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

User Guide

August 2025 Limited Release

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What's new in this edition?

This limited release of the Short-Term Acute Care Hospital (ST) Program for Evaluating Payment Patterns Electronic Report (PEPPER) presents data for a subset of the target areas previously reported before the program was paused in 2023. The report published in August 2025 is limited to the following target areas: Stroke Intracranial Hemorrhage, Respiratory Infections, Simple Pneumonia, Septicemia, and Unrelated OR Procedure.

1. What is PEPPER?

The Office of Inspector General (OIG) encourages hospitals to develop and implement a compliance program to protect their operations from fraud and abuse.[1, 2] As part of 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 an electronic data report that contains a single hospital's claims data statistics for Medicare Severity Diagnosis Related Groups (MS DRGs) and discharges at risk for improper payment due to billing, coding, and/or admission necessity issues. Each PEPPER contains statistics for the most recent federal fiscal quarters for each area at risk for improper payments (referred to in the report as "target areas"). Data in PEPPER are presented in graphs and tables that depict the hospital's target area percentages over time. PEPPER also includes reports on the hospital's top medical and surgical DRGs for one day stays. Index Analytics (IA), along with its partners Integrity Management Services, Inc. and GovCon Growth Solutions, develops and distributes PEPPER under contract with the Centers for Medicare & Medicaid Services (CMS).

All of the data tables, graphs, and reports in PEPPER were designed to assist the hospital in identifying potential overpayments as well as potential underpayments.

> ***PEPPER does not identify the presence of payment errors, but it can be used as a guide for auditing and monitoring efforts****. A hospital can use PEPPER to compare its claims data over time to identify potential areas of concern, including significant changes in billing practices; possible over- or under-coding; and changes in length of stay.*

PEPPER is available for Short-Term (ST) Acute Care Hospitals, Long-Term (LT) Acute Care Hospitals, Critical Access Hospitals (CAHs), Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), Hospices, Partial Hospitalization Programs (PHPs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). The Short-Term Acute Care PEPPER (ST PEPPER) is designed for short-term acute care hospitals and compares the individual hospital results to other short-term acute care hospitals in three comparison groups: the nation, Medicare Administrative Contractor (MAC) jurisdictions, and the state in which the hospital operates. These comparisons enable a hospital to determine whether it is an outlier, differing from other short-term acute care hospitals.

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

[1] Refer to Department of Health and Human Services/Office of Inspector General. 1998. "Compliance Program Guidance for Hospitals," Federal Register 63, no. 35, Feb. 23, 1998, 8987–8998.

[2] Refer to Department of Health and Human Services/Office of Inspector General. 2005. "Supplementing the Compliance Program Guidance for Hospitals," Federal Register 70, no. 19, Jan. 31, 2005, 4858–4876.

Note that in PEPPER, the term “outlier” is used when a hospital’s target area percent is in the top 20 percent 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 percent 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.

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

Table 1: Eligible Claims Specifications for ST PEPPER

Inclusion/Exclusion Criteria	Data Specifications
Acute care providers only	Third position of the CMS Certification Number = “0”
Services provided during the time periods included in the report	Claim “Through Date” (discharge date) falls within the fiscal quarters included in the report
Claim with valid medical record number	UB-04 FL 03a or 03b is not null (blank)
Medicare claim payment amount greater than zero	The hospital received a payment amount greater than zero on the claim (Note that Medicare Secondary Payer claims are included.)
Final action claim	The patient was discharged; exclude claim status code “still a patient” (30) in UB-04 FL 17
Exclude Health Maintenance Organization (HMO) claims	Exclude claims submitted to a Medicare HMO
Exclude cancelled claims	Exclude claims cancelled by the MAC

Short-term acute care hospitals receive PEPPER files through a secure portal on the CMS CBR PEPPER website on a quarterly basis.

1.1 ST PEPPER 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 discharges or DRG(s) that have been identified as prone to unnecessary admissions, and the denominator generally includes all discharges for the DRG(s) or 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.

Table 2 identifies ST PEPPER target areas.

Table 2: Target Area and Target Area Definitions

Target Area	Target Area Definition

Stroke Intracranial Hemorrhage	• **Numerator**: Count of discharges for the following DRGs:
	  • **061** (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with major complication or comorbidity [MCC])
	  • **062** (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent with complication or comorbidity [CC])
	  • **063** (ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent without CC/MCC)
	  • **064** (intracranial hemorrhage or cerebral infarction with MCC)
	  • **065** (intracranial hemorrhage or cerebral infarction with CC or tissue plasminogen activator [tPA] in 24 hours)
	  • **066** (intracranial hemorrhage or cerebral infarction without CC/MCC)
	• **Denominator**: Count of discharges for the following DRGs:
	  • **061**, **062**, **063**, **064**, **065**, **066**, **067** (nonspecific cerebrovascular accident [CVA] and precerebral occlusion without infarct with MCC)
	  • **068** (nonspecific CVA and precerebral occlusion without infarct without MCC)
	  • **069** (transient ischemia without thrombolytic)

Respiratory Infections	• **Numerator**: Count of discharges for the following DRGs:
	  • **177** (respiratory infections and inflammations with MCC)
	  • **178** (respiratory infections and inflammations with CC)
	• **Denominator**: Count of discharges for the following DRGs:
	  • **177, 178, 179** (respiratory infections and inflammations w/o CC/MCC)
	  • **193** (simple pneumonia and pleurisy with MCC)
	  • **194** (simple pneumonia and pleurisy with CC)
	  • **195** (simple pneumonia and pleurisy without CC/MCC)

Simple Pneumonia	• **Numerator**: Count of discharges for the following DRGs:
	  • **193** (simple pneumonia and pleurisy with MCC)
	  • **194** (simple pneumonia and pleurisy with CC)
	• **Denominator**: Count of discharges for the following DRGs:
	  • **190** (chronic obstructive pulmonary disease with MCC)
	  • **191** (chronic obstructive pulmonary disease with CC)
	  • **192** (chronic obstructive pulmonary disease without CC/MCC)
	  • **193**, **194**, **195**

Septicemia	• **Numerator**: Count of discharges for the following DRGs:
	  • **870** (septicemia or severe sepsis with mechanical ventilation >96 hours)
	  • **871** (septicemia or severe sepsis without mechanical ventilation >96 hours with MCC)
	  • **872** (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC)

Target Area	Target Area Definition

Septicemia (continued)	• **Denominator**: Count of discharges for the following DRGs:
	  • **193** (simple pneumonia and pleurisy with MCC)
	  • **194** (simple pneumonia and pleurisy with CC)
	  • **195** (simple pneumonia and pleurisy without CC/MCC)
	  • **207** (respiratory system diagnosis with ventilator support >96 hours)
	  • **208** (respiratory system diagnosis with ventilator support ≤ 96 hours)
	  • **689** (kidney and urinary tract infections with MCC)
	  • **690** (kidney and urinary tract infections without MCC)
	  • **870**, **871**, **872**

Unrelated OR Procedure	• **Numerator**: Count of discharges for the following DRGs:
	  • **981** (extensive operating room [OR] procedure unrelated to principal diagnosis with MCC)
	  • **982** (extensive OR procedure unrelated to principal diagnosis with CC)
	  • **983** (extensive OR procedure unrelated to principal diagnosis without CC/MCC)
	  • **987** (non-extensive OR procedure unrelated to principal diagnosis with MCC)
	  • **988** (non-extensive OR procedure unrelated to principal diagnosis with CC)
	  • **989** (non-extensive OR procedure unrelated to principal diagnosis without CC/MCC)
	• **Denominator**: Count of all discharges for surgical DRGs[3]

CMS approved these ST PEPPER target areas because they have been identified as prone to improper Medicare payments. Historically, many of these target areas were the focus of OIG audits, while others were identified through the former Payment Error Prevention Program and Hospital Payment Monitoring Program, which were implemented by state Medicare Quality Improvement Organizations from 1999 through 2008. More recently, the Recovery Audit Contractor (RAC) (now referred to as a Recovery Auditor or RA) Program has identified additional areas prone to improper payments.

Note: There are changes in DRGs and DRG definitions from one fiscal year to the next to consider. Refer to the Federal Register for details.

1.2 How Hospitals Can Use PEPPER Data

For Medicare data, the fiscal year (FY) runs from October 1 through September 30 with quarters as follows:

- **Quarter 1**: October through December

[3] As defined by the IPPS Final Rule Table 5.

- **Quarter 2**: January through March
- **Quarter 3**: April through June
- **Quarter 4**: July through September

ST PEPPER provides short-term acute care hospitals with their national, jurisdiction, and state percentile values for each target area with reportable data for the most recent fiscal year quarter included in PEPPER. (Refer to *Section 2.1 - Compare Targets Report*.) "Reportable data" in PEPPER means there are 11 or more numerator discharges for a given target area for a given time period. Due to CMS data restrictions, PEPPER does not display statistics when there are fewer than 11 numerator discharges for a target area for a time period. *Table 3* can assist hospitals with interpreting these values.

Note: These are generalized suggestions and do not apply to all situations. For all areas, assess whether there is sufficient volume (i.e., 10 to 30 discharges for the year, depending on the hospital's total discharges for the year) to warrant a review of cases.

Table 3: Suggested Interventions for Outliers by Target Area

Target Area(s)	Suggested Interventions for High Outliers (If At/Above 80th Percentile)	Suggested Interventions for Low Outliers (If At/Below 20th Percentile)
Stroke Intracranial Hemorrhage	• May indicate potential over-coding. • Review a sample of medical records for DRGs **061**, **062**, **063**, **064**, **065**, and **066** to determine whether coding errors exist.	• May indicate coding or billing errors related to under-coding of DRGs **061**, **062**, **063**, **064**, **065**, and **066**. • Review a sample of medical records for other DRGs, such as DRGs **067**, **068**, and **069**, to determine whether coding errors exist. • Ensure documentation supports the principal diagnosis. A coder should not code based on radiological findings without seeking clarification from the physician.

Respiratory Infections	• May indicate coding or billing errors related to over-coding for DRGs **177** or **178**.
	• Review a sample of medical records for these DRGs to determine whether coding errors exist.
	• To ensure documentation supports the principal diagnosis, hospitals may generate data profiles to identify cases with the following principal diagnosis codes:
	  ◦ ICD-10-PCS code **J69.0** (pneumonitis due to inhalation of food or vomit)
	  ◦ ICD-10-PCS code **J15.69** (Pneumonia due to other Gram-negative bacteria)
		• May indicate coding or billing errors related to under-coding for DRGs **177** or **178**.
		• Review a sample of medical records for other DRGs such as DRGs **179**, **193**, **194**, or **195** to determine whether coding errors exist.
		• Only a physician can determine a diagnosis of pneumonia. A coder should not code based on laboratory or radiological findings without seeking clarification from the physician.

Target Area(s)	Suggested Interventions for High Outliers (If At/Above 80th Percentile)	Suggested Interventions for Low Outliers (If At/Below 20th Percentile)
Respiratory Infections (continued)	(continued from previous row) • ICD-10-PCS code **J15.8** (pneumonia due to other specified bacteria)	(continued from previous row; NA)
Simple Pneumonia	• May indicate coding or billing errors related to DRGs **193** or **194**. • Review a sample of medical records for these DRGs to determine whether coding errors exist. • Hospitals should ensure documentation supports the principal diagnosis.	• May indicate coding or billing errors related to under-coding for DRGs **193** or **194**. • Review a sample of medical records for other DRGs such as DRGs **190, 191, 192**, and **195** to determine whether coding errors exist. • Only a physician can determine a diagnosis of pneumonia. A coder should not code based on laboratory or radiological findings without seeking clarification from the physician.
Septicemia	• May indicate coding or billing errors related to over-coding of DRGs **870**, **871**, or **872**. • Review a sample of medical records for these DRGs to determine whether coding errors exist. • To ensure documentation supports the principal diagnosis, hospitals may generate data profiles to identify cases with a principal diagnosis code of ICD-10-CM code **A41.9** (Sepsis, unspecified organism).	• May indicate coding or billing errors related to under-coding of DRGs **870**, **871**, or **872**. • Review a sample of medical records for other DRGs such as DRGs **689**, **690**, **193**, **194**, **195**, **207**, and **208** to determine whether coding errors exist. • Only a physician can determine a diagnosis of septicemia/sepsis. A coder should not code based on laboratory or radiological findings without seeking clarification from the physician. **Note**: There is no ICD-10-CM code for urosepsis.
Unrelated OR Procedure	• May indicate coding or billing errors related to over-coding of DRGs **981**, **982**, **983**, **987**, **988**, or **989**. • Review a sample of medical records for these DRGs to determine whether the principal diagnosis and principal procedure are correct.	May indicate the principal diagnosis is being billed with related procedures. No intervention is necessary.

Comparative data for several consecutive quarters can be used to help identify whether the hospital's target area percents changed significantly in either direction from one quarter 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. It could also reflect changing business practices (e.g., new lines of service) or changes in the external healthcare environment.

2. Using PEPPER

PEPPER is a Microsoft Excel workbook that contains numerous worksheets. Users 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., Compare Targets Report, target area data tables, target area graphs).

2.1 Compare Targets Report

Hospitals 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 quarter 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."

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

The hospital's outlier status is indicated by the color 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.

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 quarter. 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 hospital's jurisdiction percentile for a target area is not calculated if there are fewer than 11 hospitals with reportable data for the target area in a 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 hospital's state percentile for a target area is not calculated if there are fewer than 11 hospitals with reportable data for the target area in the state.

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. The state should have the last priority because it has the smallest comparison group.

- Hospitals can also use the "Sum of Payments" and "Number of Target Discharges" to help prioritize areas for review. For example, the Compare Targets Report may show that the hospital is at the 85th national percentile for the Septicemia target area and at the 83rd national percentile for the Respiratory Infection target area. If the Respiratory Infection target area has a higher "Sum of Payments" and "Number of Target Discharges" than the

Septicemia target area. In this scenario, the Respiratory Infection target area might be given priority over the Septicemia target area.

2.2 National High Outlier Ranking Report

The National High Outlier Ranking Report provides a comparison of a hospital to all other short-term acute care hospitals in the nation in terms of high outlier status (at or above the national 80th percentile), and it also ranks a hospital based on the total number of target areas and time periods for which it is a high outlier. The hospital's national percentile is used to determine high outlier status. Note that a hospital may be identified as an outlier as compared to the nation but not as compared to its jurisdiction and/or state, and vice versa.

Outlier status in the National High Outlier Ranking Report is determined using the national percentile.

The report displays the results by quarter for all target areas in a grid format. For each target area and time period, the respective cell will contain a black "0" if the hospital is a low outlier or is not an outlier, a red "1" if the hospital is a high outlier, or "n/a" if the hospital does not have reportable data for that target area and time period. All quarters for which a hospital is at or above the national 80th percentile are added up for the target areas and are summed to provide the total number of high outliers. All hospitals in the nation are ranked by the total number of high outliers. The hospital with the greatest total number of high outliers is assigned a rank of "1," the hospital with the second greatest number of high outliers is assigned a rank of "2," and so on.

Because this report focuses on high outliers, it does not consider low outlier status for the coding-focused target areas. Hospitals may use the National High Outlier Ranking Report to:

- Assess risk for improper payments;
- Trend high outlier status across target areas;
- Compare outlier status among target areas; and/or
- Provide a high-level overview to leadership.

2.3 Target Area Data Tables

PEPPER data tables display a variety of statistics for each target area summarized over the previous 7 fiscal quarters. Statistics in each data table include the proportion of the numerator and denominator discharges (percent), the total numerator count of discharges for the target area (target area discharge count), the denominator count of discharges, average length of stay (ALOS), and Medicare payment data.

The "Outlier Status" column identifies when the hospital is a high outlier (the hospital's percent will be shown in red bold print), indicating that it is at or above the national 80th percentile. The "Outlier Status" column also identifies when the hospital is a low outlier, which is a status that is applicable for coding-focused target areas; if identified as a low outlier, the hospital's percent will be shown in green italics, indicating that it is at or below the national 20th percentile. The "Outlier Status" column will display "Not an outlier" when the hospital is not an outlier for the target area and time period, and it will display "No data" when the hospital does not have reportable data for the target area and time period.

The "Target Sum Medicare Payments" column is determined by adding the claim payment amount of all the 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 assist hospitals in considering 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 to provide a visual representation of the hospital's percent for each target area over the previous 7 fiscal quarters. Hospitals can identify significant changes from one quarter to the next, which could be a result of changes in the medical staff, coding or billing staff, utilization review processes, documentation improvement, or hospital services. External changes in health care providers in the community can also impact patient population/case mix, which may be reflected in PEPPER target area statistics. Hospitals are encouraged to identify root causes of major changes to ensure that improper payments are prevented.

The graphs include 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 these groups. A table of these percents is included on each target area graph worksheet. 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.

If there are no reportable data for the hospital for a given time period due to CMS data use restrictions, there will not be a data point on the graph for that respective time period. If there are fewer than 11 hospitals with reportable data for a target area in a state for one or more time periods, there will not be a data point/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 a jurisdiction for one or more time periods, there will not be a data point/trend line for the jurisdiction comparison group in the graph.

2.4 System Requirements, Customer Support, and Technical Assistance

PEPPER is a Microsoft Excel spreadsheet, which was developed in Excel 2016, 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, submit a request for assistance on the CMS CBR PEPPER website by selecting the "Help/Contact Us" tab. This website also contains many educational resources to assist hospitals with 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.
Cerebrovascular Accident	CVA	Commonly known as a stroke, a CVA is a medical condition where blood flow to the brain is interrupted, leading to brain damage or death.
Complication or Comorbidity	CC	A CC is a condition that, while not the primary reason for hospitalization, can increase length of stay, resource utilization, or treatment complexity.
Critical Access Hospital	CAH	CAH is a designation CMS gives to a small, rural hospital that provides limited inpatient care, 24-hour emergency services, and is located far from other hospitals, allowing it to receive cost-based Medicare reimbursements to help maintain services in underserved areas.
Diagnosis-Related Group	DRG	DRG is a system developed for Medicare in 1980, becoming effective in 1983, as a part of the Prospective Payment System (PPS) to classify hospital cases expected to have similar hospital resource use.
Fiscal Year	FY	For CMS, the FY is the 12-month period used for calculating annual fiscal spending, running from October 1 of the previous year to September 30 of the calendar year for which the FY is numbered.
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 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.

Term	Abbreviation	Definition
Index Analytics	Index	Index provides data integration services, including data architecture, master data management (MDM), data quality, security, and data warehousing.
Inpatient Prospective Payment System	IPPS	IPPS (or PPS) refers to Section 1886(d) of the Social Security Act (the Act) that sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.
Inpatient Psychiatric Facility	IPF	An IPF is a facility that provides intensive, 24-hour psychiatric care for individuals who cannot be safely or adequately managed at a lower level of care and is certified under Medicare as an inpatient psychiatric hospital.
Inpatient Rehabilitation Facility	IRF	An IRF is a hospital or specialized unit within a hospital that provides intensive, specialized rehabilitation services to patients who require a high level of care and therapy after an illness, surgery, or injury.
International Classification of Diseases	ICD	The ICD is the international standard diagnostic for classifying diseases and other health problems for health management and clinical use.
Length of Stay	LOS	LOS refers to the duration of time a patient spends in a healthcare facility, measured from admissions to discharge, and is a key metric for evaluating hospital efficiency and resource utilization.
Long-Term	LT	LT refers to long-term acute care hospitals.
Major Complication or Comorbidity	MCC	MCC refers to a secondary diagnosis that significantly complicates a patient's primary condition and increases the resources needed for their care, impacting treatment, prognosis, and resource utilization.
Medicare	NA	Medicare is the federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.
Medicare Administrative Contractor	MAC	The MAC is the contracting authority replacing the fiscal intermediary and carrier in performing Medicare Fee-for-Service claims processing activities.
Medicare 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.

Term	Abbreviation	Definition
Medicare Severity Diagnosis Related Group	MS-DRG	MS-DRG refers to the system CMS uses for inpatient hospital reimbursement. This system classifies patients into groups based on their principal diagnosis, secondary diagnoses, procedures, sex, and discharge status, to better reflect the severity of their illness and resource utilization.
Medicare Spending Per Beneficiary	MSPB	CMS uses the MSPB measure to evaluate hospital efficiency by comparing Medicare payments or an episode of care (three days before, during, and 30 days after a hospital stay) to the national median hospital's spending.
Office of Inspector General	OIG	The OIG is an HHS agency that protects the integrity of HHS programs as well as the health and welfare of the beneficiaries of those programs.
Operating Room	OR	An OR is a designated area within a hospital or healthcare facility specifically equipped to perform surgical procedures.
Outlier Status	NA	Outlier status refers to percentiles at or above the 80th percentile for any target areas or at or below the 20th percentile for coding-focused target areas.
Partial Hospitalization Program	PHP	PHP refers to an intensive outpatient psychiatric treatment program.
Program for Evaluating Payment Patterns Electronic Report	PEPPER	PEPPER is an electronic data report in Microsoft Excel format that contains a single hospital's claims data statistics for diagnosis-related groups (DRGs) and discharges at high risk for improper payments due to billing, coding, and/or admission necessity issues.
Prospective Payment System	PPS	PPS (or IPPS) refers to Section 1886(d) of the Social Security Act (the Act) that sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.
Recovery Audit Contractor	RAC	RACs are responsible for identifying improper Medicare payments made to healthcare providers that existing program integrity efforts did not detect.
Recovery Auditor	RA	RAs, formerly referred to as Recovery Audit Contractors (RACs), are contracted entities that identify and recover improper Medicare payments made to healthcare providers, focusing on both overpayments and underpayments.
Short-Term	ST	ST refers to short-term acute care hospitals.
Skilled Nursing Facility	SNF	A SNF is a facility that provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but do not require the level of care provided in a hospital.

Term	Abbreviation	Definition
UB-04	UB-04	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.