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

User's Guide

Fifteenth Edition

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Fifteenth Edition, effective with the Q4FY20 release and current with the Q4FY21 release

Introduction

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 its compliance program, a hospital should conduct regular audits to ensure charges for Medicare services are correctly documented and billed. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) can help guide hospitals' auditing and monitoring activities.

PEPPER is a data report that contains a single hospital's claims data statistics for Medicare-Severity Diagnosis-Related Groups (MS-DRGs) and discharges at high risk for improper payments due to billing, coding, and/or admission necessity issues. Each PEPPER summarizes statistics for the most recent three federal fiscal years for each area at risk for payment errors (referred to in the report as "target areas"). Data in PEPPER is presented in tabular form and in graphs that depict the hospital's target area percentages over time. PEPPER also includes reports on the hospital's top diagnosis-related groups (DRGs). PEPPER is developed and distributed by the RELI Group, along with its partners TMF® Health Quality Institute and CGS, under contract with the Centers for Medicare & Medicaid Services (CMS).

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

PEPPER is available for short- and long-term acute care inpatient prospective payment system (IPPS) hospitals, critical access hospitals (CAHs), inpatient psychiatric facilities, inpatient rehabilitation facilities (IRFs), hospices, partial hospitalization programs, skilled nursing facilities, and home health agencies. *Long-Term Acute Care (LT) PEPPER* is the version of PEPPER developed specifically for long-term acute care hospitals (LT or LTCH). In *LT PEPPER*, a hospital is compared to other LTCHs in three comparison groups: the nation, Medicare Administrative Contractor (MAC) jurisdiction, and state. These comparisons enable a hospital to determine whether it is an outlier, differing from other LTCHs.

PEPPER does not identify the presence of improper payments, 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 areas of potential concern:

- Significant changes in billing practices
- Possible over- or under-coding
- Increasing lengths of stay (LOSs)

PEPPER determines outliers based on preset control limits. The upper control limit for all target areas is the national 80th percentile. Coding-focused target areas also have a lower control limit, which is the national 20th percentile. PEPPER draws attention to any findings that are at or above the upper control limit (high outliers) or at or below the lower control limit (low outliers for coding-focused areas only).

[1] 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. Available at: http://oig.hhs.gov/authorities/docs/cpghosp.pdf

[2] 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. Available at: http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf

Note that, in PEPPER, the term "outlier" is used when a hospital's target area percent is in the top 20% of all hospital target area percents in the respective comparison group (i.e., is at/above the 80th percentile) or is in the bottom 20% of all hospital target area percents in the respective comparison group (i.e., is at/below the 20th percentile for coding-focused target areas). Formal tests of significance are not used to determine outlier status in PEPPER.

Specifications for claims included in *LT PEPPER* are shown in the table below.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Long-term acute care 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 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 claims	Exclude claims submitted to a Medicare Health Maintenance Organization
Exclude cancelled claims	Exclude claims cancelled by the MAC

The *LT PEPPER* is available to the LTCH's Chief Executive Officer, Administrator, President, Quality Assurance and Performance Improvement Officer, or Compliance Officer through a secure portal on the PEPPER.CBRPEPPER.org website. Each LTCH receives only its PEPPER. The PEPPER Team does not provide PEPPERs to other contractors, although the PEPPER Team does provide a Microsoft Access database (the First-Look Analysis Tool for Hospital Outlier Monitoring [FATHOM]) to MACs and Recovery Auditors. FATHOM can be used to produce a PEPPER.

LT PEPPER CMS Target Areas

In general, the target areas are constructed as ratios and expressed as percents: the numerator represents discharges that have been identified as problematic, and the denominator represents discharges of a larger comparison group. For example, admission necessity-focused target areas generally include in the numerator the DRG(s) that have been identified as prone to unnecessary admissions, and the denominator generally includes all discharges for the DRG(s) (i.e., all discharges). Target areas related to DRG coding generally include in the numerator the DRG(s) that have been identified as prone to DRG coding errors, and the denominator includes these DRGs in addition to the DRGs to which the original DRG is frequently changed.

The *LT PEPPER* target areas are defined in the table below.

TARGET AREA	TARGET AREA DEFINITION
Septicemia	*Numerator (N):* count of discharges for DRGs 870 (septicemia or severe sepsis with mechanical ventilation >96 hours), 871 (septicemia or severe sepsis without mechanical ventilation >96 hours with major complication or comorbidity [MCC]), 872 (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC) *Denominator (D):* count of discharges for DRGs 193 (simple pneumonia and pleurisy with MCC), 194 (simple pneumonia and pleurisy with complication or comorbidity [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	*N:* count of discharges for DRGs affected by International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) procedure codes for excisional debridement (See Appendix 1) that have an excisional debridement procedure code on the claim (See Appendix 2) *D:* count of discharges for the DRGs (See Appendix 1) Note: Based on changes related to ICD-10, Appendices 1 and 2 have been updated
Short Stays	*N:* count of discharges that were discharged on or the day after the short stay outlier threshold was met *D:* count of all discharges
Short Stays for Respiratory System Diagnoses	*N:* count of discharges for DRGs 177 (respiratory infections and inflammations with MCC), 189 (pulmonary edema and respiratory failure) or 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) that occurred on the day of or day after the short stay outlier threshold was met *D:* count of all discharges for DRGs 177, 189, 193, 207, 208
Outlier Payments	*N:* count of discharges with a DRG outlier approved amount of greater than $0 *D:* count of all discharges
30-Day Readmissions to Same Hospital or Elsewhere	*N:* count of index (first) admissions during the 12-month time period for which a readmission occurred within 30 days of discharge 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), patient discharge status of the index admission is not equal to 63 (discharged/transferred to an LTCH), 91 (discharged/transferred to an LTCH with a planned acute care hospital inpatient readmission), 07 (left against medical advice) *D:* count of all discharges excluding patient discharge status codes 63, 91, 07, 20 (expired) (See Appendix 3 for how readmissions are identified)

TARGET AREA	TARGET AREA DEFINITION
STACH Admissions Following LTCH Discharge	*N*: count of discharges where the beneficiary (identified using the Health Insurance Claim number) was discharged from the LTCH during the 12-month time period and admitted to a short-term acute care hospital (STACH) within 30 days of discharge from the LTCH; excluding transfers to a STACH or an LTCH within one day of discharge as evidenced by a subsequent claim; excluding patient discharge status codes 07 (left against medical advice), 20 (expired) *D*: count of all discharges excluding transfers to a STACH or an LTCH within one day of discharge as evidenced by a subsequent claim; and excluding patient discharge status codes 07, 20 (See Appendix 4 for how STACH admissions following an LTCH discharge are identified)

These *LT PEPPER* target areas were approved by CMS because they have been identified as prone to improper Medicare payments. Historically, some of these target areas were the focus of OIG audits, while others were identified through the former Payment Error Prevention Program and former Hospital Payment Monitoring Program, which were implemented by state Medicare Quality Improvement Organizations in 1999 through 2008. Please note there are changes in DRGs and DRG definitions from one fiscal year (FY) to the next that should be considered:

- Changes for FY 2019 are documented in the *Federal Register*, Volume 83, number 160, Aug. 16, 2018, pages 41144-41784.
- Changes for FY 2018 are documented in the *Federal Register*, Volume 82, number 155, Aug. 14, 2017, pages 37990-38589.
- Changes for FY 2017 are documented in the *Federal Register*, Volume 81, number 162, Aug. 22, 2016, pages 56761-57438.

How Hospitals Can Use PEPPER Data

The *LT PEPPER* allows LTCHs to compare their billing statistics with national, jurisdiction, and state percentile values for each target area with reportable data for the most recent three fiscal years included in PEPPER.

"Reportable data" in PEPPER means there are 11 or more numerator discharges for a given target area for a given time period. When there are fewer than 11 numerator discharges for a target area for a time period, statistics are not displayed in PEPPER due to CMS data restrictions.

To calculate percentiles, the target area percents for all LTCHs with reportable data for each target area and each time period are ordered from highest to lowest. The target area percent below which 80% of all LTCHs' target area percents fall is identified as the 80th percentile. LTCHs whose target percents are at or above the 80th percentile (i.e., in the top 20%) are considered at risk for improper Medicare payments. Similarly, for areas at risk for under-coding, LTCHs whose target percents are at or below the 20th percentile (i.e., in the bottom 20%) are considered at risk for improper Medicare payments. Percentiles are calculated for each of the three comparison groups (i.e., nation, jurisdiction and state).

The PEPPER Team has developed suggested interventions that LTCHs may consider when assessing their risk for improper Medicare payments. Please note that these are generalized suggestions and will not apply to all situations. For all areas, assess whether there is sufficient volume (i.e., 10 to 30 cases for the

fiscal year, depending on the hospital's total discharges for the fiscal year) to warrant a review of cases. The following table can assist LTCHs with interpreting their percentile values, which are indications of possible risk of improper Medicare payments.

TARGET AREA	SUGGESTED INTERVENTIONS IF AT/ABOVE 80TH PERCENTILE	SUGGESTED INTERVENTIONS IF AT/BELOW 20TH PERCENTILE
Septicemia	This could indicate that there are coding or billing errors related to over-coding of DRGs 870, 871, or 872. A sample of medical records for these DRGs should be reviewed to determine whether coding errors exist. Hospitals may generate data profiles to identify cases with a principal diagnosis code of International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code A41.9 (unspecified septicemia) to ensure documentation supports the principal diagnosis.	This could indicate that there are coding or billing errors related to under-coding of DRGs 870, 871 or 872. A sample of medical records for other DRGs, such as DRGs 689, 690, 193, 194, 195, 207, and 208 should be reviewed to determine whether coding errors exist. Remember that a diagnosis of septicemia/sepsis must be determined by the physician. A coder should not code based on a laboratory 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 the coding of excisional debridement. A sample of medical records including excisional debridement procedure codes should be reviewed to ensure that the coding is supported by the documentation. Refer to *Coding Clinic* for specific guidelines regarding the coding of excisional debridement.	If your facility does not perform excisional debridement, low numbers in this target area would be 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 ***Short Stays for Respiratory System Diagnoses***	This could indicate that there are unnecessary admissions related to inappropriate use of admission screening criteria. A sample of medical records for the appropriate DRG(s) should be reviewed to determine whether inpatient admission was necessary or whether care could have been provided more efficiently in another setting.	Not applicable, as this is an admission-necessity focused target area.
Outlier Payments	This indicates that the hospital is submitting a high percentage of claims with outlier payments. Claims with outlier payments should be reviewed to ensure treatment provided was medically necessary.	Not applicable, as this is an admission-necessity focused target area.

TARGET AREA	SUGGESTED INTERVENTIONS IF AT/ABOVE 80TH PERCENTILE	SUGGESTED INTERVENTIONS IF AT/BELOW 20TH PERCENTILE
30-Day Readmissions to Same Hospital or Elsewhere	A sample of readmission cases should be reviewed to identify appropriateness of admission, discharge, quality of care and DRG assignment, and billing errors. The hospital is encouraged to generate data profiles for readmissions, such as patients readmitted the same day or next day after discharge. Suggested data elements to include in these profiles are: patient identifier, date of admission, date of discharge, patient discharge status code, principal and secondary diagnoses, procedure code(s), and DRG. Evaluate these profiles for the following indications of potential improper payments: • Patients discharged home (patient discharge status code 01) and readmitted the same or next day may indicate a potential premature discharge or incomplete care. • Patients readmitted for the same principal diagnosis as the first admission may indicate a potential premature discharge or incomplete care. LTCHs that are co-located within a STACH should verify that the correct provider number was billed (LTCH number vs. acute care number) for same-day readmissions. The second admission to a STACH should be billed to the STACH's number.	Not applicable, as this is an admission-necessity focused target area.
STACH Admissions Following LTCH Discharge	This could indicate that patients are not medically stable or prepared for discharge. The hospital 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. LTCHs co-located within STACHs may wish to identify admissions to their STACH within 30 days of discharge and review medical records for those patients.	Not applicable, as this is an admission-necessity focused target area.

Comparative data for consecutive years can be used to help identify whether the hospital's proportions changed significantly in either direction from one year to the next. This could be an indication of a procedural change in admitting, coding or billing practices, staff turnover, or a change in medical staff.

Using PEPPER

Compare Targets Report

Hospitals can use the Compare Targets Report to help them prioritize areas for auditing and monitoring. The Compare Targets Report includes all target areas with reportable data for the most recent fiscal year included in PEPPER. For each target area, the Compare Targets Report displays the hospital's number of target discharges, percent, percentiles as compared to the nation, jurisdiction, and state, and the "Sum of Payments."

Navigate through PEPPER by clicking on the worksheet tabs at the bottom of the screen. Each tab is labeled to identify the contents of each worksheet (e.g., Target Area Reports, Compare Targets Report).

The hospital's outlier status is indicated by the color of the target area percent on the Compare Targets Report. When the hospital is a high outlier for a target area, the hospital percent is printed in **red bold**. When the hospital is a low outlier (for coding-focused target areas only), the hospital percent is printed in *green italics*. When the hospital is not an outlier, the hospital's percent is printed in black. *LT PEPPER* identifies outliers as compared to all hospitals in the nation.

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. The percentile value allows a hospital to judge how its target area percent compares to all hospitals in each respective comparison group.

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

The hospital's jurisdiction percentile indicates the percentage of all other hospitals in the jurisdiction that have a target area percent less than the hospital's target area percent. The jurisdiction percentile will be blank if there are fewer than 11 hospitals with reportable data for the target area in the MAC jurisdiction.

The hospital's state percentile indicates the percentage of all other hospitals in the state that have a target area percent less than the hospital's target area percent. The state percentile will be blank if there are fewer than 11 hospitals with reportable data for the target area in the state.

For more information about how percents differ from percentiles, see the LT "Training and Resources" section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

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

hospital is an outlier. Outlier status should be evaluated in the following priority order: 1) nation, 2) jurisdiction, and 3) state. If a hospital is an outlier for the nation (i.e., as compared to all LTCHs in the nation), this should be interpreted as the highest priority. If a hospital is an outlier for its jurisdiction (i.e., as compared to all LTCHs in its jurisdiction) and not for the nation, this is somewhat of a lower priority. Lastly, if a hospital is an outlier for its state (i.e., as compared to all LTCHs in its state) and not for the nation or its jurisdiction, this would be the lowest priority, as the state has the smallest comparison group.

The "Sum of Payments" can also be used to help prioritize areas for review. For example, the Compare Report may show that the *Short Stays* target area has the highest "Sum of Payments," but the hospital's percent is at the 80th percentile as compared to the jurisdiction and at the 65th percentile as compared to the nation. The *Septicemia* target area may rank third in "Sum of Payments," but it could still be at the 80th percentile for the jurisdiction and the 90th percentile for the nation. In this scenario, the *Septicemia* target area might be given priority.

Target Area Reports

PEPPER Target Area Reports display a variety of statistics for each target area summarized over three fiscal years. Each report includes a target area graph, a target area data table, comparative data, interpretive guidance, and suggested interventions.

Target Area Graph

Each report includes a target area graph, which provides a visual representation of the hospital's target area percent over three fiscal years. The hospital's data is represented on the graph in bar format; each bar represents a fiscal year. Hospitals can identify significant changes from one year to the next, which could be a result of changes in the medical staff, coding staff, utilization review processes, or hospital services. Hospitals are encouraged to identify root causes of major changes to ensure that improper payments are prevented.

The graph includes trend lines for the percents that are at the 80th percentile (and the 20th percentile for coding-focused target areas) for the three comparison groups (i.e., nation, jurisdiction, and state) so the hospital can easily identify when they are an outlier as compared to any of the comparison groups. A table of these percents called "Comparative Data" is included under the hospital's data table. For more information about how percents differ from percentiles, see the LT "Training and Resources" section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

For each time period, a hospital's data will not be displayed in the graph if the numerator for the target area is less than 11. This is due to data use restrictions established by CMS. If there are fewer than 11 hospitals with reportable data for a target area in a state, there will not be a trend line for the state comparison group in the graph. If there are fewer than 11 hospitals with reportable data for a target area in the jurisdiction, there will not be a trend line for the jurisdiction comparison group on the graph.

Target Area Hospital Data Table

PEPPER Target Area Reports also include a data table. Statistics in each data table include the total numerator count of discharges for the target area (target area discharge count), the denominator count of discharges, the proportion of the numerator and denominator (percent), the average length of stay (ALOS), and Medicare payment data. The hospital's percent will be shown in **red bold print** if it is at or above the national 80th percentile (high outlier); for coding-focused target areas, it will be shown in *green italics* if it is at or below the national 20th percentile (low outlier) (see "Percentile" in the Glossary, page 13). For each time period, a hospital's data will not be displayed if the numerator for the target area is less than 11.

Comparative Data Table

The comparative data table provides the target area percents that are at the 80th and 20th percentiles (for coding-focused areas only) for the three comparison groups: the nation, jurisdiction, and state. These are the percent values that are graphed as trend lines on the target area graph. State percentiles are zero when there are fewer than 11 hospitals with reportable data for the target area in the state. Jurisdiction percentiles are zero when there are fewer than 11 hospitals with reportable data for the target area in the jurisdiction.

Interpretive Guidance and Suggested Interventions

Interpretive guidance is included on the Target Area Report (below the graph) to assist hospitals in considering whether they should audit a sample of records. Suggested interventions tailored to each target area are also included at the bottom of each Target Area Report.

Top DRGs Report

The Top DRGs Report lists the top DRGs for all discharges for your hospital for the most recent fiscal year. It also includes the number of short-stay outliers, total hospital discharges, the proportion of short-stay outliers to total discharges, and the average hospital LOS for each DRG. Please note that this report is limited to the top DRGs (up to 20) for which there are a total of at least 11 discharges (for the respective DRG) during the most recent fiscal year.

Nationwide Top DRGs Report

The Nationwide Top DRGs Report lists the top DRGs for all discharges in the nation for the most recent fiscal year. It also includes 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 this report is limited to displaying the top DRGs (up to 20) for which there are a total of at least 11 discharges during the most recent fiscal year.

System Requirements, Customer Support and, Technical Assistance

PEPPER is a Microsoft Excel workbook that can be opened and saved to a PC. It is not intended for use on a network, but it may be saved to as many PCs as necessary.

For help using PEPPER, please submit a request for assistance at PEPPER.CBRPEPPER.org by clicking on the "Help/Contact Us" tab. This website also contains many educational resources to assist LTCHs with PEPPER in the LT "Training and Resources" section.

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

Glossary

TERM	DESCRIPTION
Average Length of Stay	The average length of stay (ALOS) is calculated as an arithmetic mean. It is computed by dividing the total number of hospital (or inpatient) days by the total number of discharges within the time period. For the *STACH Admissions Following LTCH Discharge* target area, the ALOS is calculated using the first (LTCH) admission's LOS, not the second (STACH) admission's LOS.
Data Table	The statistical findings for a hospital are presented in tabular form, labeled by time period and indicator.
Fiscal Year	For Medicare data, the fiscal year starts on Oct. 1 and ends on Sept. 30.
Graph	In *LT PEPPER*, a graph shows a hospital's percentages for the previous three years. The hospital's percentages are compared to the 80th percentile for the state, jurisdiction, and nation for all target areas, in addition to the 20th percentile for the state, jurisdiction, and nation for coding-focused target areas. See *Percentile*.
Length of Stay	The length of stay (LOS) for an individual discharge is determined by subtracting the date of admission (i.e., admission date) from the date of discharge (i.e., discharge date). If the dates of admission and discharge fall on the same day, the LOS equals one day.
Outlier	In *LT PEPPER*, hospitals are identified as an outlier if their target area percent is at or above the national 80th percentile (high outlier) or at or below the national 20th percentile (low outlier) for coding-focused target areas.
Percentile	In PEPPER, the percentile represents the percent of hospitals in the comparison group below which a given hospital's percent value ranks. It is a number that corresponds to one of 100 equal divisions of a range of values in a group. The percentile represents the hospital's position in the group compared to all other hospitals in the comparison group for that target area and time period. For example, suppose a hospital has a target area percent of 2.3 and 80% of the hospitals in the comparison group have a percent for that target area that is less than 2.3, then we can say the hospital is at the 80th percentile. Percentiles in PEPPER are calculated from the hospitals' percents so that each hospital percent can be compared to the statewide, jurisdiction-wide, or nationwide distribution of hospital percents. For more information about how percents differ from percentiles, please see the LT "Training and Resources" section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

Acronyms and Abbreviations

ACRONYM/ ABBREVIATION	ACRONYM/ABBREVIATION DEFINITION
ALOS	The average length of stay (ALOS) is calculated as an arithmetic average or mean. It is computed by dividing the total number of hospital (or inpatient) days by the total number of discharges within a given time period.
CAH	Critical access hospital (CAH)
CC	Complication or comorbidity (CC). Patients who are more seriously ill tend to require more hospital resources than patients who are less seriously ill, even though they are admitted to the hospital for the same reason. Recognizing this, the DRG manual splits certain DRGs based on the presence of secondary diagnoses for specific complications or comorbidities.
CMS	The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for oversight of Medicare and Medicaid. CMS is a division of the U.S. Department of Health and Human Services.
DRG	The diagnosis-related group (DRG) is a system that was developed for Medicare in 1980 (it became effective in 1983) as part of the PPS to classify hospital cases expected to have similar hospital resource use.
FATHOM	First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) is a Microsoft Access application. It was designed to help MACs compare providers in areas at risk for improper payment using Medicare administrative claims data. FATHOM produces PEPPER.
FI	Fiscal intermediary (FI)
FY	Fiscal year (FY). The Medicare federal fiscal year begins on Oct. 1 and ends on Sept. 30. For example, Q2FY10 (or Q2FY2010) refers to the second quarter of federal fiscal year 2010, which began on Jan. 1, 2010, and ended on March 31, 2010.
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)
IPPS	The inpatient prospective payment system (IPPS) sets forth a system of reimbursement for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.
IRF	Inpatient rehabilitation facility (IRF)
LOS	Length of stay (LOS)
LT	Long-term (LT) refers to the *LT PEPPER*, and it may be used to refer to LTCHs
LTCH	Long-term acute care hospital (LTCH)
MAC	The Medicare Administrative Contractor (MAC) is the contracting authority that replaced the FI and carrier in performing Medicare Fee-for-Service claims processing activities.

ACRONYM/ ABBREVIATION	ACRONYM/ABBREVIATION DEFINITION
MCC	Major complication or comorbidity (MCC). Before the introduction of MS-DRG system version 25, many CMS-DRG classifications were "paired" to reflect the presence of CCs. A significant refinement of version 25 was to replace this pairing, in many instances, with a design that created a tiered system of the absence of CCs, the presence of CCs, and a higher level of presence of MCCs. As a result of this change, the historical list of diagnoses that qualified for membership on the CC list was substantially redefined and replaced with a new standard CC list and a new MCC list.
MS-DRG	Medicare-Severity Diagnosis-Related Group (MS-DRG)
OIG	Office of Inspector General (OIG)
PEPPER	Program for Evaluating Payment Patterns Electronic Report (PEPPER) is an electronic data report in Microsoft Excel format that summarizes a single hospital's claims data statistics for DRGs and discharges that are at high risk for improper payments due to billing, coding, and/or admission necessity issues.
PPS	Prospective payment system (PPS)
STACH	Short-term acute care hospital (STACH)
UB-04	The UB-04 is a standard uniform bill used by health care providers to submit claims for services. Claims for Medicare reimbursement are submitted to the provider's MAC.

Appendix 1: DRGs Affected by Excisional Debridement Procedure Codes

DRG	Description
003	Ecmo or trach w mv >96 hrs or PDx exc face, mouth & neck w maj OR
040	Periph/cranial nerve & other nerv syst proc w MCC
041	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim
042	Periph/cranial nerve & other nerv syst proc w/o CC/MCC
115	Extraocular procedures except orbit
133	Other ear, nose, mouth & throat OR procedures w CC/MCC
134	Other ear, nose, mouth & throat OR procedures w/o CC/MCC
166	Other resp system OR procedures w MCC
167	Other resp system OR procedures w CC
168	Other resp system OR procedures w/o CC/MCC
264	Other circulatory system OR procedures
356	Other digestive system OR procedures w MCC
357	Other digestive system OR procedures w CC
358	Other digestive system OR procedures w/o CC/MCC
423	Other hepatobiliary or pancreas OR procedures w MCC
424	Other hepatobiliary or pancreas OR procedures w CC
425	Other hepatobiliary or pancreas OR procedures w/o CC/MCC
463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC
464	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC
570	Skin debridement w MCC
571	Skin debridement w CC
572	Skin debridement w/o CC/MCC
579	Other skin, subcut tiss & breast proc w MCC
580	Other skin, subcut tiss & breast proc w CC
581	Other skin, subcut tiss & breast proc w/o CC/MCC
622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC
623	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC
673	Other kidney & urinary tract procedures w MCC
674	Other kidney & urinary tract procedures w CC
675	Other kidney & urinary tract procedures w/o CC/MCC
715	Other male reproductive system OR proc for malignancy w CC/MCC
716	Other male reproductive system OR proc for malignancy w/o CC/MCC
717	Other male reproductive system OR proc exc malignancy w CC/MCC
718	Other male reproductive system OR proc exc malignancy w/o CC/MCC
749	Other female reproductive system OR procedures w CC/MCC
750	Other female reproductive system OR procedures w/o CC/MCC
802	Other OR proc of the blood & blood forming organs w MCC
803	Other OR proc of the blood & blood forming organs w CC
804	Other OR proc of the blood & blood forming organs w/o CC/MCC
823	Lymphoma & non-acute leukemia w other proc w MCC
824	Lymphoma & non-acute leukemia w other proc w CC
825	Lymphoma & non-acute leukemia w other proc w/o CC/MCC
853	Infectious & parasitic diseases w OR procedure w MCC
854	Infectious & parasitic diseases w OR procedure w CC
855	Infectious & parasitic diseases w OR procedure w/o CC/MCC
856	Postoperative or post-traumatic infections w OR proc w MCC

857	Postoperative or post-traumatic infections w OR proc w CC
858	Postoperative or post-traumatic infections w OR proc w/o CC/MCC
876	OR procedure w principal diagnoses of mental illness
901	Wound debridements for injuries w MCC
902	Wound debridements for injuries w CC
903	Wound debridements for injuries w/o CC/MCC
906	Hand procedures for injuries
927	Extensive burns or full thickness burns w mv >96 hrs w skin graft
928	Full thickness burn w skin graft or inhal inj w CC/MCC
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC
939	OR proc w diagnoses of other contact w health services w MCC
940	OR proc w diagnoses of other contact w health services w CC
941	OR proc w diagnoses of other contact w health services w/o CC/MCC
957	Other OR procedures for multiple significant trauma w MCC
958	Other OR procedures for multiple significant trauma w CC
959	Other OR procedures for multiple significant trauma w/o CC/MCC
969	HIV w extensive OR procedure w MCC
970	HIV w extensive OR procedure w/o MCC
981	Extensive OR procedure unrelated to principal diagnosis w MCC
982	Extensive OR procedure unrelated to principal diagnosis w CC
983	Extensive OR procedure unrelated to principal diagnosis w/o CC/MCC
987	Non-extensive OR proc unrelated to principal diagnosis w MCC
988	Non-extensive OR proc unrelated to principal diagnosis w CC
989	Non-extensive OR proc unrelated to principal diagnosis w/o CC/MCC

Appendix 2: Excisional Debridement Procedure Codes

ICD-10-PCS Codes, 2018, 2019, 2020

0JB13ZZ	Excision of Face Subcutaneous Tissue and Fascia, PERC approach
0JBJ0ZZ	Excision of Right Hand SQ/ fascia, open approach
0JBJ3ZZ	Excision of Right Hand SQ/ fascia, percutaneous approach
0JBK0ZZ	Excision of Left Hand SQ/ fascia, open approach
0JBK3ZZ	Excision of Left Hand SQ/ fascia, percutaneous approach
0HB9XZZ	Excision of perineum skin, external approach
0JB00ZZ	Excision of Scalp Subcutaneous Tissue and Fascia, Open Approach
0JB10ZZ	Excision of Face Subcutaneous Tissue and Fascia, Open Approach
0JB40ZZ	Excision of Right Neck Subcutaneous Tissue and Fascia, Open Approach
0JB50ZZ	Excision of Left Neck Subcutaneous Tissue and Fascia, Open Approach
0JB60ZZ	Excision of Chest Subcutaneous Tissue and Fascia, Open Approach
0JB70ZZ	Excision of Back Subcutaneous Tissue and Fascia, Open Approach
0JB80ZZ	Excision of Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JB90ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Open Approach
0JBB0ZZ	Excision of Perineum Subcutaneous Tissue and Fascia, Open Approach
0JBC0ZZ	Excision of Pelvic Region Subcutaneous Tissue and Fascia, Open Approach
0JBD0ZZ	Excision of Right Upper Arm Subcutaneous Tissue and Fascia, Open Approach
0JBF0ZZ	Excision of Left Upper Arm Subcutaneous Tissue and Fascia, Open Approach
0JBG0ZZ	Excision of Right Lower Arm Subcutaneous Tissue and Fascia, Open Approach
0JBH0ZZ	Excision of Left Lower Arm Subcutaneous Tissue and Fascia, Open Approach
0JBL0ZZ	Excision of Right Upper Leg Subcutaneous Tissue and Fascia, Open Approach
0JBM0ZZ	Excision of Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach
0JBN0ZZ	Excision of Right Lower Leg Subcutaneous Tissue and Fascia, Open Approach
0JBP0ZZ	Excision of Left Lower Leg Subcutaneous Tissue and Fascia, Open Approach
0JBQ0ZZ	Excision of Right Foot Subcutaneous Tissue and Fascia, Open Approach
0JBR0ZZ	Excision of Left Foot Subcutaneous Tissue and Fascia, Open Approach
0JB03ZZ	Excision of Scalp Subcutaneous Tissue and Fascia, PERC approach
0JB43ZZ	Excision of Right Neck Subcutaneous Tissue and Fascia, PERC approach
0JB53ZZ	Excision of Left Neck Subcutaneous Tissue and Fascia, PERC approach
0JB63ZZ	Excision of Chest Subcutaneous Tissue and Fascia, PERC approach
0JB73ZZ	Excision of Back Subcutaneous Tissue and Fascia, PERC approach
0JB83ZZ	Excision of Abdomen Subcutaneous Tissue and Fascia, PERC approach
0JB93ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, PERC approach
0JBB3ZZ	Excision of Perineum Subcutaneous Tissue and Fascia, PERC approach
0JBC3ZZ	Excision of Pelvic Region Subcutaneous Tissue and Fascia, PERC approach
0JBD3ZZ	Excision of Right Upper Arm Subcutaneous Tissue and Fascia, PERC approach
0JBF3ZZ	Excision of Left Upper Arm Subcutaneous Tissue and Fascia, PERC approach
0JBG3ZZ	Excision of Right Lower Arm Subcutaneous Tissue and Fascia, PERC approach
0JBH3ZZ	Excision of Left Lower Arm Subcutaneous Tissue and Fascia, PERC approach
0JBL3ZZ	Excision of Right Upper Leg Subcutaneous Tissue and Fascia, PERC approach
0JBM3ZZ	Excision of Left Upper Leg Subcutaneous Tissue and Fascia, PERC approach
0JBN3ZZ	Excision of Right Lower Leg Subcutaneous Tissue and Fascia, PERC approach
0JBP3ZZ	Excision of Left Lower Leg Subcutaneous Tissue and Fascia, PERC approach
0JBQ3ZZ	Excision of Right Foot Subcutaneous Tissue and Fascia, PERC approach
0JBR3ZZ	Excision of Left Foot Subcutaneous Tissue and Fascia, PERC approach

Appendix 3: How Readmissions Are Identified

Below is a table showing claims submitted for one beneficiary by LTCHs over a one-year period. The claims are sorted by date on the left side of the table. Each row includes two admissions: the "index admission" and the "next admission," which may be considered as a readmission. The "next admission" on one row becomes the "index admission" on the following row.

	Index Admission Provider	Index Admission Date	Discharge Date	Patient Discharge Status Code	Next Admission Provider	Next Admission Date	Discharge Date	Calendar Gap Days	Next Admission Counts as a Readmission Against Index Admission?
1	LTCH #1	11/5/10	12/1/10	01	LTCH #2	12/20/10	1/2/11	19	Yes, to LTCH #1
2	LTCH #2	12/20/10	1/2/11	63	LTCH #1	1/2/11	1/30/11	0	No
3	LTCH #1	1/2/11	1/30/11	01	(no further admissions)				n/a

Detailed discussion:

- Row 1: The beneficiary was admitted to LTCH #1 on 11/5/10 and was discharged home (patient discharge status code 01) on 12/1/10. The beneficiary was admitted 12/20/10 to LTCH #2. This admission counts as a readmission within 30 days for LTCH #1 against the 11/5/10 index admission.
- Row 2: The beneficiary was admitted 12/20/10 to LTCH #2. The beneficiary was discharged/transferred to LTCH #1 (patient discharge status code 63) on 1/2/11. The admission to LTCH #1 does not count as a *30-Day Readmission* against the LTCH #2 index admission of 12/20/10 because the patient was discharged/transferred from LTCH #2 to LTCH #1 (patient discharge status code 63).
- Row 3: The beneficiary was admitted to LTCH #1 on 1/2/11 and was discharged home (patient discharge status code 01) on 1/30/11.

For the *30-Day Readmissions* target area, if a beneficiary is discharged from an LTCH with a patient discharge status code of “63” (discharged or transferred to an LTCH), “91” (discharged/transferred to an LTCH with a planned acute care hospital inpatient readmission), or “07” (left against medical advice), then the next LTCH admission within 30 days will not be considered a readmission.

Note: Any admissions of beneficiaries to a STACH, CAH, or any other type of provider are not considered as a readmission for this measure. Only admissions to LTCHs can be considered as a readmission.

Appendix 4: How STACH Discharges Following LTCH Discharge Are Identified

This example is provided to assist providers in understanding how STACH admissions following an LTCH discharge are identified and counted in PEPPER. A STACH admission is considered a *STACH Admissions Following LTCH Discharge* only for the LTCH discharge immediately preceding the STACH admission (considering all claims for the beneficiary) if:

- The STACH admission occurs within 30 days of the LTCH discharge date, and
- The beneficiary discharged from the LTCH was not transferred to a STACH or an LTCH within one day of discharge, as evidenced by a subsequent claim, and
- The LTCH discharge does not have a patient discharge status code of "07" (left against medical advice) or "20" (expired).

Below is a table showing claims submitted for one beneficiary over a one-year period. The claims are sorted by date on the left side of the table. Each row includes two admissions: the "index admission" and the "next admission," which may be considered as a readmission. The "next admission" on one row becomes the "index admission" on the following row.

	Index Admission Provider	**Index Admission Date**	**Discharge Date**	**Patient Discharge Status Code**	**Next Admission Provider**	**Next Admission Date**	**Discharge Date**	**Calendar Gap Days**	**Next Admission Counts as a Readmission Against Index Admission?**
1	LTCH #1	7/1/12	10/2/12	02	STACH #1	10/2/12	10/9/12	0	No
2	STACH #1	10/2/12	10/9/12	62	IRF #1	10/9/12	11/1/12	0	Not applicable as the index admission is not to an LTCH
3	IRF #1	10/9/12	11/1/12	01	LT #1	11/5/12	12/31/12	4	Not applicable as the index admission is not to an LTCH
4	LTCH #1	11/5/12	12/31/12	01	STACH #2	1/15/13	1/18/13	15	Yes, to LTCH #1
5	STACH #2	1/15/13	1/18/13	06	(no further admissions)				n/a

Detailed discussion:

- Row 1: The beneficiary was discharged from LTCH #1 on 7/1/12 and was transferred (patient discharge status code 02) to STACH #1 on 10/2/12. The admission to STACH #1 does not count against the index admission of 7/1/12 for LTCH #1 because the patient was transferred to STACH #1 from LTCH #1.
- Row 2: The beneficiary was admitted to STACH #1 on 10/2/12 and was transferred (patient discharge status code 62) to IRF #1 on 10/9/12. The index admission to STACH #1 is not considered; only index admissions to an LTCH are considered for this measure.
- Row 3: The beneficiary was admitted to IRF #1 on 10/9/12 and was discharged home (patient discharge status code 01) on 11/1/12. The beneficiary was admitted to LTCH #1 on 11/5/12. The index admission to IRF #1 is not considered; only index admissions to an LTCH are considered for this measure.
- Row 4: The beneficiary was admitted to LTCH #1 on 11/5/12 and was discharged home (patient discharge status code 01) on 12/31/12. The beneficiary was admitted to STACH #2 on 1/15/13. This admission counts as a "STACH admission within 30 days following LTCH discharge) against LTCH #1 index admission of 11/5/12.
- Row 5: The beneficiary was admitted to STACH #2 on 1/15/13 and was discharged home with home health (patient discharge status code 06) on 1/18/13.