Partial Hospitalization Program (PHP) Program for Evaluating Payment Patterns Electronic Report (PEPPER)

User Guide

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What's new in this edition?

No changes to this edition.

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. 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 auditing and monitoring activities.

National partial hospitalization program (PHP) claims data was analyzed to identify areas within the PHP benefit that may be at risk for improper Medicare payments. These areas are referred to as "target areas." PEPPER is a data report that provides a single PHP claims-based data statistics, derived from UB-04 claims submitted to the Medicare Administrative Contractor (MAC) for each of these target areas. Each PHP receives a PEPPER, which includes statistics for all target areas, regardless of whether the PHP data indicate potential concern. The report shows how the PHP data compare to national, jurisdiction, and state statistics. Data in PEPPER are presented in tabular format and graphical displays that show the PHP target area percentages over time. All data tables, graphs, and reports in PEPPER are designed to support PHPs in identifying potential improper payments. Index Analytics (IA), together 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 data tables, graphs, and reports in PEPPER are designed to help PHPs identify potential overpayments as well as potential underpayments.

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

PEPPER is available for Partial Hospitalization Programs (PHPs), Short-Term Acute Care Hospitals (STACH), Long-Term Acute Care Hospitals (LTACHs), Critical Access Hospitals (CAHs), Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), Hospices, Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). Each PHP PEPPER summarizes claims data statistics, derived from paid PHP Medicare UB-04 claims, for the three most recent calendar years (CY). A CY spans January 1 through December 31. A PHP is compared to other PHPs in three comparison groups: the nation, the Medicare MAC jurisdiction, and the state in which the PHP operates. These comparisons help a PHP determine whether it is an outlier, meaning its billing patterns differ from those of other PHPs, and whether it may be at risk for improper Medicare payments.

PHPs provide intensive psychiatric care in an organized outpatient psychiatric setting. The treatment may be provided by a hospital outpatient department (through a short- or long-term acute care hospital, an IPF, an IRF, or a children's hospital) or a community mental health center (CMHC) for patients who may otherwise require inpatient care. In the PHP PEPPER and throughout this guide, PHPs administered through short- and long-term acute care hospitals, IPFs, IRFs, children's hospitals, and CMHCs are grouped together and referred to collectively as PHPs.

PEPPER identifies areas at risk for improper Medicare payments based on preset control limits. The upper control limit for all target areas is the national 80th percentile.

In order to be included in the PHP PEPPER, claims must meet the specifications shown below.

Table 1 provides the specifications for claims eligible for inclusion in PHP PEPPER. *Table 2* provides the eligibility criteria for claims submitted by CMHCs.

Table 1: Eligible Claims Specifications for PHP PEPPER

Inclusion/Exclusion Criteria	Data Specifications
Claim facility type equal to "1"	UB-04 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 1 (Hospital)
Include claim service classification type of "Outpatient"	UB-04 FL 04 Type of Bill, third digit (Bill Classification) = 3 (Outpatient)
Condition code equal to "41"	UB-04 FL 19 – 28, Condition Code = 41 (Partial hospitalization, - effective 03/1992, indicates the claim is for partial hospitalization services. For outpatient services, this includes a variety of psych programs.)
Final action claim	A final action claim is a non-rejected claim that has been paid and for which all disputes, adjustments, and claim details have been clarified.
Services provided during the time period used to create the episode of care	Claim "From Date" and claim "Through Date" fall within the three CYs included in the report. Additional claims for the previous CY will be included for episodes of care beginning prior to the reporting period. See below for more explanation of the episode of care. **Note**: For the *30-Day Readmissions target area*, the index episode must occur during the reporting period. A resumption of care is identified by an episode of care with a "From Date" within 30 days of the previous episode's "Through Date."
Medicare claim payment amount greater than zero	The PHP received a payment amount greater than zero for the claim (including Medicare Secondary Payer claims).
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Advantage (Health Maintenance Organization) plan.
Exclude cancelled claims	Exclude claims cancelled by the MAC.

Table 2: Claims Specifications for CMHC PHPs

Inclusion/Exclusion Criteria	Data Specifications
Claim facility type equal to "7"	CMS-1450 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 7 (Clinic or hospital-based renal dialysis facility.)
Claim service classification type of "Community Mental Health Center"	CMS-1450 FL 04 Type of Bill, third digit (Bill Classification) = 6 (CMHC)
Final action claim	A final action claim is a non-rejected claim that has been paid and for which all disputes, adjustments, and claim details have been clarified.

Inclusion/Exclusion Criteria	Data Specifications
Services provided during the time period used to create the episode of care	Claim “From Date” and claim “Through Date” fall within the three CYs included in the report. Additional claims for the previous CY will be included for episodes of care beginning prior to the reporting period. **Note**: For the *30-Day Readmissions target area*, the index episode must occur during the reporting period. A resumption of care is identified by an episode of care with a “From Date” within 30 days of the previous episode’s “Through Date.”
Medicare claim payment amount greater than zero	The PHP received a payment amount greater than zero for the claim (including Medicare Secondary Payer claims).
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Advantage (Health Maintenance Organization) plan.
Exclude cancelled claims	Exclude claims cancelled by the MAC.

PHPs receive PEPPER files annually through a secure portal on the CMS CBR PEPPER website.

A beneficiary may receive PHP services for periods ranging from one day to several months. PEPPER target areas report on services provided to beneficiaries whose episode of care ended during the specified reporting period (CY). An episode of care is created from the claims a provider submits for a beneficiary and represents a single treatment episode.

All claims submitted by a provider for a beneficiary are collected and sorted by service date, from the earliest “Claim From” date to the latest. An episode of care includes claims with no break in service greater than seven days between consecutive claims. A gap of more than seven days between one claim's “Through Date” and the next claim's “From Date” marks the beginning of a new episode of care. An episode is included in the reporting period if the last claim in the episode has a “Through Date” within that period. Claims are collected for one year before each reporting period to allow longer episodes of care to be evaluated.

1.1 PHP PEPPER Target Areas

In general, PEPPER target areas are calculated as ratios and expressed as percentages. The numerator represents the episodes or days of service that may indicate a risk for improper Medicare payment, while the denominator represents the broader comparison group of episodes or days of service. The target area definitions below describe how the CY 2025 PHP PEPPER metrics are calculated. Users may notice slight differences from prior years' PHP PEPPERs because of updates to the claims data used to calculate these metrics.

Table 3 identifies the definitions for the PHP PEPPER target areas.

Table 3: Target Area and Target Area Definitions

Target Area	Target Area Definition
Group Therapy	**Numerator**: Count of beneficiary episodes ending in the report period with only group therapy billed (Healthcare Common Procedure Coding System (HCPCS) codes G0410 or G0411). **Denominator**: Count of all beneficiary episodes ending in the report period.

Target Area	Target Area Definition
No Individual Psychotherapy	**Numerator**: Count of beneficiary episodes ending in the report period with no units of individual psychotherapy billed. **Numerator Exclusions**: Exclude episodes with the following Current Procedural Terminology (CPT®) codes: • **90785** (Psychotherapy Interactive Complexity), • **90832** (Psychotherapy, 30 minutes with patient), • **90833** (Psychotherapy, 30 minutes with patient when performed with an evaluation and management service), • **90834** (Psychotherapy, 45 minutes with patient), • **90836** (Psychotherapy, 45 minutes with patient when performed with an evaluation and management service), • **90837** (Psychotherapy, 60 minutes with patient), • **90838** (Psychotherapy, 60 minutes with patient when performed with an evaluation and management service), • **90845** (Psychoanalysis), • **90865** (Narcosynthesis), or • **90880** (Hypnotherapy). **Denominator**: Count of all beneficiary episodes ending in the report period.
60+ Days of Service	**Numerator**: Count of beneficiary episodes ending in the report period with greater than or equal to 60 days of service provided by the PHP. **Denominator**: Count of all beneficiary episodes ending in the report period.
30-Day Readmissions	**Numerator**: Count of all index (first) beneficiary episodes ending in the report period for which the beneficiary returned for care within 30 days to the same or to another partial hospitalization program. **Denominator**: Count of all beneficiary episodes ending in the report period.

CMS approved these PHP PEPPER target areas because they have been identified as being at higher risk for improper Medicare payments.

Group therapy is less costly to provide than individual therapy; therefore, there may be a financial incentive for PHPs to provide group therapy when individual therapy may be more appropriate for a beneficiary. The PHP PEPPER identifies the proportion of all episodes of care during which the beneficiary received only group therapy. Similarly, the PHP PEPPER identifies the proportion of PHP episodes of care where the beneficiary did not receive any individual psychotherapy. While individual psychotherapy is not a Medicare requirement, PHPs are generally expected to provide some level of individual psychotherapy because PHP services are furnished in lieu of inpatient psychiatric hospitalization. This service is typically provided in addition to a range of other therapeutic services during a Medicare beneficiary's course of treatment.

There is no limit on the length of time a beneficiary may receive PHP services; therefore, there is a risk that PHPs may continue PHP services beyond the point where those services are necessary. The PHP PEPPER identifies the proportion of all episodes of care during which the beneficiary received more than 60 days of service.

The PHP PEPPER identifies the proportion of Medicare beneficiaries who were readmitted to the same PHP or to another PHP within 30 days of the last date of an episode of care. This could indicate that the beneficiary was discharged prematurely or that the discharge planning process could be strengthened.

1.2 How PHPs Can Use PEPPER Data

For Medicare data, the CY runs from January 1 through December 31. The PHP PEPPER enables PHPs to compare their billing statistics with national, jurisdiction, and state percentile values for each target area with reportable data for the three most recent CYs included in the report. “Reportable data” in PEPPER means that the numerator or denominator count is at least 11. When either the numerator or denominator is fewer than 11, statistics are not displayed in PEPPER due to CMS data restrictions.

To calculate percentiles, the target area percentages for all PHPs with reportable data for a given target area and reporting period are ranked from highest to lowest. The value below which 80 percent of PHPs' target area percentages fall is identified as the 80th percentile. PHPs with target area percentages at or above the 80th percentile (i.e., the top 20 percent) are considered at risk for improper Medicare payments. Percentiles are calculated separately for each comparison group: nation, jurisdiction, and state. A higher percentile indicates a greater risk for improper Medicare payments.

The PEPPER Team has developed suggested interventions that PHPs may consider when evaluating their risk for improper Medicare payments. Please note that these are generalized suggestions and may not apply to all situations. For all areas, assess whether there is sufficient volume (i.e., numerator count of 10 to 30 for the time period, depending on the PHP’s total denominator count) to warrant a review. The following table can assist PHPs in interpreting their percentile values, which serve as indicators of potential risk for improper Medicare payments.

Table 4 provides suggested interventions for outliers by target area.

Table 4: Suggested Interventions for Outliers by Target Area

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)
Group Therapy	This could indicate that the PHP is not providing the individualized plan of care necessary to address beneficiaries’ needs, or that the PHP is not correctly including all services on the claim. The PHP should ensure that beneficiary plans of care are appropriate and individualized to meet the beneficiary’s condition. The PHP should ensure that all services provided are correctly documented in the medical record and included on the claim.
No Individual Psychotherapy	This could indicate that the PHP is not providing the intensity of services necessary to address beneficiaries’ needs or that the PHP is not correctly including all services on the claim. The PHP should ensure that beneficiary plans of care are appropriate and individualized to meet the beneficiary’s condition. The PHP should ensure that all services provided are correctly documented in the medical record and included on the claim.
60+ Days of Service	This could indicate that the PHP is continuing treatment beyond the point where those services are necessary. The PHP should review documentation for beneficiary episodes of care with 60 or more days of service to ensure that continued care in the PHP is appropriate for

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)
	each beneficiary. The PHP should also review plans of care and discharge plans to ensure their appropriateness.
30-Day Readmissions	This could indicate that the PHP is discharging beneficiaries prematurely or that the discharge planning process could be strengthened. The PHP should review documentation for beneficiaries readmitted to their PHP to assess appropriateness of discharge and discharge planning processes.

Comparative data across three consecutive years can help identify significant changes in a PHP's target area percentages, whether increasing or decreasing from one year to the next. These changes may reflect shifts in admission practices, staff turnover, or changes in medical staff.

2. Using PEPPER

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

2.1 Compare Targets Report

PHPs 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 year included in PEPPER. For each target area, the Compare Targets Report displays the PHP's number of target discharges, target percent, percentile rankings compared with the nation, jurisdiction, state, and the "Sum of Payments" (when calculated).

The PHP PEPPER identifies providers whose data may indicate a risk for improper Medicare payments compared with other PHPs nationwide. On the Compare Targets Report, target area percentages at or above the national 80th percentile are displayed in **bold red text**; percentages below the 80th percentile are displayed in black text.

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

The PHP's national percentile indicates the percentage of PHPs nationwide with a target area percentage lower than the PHP's target area percentage.

The PHP's jurisdiction percentile indicates the percentage of PHPs within the MAC jurisdiction with a target area percentage lower than the PHP's target area percentage. The jurisdiction percentile for a target area is blank if fewer than 11 PHPs in the jurisdiction have reportable data for that target area.

The PHP's state percentile indicates the percentage of PHPs in the state with a target area percentage lower than the PHP's target area percentage. The state percentile for a target area is blank if fewer than 11 PHPs in the state have reportable data for that target area.

When interpreting the Compare Targets Report, PHPs should consider their percentile values for the nation, jurisdiction, and state. Percentile values at or above the 80th percentile indicate that the PHP is at risk for improper Medicare payments. Providers should give the greatest weight to their national percentile, as it reflects how the PHP compares with all PHPs nationwide.

Percentile values at or above the jurisdiction's 80th percentile or the state's 80th percentile should also be considered, although they represent a lower priority. Because jurisdiction and state comparison groups are smaller, their percentile values may be less meaningful. In addition, regional differences in practice patterns may influence jurisdiction and state percentiles.

The PHP PEPPER identifies providers whose data suggest they may be at risk for improper Medicare payments when compared with all PHPs nationwide. The PHP's risk status is indicated by the color of the target area percent on the Compare Targets Report. When the PHP's percent is at or above the national 80th percentile for a target area, it appears in **bold red text**. When the PHP's percent is below the national 80th percentile, it appears in black text.

The "Sum of Payments" and the "Target Count" can help PHPs prioritize areas for review. Target areas for which a provider is at or above the 80th percentile and has a high "Sum of Payments" and/or a high number of target discharges may warrant a higher review priority than areas for which the provider is at or above the 80th percentile but has a lower "Sum of Payments" or fewer target discharges.

2.2 Target Area Data Tables

PEPPER data tables display a variety of statistics for each target area summarized over three years. These statistics include the proportion of numerator and denominator discharges (percent), the total numerator count of discharges for the target area (target count), the denominator count of discharges, average length of stay (ALOS), and Medicare payment data.

The numerator, or target count, is calculated by summing the count of episodes that meet the numerator definition for each target area. The denominator count is calculated by summing the count of episodes that meet the denominator definition for each target area. The Target ALOS is calculated by averaging the length of stay (LOS) for episodes that meet the numerator definition for the target area, while the Denominator ALOS is calculated by averaging the LOS for the episodes that meet the denominator criteria for the target area.

The "Outlier Status" column identifies when a PHP is a high outlier, meaning the PHP's percentile is at or above the national 80th percentile. In these cases, the percentile value appears in **bold red text**. The "Outlier Status" column will display "Not an outlier" when the PHP is not an outlier for the target area and time period and "No data" when the PHP does not have reportable data for that target area and time period.

The "Target Sum Medicare Payments" column is determined by adding the claim payment amount of all claims meeting 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. Interpretive guidance is included on the data tables to help PHPs determine whether they should audit a sample of records. Suggested interventions tailored to each target area are also included on each data table.

Below the data tables are graphs that provide a visual representation of the PHP's percentage for each target area over the previous three years. These graphs allow PHPs to identify significant changes from one quarter to the next, which may result from shifts in medical staff, coding or billing staff, utilization review processes, documentation improvement, or PHP services. External factors, such as changes in health care providers within the community, may

also influence patient population, which can be reflected in PEPPER target area statistics. PHPs are encouraged to identify the root causes of significant changes to help prevent improper Medicare payments.

The graphs include trend lines representing the 80th percentile values for each of the three comparison groups (nation, jurisdiction, and state), allowing PHPs to easily identify when they are outliers relative to any of these groups. A table displaying these percents is included on each target area graph worksheet. State percentiles are shown as zero when fewer than 11 PHPs in the state have reportable data for the target area. Jurisdiction percentiles are shown as zero when fewer than 11 PHPs in the jurisdiction have reportable data for the target area. If there is no reportable data for a given quarter, the table will display "#N/A" in the corresponding cell.

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

2.2.1 PHP Top Diagnoses Reports

The PHP Top Diagnoses Report lists the top diagnosis categories with the highest volume of episodes of care ending at the PHP during the most recent CY. The diagnosis category for each episode is determined using the default Clinical Classification Software Refined (CCSR) category associated with the principal diagnosis code (ICD-10) reported on the first claim in the episode. Additional information about CCSR categories is available at https://www.hcup-us.ahrq.gov/tools_software.jsp.

For each diagnosis category listed, the report includes the total number of PHP episodes, the proportion of episodes in the diagnosis category relative to the total number of episodes, and the PHP ALOS. The report is limited to the top diagnosis categories (up to ten) with at least 11 episodes of care during the most recent CY.

2.2.2 Nationwide PHP Top Diagnosis Reports

The Nationwide PHP Top Diagnoses Report lists the top diagnosis categories with the highest volume of episodes of care nationwide during the most recent CY. The diagnosis category for each episode is assigned based on the default CCSR category for the principal diagnosis on the first claim in the episode.

For each diagnosis category listed, the report includes the total number of episodes nationwide, the national proportion of episodes for the diagnosis category to total episodes, and the national ALOS. This report is limited to the top diagnosis categories (up to ten) with at least 11 episodes of care during the most recent CY.

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; however, 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. This website also provides a variety of educational resources to support PHPs in using PEPPER effectively.

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

Appendix A: Terms and Abbreviations

Table 5 provides a list of terms, abbreviations, and definitions in this document.

Table 5: Terms and Abbreviations

Term	Abbreviation	Definition
Agency for Healthcare Research and Quality	AHRQ	AHRQ is the lead federal agency within the U.S. Department of Health and Human Services (HHS) tasked with producing and supporting research to make healthcare safer, more accessible, equitable, affordable, and of higher quality for all Americans.
Average Length of Stay	ALOS	ALOS is based on the episode of care. It is computed by dividing the total number of days within all episodes of care by the total number of episodes of care at the PHP within a given time period. It represents the arithmetic average, or mean, and includes a count of all days for episodes that end within the last CY of the report.
Calendar Year	CY	A CY is a standard 12-month period that begins on January 1 and ends on December 31.
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.
Clinical Classifications Software Refined	CCSR	CCSR is a healthcare categorization tool developed by the Agency for Healthcare Research and Quality (AHRQ).
Community Mental Health Center (CMHC)	CMHC	A CMHC is a state-certified facility providing comprehensive, accessible behavioral healthcare to local populations.
Comparative Billing Report	CBR	A CBR provides comparative data on Medicare billing trends, allowing an individual health care provider to compare their billing practices to peers in the same state and across the nation by specialty.
Critical Access Hospital	CAH	CAH is a designation CMS gives to a small, rural hospital that provides limited inpatient care, 24-hour emergency services, and is located far from other hospitals, allowing it to receive cost-based Medicare reimbursements to help maintain services in underserved areas.
Current Procedural Terminology	CPT	CPT is a medical code set developed and maintained by the American Medical Association (AMA) that provides a uniform language for reporting medical procedures and services.
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.
Form Locator	FL	A form locator is a numbered field on a standardized, multi-section document that directs you to a specific piece of information.

Term	Abbreviation	Definition
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.
Healthcare Common Procedure Coding System	HCPCS	HCPCS is a set of healthcare procedure codes based on the American Medical Association (AMA) current procedural terminology (Commonly pronounced Hick-Picks).
Home Health Agency	HHA	An HHA is a public agency or private organization, or sub-division of such agency or organization that provides skilled nursing services and at least one other therapeutic service in the residence of the client.
Hospice	NA	Hospice is inpatient or outpatient supportive care given to a terminally ill client and the family. The focus of this care is to enable the client to remain in the familiar surroundings of their home for as long as they can.
Index Analytics	IA	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.
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.
International Classification of Diseases (ICD), 10th Revision, Clinical Modification (CM)	ICD-10-CM	ICD-10-CM is a standardized medical coding system used by healthcare providers to classify and code all diagnoses, symptoms, and procedures in the United States.
Length of Stay	LOS	LOS refers to the duration of time a patient spends in a healthcare facility, measured from admissions to discharge, and is a key metric for evaluating hospital efficiency and resource utilization.
Long-Term Acute Care Hospital	LTACH	An LTACH is a specialty facility for critically ill patients with complex medical conditions requiring extended hospital stays, typically 25 days or longer.

Term	Abbreviation	Definition
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.
Office of Inspector General	OIG	The OIG is an HHS agency that protects the integrity of HHS programs as well as the health and welfare of the beneficiaries of those programs.
Outlier Status	NA	Outlier status refers to percentiles at or above the 80th percentile for any target areas or at or below the 20th percentile for coding-focused target areas.
Partial Hospitalization Program	PHP	PHP refers to an intensive outpatient psychiatric treatment program.
Percentile	NA	In PEPPER, the percentile represents the percent of PHPs in the comparison group below which a given PHP'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 PHP's position in the group compared to all other PHPs in the comparison group for that target area and time period. For example, suppose a PHP has a target area percent of 2.3 and 80% of the PHPs in the comparison group have a percent for that target area that is less than 2.3. Then we can say the PHP is at the 80th percentile. Percentiles in PEPPER are calculated from the PHPs' percents so that each PHP percent can be compared to the statewide, jurisdiction-wide, or nationwide distribution of PHP percents.
Personal Computer	PC	A PC is a general-purpose computer designed for individual use, distinguishing it from larger, multi-user systems like mainframes or supercomputers.
Procedure Coding System	PCS	PCS is a standardized set of codes used in healthcare to report medical procedures, services, and supplies for billing and record-keeping purposes.
Program for Evaluating Payment Patterns Electronic Report	PEPPER	PEPPER is an electronic data report in Microsoft Excel format that contains a single hospital's claims data statistics for diagnosis-related groups (DRGs) and discharges at high risk for improper payments due to billing, coding, and/or admission necessity issues.
Prospective Payment System	PPS	PPS (or IPPS) refers to Section 1886(d) of the Social Security Act (the Act) that sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.

Term	Abbreviation	Definition
Short-Term Acute Care Hospital	STACH	A STACH is a medical facility designed to treat severe, sudden illnesses, injuries, or surgical recoveries.
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.