction percentile indicates the percentage of other IRFs in the jurisdiction that have a target area percent less than the IRF's target area percent. A jurisdiction percentile is not calculated when fewer than 11 hospitals in the jurisdiction have reportable data for that target area.

The IRF's state percentile indicates the percentage of other IRFs in the state that have a target area percent less than the IRF's target area percent. A state percentile is not calculated when fewer than 11 IRFs in the state have reportable data for that target area.

When interpreting the Compare Targets Report, IRFs should consider their percentile values for the nation, jurisdiction, and state. Percentile values at or above the 80th percentile for any target area indicate high-outlier status. Outlier status should be evaluated in the following order of priority: (1) nation, (2) jurisdiction, and (3) state. The state comparison group is given the lowest priority because it represents the smallest population.

IRFs 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," yet the IRF's percent is at the 80th percentile for its jurisdiction and the 65th percentile nationally. In contrast, the Miscellaneous CMGs target area may have a smaller "Sum of Payments," but could still be at the 80th percentile for the jurisdiction and the 90th percentile for the nation. In this scenario, the Miscellaneous CMGs 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 across three fiscal years. These statistics include the proportion of numerator and denominator discharges (percent), the total number of numerator discharges for the target area (target-area discharge count), the denominator count, average length of stay (ALOS), and Medicare payment data.

The "Outlier Status" column identifies when the IRF is a high outlier; in these cases, the IRF's percentile is displayed in bold red text, indicating that it is at or above the national 80th

percentile. The column will display “Not an outlier” when the IRF is not an outlier for the target area and time period, and “No data” when the IRF does not have reportable data for that target area and time period.

The “Target Sum Medicare Payments” column shows the total Medicare payments for all claims included in the target-area numerator. The “Target Average Medicare Payment” is derived by dividing this sum by the Target Area Discharge Count. Interpretive guidance is included on each data table to help IRFs decide whether to audit records, along with suggested interventions specific to each target area.

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

The graphs include trend lines representing the percents at the 80th percentile for the nation, jurisdiction, and state, allowing IRFs to easily identify when they are high outliers relative to any comparison group. A table displaying these percentile values is included on each target-area graph worksheet. State percentiles are shown as zero when fewer than 11 IRFs in the state have reportable data for the target area. Jurisdiction percentiles are shown as zero when fewer than 11 IRFs in the jurisdiction have reportable data. 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 IRF for a given time period due to CMS data-use restrictions, no data point will appear on the graph for that period. Likewise, if fewer than 11 IRFs 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.

2.2.1 IRF Top CMG Reports

The IRF Top CMGs Report lists the top CMGs by discharge volume (including all tiers - A, B, C, and D) for the IRF in the most recent fiscal year. It includes the total number of IRF discharges for each CMG, the proportion of each CMG’s discharges relative to total IRF discharges, and the IRF’s ALOS for each CMG. This report is limited to the top CMGs (up to 20), for which there are at least 11 total discharges during the most recent fiscal year.

The Jurisdiction-Wide Top CMGs Report lists the top CMGs by discharge volume (including all tiers - A, B, C, and D) for all IRFs in the MAC jurisdiction for the most recent fiscal year. It includes the total jurisdiction-wide discharges for each CMG, the proportion of each CMG’s discharges relative to total discharges, the jurisdiction ALOS for each CMG, and the national ALOS for each CMG. This report is limited to the top CMGs (up to 20) that have at least 11 total discharges during the most recent fiscal year.

The IRF ALOS by CMG Tier and Discharge Destination Report identifies the number of discharges during the most recent fiscal year for each of the four CMG tier levels:

- Tier A, no comorbidity
- Tier B, high comorbidity
- Tier C, medium comorbidity
- Tier D, low comorbidity

It also identifies the number of discharges during the most recent fiscal year for five categories of discharge destination. These categories are defined by patient discharge status codes.

Table 4 provides the list of patient discharge status codes used to identify discharges for each destination.

Table 4: Discharge Destination Patient Discharge Codes

Discharge Destination	Patient Discharge Status Codes
Home	• 01 (discharged to home/self-care) • 81 (discharged to home/self-care with a planned acute care hospital readmission)
Transfer to Short-Term or Long-Term Acute Care Hospital	• 02 (discharged/transferred to a STACH) • 63 (discharged/transferred to an LTACH) • 82 (discharged/transferred to a STACH with a planned acute care hospital readmission) • 91 (discharged/transferred to an LTACH with a planned acute care hospital readmission)
Transfer to SNF	• 03 (discharged/transferred to an SNF) • 61 (discharged/transferred to a swing-bed) • 83 (discharged/transferred to an SNF with a planned acute care hospital readmission) • 89 (discharged to a swing bed with a planned acute care hospital readmission)
Home with Home Health	• 06 (discharged/transferred home with home health) • 86 (discharged/transferred home with home health with a planned acute care hospital readmission)
Other	All other patient discharge status codes

For each category, the report identifies the total number of IRF discharges, the proportion of those discharges relative to total discharges, the IRF's ALOS, and the national ALOS. This report is limited to CMG tier groups and discharge-destination categories with at least 11 discharges during the most recent fiscal year.

The Jurisdiction-Wide ALOS by CMG Tier and Discharge Destination Report identifies the number of discharges during the most recent fiscal year in the jurisdiction for each of the four CMG tier levels. It also identifies the number of discharges in the jurisdiction for the five discharge-destination categories. For each category, the report provides the total number of jurisdiction-wide discharges, the proportion of those discharges relative to total discharges, the jurisdiction ALOS, and the national ALOS.

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 on 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. This website also provides a variety of educational resources to support hospitals 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 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.
Case-Mix Group	CMG	A CMG is a healthcare classification system that categorizes patients with similar clinical characteristics and resource needs.
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, previously known as an Online Survey Certification and Reporting System (OSCAR) number or Medicare Provider Number, is a unique identifier assigned by CMS to healthcare providers and suppliers participating in Medicare. It serves to verify that a provider is Medicare certified and to identify the specific types of services they are authorized to provide.
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.
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.

Term	Abbreviation	Definition
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	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 Rehabilitation Facility Prospective Payment System	IRF PPS	IRF PPS, administered by CMS, is the standardized, case-based Medicare reimbursement model used to pay hospitals and rehabilitation units for intensive inpatient services.
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	NA
Long-Term Acute Care Hospital	LTACH	An LTACH is a specialized, acute-care hospital designed for patients with medically complex conditions who require extended hospital stays (typically 25 days or longer).
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.

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.
Not Applicable	NA	NA
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.
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	ST	NA
Short-Term Acute Care Hospital	STACH	A STACH is a medical facility that provides immediate, active treatment for severe injuries, sudden illnesses, or post-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: Historical Target Area Definitions for FY 2023 and FY 2024

Table 6 provides historical target area definitions for FY 2023 and FY 2024.

Table 6: Historical Target Area Definitions for FY 2023 and FY 2024

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
Miscellaneous CMGs	**Numerator**: Count of discharges for CMGs: • **2001** (Miscellaneous M>49.15), • **2002** (Miscellaneous M>38.75 and M<49.15), • **2003** (Miscellaneous M>27.85 and M<38.75), or • **2004** (Miscellaneous M<27.85). **Denominator**: Count of all discharges.	**Numerator**: Count of discharges for CMGs: • **2001** (Miscellaneous M>49.15), • **2002** (Miscellaneous M>38.75 and M<49.15), • **2003** (Miscellaneous M>27.85 and M<38.75), or • **2004** (Miscellaneous M<27.85). **Denominator**: Count of all discharges.
CMGs at Risk for Unnecessary Admissions	**Numerator**: Count of discharges with no tier group assignment for CMGs: • **0101** (Stroke M>51.05), • **0501** (Non-Traumatic Spinal Cord Injury M>51.35), • **0601** (Neurological M>47.75), 0801 (Replacement of Lower Extremity Joint M>49.55), • **0802** (Replacement of Lower Extremity Joint M>37.05 and M<49.55), • **0901** (Other Orthopedic M>44.75), 1401 (Cardiac M>48.85), or • **1501** (Pulmonary M>49.25). **Denominator**: Count of all discharges.	**Numerator**: Count of discharges with no tier group assignment for CMGs: • **0101** (Stroke M>51.05), • **0501** (Non-Traumatic Spinal Cord Injury M>51.35), • **0601** (Neurological M>47.75), 0801 (Replacement of Lower Extremity Joint M>49.55), • **0802** (Replacement of Lower Extremity Joint M>37.05 and M<49.55), • **0901** (Other Orthopedic M>44.75), 1401 (Cardiac M>48.85), or • **1501** (Pulmonary M>49.25). **Denominator**: Count of all discharges.
Outlier Payments	**Numerator**: Count of discharges with an outlier approved amount greater than $0. **Denominator**: Count of all discharges.	**Numerator**: Count of discharges with an outlier approved amount greater than $0. **Denominator**: Count of all discharges.

STACH Admissions Following IRF Discharge	**Numerator**: Count of discharges where the beneficiary (identified using the Health Insurance Claim number) was discharged from the IRF during the 12-month time period and admitted to a STACH within 30 days of discharge from the IRF. **Numerator Exclusions**: Excluding transfers to a STACH, a LTACH, or an IRF within one day of discharge as evidenced by a subsequent claim. Exclude patient discharge status codes: • **07** (left against medical advice) • **20** (expired) **Denominator**: Count of all discharges. **Denominator Exclusions**: Exclude transfers to a STACH, LTACH, or IRF within one day of discharge as evidenced by a subsequent claim. Exclude patient discharge status codes **07**, **20**.	**Numerator**: Count of discharges where the beneficiary (identified using the Health Insurance Claim number) was discharged from the IRF during the 12-month time period and admitted to a STACH within 30 days of discharge from the IRF. **Numerator Exclusions**: Exclude transfers to a STACH, a LTACH, or an IRF within one day of discharge as evidenced by a subsequent claim. Exclude patient discharge status codes: • **07** (left against medical advice) • **20** (expired) **Denominator**: Count of all discharges. **Denominator Exclusions**: Exclude transfers to a STACH, LTACH, or IRF within one day of discharge as evidenced by a subsequent claim. Exclude patient discharge status codes **07**, **20**.
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 IRF for the same beneficiary (identified using the Health Insurance Claim number). **Denominator**: Count of all discharges excluding patient discharge status code **20** (expired).	**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 IRF for the same beneficiary (identified using the Health Insurance Claim number). **Denominator**: Count of all discharges excluding patient discharge status code **20** (expired).
Short Stays	**Numerator**: Count of discharges with a LOS less than or equal to three days. **Numerator Exclusion**: Exclude patient discharge status code **20** (expired). **Denominator**: Count of all IRF discharges. **Denominator Exclusion**: Exclude patient discharge status code **20**.	**Numerator**: Count of discharges with a LOS less than or equal to three days. **Numerator Exclusion**: Exclude patient discharge status code **20** (expired). **Denominator**: Count of all IRF discharges. **Denominator Exclusion**: Exclude patient discharge status code **20**.

Appendix C: How Readmissions Are Identified

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

STACH Admissions Following IRF Discharge:

- Readmissions are counted when the discharge from the index (first) IRF admission occurs within the 12-month period. Each IRF admission may serve as an index admission for determining whether a subsequent STACH admission occurs within 30 days of the IRF discharge date.
- Each patient admission can be identified as a readmission only in relation to the IRF admission that immediately precedes it.
- Index admissions with a transfer to a STACH, LTACH, or another IRF within one day of the IRF discharge, as evidenced by a subsequent claim, are excluded from the numerator and cannot be identified as index admissions.
- Index admissions with a patient discharge status code of "07" (Left Against Medical Advice) or "20" (Expired) are excluded from the numerator and cannot be identified as index admissions.

3- to-5-Day Readmissions:

- Readmissions are counted when the discharge from the index (first) IRF admission occurs within the 12-month period and the patient is readmitted to the same IRF within three to five calendar days (four to six consecutive days) following the IRF discharge.
- Index admissions with a patient discharge status code of "20" (Expired) are excluded from the numerator and cannot be identified as index admissions.
- Admissions of beneficiaries to other settings, such as skilled nursing facilities, swing beds, short-term acute care hospitals, inpatient psychiatric facilities, critical access hospitals, or any other type of provider, are not considered for this measure. Only admissions to IRFs are included. 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 IRF (e.g., a skilled nursing facility or inpatient psychiatric facility unit) under the IRF's provider number instead of the provider number for the unit.
  - Incorrect coding of the patient discharge status code when the patient is discharged or transferred to another IRF. As noted above, index admissions with a patient discharge status code of "07" or "20" are excluded from the numerator and cannot be identified as index admissions.

C.1 Example 1 – Two IRF Stays, One Qualifying STACH Admission Following IRF Discharge Target Area

The following table displays claims submitted for one beneficiary. The table is 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." in the table header), which may be considered 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 Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Next Adm. Counts as STACH Admiss following IRF Disch
1	IRF #1	01/20/2025	02/01/2025	01	2	STACH #1	02/05/2025	02/10/2025	Yes, to IRF #1
2	STACH #1	02/05/2025	02/10/2025	62	3	IRF #2	02/10/2025	02/20/2025	Not applicable as the index admission is not an IRF
3	IRF #2	02/10/2025	02/20/2025	02	4	STACH #1	02/20/2025	02/22/2025	No, transfer to STACH
4	STACH #1	02/20/2025	02/22/2025	01	NA	No further admissions	No further admissions	No further discharge dates	NA

Detailed Discussion:

- **Row 1**: The beneficiary was admitted to IRF #1 on 01/20/2025 and was discharged home (patient discharge status code 01). The beneficiary was then admitted to STACH #1 on 02/05/2025. This STACH admission counts as a *STACH Admission Following IRF Discharge* ("STACH admission within 30 days of IRF discharge") for IRF #1, based on the 01/20/2025 index admission.
- **Row 2**: The beneficiary was admitted to STACH #1 on 02/05/2025 and was transferred (patient discharge status code 62) to IRF #2 on 02/10/2025. The STACH #1 admission is not considered an index admission; only admissions to an IRF can serve as index admissions for this measure.

- **Row 3**: The beneficiary was admitted to IRF #2 on 02/10/2025 and was transferred (patient discharge status code 02) to STACH #1 on 02/20/2025. This admission is not counted as a *STACH Admission Following IRF Discharge* because the beneficiary was transferred to a STACH (patient discharge status code 02).
- **Row 4**: The beneficiary was admitted to STACH #1 on 02/20/2025 and was discharged home (patient discharge status code 01) on 02/22/2025.

C.2 Example 2 - Two IRF Stays, One Qualifying Readmission for 3- to 5-Day Readmissions Target Area

The following table displays claims submitted for one beneficiary. The table is 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." in the table header), which may be considered 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 3 to 5 Day Readm.
1	IRF #1	11/20/2025	12/01/2025	01	2	IRF #1	12/05/2025	12/10/2025	Yes, to IRF #1
2	IRF #1	12/05/2025	12/10/2025	01	NA	No further admissions	No further admissions	No further discharges	N/A

Detailed Discussion:

- **Row 1**: The beneficiary was admitted to IRF #1 on 11/20/2025 and discharged home (patient discharge status code 01) on 12/01/2025. The beneficiary was readmitted to IRF #1 on 12/05/2025, which is four calendar days after being discharged from IRF #1. This admission counts as a *3- to 5-Day Readmission* to IRF #1 against the 11/20/2025 index admission because it occurred within three to five calendar days after the beneficiary was discharged from IRF #1.
- **Row 2**: The beneficiary was admitted to IRF #1 on 12/05/2025 and discharged home (patient discharge status code 01) on 12/10/2025 with no additional claims during the fiscal year period.

Note: For the *3- to 5-Day Readmissions* target area, the patient discharge status code of the index admission is not considered.