Skilled Nursing Facility (SNF) Program for Evaluating Payment Patterns Electronic Report (PEPPER)

User Guide

FY 2025 Release

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What's new in this edition?

Patients who expire (Patient Status Code 20) are now excluded from the numerator of the 3- to 5-Day Readmissions target area.

1. What is PEPPER?

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

PEPPER is an electronic data report that contains a single SNF's Medicare claims data statistics for discharges identified as being at risk for improper payment due to billing, coding, or admission-necessity issues. Each PEPPER contains statistics for the most recent federal fiscal year (FY) across defined "target areas" associated with potential improper payments. Data are displayed in graphs and tables that depict the SNF's target area percentages over time.

Index Analytics (IA), along with its partners Integrity Management Services, Inc. (IntegrityM), and GovCon Growth Solutions, LLC, develops and distributes PEPPER under contract with the Centers for Medicare & Medicaid Services (CMS).

All data tables, graphs, and reports in PEPPER are designed to assist SNF's identify potential overpayments and underpayments.

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

PEPPER is available for SNFs, Short-Term Acute Care Hospitals (STACHs), Critical Access Hospitals (CAHs), Long-Term Acute Care Hospitals (LTACHs), Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), Hospices, Partial Hospitalization Programs (PHPs), and Home Health Agencies (HHAs).

SNFs are specially qualified facilities that provide skilled nursing care, rehabilitation services, and other services to Medicare beneficiaries who meet certain conditions. An SNF may be freestanding or operate as a distinct part of a nursing home or hospital. In addition, STACHs in rural areas with fewer than 100 beds may qualify to provide SNF services as swing bed facilities.

SNFs are reimbursed under the Skilled Nursing Facility Prospective Payment System (SNF PPS). CAHs with swing beds are exempt from the SNF PPS. A beneficiary may receive up to 100 days of SNF care per spell of illness following a medically necessary inpatient hospital stay of at least three days. SNFs use the Minimum Data Set (MDS) to assess each beneficiary's clinical condition, functional status, and expected and actual use of services. Prior to October 1, 2019, certain items on the MDS classified beneficiaries into case-mix categories known as Resource Utilization Groups (RUGs). The RUG classification determined the amount Medicare paid an SNF for each day a beneficiary received services. Payments were based primarily on the amount of therapy provided to beneficiaries.

On October 1, 2019, CMS implemented the Patient Driven Payment Model (PDPM), which was designed to improve Medicare payments made under the SNF PPS by improving payment accuracy and appropriateness. To achieve this, the PDPM focuses on the patient rather than the volume of services provided. The PDPM was also designed to reduce the administrative burden on providers.

The PDPM consists of five case-mix adjusted components: physical therapy, occupational therapy, speech language pathology (SLP), nursing, and non-therapy ancillary. The PDPM also

includes a variable per diem adjustment that modifies the per diem rate over the course of a patient's SNF stay.

For additional information and resources related to the SNF PPS, visit the CMS Skilled Nursing Facility Patient Driven Payment Model webpage.

Note: SNF PEPPER target areas and supplemental reports will continue to evolve over time to identify potential vulnerabilities associated with the PDPM rather than those associated with the RUG system.

The SNF PEPPER is the version of PEPPER developed specifically for SNFs reimbursed under the SNF PPS. **In PEPPER and throughout this guide, freestanding SNFs, distinct part unit SNFs, and swing bed SNFs are grouped together and collectively referred to as SNFs. CAHs with swing beds are not included; therefore, an SNF PEPPER is not available for CAH swing bed units**.

Each Skilled Nursing Facility PEPPER (SNF PEPPER) summarizes statistics for the most recent three federal fiscal years. The SNF PEPPER is designed for SNFs and compares each SNF's results with those of other SNFs across three comparison groups: the nation, the Medicare Administrative Contractor (MAC) jurisdiction, and the state in which the SNF operates. These comparisons enable an SNF to determine whether it is an outlier relative to other SNFs. PEPPER identifies outliers based on preset control limits. For all target areas, the upper control limit is the 80th percentile, and the lower control limit is the 20th percentile. PEPPER highlights findings that are at or above the upper control limit (high outliers) or at or below the lower control limit (low outliers).

In PEPPER, the term "outlier" refers to SNFs whose target area percentage falls within the top 20 percent of all hospital target area percentages in the comparison group (that is, at or above the 80th percentile) or within the bottom 20 percent of all hospital target area percentages in the comparison group (that is, at or below the 20th percentile for coding-focused target areas). Formal tests of significance are not used to determine outlier status in PEPPER.

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

Table 1: Eligible Claims Specifications for SNF PEPPER

Inclusion/Exclusion Criteria	Data Specifications
SNFs or hospitals with swing beds	Third through sixth positions of the CMS Certification Number (CCN) are between "5000" and "6499" for SNFs or the third position of the CCN is 'U', 'W', or 'Y' for hospitals.
Claim facility type of "SNF" or "hospital"	UB-04 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 2 (SNF) or 1 (Hospital)
SNF non-swing bed and SNF swing bed claims	National Claims History Claim Type Code = 20 (SNF Non-Swing Bed) or 30 (SNF Swing Bed)
Claim service classification type of "inpatient" or "swing beds"	UB-04 FL 04 Type of Bill, third digit (Bill Classification) = 1 (Inpatient Part A) or 8 (Swing beds)
Services provided during the time period used to create the episode of care	Claim "From Date" and claim "Through Date" fall within the three fiscal years included in the report. Additional claims for the last four months of the previous fiscal year will be included for episodes of care beginning prior to the reporting period. See below for more explanation of the episode of care.

Inclusion/Exclusion Criteria	Data Specifications
Medicare claim payment amount greater than zero	The provider received a payment amount greater than zero on the claim (Note: Medicare Secondary Payer claims are included).
Final action claim	A final action claim is a non-rejected claim for which a payment has been made. All disputes and adjustments have been resolved and details clarified.
Exclude Health Maintenance Organization (HMO) claims	Exclude claims submitted to a Medicare Advantage Plan.
Exclude cancelled claims	Exclude claims canceled by the MAC.

The PEPPER target areas were designed to report on services provided to beneficiaries whose SNF episodes of care ended during the specified time period (the federal fiscal year). An episode of care is created from the claims submitted by an SNF for each beneficiary. Episodes of care are created as follows:

- All claims submitted by an SNF for a beneficiary are collected and sorted from the earliest "Claim From" date to the latest.
- If the patient discharge status code on the latest claim in a series indicates that the beneficiary was discharged or did not return for continued care, the beneficiary's episode of care is included in the reporting period in which the latest "Through Date" falls.
- If there is a gap of more than 30 days between one claim's "Through Date" and the next claim's "From Date", the gap is considered the end of one episode of care and the beginning of a new episode of care.
- Each episode of care is included in the reporting period in which the latest "Through Date" falls.

1.1 SNF PEPPER Target Areas

In general, target areas are constructed as ratios and expressed as percents. The numerator represents episodes of care that may be identified as problematic, while the denominator represents episodes of care from a broader comparison group. *Table 2* presents the definitions of the SNF PEPPER target areas for FY 2023 through FY 2025.

Table 2: Target Area and Target Area Definitions

Target Area	Target Area Definition
High Physical Therapy and Occupational Therapy Case Mix	**Numerator:** Count of SNF claims where the first character of the Health Insurance Prospective Payment System (HIPPS) code, representing the physical and occupational therapy component, is one of the following: C, D, F, G, J, K, N, or O. **Denominator**: Count of all SNF claims.
High Speech Language Pathology (SLP) Case Mix	**Numerator**: Count of SNF claims where the second character of the HIPPS code, representing the SLP component, is one of the following: C, F, I, or L. **Denominator**: Count of all SNF claims.

Target Area	Target Area Definition
High Nursing Case Mix	**Numerator**: Count of SNF claims where the third character of the HIPPS code, representing the nursing payment group, is one of the following: A, B, C, D, H, or L. **Denominator**: Count of all SNF claims.
20-Days Episodes of Care	**Numerator**: Count of beneficiary episodes ending in the report period with a length of stay (LOS) of 20 days. **Denominator**: Count of all beneficiary episodes ending in the report period.
90+ Day Episodes of Care	**Numerator**: Count of beneficiary episodes ending in the report period with an LOS greater than or equal to 90 days. **Denominator**: Count of beneficiary episodes ending in the report period.
3- to 5-Day Readmission	**Numerator**: Count of readmissions within three to five calendar days (four to six consecutive days) to the same SNF for the same beneficiary (identified using the Health Insurance Claim number) occurring during a beneficiary episode ending in the report period. **Numerator Exclusions**: Exclude claims with patient discharge status code **20** (expired). **Denominator**: Count of all claims associated with SNF episodes ending in the report period. **Denominator Exclusions**: Exclude claims with patient discharge status code **20** (expired).

CMS approved these SNF PEPPER target areas because they have been identified as potentially at risk for improper Medicare payments. A high target area percentage does not necessarily indicate the presence of an improper payment or that a provider is doing anything wrong. However, providers with high target area percentages may wish to review their medical record documentation to ensure that the services provided to beneficiaries are appropriate and medically necessary and that the documentation supports the level of care and services for which Medicare reimbursement was received.

The High Physical Therapy and Occupational Therapy Case Mix target area assesses the use of the physical therapy (PT) and occupational therapy (OT) case mix groups with the highest PT or OT case mix indexes. The High Speech Language Pathology (SLP) Case Mix target area assesses the frequency of four SLP case mix groups with the highest case mix indexes. The High Nursing Case Mix target area assesses the use of six of the highest paying nursing payment categories.

The SNF benefit provides 20 days of 100% Medicare coverage, after which coverage decreases to 80%. Because SNFs may have a financial incentive to retain beneficiaries through day 20, facilities with high proportions of 20-day episodes may wish to review their medical record documentation to ensure that beneficiaries required a skilled level of care throughout their SNF stay.

Medicare reimburses up to 100 days of skilled care per beneficiary's spell of illness. SNFs with a high proportion of episodes of care lasting 90 or more days may wish to review their medical record documentation to ensure that the services provided to beneficiaries are medically necessary and that beneficiaries required a skilled level of care throughout their SNF stay.

Under the PDPM, providers may have a financial incentive to discharge a patient from a covered Part A SNF stay and then readmit the patient to reset the variable per diem payment schedule. To mitigate this potential incentive, PDPM includes an interrupted stay policy that combines multiple SNF stays into a single stay when a beneficiary is discharged and readmitted within a specified time frame.

If a beneficiary is discharged from an SNF and readmitted to the same SNF within three consecutive calendar days, the subsequent stay is considered a continuation of the previous stay, and the variable per diem payment schedule resumes at the point reached before discharge. If a beneficiary is readmitted more than three consecutive calendar days after discharge or is admitted to a different SNF, the subsequent stay is considered a new stay, and the variable per diem payment schedule resets to day one.

1.2 How SNFs Can Use PEPPER Data

SNF PEPPER provides SNFs with their national, jurisdiction, and state percentile values for each target area with reportable data for the three most recent federal fiscal years (October 1 through September 30) included in the report (refer to *Section 2.1*). In PEPPER, *Reportable Data* means that a target area has 11 or more numerator discharges during a specific reporting period. Due to CMS data restrictions, PEPPER does not display statistics for target areas with fewer than 11 numerator discharges during that period.

The PEPPER Team has developed suggested interventions that SNFs may consider when assessing their risk for improper Medicare payments. Please note that these are generalized suggestions and may not apply to all situations.

Before submitting claims for reimbursement, SNFs may consider scheduling regular meetings attended by the director of nursing, MDS coordinator, therapy director, business office manager, and other appropriate team members to verify that all aspects of care, documentation, and billing comply with Medicare regulations. For all target areas, assess whether there is sufficient volume to warrant a review (that is, a numerator count of 10 to 30 for the reporting period, depending on the SNF's total number of claims).

The following table can assist SNFs in interpreting their percentile values, which may indicate a potential risk of improper Medicare payments.

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)
High Physical Therapy and Occupational Therapy Case Mix	• This could indicate issues with how the patient's functional score is coded in the MDS. • The SNF should review nursing and therapy documentation in the medical record to ensure the appropriateness of MDS coding, specifically regarding the ten Section GG items used for the PT and OT component.	• This could indicate issues with insufficient medical record documentation needed to accurately reflect the functional score of the patient. • The SNF should review the accuracy and completeness of the medical record with nursing and therapy staff, specifically regarding the Section GG items used for the PT and OT component.

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)
High Speech Language Pathology Case Mix	• This could indicate issues with the MDS coding of the five patient characteristics included in the SLP component: acute neurologic condition, SLP-related comorbidity, cognitive impairment, swallowing disorder, or mechanically altered diet. • The SNF should review documentation to ensure that all SLP-component patient characteristics coded on the MDS are substantiated in the medical record.	• This could indicate issues with insufficient medical record documentation needed to accurately reflect the five patient characteristics included in the SLP component: acute neurologic condition, SLP-related comorbidity, cognitive impairment, swallowing disorder, or mechanically altered diet. • The SNF should review the accuracy and completeness of medical record documentation with nursing, therapy, and other staff to ensure that all SLP component patient characteristics are adequately captured on the MDS.
High Nursing Case Mix	• This could indicate issues with the MDS coding. • The SNF should review documentation to ensure that all patient characteristics related to the nursing component, including items indicating signs and symptoms of depression (i.e., D0300 or D0600), are accurately coded on the MDS and substantiated in the medical record.	This could indicate issues with insufficient medical record documentation, which is needed to accurately reflect patient characteristics.
20-Day Episodes of Care	• This could indicate that the SNF is continuing treatment beyond the point where services are necessary. • The SNF should review documentation for beneficiary episodes of care with an LOS of 20 days to ensure that continued care was appropriate and that beneficiaries received a skilled level of care. The SNF should also review the appropriateness of plans of care and discharge planning.	Not Applicable

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)
90+ Day Episodes of Care	• This could indicate that the SNF is continuing treatment beyond the point where services are necessary. • The SNF should review documentation for beneficiary episodes of care with an LOS of 90 or more days to ensure that continued care was appropriate and that beneficiaries received a skilled level of care. The SNF should also review the appropriateness of plans of care and discharge planning.	Not Applicable
3- to 5-Day Readmissions	• This could indicate that patients are being discharged prematurely or that patients are being readmitted after the interrupted stay threshold, thereby resetting the variable per diem adjustment. A sample of readmission cases should be reviewed to identify the appropriateness of admission, discharge, quality of care, post-discharge care, and identify billing errors. • The facility is encouraged to generate data profiles for readmissions to its facility within three to five consecutive calendar days. • Suggested data elements to include in these profiles are as follows: patient identifier, date of admission, date of discharge, patient discharge status code, and principal and secondary diagnoses.	Not Applicable

Comparative data across several consecutive years can help identify whether an SNF's target area percents have changed significantly from one year to the next. Such changes may indicate shifts in admission or assessment practices, staff turnover, or changes in patient case mix.

2. Using PEPPER

PEPPER is a Microsoft Excel workbook that contains multiple worksheets. Users can navigate through PEPPER by selecting the worksheet tabs at the bottom of the screen. Each tab is labeled to identify the worksheet content (e.g., Definitions, Compare, or a specific target area).

2.1 Compare Targets Report

SNFs can use the Compare Targets Report to help 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 report displays the SNF's number of target discharges, percent, and percentile values compared with the nation, jurisdiction, state, and Sum of Payments.

> *The Compare Targets Report is the only report in PEPPER that allows SNFs to assess their high and low outlier status across all target areas simultaneously.*

The SNF's outlier status is indicated by the color and font style of the target area percentile on the Compare Targets Report. If the SNF is a high outlier for a target area, the SNF percentile is displayed in **red bold text**. If the SNF is a low outlier, the SNF percentile is displayed in *green italic text*. If the SNF is not an outlier, the percentile is displayed in black text.

The Compare Targets Report provides the SNF's percentile values for the nation, jurisdiction, and state for all target areas with reportable data in the most recent fiscal year. These values allow a SNF to assess how its target area percents compare with those of other SNFs in each comparison group.

The SNF's national percentile indicates the percentage of SNFs nationwide that have a target area percent lower than the SNF's target area percent.

The SNF's jurisdiction percentile indicates the percentage of SNFs in the jurisdiction that have a target area percent lower than that of the SNF. The jurisdiction percentile is not calculated for a target area when fewer than 11 SNFs in the jurisdiction have reportable data for that target area.

The SNF's state percentile indicates the percentage of SNFs in the state that have a target area percent lower than that of the SNF. The state percentile is not calculated for a target area when fewer than 11 SNFs in the state have reportable data for that target area.

When interpreting the Compare Targets Report, SNFs should consider their target area percentile values for the nation, jurisdiction, and state. Percentile values at or above the 80th percentile indicate that the SNF is an outlier for a target area. Outlier status should be evaluated in the following priority order: 1) nation, 2) jurisdiction, and 3) state. State percentiles should be given the lowest priority because the state comparison group is the smallest.

The "Target Count" can also be used to help prioritize areas for review. Target areas for which a provider is at or above the 80th percentile and has a large target count may be given higher priority than target areas for which a provider is at or above the 80th percentile and has a smaller target count.

2.2 Target Area Data Tables

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

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

percentile. The “Outlier Status” column also identifies when the SNF is a low outlier. In these cases, the SNF’s percentile is displayed in *green italics*, indicating that it is at or below the national 20th percentile.

The “Outlier Status” column displays “Not an outlier” when the SNF is not an outlier for the target area and time period. It will display “No data” when the SNF does not have reportable data for that target area and time period.

Below the data tables are graphs that provide a visual representation of the SNF’s percentage for each target area over three fiscal years. SNFs can identify significant year-to-year changes, which may result from shifts in medical staff, coding or billing staff, utilization review processes, documentation improvement efforts, or hospital services. External changes among health care providers in the community can also affect patient population and case mix, which may be reflected in PEPPER target area statistics. SNFs are encouraged to identify the root causes of major changes to help ensure that improper payments are prevented.

The graphs include trend lines for the percents at the 80th percentile (and at the 20th percentile for coding-focused target areas) for the three comparison groups (nation, jurisdiction, and state), allowing the SNF to easily identify when it is an outlier compared to any of these groups. A table of these percents is included on each target area graph worksheet. State percentiles are zero when fewer than 11 SNFs have reportable data for the target area in the state. Jurisdiction percentiles are zero when fewer than 11 SNFs have reportable data for the target area in the jurisdiction. If there are no reportable data for the time period, the table will display #N/A in the cell.

If there are no reportable data for the SNF for a given time period due to CMS data use restrictions, the graph does not display a data point for that time period. If fewer than 11 SNFs have reportable data for a target area in a state or jurisdiction for one or more time periods, the graph does not display a data point or trend line for the state or jurisdiction comparison group.

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 to 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 on the CMS CBR PEPPER website by selecting the “Help/Contact Us” tab. The website also provides numerous educational resources to support SNFs 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: Terms and Abbreviations

Table 4 provides a list of terms, abbreviations, and definitions in this document.

Table 4: Terms and Abbreviations

Term	Abbreviation	Definition
Average Length of Stay	ALOS	ALOS refers to the average number of days a patient stays in a hospital, calculated by dividing the total number of inpatient hospital days by the total number of discharges within a given period.
Centers for Medicare & Medicaid Services	CMS	CMS is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program, and health insurance portability standards.
CMS Certification Number	CCN	A CCN, previously known as an Online Survey Certification and Reporting System (OSCAR) number or Medicare Provider Number, is a unique identifier assigned by CMS to healthcare providers and suppliers participating in Medicare. It serves to verify that a provider is Medicare certified and to identify the specific types of services they are authorized to provide.
Critical Access Hospital	CAH	A 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.
Episode of Care	NA	An episode of care is created using claims submitted by a SNF. To create an episode of care: All claims submitted by a SNF for a beneficiary are collected and sorted from the earliest "Claim From" date to the latest. If the patient discharge status code on the latest claim in a series indicates that the beneficiary was discharged or did not return for continued care, then that beneficiary's episode of care is included in the time/report period in which the latest "Through Date" falls. If the latest claim in the series ended in the last month of the time/report period (e.g., Sept. 1 - 30, 2019, for the Q4FY19 release) and indicates that the beneficiary was still a patient (patient discharge status code "30"), then that beneficiary's episode of care is not included. If there is a gap between one claim's "Through Date" to the next claim's "From Date" of more than 30 days, then that is considered the ending of one episode of care and the beginning of a new episode of care. Each episode of care is included in the time/report period in which the latest "Through Date" falls. Claims are collected for four months prior to each time period so that the longer LOSs may be evaluated.

Term	Abbreviation	Definition
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 Insurance Prospective Payment System	HIPPS	HIPPS rate codes represent specific sets of patient characteristics (or case-mix groups) that determine payment under several prospective payment systems.
Health Maintenance Organization	HMO	An HMO is a type of Medicare managed care plan where a group of doctors, hospitals, and other healthcare providers agree to give healthcare to Medicare beneficiaries for a set amount of money from Medicare every month.
Home Health Agency	HHA	An HHA is a public agency or private organization, or sub-division of such agency or organization that provides skilled nursing services and at least one other therapeutic service in the residence of the client.
Hospice	NA	Hospice is inpatient or outpatient supportive care given to a terminally ill client and the family. The focus of this care is to enable the client to remain in the familiar surroundings of their home for as long as they can.
Index Analytics	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.
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	LTACH refers to hospitals that provide specialized care for patients with medically complex conditions requiring extended hospital stays, often after a stay in a traditional acute care hospital's intensive care unit.

Term	Abbreviation	Definition
Long-Term	LT	LT refers to long-term acute care hospitals.
Medicare	NA	Medicare is the federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.
Medicare Administrative Contractor	MAC	The MAC is the contracting authority replacing the fiscal intermediary and carrier in performing Medicare Fee-for-Service claims processing activities.
Medicare Advantage	MA	MA Plans, also known as Part C Plans, are healthcare plans offered by private companies approved by Medicare.
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.
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.
Minimum Data Set	MDS	MDS is a core set of screening, clinical, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid.
Not Applicable	NA	Not Applicable
Occupational Therapy	OT	OT is a healthcare profession that helps people of all ages build or regain the skills they need to perform everyday activities and live independently.
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.
Patient Drive Payment Model	PDPM	PDPM is a Centers for Medicare & Medicaid Services (CMS) reimbursement system for Medicare Part A stays in skilled nursing facilities (SNFs).
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.
Physical Therapy	PT	PT is a healthcare profession and treatment that helps people restore movement, reduce pain, and improve physical function after an injury, illness, or surgery.

Term	Abbreviation	Definition
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.
Resource Utilization Groups	RUGS	RUGs are a patient classification system used to group skilled nursing facility (SNF) residents based on their clinical severity and resource needs. Derived from Minimum Data Set (MDS) assessments, RUG categories historically drove Medicare Part A reimbursement by tying payment rates directly to the intensity and complexity of care provided.
Section GG	NA	The ten specific Section GG items used by the Centers for Medicare & Medicaid Services (CMS) to calculate the Patient-Driven Payment Model (PDPM) functional score and the Discharge Function Score consist of specific self-care, bed mobility, transfer, and walking activities.
Short-Term	ST	A short-term hospital stay is an inpatient admission typically lasting between a few hours to roughly 72 hours.
Short-Term Acute Care Hospital	STACH	STACH is a medical facility that delivers active, immediate treatment for severe injuries, sudden illnesses, or surgical recovery.
Skilled Nursing Facility	SNF	An SNF is a facility that provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but do not require the level of care provided in a hospital.
Skilled Nursing Facility Prospective Payment System	SNF PPS	SNF PPS is a Medicare per diem payment model that reimburses nursing homes a set daily rate based on patient care needs rather than the volume of services provided.
Speech Language Pathology	SLP	SLP is a healthcare and academic field focused on the evaluation, diagnosis, treatment, and prevention of communication, cognitive-communication, voice, and swallowing disorders in people of all ages.
UB-04 Form Locator	NA	Institutional healthcare providers, such as hospitals and rehabilitation facilities, use the UB-04 standardized claim form (also known as CMS-1450), to submit billing information to insurance companies, including Medicare and Medicaid.

Appendix B: How Readmissions Are Identified

These example scenarios are included to help providers understand how readmissions are identified and counted in PEPPER.

- Readmissions are counted when a patient is readmitted to the same SNF within three to five calendar days (four to six consecutive days) following discharge from the SNF.
- Within each episode, index admissions with a patient discharge status code of “20” (Expired) are excluded from the numerator and cannot be identified as index admissions.
- Common billing errors that may result in claims being identified as readmissions include the following:
  - Incorrect coding of the patient discharge status code when the patient is discharged or transferred to another facility.

B.1 Example 1: 1 SNF Episode, 1-Readmission

The following table displays claims submitted for one beneficiary. The table is sorted by date based on the first column. Each row includes two admissions: the "Index Admission" (shortened to "Index Adm." in the table header) and the "Next Admission" (shortened to "Next Adm." in the table header), which may be considered a readmission. The next admission in one row becomes the index admission in the following row.

Table 5: Example 1

# (Index)	Index Adm. Provider	Index Adm. Date	Discharge Date	Patient Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Next Adm. Counts as 3- to 5-Day Readmission
1	SNF #1	02/01/2024	02/08/2024	02	2	STACH #1	02/08/2024	02/11/2024	No, stay not at SNF #1
2	STACH #1	02/08/2024	02/11/2024	03	3	SNF #1	02/11/2024	02/20/2024	Yes, counts as 1
3	SNF #1	02/11/2024	02/20/2024	01	N/A	No further admissions	No further admissions	No further discharge dates	N/A

Detailed Discussion:

- **Row 1**: The beneficiary was admitted to SNF #1 on 02/01/2024 and was discharged from the SNF and admitted to STACH #1 on 02/08/2024. This date marks the first non-covered day. The beneficiary remained in the hospital until 02/11/2024, which was the fourth non-covered day.
- **Row 2**: The beneficiary returned to SNF #1 on 02/11/2024 after four non-covered SNF Medicare Part A days. This was the first day outside the three-day interruption window. The SNF PPS treated this as a new stay and required a five-day PPS assessment. The variable payment rate schedule restarted on day one. This scenario would be counted as a 3- to 5-Day Readmission in PEPPER.
- **Row 3**: The beneficiary returned home and had no further admissions following the stay at SNF #1 from 02/11/2024 to 02/20/2024. Therefore, there were no additional admissions to count as a readmission for the 3- to 5-Day Readmission target area for this SNF episode.

B.2 Example 2: 3 Beneficiary Stays, No Readmissions

The following table displays claims submitted for one beneficiary. The table is sorted by date based on the first column. Each row includes two admissions: the "Index Admission" (shortened to "Index Adm." in the table header) and the "Next Admission" (shortened to "Next Adm." in the table header), which may be considered a readmission. The next admission in one row becomes the index admission in the following row.

Table 6: Example 2

# (Index)	Index Adm. Provider	Index Adm. Date	Discharge Date	Patient Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Next Adm. Counts as 3- to 5-Day Readmission
1	SNF #1	02/01/2024	02/08/2024	02	2	STACH #1	02/08/2024	02/09/2024	No, stay not at SNF #1
2	STACH #1	02/08/2024	02/09/2024	01	3	SNF #1	02/10/2024	02/20/2024	No, returns within 3 days
3	SNF #1	02/10/2024	02/20/2024	01	N/A	No further admissions	No further admissions	No further discharge dates	N/A

Detailed Discussion:

- **Row 1**: The beneficiary was admitted to SNF #1 on 02/01/2024 and was discharged from the SNF and admitted to STACH #1 on 02/08/2024. This date marked the first non-covered day. The beneficiary remained in the hospital until 02/09/2024, which was the second non-covered day.
- **Row 2**: The beneficiary returned to SNF #1 on 02/10/2024 after two complete non-covered SNF Medicare Part A days. This was the last day of the three-day period that began on the first non-covered day following an SNF stay covered by Medicare Part A. The SNF PPS treated this as an interrupted stay. This day was considered covered because there was not a complete period of three consecutive non-covered days. This scenario would not be counted as a 3- to 5-Day Readmission in PEPPER.
- **Row 3**: The beneficiary returned home and had no further admissions following the stay at SNF #1 from 02/10/2024 to 02/20/2024. Therefore, there were no additional admissions to count as a readmission for the 3- to 5-Day Readmission target area for this SNF episode.