Long-Term Acute Care Hospital Program for Evaluating Payment Patterns Electronic Report

User Guide

FY 2025 Release

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What's new in this edition?

This edition reflects updated Diagnosis Related Group (DRG) code sets for the Excisional Debridement target area, removing DRGs 133 and 134 and replacing them with DRGs 143, 144, and 145.

1. What is PEPPER?

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

PEPPER is an electronic data report that contains a single hospital's claims data statistics for Medicare Severity Diagnosis Related Groups (MS DRGs) and discharges at risk for improper payment due to billing, coding, and/or admission necessity issues. Each PEPPER contains statistics for the most recent federal fiscal years 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 hospital's target area percentages over time. PEPPER also includes reports on the hospital's top DRGs and nationwide top DRGs by volume of discharges. Index Analytics (IA), along with its partners Integrity Management Services, Inc. (IntegrityM) and GovCon Growth Solutions, LLC, develops and distributes PEPPER under contract with the Centers for Medicare & Medicaid Services (CMS).

All of the data tables, graphs, and reports in PEPPER were designed to assist the hospital in identifying 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****. A hospital can use PEPPER to compare its claims data over time to identify potential areas of concern, including significant changes in billing practices; possible over- or under-coding; and changes in length of stay.*

PEPPER is available for Long-Term Acute Care Hospitals (LTACHs), Short-Term Acute Care Hospitals (STACHs), 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 Long-Term Acute Care PEPPER (LTACH PEPPER) is designed specifically for LTACHs and compares each hospital's results to three comparison groups: the nation, Medicare Administrative Contractor (MAC) jurisdictions, and the state in which the hospital operates. These comparisons help hospitals determine whether they are outliers relative to other LTACHs.

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

[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.

attention to any findings that are at or above the upper control limit (high outlier) or at or below the lower control limit.

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

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

Table 1: Eligible Claims Specifications for LTACH PEPPER

Inclusion/Exclusion Criteria	Data Specifications
LTACH providers only	Third through sixth positions of the CMS Certification Number are between “2000” and “2299”.
Services provided during the time periods included in the report	Claim “Through Date” (discharge date) falls within the three fiscal years included in the report.
Claim with a valid medical record number	UB-04 FL 03a or 03b is not null (blank).
Medicare claim payment amount greater than zero	The hospital received a payment amount greater than zero on the claim (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 HMO.
Exclude cancelled claims	Exclude claims cancelled by the MAC.

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

1.1 LTACH PEPPER Target Areas

In general, target areas are constructed as ratios and expressed as percents. The numerator represents discharges identified as problematic, and the denominator represents discharges from a broader comparison group. For admission-necessity–focused target areas, the numerator typically includes discharges or DRGs prone to unnecessary admissions, while the denominator includes all discharges for those DRGs or all discharges overall. For DRG-coding–related target areas, the numerator includes DRGs identified as prone to coding errors, and the denominator includes those DRGs plus the DRGs to which the original DRG is frequently reassigned.

Table 2 identifies the Fiscal Year (FY) 2025 definitions for the LTACH PEPPER target areas. The 2023 and 2024 definitions are available in *Appendix D.*

Table 2: Target Area and Target Area Definitions

Target Area	Target Area Definition
Septicemia	**Numerator**: Count of discharges for the following DRGs: • **870** (septicemia or severe sepsis with mechanical ventilation >96 hours), • **871** (septicemia or severe sepsis without mechanical ventilation >96 hours with MCC), • **872** (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC). **Denominator**: Count of discharges for the following DRGs: • **193** (simple pneumonia and pleurisy with MCC), • **194** (simple pneumonia and pleurisy with CC), • **195** (simple pneumonia and pleurisy without CC/MCC), • **207** (respiratory system diagnosis with ventilator support >96 hours), • **208** (respiratory system diagnosis with ventilator support ≤ 96 hours), • **689** (kidney and urinary tract infections with MCC), • **690** (kidney and urinary tract infections without MCC), • **870**, **871**, **872**.
Excisional Debridement	**Numerator**: Count of discharges for the following DRGs affected by International Classification of Diseases (ICD), 10th Revision, Procedure Coding System (ICD-10-PCS) procedure codes for excisional debridement that have an excisional debridement procedure code on the claim. **Denominator**: Count of discharges for the DRGs for excisional debridement. **Note**: Refer to *Appendix A* for the complete set of codes relevant for this target area.
Short Stays	**Numerator**: Count of discharges occurring on or one day after meeting the short-stay outlier threshold. **Denominator**: Count of all discharges.
Short Stays for Respiratory System Diagnoses	**Numerator**: Count of discharges that occurred on the day of or day after the short stay outlier threshold was met for the following DRGs: • **177** (respiratory infections and inflammations with MCC), • **189** (pulmonary edema and respiratory failure), • **193** (simple pneumonia and pleurisy with MCC), • **207** (respiratory system diagnosis with ventilator support >96 hours), • **208** (respiratory system diagnosis with ventilator support <96 hours). **Denominator**: Count of all discharges for the following DRGs: **177**, **189**, **193**, **207**, and **208**
Outlier Payments	**Numerator**: Count of discharges with a DRG outlier approved amount of greater than $0. **Denominator**: Count of all discharges.

Target Area	Target Area Definition
30-Day Readmissions to Same Hospital or Elsewhere	**Numerator**: Count of index (first) admissions during the 12-month time period for which a readmission occurred within 30 days to the same hospital or to another long-term acute care prospective payment system (PPS) hospital for the same beneficiary (identified using the Health Insurance Claim number). **Numerator Exclusions**: Exclude claims for the index admission where the patient discharge status is one of the following: • 07 (left against medical advice), • 20 (expired), • 63 (discharged/transferred to an LTACH), or • 91 (discharged/transferred to an LTACH with a planned acute care hospital inpatient readmission). **Denominator**: Count of all discharges. **Denominator Exclusions**: Exclude claims where the patient discharge status is one of the following: 07, 20, 63, or 91. **Note**: Refer to *Appendix B* for examples of how readmissions are identified.
STACH Admissions Following LTACH Discharge	**Numerator**: Count of discharges where the beneficiary (identified using the Health Insurance Claim number) was discharged from the LTACH during the 12-month time period and admitted to a short-term acute care hospital (STACH) within 30 days of discharge from the LTACH. **Numerator Exclusions**: Exclude the transfer of a beneficiary to a STACH or an LTACH within one day (discharge day or the next day) of discharge from an LTACH, as shown by a subsequent claim. Exclude index admissions claims with patient discharge status codes: • **07** (left against medical advice), or • **20** (expired) **Denominator**: Count of all discharges **Denominator Exclusions**: Exclude the transfer of a beneficiary to a STACH or an LTACH within one day (discharge day or the next day) of discharge from an LTACH, as shown by a subsequent claim. Exclude claims where the patient discharge status is one of the following: **07,** or **20.** **Note**: Refer to *Appendix B* for examples of how readmissions are identified.

CMS approved these LTACH 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 the Recovery Auditor (RA)—Program has identified additional areas vulnerable to improper payments.

Note: DRGs and DRG definitions may change from one fiscal year to the next. Refer to the Federal Register for details. A complete list of Medical and Surgical DRGs, including those with CC, MCC, CC/MCC, and without CC, MCC, or CC/MCC, is available in the CMS MS-DRG Definitions Manual on the CMS website ICD-10-CM/PCS MS-DRG Definitions Manual.

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

Readmissions have been associated with billing errors, premature discharge, incomplete care, and inappropriate readmission. PEPPER includes two target areas related to readmissions within 30 days of discharge: one capturing patients readmitted to the same LTACH or to another long-term acute care PPS hospital, and the other capturing patients readmitted to a STACH within 30 days of discharge from the LTACH. PEPPER readmission statistics do not incorporate risk adjustment or exclude planned readmissions due to the significant complexity and processing time required to generate these data.

PEPPER does not include condition-specific readmission information because these readmissions occur too infrequently for most hospitals to have sufficient data for reporting.

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

Please note that DRGs and DRG definitions may change from one fiscal year to the next. Details can be found in the Federal Register. Target area definitions for FY 2023 and FY 2024 are provided in *Appendix B*.

1.2 How Hospitals Can Use PEPPER Data

For Medicare data, the fiscal year runs from October 1 through September 30. LTACH PEPPER provides hospitals with their national, jurisdiction, and state percentile values for each target area with reportable data for the most recent three fiscal years included in the report. “Reportable data” 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.

The guidance for outliers provided below offers general suggestions and may not apply to all situations. For all target areas, assess whether there is sufficient volume (typically 10 to 30 discharges for the year, depending on the hospital’s total annual discharges) to warrant a review of cases.

Table 3 provides suggested interventions for outliers by target area.

Table 3: Suggested Interventions for Outliers by Target Area

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
Septicemia	• This could indicate coding or billing errors related to over-coding of DRGs **870**, **871**, or **872**. • Review a sample of medical records for these DRGs to determine whether coding errors exist. • To ensure documentation supports the principal diagnosis, hospitals may generate data profiles to identify cases with ICD-10-CM code A41.9 (unspecified septicemia).	• This could indicate coding or billing errors related to under-coding of DRGs **870**, **871**, or **872**. • Review a sample of medical records for other DRGs, such as DRGs 689, 690, 193, 194, 195, 207, and 208 to determine whether coding errors exist. • Only a physician can determine a diagnosis of septicemia/sepsis. A coder should not code based on a laboratory or radiological finding without seeking clarification from the physician. **Note**: There is no ICD-10-CM code for urosepsis.
Excisional Debridement	• This could indicate that there are coding or billing errors related to over-coding of excisional debridement. • A sample of medical records including excisional debridement procedure codes should be reviewed to determine if coding errors exist and ensure that the coding is supported by the documentation. • Refer to Coding Clinic for specific guidelines regarding the coding of excisional debridement. If particular diagnoses are found to be problematic, provide education.	• If your facility does not perform excisional debridement, low numbers in this target area are expected. • If the excisional debridement number is lower than expected, this could indicate that there are coding or billing errors related to under-coding for excisional debridement. • A sample of medical records involving debridement should be reviewed to ensure that the coding is supported by the documentation. • Refer to Coding Clinic for specific guidelines regarding the coding for debridement.
Short Stays for Respiratory System Diagnoses	• This could indicate that there are unnecessary admissions related to inappropriate use of admission screening criteria. • Review a sample of medical records for the appropriate DRG(s) to determine whether inpatient admission was necessary or whether care could have been provided more efficiently in another setting.	Not applicable, as these are admission-necessity focused target areas.

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
Outlier Payments	• This indicates that the hospital is submitting a high percentage of claims with outlier payments. • Review claims with outlier payments to ensure treatment provided was medically necessary.	Not applicable, as this is an admission-necessity focused target area.

30-Day Readmissions to the Same Hospital or Elsewhere and 30-Day Readmissions to the Same Hospital	• A sample of readmission cases should be reviewed to identify appropriateness of admission, discharge, quality of care, DRG assignment, and billing errors.
	• Hospitals may generate data profiles for readmissions, such as patients readmitted the same day or next day after discharge.
	• Hospitals may use patient identifier, date of admission, date of discharge, patient discharge status code, principal and secondary diagnoses, procedure code(s), and DRG to profile these admissions and identify patterns.
	• These profiles should be evaluated for indicators of potential improper payments, including:
	  ◦ Patients discharged home (patient discharge status code 01) and readmitted the same or next day, as this may indicate a premature discharge or incomplete care.
	  ◦ Patients readmitted for the same principal diagnosis as the first admission, as this may indicate a premature discharge or incomplete care.
	  ◦ LTACHs co-located within a STACH should verify that the correct provider number was billed for same-day readmissions. The second admission to a STACH should be billed to the STACH's provider number.
		Not applicable, as these are admission-necessity focused target areas.

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
STACH Admissions Following LTACH Discharge	• This could indicate that patients are not medically stable or prepared for discharge. • The LTACH should ensure that patient discharge planning is initiated early during patient 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. • LTACHs co-located within STACHs should identify admissions to their STACH within 30 days of an LTACH discharge and review the medical records for those patients.	Not applicable, as this is an admission-necessity focused target area.

Comparative data across several consecutive years can help identify whether the hospital's target area percents have changed meaningfully from one year to the next. Such shifts may indicate changes in admitting, coding, or billing practices, staff turnover, or modifications in the 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 the workbook by selecting the worksheet tabs at the bottom of the screen. Each tab is labeled to indicate its contents (e.g., Definitions, Compare, and individual target area worksheets).

2.1 Compare Targets Report

Hospitals 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 hospital'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 hospitals to assess high and low outlier status for all target areas simultaneously.*

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

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

The hospital's national percentile indicates the percentage of all hospitals in the nation that have a target area percent lower than the hospital's target area percent.

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

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

When interpreting the Compare Targets Report, hospitals should consider their percentile values for the nation, jurisdiction, and state. Percentiles at or above the 80th percentile (for all target areas) or at or below the 20th percentile (for coding-focused target areas) indicate 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.

Hospitals can also use the "Sum of Payments" metric to help prioritize areas for review. For example, the Compare Targets Report may show that the Short Stays target area has the highest "Sum of Payments," yet the hospital's percent is at the 80th percentile for the jurisdiction and the 65th percentile for the nation. In contrast, the Septicemia target area may rank third in "Sum of Payments," but still be at the 80th percentile for the jurisdiction and the 90th percentile for the nation. In this scenario, the Septicemia target area may warrant higher priority than the Short Stays target area.

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 of discharges, average length of stay (ALOS), and Medicare payment information.

The "Outlier Status" column identifies when the hospital is a high outlier; in these cases, the hospital's percentile is displayed in red bold, indicating that it is at or above the national 80th percentile. The column also identifies low outliers, with the hospital's percentile shown in green italics to indicate that it is at or below the national 20th percentile. When the hospital is not an outlier for the target area and time period, the column displays "Not an outlier." When the hospital does not have reportable data for the target area and time period, it displays "No data."

The "Target Sum Medicare Payments" column reflects the total Medicare payment amount for all claims that meet the target area numerator definition. The "Target Average Medicare Payment" column is calculated by dividing the Target Sum Medicare Payments by the Target Area Discharge Count. Each data table includes interpretive guidance to help hospitals determine whether a sample of records should be audited. Suggested interventions tailored to each target area are also provided.

Graphs displayed beneath the data tables illustrate the hospital's target area percentages over three fiscal years. They allow hospitals to spot notable changes from one year to the next, which may stem from staffing changes, coding or billing updates, utilization review adjustments, documentation improvements, or shifts in hospital services. Community-level changes in healthcare providers can also affect patient mix and may appear in PEPPER results. Hospitals are encouraged to investigate the underlying causes of major shifts to help prevent improper payments.

The graphs include trend lines showing the percents at the 80th percentile (and the 20th percentile for coding-focused target areas) for the nation, jurisdiction, and state, allowing hospitals to easily identify when they are 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 eleven hospitals in the state have reportable data for the target area. Jurisdiction percentiles are shown as zero when fewer than eleven hospitals in the jurisdiction have reportable data. If no reportable data exist for the time period, the table displays #N/A in the cell.

If the hospital has no reportable data 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 eleven hospitals 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.

The Hospital Top DRGs table lists the top DRGs for all discharges at the hospital for the most recent fiscal year. It also provides the number of short-stay outliers, total hospital discharges, the proportion of short-stay outliers to total discharges, and the ALOS for each DRG.

The Nationwide Top DRGs table lists the top DRGs for all discharges in the nation for the most recent fiscal year. It also provides the number of short-stay outliers, total discharges, the proportion of short-stay outliers to total discharges, and the ALOS for each DRG.

Please note that these reports display only the top 20 ranked DRGs for which there are at least eleven short-stay outlier discharges during the most recent fiscal year. If multiple DRGs share the same rank, all tied DRGs will be shown. If no DRGs meet the minimum threshold of eleven discharges, the table will not display any data.

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 through the CMS CBR PEPPER website by selecting the "Help/Contact Us" tab. The website also provides a variety of educational resources to support hospitals in using PEPPER.

Please **do not** contact your Medicare Quality Improvement Organization or any other association for assistance with PEPPER, as these organizations are not involved in the production or distribution of PEPPER.

Appendix A: Code Sets for Excisional Debridement Target Area

Table 4 lists the DRGs affected by Excisional Debridement Procedure Codes for FY 2025.

Table 4: DRGs Affected by Excisional Debridement Procedure Codes

DRG	Description
3	ECMO OR TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT FACE, MOUTH, AND NECK WITH MAJOR O.R. PROCEDURES
40	PERIPHERAL, CRANIAL NERVE, AND OTHER NERVOUS SYSTEM PROCEDURES WITH MCC
41	PERIPHERAL, CRANIAL NERVE, AND OTHER NERVOUS SYSTEM PROCEDURES WITH CC OR PERIPHERAL NEUROSTIMULATOR
42	PERIPHERAL, CRANIAL NERVE, AND OTHER NERVOUS SYSTEM PROCEDURES WITHOUT CC/MCC
115	EXTRAOCULAR PROCEDURES EXCEPT ORBIT
143	OTHER EAR, NOSE, MOUTH, AND THROAT O.R. PROCEDURES WITH MCC
144	OTHER EAR, NOSE, MOUTH, AND THROAT O.R. PROCEDURES WITH CC
145	OTHER EAR, NOSE, MOUTH, AND THROAT O.R. PROCEDURES WITHOUT CC/MCC
166	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH MCC
167	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH CC
168	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITHOUT CC/MCC
264	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES
356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH MCC
357	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC
358	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITHOUT CC/MCC
423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITH MCC
424	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITH CC
425	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITHOUT CC/MCC
463	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WITH MCC

DRG	Description
464	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WITH CC
465	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC
513	HAND OR WRIST PROCEDURES, EXCEPT MAJOR THUMB OR JOINT PROCEDURES WITH CC/MCC
514	HAND OR WRIST PROCEDURES, EXCEPT MAJOR THUMB OR JOINT PROCEDURES WITHOUT CC/MCC
570	SKIN DEBRIDEMENT WITH MCC
571	SKIN DEBRIDEMENT WITH CC
572	SKIN DEBRIDEMENT WITHOUT CC/MCC
579	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH MCC
580	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH CC
581	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITHOUT CC/MCC
622	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL, AND METABOLIC DISORDERS WITH MCC
623	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL, AND METABOLIC DISORDERS WITH CC
624	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL, AND METABOLIC DISORDERS WITHOUT CC/MCC
673	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITH MCC
674	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITH CC
675	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITHOUT CC/MCC
715	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY WITH CC/MCC
716	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY WITHOUT CC/MCC
717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES EXCEPT MALIGNANCY WITH CC/MCC
718	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES EXCEPT MALIGNANCY WITHOUT CC/MCC

DRG	Description
749	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES WITH CC/MCC
750	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES WITHOUT CC/MCC
802	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITH MCC
803	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITH CC
804	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITHOUT CC/MCC
823	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH OTHER PROCEDURES WITH MCC
824	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH OTHER PROCEDURES WITH CC
825	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH OTHER PROCEDURES WITHOUT CC/MCC
853	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH MCC
854	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH CC
855	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITHOUT CC/MCC
856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS WITH O.R. PROCEDURES WITH MCC
857	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS WITH O.R. PROCEDURES WITH CC
858	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS WITH O.R. PROCEDURES WITHOUT CC/MCC
876	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS
901	WOUND DEBRIDEMENTS FOR INJURIES WITH MCC
902	WOUND DEBRIDEMENTS FOR INJURIES WITH CC
903	WOUND DEBRIDEMENTS FOR INJURIES WITHOUT CC/MCC
906	HAND PROCEDURES FOR INJURIES
927	EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITH SKIN GRAFT
928	FULL THICKNESS BURN WITH SKIN GRAFT OR INHALATION INJURY WITH CC/MCC

DRG	Description
929	FULL THICKNESS BURN WITH SKIN GRAFT OR INHALATION INJURY WITHOUT CC/MCC
939	O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES WITH MCC
940	O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES WITH CC
941	O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES WITHOUT CC/MCC
957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITH MCC
958	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITH CC
959	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITHOUT CC/MCC
969	HIV WITH EXTENSIVE O.R. PROCEDURES WITH MCC
970	HIV WITH EXTENSIVE O.R. PROCEDURES WITHOUT MCC
981	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC
982	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC
983	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITHOUT CC/MCC
987	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC
988	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC
989	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITHOUT CC/MCC

Table 5 lists the Excisional Debridement ICD-10-PCS codes for FY 2025.

Table 5: Excisional Debridement Procedure Codes

ICD-10-PCS Code	Description
0HB9XZZ	Excision of Perineum Skin, External Approach
0JB00ZZ	Excision of Scalp Subcutaneous Tissue and Fascia, Open Approach
0JB03ZZ	Excision of Scalp Subcutaneous Tissue and Fascia, Percutaneous Approach

ICD-10-PCS Code	Description
0JB10ZZ	Excision of Face Subcutaneous Tissue and Fascia, Open Approach
0JB13ZZ	Excision of Face Subcutaneous Tissue and Fascia, Percutaneous Approach
0JB40ZZ	Excision of Right Neck Subcutaneous Tissue and Fascia, Open Approach
0JB43ZZ	Excision of Right Neck Subcutaneous Tissue and Fascia, Percutaneous Approach
0JB50ZZ	Excision of Left Neck Subcutaneous Tissue and Fascia, Open Approach
0JB53ZZ	Excision of Left Neck Subcutaneous Tissue and Fascia, Percutaneous Approach
0JB60ZZ	Excision of Chest Subcutaneous Tissue and Fascia, Open Approach
0JB63ZZ	Excision of Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JB70ZZ	Excision of Back Subcutaneous Tissue and Fascia, Open Approach
0JB73ZZ	Excision of Back Subcutaneous Tissue and Fascia, Percutaneous Approach
0JB80ZZ	Excision of Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JB83ZZ	Excision of Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
0JB90ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Open Approach
0JB93ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBB0ZZ	Excision of Perineum Subcutaneous Tissue and Fascia, Open Approach
0JBB3ZZ	Excision of Perineum Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBC0ZZ	Excision of Pelvic Region Subcutaneous Tissue and Fascia, Open Approach
0JBC3ZZ	Excision of Pelvic Region Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBD0ZZ	Excision of Right Upper Arm Subcutaneous Tissue and Fascia, Open Approach
0JBD3ZZ	Excision of Right Upper Arm Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBF0ZZ	Excision of Left Upper Arm Subcutaneous Tissue and Fascia, Open Approach
0JBF3ZZ	Excision of Left Upper Arm Subcutaneous Tissue and Fascia, Percutaneous Approach

ICD-10-PCS Code	Description
0JBG0ZZ	Excision of Right Lower Arm Subcutaneous Tissue and Fascia, Open Approach
0JBG3ZZ	Excision of Right Lower Arm Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBH0ZZ	Excision of Left Lower Arm Subcutaneous Tissue and Fascia, Open Approach
0JBH3ZZ	Excision of Left Lower Arm Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBJ0ZZ	Excision of Right Hand Subcutaneous Tissue and Fascia, Open Approach
0JBJ3ZZ	Excision of Right Hand Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBK0ZZ	Excision of Left Hand Subcutaneous Tissue and Fascia, Open Approach
0JBK3ZZ	Excision of Left Hand Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBL0ZZ	Excision of Right Upper Leg Subcutaneous Tissue and Fascia, Open Approach
0JBL3ZZ	Excision of Right Upper Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBM0ZZ	Excision of Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach
0JBM3ZZ	Excision of Left Upper Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBN0ZZ	Excision of Right Lower Leg Subcutaneous Tissue and Fascia, Open Approach
0JBN3ZZ	Excision of Right Lower Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBP0ZZ	Excision of Left Lower Leg Subcutaneous Tissue and Fascia, Open Approach
0JBP3ZZ	Excision of Left Lower Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBQ0ZZ	Excision of Right Foot Subcutaneous Tissue and Fascia, Open Approach
0JBQ3ZZ	Excision of Right Foot Subcutaneous Tissue and Fascia, Percutaneous Approach
0JBR0ZZ	Excision of Left Foot Subcutaneous Tissue and Fascia, Open Approach
0JBR3ZZ	Excision of Left Foot Subcutaneous Tissue and Fascia, Percutaneous Approach
0JB13ZZ	Excision of Buttock Skin, External Approach

Appendix B: How Readmissions Are Identified

These examples are provided to help users understand how readmissions are identified and counted in PEPPER's *30-Day Readmissions to Same LTACH or Elsewhere and STACH Admissions Following LTACH Discharges* target areas. When reviewing these examples, keep in mind that:

1. Readmissions are counted in the 12-month period in which the discharge date of the index (first) admission occurs. Each patient admission may serve as an index admission for a subsequent LTACH or STACH admission if the subsequent admission occurs within 30 days of the index admission's discharge date.
2. Each patient admission can be identified as a readmission only for the LTACH admission that immediately precedes it. Index admissions with a patient discharge status code of "63" (discharged/transferred to an LTACH), "91" (discharged/transferred to an LTACH with a planned acute care hospital inpatient readmission), or "20" (expired) are excluded from the numerator and cannot serve as index admissions for the 30-Day Readmissions to Same Hospital or Elsewhere target area.
3. Index admissions with a patient discharge status code of "07" (left against medical advice), "20" (expired), or those followed by a transfer to a STACH or LTACH within one day of discharge, as evidenced by a subsequent claim, are excluded from the numerator and cannot serve as index admissions for the *STACH Admissions Following LTACH Discharges* target area.
4. Any admissions of beneficiaries to other settings, such as skilled nursing facilities, swing beds, inpatient rehabilitation facilities, inpatient psychiatric facilities, critical access hospitals, or any other provider type, are not considered for this measure. Only admissions to LTACHs and STACHs 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 LTACH (e.g., inpatient rehabilitation or inpatient psychiatric facility unit) under the LTACH's provider number instead of the unit's provider number.
    - Incorrectly coding the patient discharge status when the patient is discharged or transferred to another LTACH. As noted above, index admissions with discharge status codes 07, 20, 63, or 91 are excluded from the numerator and cannot be identified as index admissions.

B.1 Example 1 - Three LTACH Stays, One Qualifying Readmission for Readmission Same and Readmission Same or Elsewhere Target Areas

The following table displays claims submitted for one beneficiary by LTACHs over a one-year period. The claims are sorted chronologically based on the date in the first column. Each row contains two admissions: the Index Admission (abbreviated as Index Adm. in the table header) and the Next Admission (abbreviated as Next Adm.), which may qualify as a readmission. The next admission listed on one row becomes the index admission on the subsequent 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	Next Adm. Counts as 30-Day Readm. to Same or Elsewhere ?	Next Adm. Counts as STACH Readm. Following LTACH discharge?
1	LTACH #1	11/05/2024	12/01/2024	01	2	LTACH #2	12/20/2024	01/02/2025	Yes, to LTACH #1 in Q2FY24	No
2	LTACH #2	12/20/2024	01/02/2025	63	3	LTACH #1	01/02/2025	01/30/2025	No	No
3	LTACH #1	01/02/2025	01/30/2025	01	NA	No further admissions	No further admissions	No further discharge dates	NA	NA

Detailed Discussion:

- **Row 1**: The beneficiary was admitted to LTACH #1 on 11/05/2024 and discharged home (patient discharge status code 01) on 12/01/2024. The beneficiary was then admitted to LTACH #2 on 12/20/2024. This 12/20/2024 admission to LTACH #2 counts as a *30-Day Readmission to Same Hospital or Elsewhere* for LTACH #1, because it occurred within 30 days of the 12/01/2024 discharge date of the 11/05/2024 index admission.

- **Row 2**: The beneficiary was admitted to LTACH #2 on 12/20/2024 and discharged/transferred to LTACH #1 (patient discharge status code 63) on 01/02/2025. The admission to LTACH #1 does not count as a 30-Day Readmission for the 12/20/2024 index admission at LTACH #2 because the beneficiary was discharged/transferred from LTACH #2 to LTACH #1 with status code 63.
- **Row 3**: The beneficiary was admitted to LTACH #1 on 01/02/2025 and discharged home (patient discharge status code 01) on 01/30/2025.

B.2 Example 2 - Four Hospital Stays, One Qualifying Readmissions for STACH Admission within 30 days following LTACH Discharge Target Areas

The following table displays claims submitted for one beneficiary. The claims are sorted chronologically based on the date in the first column. Each row contains two admissions: the Index Admission (abbreviated as Index Adm. in the table header) and the Next Admission (abbreviated as Next Adm.), which may be considered a readmission. The next admission listed on one row becomes the index admission on the subsequent 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	Next Adm. Counts as 30-Day Readm. to Same or Elsewhere?	Next Adm. Counts as STACH Readm. Following LTACH discharge?
1	LTACH #1	07/01/2024	10/02/2024	02	2	STACH #1	10/02/2024	10/09/2024	No	No
2	STACH #1	10/02/2024	10/09/2024	62	3	IRF #1	10/09/2024	11/01/2024	No	No
3	IRF #1	10/09/2024	11/01/2024	01	4	LTACH #1	11/05/2024	12/31/2024	No	No
4	LTACH #1	11/05/2024	12/31/2024	01	5	STACH #2	01/15/2025	01/18/2025	No	Yes, to STACH #2
5	STACH #2	01/15/2025	01/18/2025	06	NA	No further admissions	No further admissions	No further discharge dates	NA	NA

Detailed Discussion:

- **Row 1**: The beneficiary was discharged from LTACH #1 on 10/02/2024 and transferred to STACH #1 on the same day (patient discharge status code 02). This admission to STACH #1 does not count as a readmission against the 07/01/2024 index admission for LTACH #1 because the beneficiary was transferred directly from LTACH #1 to STACH #1.
- **Row 2**: The beneficiary was admitted to STACH #1 on 10/02/2024 and transferred to IRF #1 on 10/09/2024 (patient discharge status code 62). This STACH admission is not considered an index admission for this measure; only admissions to an LTACH may serve as index admissions.
- **Row 3**: The beneficiary was admitted to IRF #1 on 10/09/2024 and discharged home (patient discharge status code 01) on 11/01/2024. The beneficiary was then admitted to LTACH #1 on 11/05/2024. The IRF #1 admission is not considered an index admission; only admissions to an LTACH may serve as index admissions for this measure.

- **Row 4**: The beneficiary was admitted to LTACH #1 on 11/05/2024 and discharged home (patient discharge status code 01) on 12/31/2024. The beneficiary was then admitted to STACH #2 on 01/15/2025. This admission counts as a STACH admission within 30 days following LTACH discharge for the 11/05/2024 index admission at LTACH #1.
- **Row 5**: The beneficiary was admitted to STACH #2 on 01/15/2025 and discharged home with home health services (patient discharge status code 06) on 01/18/2025.

Appendix C: Terms and Abbreviations

Table 8 provides a list of terms, abbreviations, and definitions in this document.

Table 8: 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.
Complication or Comorbidity	CC	A CC is a condition that, while not the primary reason for hospitalization, can increase length of stay, resource utilization, or treatment complexity.
Critical Access Hospital	CAH	CAH is a designation CMS gives to a small, rural hospital that provides limited inpatient care, 24-hour emergency services, and is located far from other hospitals, allowing it to receive cost-based Medicare reimbursements to help maintain services in underserved areas.
Diagnosis-Related Group	DRG	DRG is a system developed for Medicare in 1980, becoming effective in 1983, as a part of the PPS to classify hospital cases expected to have similar hospital resource use.
Fiscal Year	FY	For CMS, the FY is the 12-month period used for calculating annual fiscal spending, running from October 1 of the previous year to September 30 of the calendar year for which the FY is numbered.
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 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 (ICD), 10th Revision, Clinical Modification (CM)	ICD-10-CM	ICD-10-CM is a U.S.-specific coding system used in hospital inpatient settings to classify medical procedures.
International Classification of Diseases (ICD), 10th Revision, Procedure Coding System (PCS)	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	LTACH is a specialized facility that provides extended hospital-level care for medically complex patients.
Major Complication or Comorbidity	MCC	MCC refers to a secondary diagnosis that significantly complicates a patient's primary condition and increases the resources needed for their care, impacting treatment, prognosis, and resource utilization.
Medicare	NA	Medicare is the federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.
Medicare Administrative Contractor	MAC	The MAC is the contracting authority replacing the fiscal intermediary and carrier in performing Medicare Fee-for-Service claims processing activities.
Medicare Part A	NA	Medicare Part A is the part of Medicare that covers hospice care, home healthcare, skilled nursing facilities, and inpatient hospital stays.

Term	Abbreviation	Definition
Medicare Part B	NA	Medicare Part B is the part of Medicare that covers doctor services, outpatient hospital care, and other medical services that Part A does not cover such as physical and occupational therapy, X-rays, medical equipment, or limited ambulance service.
Medicare Severity Diagnosis Related Group	MS-DRG	MS-DRG refers to the system CMS uses for inpatient hospital reimbursement. This system classifies patients into groups based on their principal diagnosis, secondary diagnoses, procedures, sex, and discharge status, to better reflect the severity of their illness and resource utilization.
Medicare Spending Per Beneficiary	MSPB	CMS uses the MSPB measure to evaluate hospital efficiency by comparing Medicare payments or an episode of care (three days before, during, and 30 days after a hospital stay) to the national median hospital's spending.
Not Applicable	NA	Not applicable
Office of Inspector General	OIG	The OIG is an HHS agency that protects the integrity of HHS programs as well as the health and welfare of the beneficiaries of those programs.
Operating Room	O.R.	An OR is a designated area within a hospital or healthcare facility specifically equipped to perform surgical procedures.
Outlier Status	NA	Outlier status refers to percentiles at or above the 80th percentile for any target areas or at or below the 20th percentile for coding-focused target areas.
Partial Hospitalization Program	PHP	PHP refers to an intensive outpatient psychiatric treatment program.
Personal Computer	PC	A PC is a general-purpose computer designed for individual use, distinguishing it from larger, multi-user systems like mainframes or supercomputers.
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 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.

Term	Abbreviation	Definition
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	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.
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 D: Historical Target Area Definitions for FY 2023 and FY 2024

Table 9 provides the target area definitions for FY 2023 and FY 2024.

Table 9: Historical Target Area Definitions for FY 2023 and 2024

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
Septicemia	**Numerator**: Count of discharges for the following DRGs: • **870** (septicemia or severe sepsis with mechanical ventilation >96 hours), • **871** (septicemia or severe sepsis without mechanical ventilation >96 hours with MCC), and • **872** (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC). **Denominator**: Count of discharges for the following DRGs: • **193** (simple pneumonia and pleurisy with MCC), • **194** (simple pneumonia and pleurisy with CC), • **195** (simple pneumonia and pleurisy without CC/MCC), • **207** (respiratory system diagnosis with ventilator support >96 hours), • **208** (respiratory system diagnosis with ventilator support ≤ 96 hours), • **689** (kidney and urinary tract infections with MCC), • **690** (kidney and urinary tract infections without MCC), and • **870**, **871**, **872.**	**Numerator**: Count of discharges for the following DRGs: • **870** (septicemia or severe sepsis with mechanical ventilation >96 hours), • **871** (septicemia or severe sepsis without mechanical ventilation >96 hours with MCC), and • **872** (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC). **Denominator**: Count of discharges for the following DRGs: • **193** (simple pneumonia and pleurisy with MCC), • **194** (simple pneumonia and pleurisy with CC), • **195** (simple pneumonia and pleurisy without CC/MCC), • **207** (respiratory system diagnosis with ventilator support >96 hours), • **208** (respiratory system diagnosis with ventilator support ≤ 96 hours), • **689** (kidney and urinary tract infections with MCC), • **690** (kidney and urinary tract infections without MCC), and • **870**, **871**, **872.**

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
Excisional Debridement	**Numerator**: Count of discharges for the following DRGs affected by International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) procedure codes for excisional debridement that have an excisional debridement procedure code on the claim. **Denominator**: Count of discharges for the DRGs for excisional debridement. **Note**: Refer to *Appendix A* for the complete set of codes relevant for this target area.	**Numerator**: Count of discharges for the following DRGs affected by International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) procedure codes for excisional debridement that have an excisional debridement procedure code on the claim. **Denominator**: Count of discharges for the DRGs for excisional debridement. **Note**: Refer to *Appendix A* for the complete set of codes relevant for this target area.
Short Stays	**Numerator**: Count of discharges that were discharged on or the day after the short stay outlier threshold was met. **Denominator**: Count of all discharges	**Numerator**: Count of discharges that were discharged on or the day after the short stay outlier threshold was met. **Denominator**: Count of all discharges
Short Stays for Respiratory System Diagnoses	**Numerator**: Count of discharges for the following DRGs: • **177** (respiratory infections and inflammations with MCC), • **189** (pulmonary edema and respiratory failure), • **193** (simple pneumonia and pleurisy with MCC), • **207** (respiratory system diagnosis with ventilator support >96 hours), and • **208** (respiratory system diagnosis with ventilator support <96 hours) that occurred on the day of or day after the short stay outlier threshold was met **Denominator**: Count of all discharges for the following DRGs: **177, 189, 193, 207, 208**	**Numerator**: Count of discharges for the following DRGs: • **177** (respiratory infections and inflammations with MCC), • **189** (pulmonary edema and respiratory failure), • **193** (simple pneumonia and pleurisy with MCC), • **207** (respiratory system diagnosis with ventilator support >96 hours), and • **208** (respiratory system diagnosis with ventilator support <96 hours) that occurred on the day of or day after the short stay outlier threshold was met **Denominator**: Count of all discharges for the following DRGs: **177, 189, 193, 207, 208**
Outlier Payments	**Numerator**: Count of discharges with a DRG outlier approved amount of greater than $0. **Denominator**: Count of all discharges	**Numerator**: Count of discharges with a DRG outlier approved amount of greater than $0. **Denominator**: Count of all discharges

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
30-Day Readmissions to the Same Hospital or Elsewhere	**Numerator**: Count of index (first) admissions during the 12-month time period for which a readmission occurred within 30 days to the same hospital or to another long term acute care prospective payment system (PPS) hospital for the same beneficiary (identified using the Health Insurance Claim number). **Numerator Exclusions**: Exclude claims for the index admission or readmission where the patient discharge status is one of the following: • **63** (discharged/transferred to an LTACH), • **91** (discharged/transferred to an LTACH with a planned acute care hospital inpatient readmission), • **07** (left against medical advice), • **20** (expired). **Denominator**: Count of all discharges **Denominator Exclusions**: Exclude claims where the patient discharge status is one of the following: **63**, **91**, **07**, **20**.	**Numerator**: Count of index (first) admissions during the 12-month time period for which a readmission occurred within 30 days to the same hospital or to another long-term acute care prospective payment system (PPS) hospital for the same beneficiary (identified using the Health Insurance Claim number). **Numerator Exclusions**: Exclude claims for the index admission or readmission where the patient discharge status is one of the following: • **63** (discharged/transferred to an LTACH), • **91** (discharged/transferred to an LTACH with a planned acute care hospital inpatient readmission), • **07** (left against medical advice), • **20** (expired). **Denominator**: Count of all discharges **Denominator Exclusions**: Exclude claims where the patient discharge status is one of the following: **63**, **91**, **07**, **20**.

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
STACH Admissions Following LTACH Discharge	**Numerator**: Count of discharges where the beneficiary (identified using the Health Insurance Claim number) was discharged from the LTACH during the 12-month time period and admitted to a STACH within 30 days of discharge from the LTACH. **Numerator Exclusions**: Excluding transfers to a STACH or an LTACH within one day of discharge as evidenced by a subsequent claim; excluding patient discharge status codes: • **07** (left against medical advice), • **20** (expired) **Denominator**: Count of all discharges **Denominator Exclusions**: Exclude transfers to a STACH or an LTACH within one day of discharge as evidenced by a subsequent claim and claims where the patient discharge status is one of the following: **07,** and **20.**	**Numerator**: Count of discharges where the beneficiary (identified using the Health Insurance Claim number) was discharged from the LTACH during the 12-month time period and admitted to a STACH within 30 days of discharge from the LTACH. **Numerator Exclusions**: Excluding transfers to a STACH or an LTACH within one day of discharge as evidenced by a subsequent claim; excluding patient discharge status codes: • **07** (left against medical advice), • **20** (expired) **Denominator**: Count of all discharges **Denominator Exclusions**: Exclude transfers to a STACH or an LTACH within one day of discharge as evidenced by a subsequent claim and claims where the patient discharge status is one of the following: **07,** and **20.**