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

User Guide

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Table of Contents

List of Tables

What's new in this edition?

The existing Surgical Complication and Comorbidity (CC) Major Complication and Comorbidity (MCC) target area has been modified as of the Quarter 1 (Q1) of Fiscal Year (FY) 2024 (Q1FY2024) to remove Diagnosis Related Group (DRG) codes 246 and 248 and replace them with DRG 321 (Percutaneous cardiovascular procedures with intraluminal device with MCC or 4+ Arteries/Intraluminal Devices) and DRG 322 (Percutaneous cardiovascular procedures with intraluminal device without MCC. Refer to the Surgical DRGs with CC or MCC row in *Table 2*.

The existing Percutaneous Cardiovascular Procedures target area has been modified as of Q1FY2024 to remove DRG codes 246, 247, 248, and 249 and replace them with DRG 321 (Percutaneous cardiovascular procedures with intraluminal device with MCC or 4+ Arteries/Intraluminal Devices) and DRG 322 (Percutaneous cardiovascular procedures with intraluminal device without MCC). Refer to the Percutaneous Cardiovascular Procedures row in *Table 2*.

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. (IntegrityM) and GovCon Growth Solutions, LLC, develops and distributes PEPPER under contract with the Centers for Medicare & Medicaid Services (CMS).

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

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

PEPPER is available for 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, while the lower control limit 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.

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 or above the 80th percentile) or is in the bottom 20 percent of all hospital target area percents in

[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.

the respective comparison group (i.e., 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 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 a valid medical record number	UB-04 FL 03a or 03b is not null (blank)
Medicare claim payment amount greater than zero	The hospital received a payment amount greater than zero on the claim (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 the FY 2025 definitions for the ST PEPPER target areas. The 2023 and 2024 definitions are available in *Appendix B*.

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 infarction with MCC), • **068** (nonspecific CVA and precerebral occlusion without infarction without MCC), • **069** (transient ischemia without thrombolytic).
Respiratory Infection	**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** (simple pneumonia and pleurisy without CC/MCC).

Target Area	Target Area Definition
Septicemia	**Numerator**: Count of discharges for the following DRGs: • **870** (septicemia or severe sepsis with mechanical ventilation >96 hours), • **871** (septicemia or severe sepsis without mechanical ventilation >96 hours with MCC), and • **872** (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC). **Denominator**: Count of discharges for the following DRGs: • **193** (simple pneumonia and pleurisy with MCC), • **194** (simple pneumonia and pleurisy with CC), • **195** (simple pneumonia and pleurisy without CC/MCC), • **207** (respiratory system diagnosis with ventilator support >96 hours), • **208** (respiratory system diagnosis with ventilator support ≤ 96 hours), • **689** (kidney and urinary tract infections with MCC), • **690** (kidney and urinary tract infections without MCC), and • **870**, **871**, or **872**.
Unrelated Operating Room (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), and • **989** (non-extensive OR procedure unrelated to principal diagnosis without CC/MCC). **Denominator**: Count of all discharges for surgical DRGs.[3]

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

Target Area	Target Area Definition
Medical DRGs with CC or MCC	**Numerator**: Count of discharges for medical DRGs with "w CC", "w MCC," or "w CC/MCC" in DRG description. **Numerator Exclusions**: Exclude DRGs that can be assigned on the basis of a CC, MCC, or medication administration. For FY 2025, this includes the following DRGs: • **065** (intracranial hemorrhage or cerebral infarction with CC or tPA in 24 hours), • **124** (other disorders of the eye with mcc or thrombolytic agent), and • **838** (chemo with acute leukemia as secondary diagnosis (SDX) with CC or high dose chemo agent). **Denominator**: Count of discharges for medical DRGs with "w CC," "w MCC," "w CC/MCC," "wo CC," "wo MCC," or "wo CC/MCC" in the DRG description. **Denominator Exclusions**: Exclude DRGs that can be assigned on the basis of a CC, MCC, or medication administration. For FY 2025, this includes DRGs **065**, **124**, and **838**.
Surgical DRGs with CC or MCC	**Numerator**: Count of discharges for surgical DRGs with "w CC", "w MCC," or "w CC/MCC" in DRG description. **Numerator Exclusions**: Exclude DRGs that can be assigned on the basis of a CC, MCC, or a procedure. For Fiscal Year 2025, this includes the following DRGs: • **005** (liver transplant with MCC or intestinal transplant), • **023** (craniotomy with major device implant or acute complex CNS principal diagnosis with MCC or chemotherapy implant or epilepsy with neurostimulator), • **029** (spinal procedures with CC or spinal neurostimulators), • **041** (peripheral, cranial nerve and other nervous system procedures with CC or peripheral neurostimulator), • **276** (cardiac defibrillator implant with MCC or carotid sinus neurostimulator), • **321** (percutaneous cardiovascular procedures with intraluminal device with MCC or 4+ arteries/intraluminal devices), • **426** (multiple level combined anterior and posterior spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device), • **447** (multiple level spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device), • **450** (single level spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device), • **469** (major hip and knee joint replacement or reattachment of lower extremity with MCC or total ankle replacement), and • **518** (back and neck procedures except spinal fusion with MCC or disc device or neurostimulator). **Denominator**: Count of discharges for surgical DRGs with "w CC," "w MCC," "w CC/MCC," "wo CC," "wo MCC," or "wo CC/MCC" in the DRG description. **Denominator Exclusions**: Exclude DRGs that can be assigned on the basis of a CC, MCC, or medication administration. For FY 2025, this includes DRGs **005**, **023**, **029**, **041**, **276**, **321**, **426**, **447**, **450**, **469**, or **518**.

Target Area	Target Area Definition
Single CC or MCC	**Numerator**: Count of discharges for DRGs assigned on the basis of a CC or MCC with only one CC or MCC coded on the claim. **Numerator Exclusions**: Exclude DRGs that can be assigned on the basis of a CC, MCC, or a procedure. **Denominator**: Count of discharges for DRGs assigned on the basis of a CC or MCC. **Denominator Exclusions**: Exclude DRGs that can be assigned on the basis of a CC, MCC, or a procedure.
Severe Malnutrition	**Numerator**: Count of discharges for DRGs that can be assigned on the basis of an MCC, with one of the severe malnutrition codes (**E40**, **E41**, **E42**, or **E43**) as the only MCC. **Denominator**: Count of discharges for DRGs that are assigned on the basis of an MCC when one or more MCCs includes severe malnutrition.
Ventilator Support	**Numerator:** Count of discharges for the following DRGs, with International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) procedure code **5A1955Z** (ventilator support >96 consecutive hours) on the claim: • **003** (extracorporeal membrane oxygenation or tracheostomy with mechanical ventilation >96 hours or principal diagnosis except face, mouth, and neck with major OR procedure), • **004** (tracheostomy with mechanical ventilation >96 hours or principal diagnosis except face, mouth, and neck without major OR procedure), • **207** (respiratory system diagnosis with ventilator support >96 hours), • **870** (septicemia or severe sepsis with mechanical ventilation >96 hours), • **927** (extensive burns or full thickness burns with mechanical ventilation >96 hours with skin graft), and • **933** (extensive burns or full thickness burns with mechanical ventilation >96 hours without skin graft). **Denominator**: Count of discharges for the following DRGs: • **003**, **004**, **207**, • **208** (respiratory system diagnosis with ventilator support < 96 hours), • **870**, • **871** (septicemia or severe sepsis without mechanical ventilation >96 hours with MCC), • **872** (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC), • **927**, • **928** (full thickness burns with skin graft or inhalation injury with CC or MCC), • **929** (full thickness burns with skin graft or inhalation injury without CC or MCC), • **933**, and • **934** (full thickness burn without skin graft or inhalation injury).

Target Area	Target Area Definition
Percutaneous Cardiovascular Procedures	**Numerator**: Count of discharges for the following DRGs: • **321** (Percutaneous cardiovascular procedures with intraluminal device with MCC or 4+ Arteries/Intraluminal Devices), and • **322** (Percutaneous cardiovascular procedures with intraluminal device without MCC). **Denominator**: Count of discharges for the following DRGs: **321** and **322.** Including outpatient claims with Current Procedural Terminology® (CPT®) codes **92928**, **92933**, **92937**, or **92943** or with Healthcare Common Procedure Coding System (HCPCS) codes **C9600**, **C9602**, **C9604**, or **C9607.**
Total Knee Replacement	**Numerator**: Count of discharges with at least one of the ICD-10-PCS knee replacement procedure codes. **Denominator:** Count of discharges with at least one of the ICD-10-PCS knee replacement procedure codes, and outpatient claims with CPT® code **27447**.
Syncope	**Numerator**: Count of discharges for DRG **312** (syncope and collapse). **Denominator**: Count of discharges for medical DRGs in Major Diagnostic Category (MDC) **05** (circulatory system).
Other Circulatory System Diagnoses	**Numerator**: Count of discharges for DRGs: • **314** (other circulatory system diagnoses with MCC), • **315** (other circulatory system diagnoses with CC), and • **316** (other circulatory system diagnoses without CC/MCC). **Denominator**: Count of discharges for medical DRGs in MDC **05** (circulatory system).
Other Digestive System Diagnosis	**Numerator**: Count of discharges for DRGs: • **393** (other digestive system diagnoses with MCC), • **394** (other digestive system diagnoses with CC), and • **395** (other digestive system diagnoses without CC/MCC). **Denominator**: Count of discharges for medical DRGs in MDC **06** (digestive system).
Medical Back Problems	**Numerator**: Count of discharges for DRGs: • **551** (medical back problems with MCC), and • **552** (medical back problems without MCC). **Denominator**: Count of all discharges for medical DRGs in MDC **08** (musculoskeletal system and connective tissue).
Spinal Fusion	**Numerator**: Count of discharges that have at least one **ICD-10-PCS** spinal fusion procedure code, and outpatient claims with at least one **CPT**® spinal fusion procedure code. **Denominator**: Count of discharges that have at least one **ICD-10-PCS** spinal procedure code and outpatient claims with at least one **CPT**® spinal procedure code.

Target Area	Target Area Definition
3-Day Skilled Nursing Facility (SNF)-Qualifying Admissions	**Numerator**: Count of discharges to an SNF with a 3-day length of stay (LOS). Discharges to an SNF are identified by the following patient discharge status codes: • **03** (discharged or transferred to an SNF), • **61** (discharged or transferred to a swing bed), • **83** (discharged or transferred to an SNF with a planned acute care hospital inpatient admission), and • **89** (discharged or transferred to a swing bed with a planned acute care hospital inpatient admission). **Denominator**: Count of all discharges to an SNF, identified by the following patient discharge status codes: **03**, **61**, **83**, or **89**.
30-Day Readmissions to Same Hospital or Elsewhere	**Numerator**: Count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the same hospital or to another short-term acute care prospective payment system (PPS) hospital for the same beneficiary (identified using the Health Insurance Claim number). **Numerator Exclusions**: Exclude claims for the index admission or readmission where the patient discharge status is one of the following: • **02** (discharged/transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), or • **82** (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software (CCS) diagnosis categories. **Denominator**: Count of all discharges. **Denominator Exclusions**: Claims for the index admission or readmission where the patient discharge status is one of the following: **02**, **07**, **20**, or **82**. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCS diagnosis categories. (Refer to *Appendix B* for more specifics regarding how readmissions are identified.)

Target Area	Target Area Definition
30-Day Readmissions to Same Hospital	**Numerator**: Count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the same hospital for the same beneficiary (identified using the Health Insurance Claim number). **Numerator Exclusions**: Exclude claims for the index admission or readmission where the patient discharge status is one of the following: • **02** (discharged/transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), or • **82** (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCS diagnosis categories. **Denominator**: Count of all discharges. **Denominator Exclusions**: Exclude claims for the index admission or readmission where the patient discharge status is one of the following: **02**, **07**, **20**, or **82.** Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCS diagnosis categories. (Refer to *Appendix B* for more specifics regarding how readmissions are identified.)
2-Day Stays for Medical DRGs	**Numerator**: Count of discharges for medical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days). **Numerator Exclusions**: Exclude claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), or • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for medical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, or **82**. Exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.

Target Area	Target Area Definition
2-Day Stays for Surgical DRGs	**Numerator**: Count of discharges for surgical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days). **Numerator Exclusions**: Exclude claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), or • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for surgical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, or **82**. Exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.
1-Day Stays for Medical DRGs	**Numerator**: Count of discharges for medical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day). **Numerator Exclusions**: Claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), or • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for medical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, or **82**. Exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.

Target Area	Target Area Definition
1-Day Stays for Surgical DRGs	**Numerator**: Count of discharges for surgical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day). **Numerator Exclusions**: Exclude claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), or • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). And exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for surgical DRGs **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, or **82**. And exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.

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. A full list of Medical and Surgical DRGs, including those with CC, MCC, CC/MCC, and without CC, MCC, CC/MCC in the description are available in the CMS MS-DRG Definitions Manual available on the CMS website: ICD-10-CM/PCS MS-DRG Definitions Manual.

The OIG found widespread miscoding of severe malnutrition in instances where hospitals should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all.[4] Four ICD-10 diagnosis codes - E40, E41, E42, and E43 - qualify as an MCC and can raise the payment for a claim if included as a secondary diagnosis.

Effective January 1, 2018, total knee replacement procedures were removed from CMS's inpatient only list, allowing these procedures to be performed on an inpatient or outpatient basis. CMS maintains that the decision to admit a patient as an inpatient is a complex medical

[4] Department of Health and Human Services, Office of the Inspector General. 2020. *Hospitals Overbilled Medicare $1 Billion by Incorrectly Assigning Severe Malnutrition Diagnosis Codes to Inpatient Hospital Claims*, Report No. A-03-17-00010, July 2020. Available at: Department of Health and Human Services OFFICE OF INSPECTOR GENERAL

decision, based on the physician's clinical expectation of how long hospital care is anticipated to be necessary and the individual beneficiary's unique clinical circumstances. Analysis of claims data for calendar year 2019 indicates that approximately 30 percent of hospitals perform all total knee replacement procedures as inpatient. Short inpatient hospital admissions, in particular one-day stays, have had high rates of unnecessary admissions historically. CMS reported an improper payment rate of 24.3 percent in the *2024 Medicare Fee-for Service Supplemental Payment Data Report* for inpatient stays lasting one night or less.[5] The FY 2014 Inpatient Prospective Payment System (IPPS) Final Rule changed admission and medical review criteria that CMS contractors (i.e., MACs and RAs) use to review inpatient hospital admissions for payment purposes. Generally, inpatient hospital admission is considered appropriate if the physician expects the beneficiary to require a stay that crosses two midnights and admits the beneficiary based on that expectation.[6]

To assist hospitals with monitoring short stays, several target areas in PEPPER focus on one- and two-day stays. Under the CMS admission and medical review criteria, one-day stays may not be appropriate inpatient admissions, and two-day stays may be appropriate admissions. Hospitals can examine their statistics for these target areas to help them assess their risk for unnecessary admissions and to monitor changes in admission practices over time.

Readmissions have been associated with billing errors, premature discharge, incomplete care, and inappropriate readmission. There are two target areas relating to readmissions within 30 days of discharge: one including statistics for patients who were readmitted to either the same hospital or to another short-term acute care hospital, and the other including statistics for patients who were readmitted to the same hospital. The PEPPER readmission statistics do not incorporate risk adjustment or exclude planned readmissions due to the significant complexity and processing time to generate statistics for inclusion in the PEPPER.

PEPPER does not include condition-specific readmission information as these readmissions do not occur frequently enough during a quarter for most hospitals to have sufficient data to report.

In addition, some hospitals have requested patient-level data for their readmissions. Due to patient privacy regulations, the PEPPER Team cannot disclose to providers any information that would identify when a beneficiary was admitted to another provider.

Three-day SNF-qualifying admissions have been found to be problematic in terms of admission necessity, and historical data indicates that three-day SNF-qualifying admissions have a higher incidence of unnecessary admissions than other three-day admissions.

The coding of CCs and more recently MCCs has been found to be problematic. Oversight agencies have identified coding errors related to the addition of a CC or MCC that were not substantiated by documentation in the medical record. The target areas relating to medical and surgical DRGs with a CC or MCC and to discharges with a single CC or MCC focus on this issue. Note that as of October 01, 2015, a principal diagnosis may also be a CC or MCC.

[5] Department of Health and Human Services. 2024. *2024 Medicare Fee-for-Service Supplemental Improper Payment Data*, page 26. Available at: 2024 Medicare Fee-for Service Supplemental Improper Payment Data

[6] Department of Health and Human Services/Centers for Medicare & Medicaid Services. 2013. *Federal Register* 78, no. 160, Aug. 19, 2013. Available at: Federal Register/Vol. 78, No. 160/Monday, August 19, 2013/Rules and Regulations

Please note there are changes in DRGs and DRG definitions from one fiscal year to the next that should be considered. Details can be found in the Federal Register. A list of the target area definitions for FY 2023 and FY 2024 are listed in *Appendix B*.

1.2 How Hospitals Can Use PEPPER Data

For Medicare data, the FY runs from October 01 through September 30 with quarters as follows:

- **Quarter 1**: October through December
- **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*) "Reportable Data" in PEPPER means there are eleven 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.

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 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)
Stroke Intracranial Hemorrhage	• This could indicate potential coding or billing errors related to over-coding of DRGs **061**, **062**, **063**, **064**, **065**, and **066**. • Review a sample of medical records for these DRGs to determine whether coding errors exist.	• This could 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. • Remember to ensure that the documentation supports the principal diagnosis. • A coder should not code based on radiological findings without seeking clarification from the physician.

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)

Respiratory Infections	• This could indicate potential 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:
	  • International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code **J69.0** (pneumonitis due to inhalation of food or vomit)
	  • ICD-10-CM code **J15.69** (Pneumonia due to other Gram-negative bacteria)
	  • ICD-10-CM code **J15.8** (pneumonia due to other specified bacteria)
		• This could 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.

Simple Pneumonia	• This could indicate potential coding or billing errors related to over-coding of DRGs **193** or **194**. • Review a sample of medical records for these DRGs to determine whether coding errors exist. • Remember to ensure that the documentation supports the principal diagnosis.	• This could 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.

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
Septicemia	• This could indicate coding or billing errors related to over-coding of DRGs **870**, **871**, or **872**. • Review a sample of medical records for these DRGs to determine whether coding errors exist. • To ensure documentation supports the principal diagnosis, hospitals may generate data profiles to identify cases with a principal diagnosis code of ICD-10-CM code **A41.9** (Sepsis, unspecified organism).	• This could indicate coding or billing errors related to under-coding of DRGs **870**, **871**, or **872**. • Review a sample of medical records for other DRGs such as DRGs **689**, **690**, **193**, **194**, **195**, **207**, and **208** to determine whether coding errors exist. • Only a physician can determine a diagnosis of septicemia/sepsis. A coder should not code based on laboratory or radiological findings without seeking clarification from the physician. **Note**: There is no ICD-10-CM code for urosepsis.
Unrelated OR Procedure	• This could 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.	This could indicate that the principal diagnosis is being billed with related procedures. No intervention is necessary.
Medical CC/MCC	• This could indicate that there are coding or billing errors related to over-coding due to unsubstantiated CCs or MCCs. • A sample of medical records for medical DRGs with CCs or MCCs should be reviewed to determine whether coding errors exist. • Hospitals may generate data profiles to identify proportions of their CCs or MCCs to determine whether there are any particular medical DRGs on which to focus. • Remember that a diagnosis of a CC or MCC must be determined by the physician. • A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. • If particular diagnoses are found to be problematic, provide education.	• This could indicate that there are coding or billing errors related to under-coding for CCs or MCCs. • A sample of medical records for medical DRGs without a CC or MCC should be reviewed to determine whether coding errors exist. • Remember that in order for a diagnosis to be coded as a CC or MCC, it must be substantiated by documentation. • A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. • Consider whether the use of a physician query would have substantiated a CC or MCC.

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)
Surgical CC/MCC	• This could indicate that there are coding or billing errors related to over-coding due to unsubstantiated CCs or MCCs. • A sample of medical records for surgical DRGs with CCs or MCCs should be reviewed to determine whether coding errors exist. • Hospitals may generate data profiles to identify proportions of their CCs or MCCs to determine whether there are any particular surgical DRGs on which to focus. • Remember that a diagnosis of a CC or MCC must be determined by the physician. • A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. • If particular diagnoses are found to be problematic, provide education.	• This could indicate that there are coding or billing errors related to under-coding for CCs or MCCs. • A sample of medical records for surgical DRGs without a CC or MCC should be reviewed to determine whether coding errors exist. • Remember that in order for a diagnosis to be coded as a CC or MCC, it must be substantiated by documentation. • A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. • Consider whether the use of a physician query would have substantiated a CC or MCC.
Single CC or MCC	• This could indicate that there are coding or billing errors related to over-coding due to unsubstantiated CCs or MCCs. • A sample of medical records for a single CC or MCC should be reviewed to determine whether coding errors exist. Hospitals may generate data profiles to identify proportions of their CCs or MCCs to determine whether there are any particular medical and/or surgical DRGs on which to focus. • If particular diagnoses are found to be problematic, provide education.	• This could indicate that there are coding or billing errors related to under-coding for CCs or MCCs. • A sample of medical records for medical and/or surgical DRGs without a CC or MCC should be reviewed to determine whether coding errors exist. • Remember that in order for a diagnosis to be coded as a CC or MCC, it must be substantiated by documentation. • A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. Consider whether the use of a physician query would have substantiated a CC or MCC.

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)
Severe Malnutrition	• This could indicate that there are coding errors related to unsubstantiated coding of one of the severe malnutrition codes (i.e., **E40**, **E41**, **E42**, or **E43**) as the only MCC. • A sample of medical records with a severe malnutrition code as the only MCC should be reviewed to determine whether coding errors exist. • A diagnosis of severe malnutrition must be determined by the physician. • A coder should not code based on laboratory findings or nutritional consultation without seeking physician determination of the clinical significance of the abnormal findings.	• This could indicate that there are coding errors related to potential under-coding of severe malnutrition codes (i.e., **E40**, **E41**, **E42**, or **E43**). • A sample of medical records should be reviewed to determine whether coding errors exist. • A diagnosis of severe malnutrition must be determined by the physician. • A coder should not code based on laboratory findings or nutritional consultation without seeking physician determination of the clinical significance of the abnormal findings.
Ventilator Support	• This could indicate that there are coding or billing errors related to over-coding of DRGs **003**, **004**, **207**, **870**, **927**, or **933**. • A sample of medical records for these DRGs should be reviewed to determine whether the type of tracheostomy and mechanical ventilation were coded correctly. • Verify that the number of continuous invasive mechanical ventilation hours was coded accurately.	• This could indicate under-coding related to incorrect computation of the number of hours the patient was receiving continuous invasive mechanical ventilation. • Review cases with ICD-10-PCS procedure codes **5A1935Z** (mechanical ventilation less than 24 consecutive hours) and **5A1945Z** (mechanical ventilation 24-96 consecutive hours) to verify that the number of continuous invasive mechanical ventilation hours was coded accurately.
Percutaneous Cardiovascular Procedures	• This could indicate that there are unnecessary admissions related to the use of outpatient observation or inappropriate use of admission screening criteria associated with DRGs **321** and **322**. • A sample of medical records for these DRGs should be reviewed to determine whether inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation).	Not applicable, as this is an admission-necessity focused 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)
Total Knee Replacement	• This could indicate that there are unnecessary admissions related to the inappropriate use of admission screening criteria associated with total knee replacement procedures. • A sample of medical records for these procedures should be reviewed to determine whether inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation).	Not applicable, as this is an admission-necessity focused target area.
Syncope	• This could indicate potential unnecessary admissions related to the failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRG **312**. • Review a sample of medical records for DRG **312** to determine whether care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). **Note**: Code to the underlying cause of syncope, if known.	Not applicable, as this is an admission-necessity focused target area.
Other Circulatory System Diagnoses	• This could indicate potential unnecessary admissions related to the failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRGs **314**, **315**, or **316**. • A sample of medical records for these DRGs should be reviewed to determine whether care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation).	Not applicable, as this is an admission-necessity focused 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)
Other Digestive System Diagnoses	• This could indicate potential unnecessary admissions related to the failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRGs **393**, **394**, or **395**. • A sample of medical records for these DRGs should be reviewed to determine whether care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation).	Not applicable, as this is an admission-necessity focused target area.
Medical Back	• This could indicate potential unnecessary admissions related to the failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRGs **551** or **552**. • A sample of medical records for these DRGs should be reviewed to determine whether inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation).	Not applicable, as this is an admission-necessity focused target area.
Spinal Fusion	• This could indicate that unnecessary spinal fusion procedures may have been performed. • A sample of medical records for spinal fusion cases, including both the inpatient and outpatient setting, should be reviewed to validate the medical necessity of the procedure. • Medical record documentation of 1) previous non-surgical treatment, 2) physical examination clearly documenting the progression of neurological deficits, extremity strength, activity modification, and pain levels, 3) diagnostic test results and interpretation, and 4) adequate history of the presenting illness, may help substantiate the necessity of the procedure.	Not applicable, as this is an admission-necessity focused 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)
3-Day Skilled Nursing Facility-Qualifying Admissions	• This could indicate that there are unnecessary admissions related to the inadequate use of medical necessity to qualify patients for an SNF admission. • A sample of medical records with 3-day lengths of stay and patient discharge status codes of **03**, **61**, **83** or **89** should be reviewed to determine whether the admission was necessary.	Not applicable, as this is an admission-necessity focused target area.
30-Day Readmissions to the Same Hospital or Elsewhere and 30-Day Readmissions to the Same Hospital	• A sample of readmission cases should be reviewed to identify appropriateness of admission, discharge, quality of care, DRG assignment, and billing errors. • Hospitals may generate data profiles for readmissions, such as patients readmitted the same day or next day after discharge. • Hospitals may use patient identifier, date of admission, date of discharge, patient discharge status code, principal and secondary diagnoses, procedure code(s), and DRG to profile these admissions and identify patterns.	Not applicable, as these are admission-necessity focused target areas.
2-Day Stay Medical DRGs and 2-Day Stay Surgical DRGs	• This could indicate that there are unnecessary admissions related to the inappropriate use of admission screening criteria or outpatient observation. • A sample of medical records with two-day length of stay should be reviewed to determine whether inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). Hospitals may generate data profiles to identify 2-day stays sorted by DRG, physician, or admission source to assist in the identification of any patterns related to increasing two-day stays.	Not applicable, as these are admission-necessity focused target areas.

Target Area(s)	Suggested Interventions for High Outliers (If at or above the 80th Percentile)	Suggested Interventions for Low Outliers (If at or below the 20th Percentile)
1-Day Stay Medical DRGs and 1-Day Stay Surgical DRGs	• This could indicate that there are unnecessary admissions related to the inappropriate use of admission screening criteria or outpatient observation. • A sample of medical records with 1-day length of stay cases should be reviewed to determine whether inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). • Hospitals may generate data profiles to identify 1-day stays sorted by DRG, physician, or admission source to assist in the identification of any patterns related to 1-day stays. • Hospitals may also wish to identify whether patients admitted for 1-day stays were treated in outpatient, outpatient observation, or the emergency department for one or more nights prior to the inpatient admission. Hospitals should not review 1-day stays that are associated with procedures designated by CMS as “inpatient only.”	Not applicable, as these are admission-necessity focused target areas.

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., Definitions, Compare, Outlier Rank, and specific Target Area).

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, and percentiles, as compared to the nation, jurisdiction, state, and the "Sum of Payments."

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

The hospital's outlier status is indicated by the color of the target area percent on the Compare Targets Report. When the hospital is a high outlier for a target area, the hospital percentile is printed in red bold. When the hospital is a low outlier, the hospital percentile is printed in green italics. When the hospital is not an outlier, the hospital's percentile 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, 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. 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 nine 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 percentile 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. In such cases, 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 percentage for each target area over the previous nine 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 is no reportable data for the quarter, the table will display #N/A in the cell.

If there is 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 or in the jurisdiction for one or more time periods, there will not be a data point/trend line for the state or jurisdiction comparison group in the graph.

2.3.1 Hospital and Jurisdiction Top DRGs for One-Day Stay and Same-Day Stay Discharge Reports

Below the tables and graphs for the one-day stay Medical DRGs and one-day stay Surgical DRGs target areas are two supplemental reports that list the top Medical and Surgical DRGs for same-day and one-day stays for your hospital and your jurisdiction, respectively.

The Hospital Top DRGs table lists the top DRGs for same-day and one-day stays for your hospital in the most recent four fiscal quarters, excluding patient discharge status codes **02**, **07**, **20**, and **82**, along with claims with occurrence span code **72** with "through" date on or day prior to inpatient admission. It also includes the total hospital discharges for each of the top DRGs listed, the proportion of same-day and one-day stays to total discharges and the average hospital LOS for each DRG.

The Jurisdiction Top DRGs table lists the top DRGs for same-day and one-day stays for all hospitals in your jurisdiction in the most recent four fiscal quarters, excluding patient discharge status codes **02**, **07**, **20**, and **82**, along with claims with occurrence span code **72** with a "through" date on or the day prior to an inpatient admission. It also includes the total jurisdiction-wide discharges for each of the top DRGs listed, the proportion of same-day and one-day stays to total discharges, and the ALOS for each DRG.

Please note that these reports are limited to display the top 20 ranked DRGs, for which there are a total of at least 11 same-day and one-day stays (for the respective DRG) during the most recent four fiscal quarters. If multiple DRGs share the same rank, all tied DRGs will be displayed. If there are no DRGs with a total of at least 11 same-day and one-day stays during the most recent four fiscal quarters, then no data will display on the table.

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 personal computer (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.
Clinical Classifications Software	CCS	CCS is used to analyze costs, usage, and outcomes associated with patient diagnoses and procedures.
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.
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.
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.
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.

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.
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).
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	Index	Index provides data integration services, including data architecture, master data management, data quality, security, and data warehousing.
Inpatient Prospective Payment System	IPPS	IPPS (or PPS) refers to Section 1886(d) of the Social Security 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, 10th Revision, Procedure Coding System	ICD-10-PCS	ICD-10-PCS is a U.S.-specific coding system used in hospital inpatient settings to classify medical procedures.
Integrity Management Services, Inc.	IntegrityM	IntegrityM is a women-owned small business empowering Federal Government, State agencies, and private sector organizations to make more informed decisions.

Term	Abbreviation	Definition
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.
Major Diagnostic Category	MDC	MDC is a classification that groups inpatient diagnoses based on a similar body system or etiology, like the circulatory or respiratory system.
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.
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.

Term	Abbreviation	Definition
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.
Percutaneous Cardiovascular	CV	CV refers to a group of minimally invasive medical procedures that use catheters to treat cardiovascular diseases.
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.
Quarter 1	Q1	NA
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.
Secondary Diagnosis	SDX	SDX is any medical condition that coexists with the primary reason for a patient's admission or treatment.
Short-Term	ST	ST refers to short-term acute care hospitals.
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.

Term	Abbreviation	Definition
Tissue Plasminogen Activator	tPA	tPA is a protein that acts as a "clot buster" to dissolve blood clots.
UB-04	NA	Institutional healthcare providers, such as hospitals and rehabilitation facilities, use the UB-04 standardized claim form (also known as CMS-1450), to submit billing information to insurance companies, including Medicare and Medicaid.

Appendix B: Historical Target Area Definitions for FY 2023 and 2024

Table 5: Historical Target Area Definitions for FY 2023 and 2024

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
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), and • **066** (intracranial hemorrhage or cerebral infarction without CC/MCC). **Denominator**: Count of discharges for the following DRGs: • **061**, **062**, **063**, **064**, **065**, **066**, and **067** (nonspecific CVA and precerebral occlusion without infarction with MCC), • **068** (nonspecific CVA and precerebral occlusion without infarction without MCC), and • **069** (transient ischemia without thrombolytic).	**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), and • **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 CVA and precerebral occlusion without infarction with MCC), • **068** (nonspecific CVA and precerebral occlusion without infarction without MCC), and • **069** (transient ischemia without thrombolytic).

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
Respiratory Infection	**Numerator**: Count of discharges for the following DRGs: • **177** (respiratory infections and inflammations with MCC), and • **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), and • **195** (simple pneumonia and pleurisy without CC/MCC).	**Numerator**: Count of discharges for the following DRGs: • **177** (respiratory infections and inflammations with MCC), and • **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), and • **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), and • **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**, and • **195** (simple pneumonia and pleurisy without CC/MCC).	**Numerator**: Count of discharges for the following DRGs: • **193** (simple pneumonia and pleurisy with MCC), and • **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**, and • **195** (simple pneumonia and pleurisy without CC/MCC).

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

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
Unrelated Operating Room (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), and • **989** (non-extensive OR procedure unrelated to principal diagnosis without CC/MCC). **Denominator**: Count of all discharges for surgical DRGs.[7]	**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), and • **989** (non-extensive OR procedure unrelated to principal diagnosis without CC/MCC). **Denominator**: Count of all discharges for surgical DRGs.[8]

[7] As defined by the 2023 IPPS Final Rule Table 5
[8] As defined by the 2024 IPPS Final Rule Table 5

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
Medical DRGs with CC or MCC	**Numerator**: Count of discharges for medical DRGs with "w CC", "w MCC," or "w CC/MCC" in the DRG description. **Numerator Exclusions**: Exclude DRGs that can be assigned on the basis of a CC, MCC, or medication administration. For FY 2023, this includes the following DRGs: • **065** (intracranial hemorrhage or cerebral infarction with CC or tPA in 24 hours), and • **838** (chemo with acute leukemia as secondary diagnosis (SDX) with CC or high dose chemo agent). **Denominator**: Count of discharges for medical DRGs with "w CC," "w MCC," "w CC/MCC," "wo CC," "wo MCC," or "wo CC/MCC" in the DRG description. **Denominator Exclusions**: Exclude DRGs **065** and **838**.	**Numerator**: Count of discharges for medical DRGs with "w CC", "w MCC," or "w CC/MCC" in the DRG description. **Numerator Exclusions**: Exclude DRGs that can be assigned on the basis of a CC, MCC, or medication administration. For FY 2024, this includes the following DRGs: • **065** (intracranial hemorrhage or cerebral infarction with CC or tPA in 24 hours), • **124** (other disorders of the eye with mcc or thrombolytic agent), and • **838** (chemo with acute leukemia as secondary diagnosis (SDX) with CC or high dose chemo agent). **Denominator**: Count of discharges for medical DRGs with "w CC," "w MCC," "w CC/MCC," "wo CC," "wo MCC," or "wo CC/MCC" in the DRG description. **Denominator Exclusions**: Exclude DRGs **065**, **124**, and **838**.
Surgical DRGs with CC or MCC	**Numerator**: Count of discharges for surgical DRGs with "w CC", "w MCC," or "w CC/MCC" in the DRG description. **Numerator Exclusions**: DRGs that can be assigned on the basis of a CC, MCC, or a procedure. For Fiscal Year 2025, this includes the following DRGs: • **005** (liver transplant with MCC or intestinal transplant), • **023** (craniotomy with major device implant or acute complex CNS principal diagnosis with MCC or chemotherapy implant or epilepsy with neurostimulator), • **029** (spinal procedures with CC or spinal neurostimulators), • **041** (peripheral, cranial nerve and other nervous system procedures with CC or peripheral neurostimulator),	**Numerator**: Count of discharges for surgical DRGs with "w CC", "w MCC," or "w CC/MCC" in the DRG description. **Numerator Exclusions**: DRGs that can be assigned on the basis of a CC, MCC, or a procedure. For Fiscal Year 2025, this includes the following DRGs: • **005** (liver transplant with MCC or intestinal transplant), • **023** (craniotomy with major device implant or acute complex CNS principal diagnosis with MCC or chemotherapy implant or epilepsy with neurostimulator), • **029** (spinal procedures with CC or spinal neurostimulators), • **041** (peripheral, cranial nerve and other nervous system procedures with CC or peripheral neurostimulator),

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
Surgical DRGs with CC or MCC (Continued)	• **246** (percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries or stents), • **248** (percutaneous cardiovascular procedures with non-drug-eluting stent with MCC or 4+ arteries or stents), • **469** (major hip and knee joint replacement or reattachment of lower extremity with MCC or total ankle replacement), and • **518** (back and neck procedures except spinal fusion with MCC or disc device or neurostimulator). **Denominator**: Count of discharges for surgical DRGs with "w CC," "w MCC," "w CC/MCC," "wo CC," "wo MCC," or "wo CC/MCC" in the DRG description. **Denominator Exclusions**: Exclude DRGs **005**, **023**, **029**, **041**, **246**, **248**, **469**, and **518**.	• **321** (percutaneous cardiovascular procedures with intraluminal device with MCC or 4+ arteries/intraluminal devices), • **469** (major hip and knee joint replacement or reattachment of lower extremity with MCC or total ankle replacement), and • **518** (back and neck procedures except spinal fusion with MCC or disc device or neurostimulator). **Denominator**: Count of discharges for surgical DRGs with "w CC," "w MCC," "w CC/MCC," "wo CC," "wo MCC," or "wo CC/MCC" in the DRG description. **Denominator Exclusions**: Exclude DRGs **005**, **023**, **029**, **041**, **321**, **469**, and **518**.
Single CC or MCC	**Numerator**: Count of discharges for DRGs assigned on the basis of a CC or MCC with only one CC or MCC coded on the claim. **Numerator Exclusions**: DRGs that can be assigned on the basis of a CC, MCC, or a procedure. **Denominator**: Count of discharges for DRGs assigned on the basis of a CC or MCC. **Denominator Exclusions**: DRGs that can be assigned on the basis of a CC, MCC, or a procedure.	**Numerator**: Count of discharges for DRGs assigned on the basis of a CC or MCC with only one CC or MCC coded on the claim. **Numerator Exclusions**: DRGs that can be assigned on the basis of a CC, MCC, or a procedure. **Denominator**: Count of discharges for DRGs assigned on the basis of a CC or MCC. **Denominator Exclusions**: DRGs that can be assigned on the basis of a CC, MCC, or a procedure.
Severe Malnutrition	**Numerator**: Count of discharges for DRGs that can be assigned on the basis of an MCC, with one of the severe malnutrition codes (**E40**, **E41**, **E42**, or **E43**) as the only MCC. **Denominator**: Count of discharges for DRGs that are assigned on the basis of an MCC when one or more MCCs includes severe malnutrition.	**Numerator**: Count of discharges for DRGs that can be assigned on the basis of an MCC, with one of the severe malnutrition codes (**E40**, **E41**, **E42**, or **E43**) as the only MCC. **Denominator**: Count of discharges for DRGs that are assigned on the basis of an MCC when one or more MCCs includes severe malnutrition.

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
Ventilator Support	**Numerator**: Count of discharges for the following DRGs, with ICD-10-PCS procedure code **5A1955Z** (ventilator support >96 consecutive hours) on the claim: • **003** (extracorporeal membrane oxygenation or tracheostomy with mechanical ventilation >96 hours or principal diagnosis except face, mouth, and neck with major OR procedure), • **004** (tracheostomy with mechanical ventilation >96 hours or principal diagnosis except face, mouth, and neck without major OR procedure), • **207** (respiratory system diagnosis with ventilator support >96 hours), • **870** (septicemia or severe sepsis with mechanical ventilation >96 hours), • **927** (extensive burns or full thickness burns with mechanical ventilation >96 hours with skin graft), and • **933** (extensive burns or full thickness burns with mechanical ventilation >96 hours without skin graft). **Denominator**: Count of discharges for the following DRGs: • **003, 004, 207,** • **208** (respiratory system diagnosis with ventilator support < 96 hours), • **870,** • **871** (septicemia or severe sepsis without mechanical ventilation >96 hours with MCC), • **872** (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC), • **927**, • **928** (full thickness burns with skin graft or inhalation injury with CC or MCC),	**Numerator**: Count of discharges for the following DRGs, with ICD-10-PCS procedure code **5A1955Z** (ventilator support >96 consecutive hours) on the claim: • **003** (extracorporeal membrane oxygenation or tracheostomy with mechanical ventilation >96 hours or principal diagnosis except face, mouth, and neck with major OR procedure), • **004** (tracheostomy with mechanical ventilation >96 hours or principal diagnosis except face, mouth, and neck without major OR procedure), • **207** (respiratory system diagnosis with ventilator support >96 hours), • **870** (septicemia or severe sepsis with mechanical ventilation >96 hours), • **927** (extensive burns or full thickness burns with mechanical ventilation >96 hours with skin graft), and • **933** (extensive burns or full thickness burns with mechanical ventilation >96 hours without skin graft). **Denominator**: Count of discharges for the following DRGs: • **003, 004, 207,** • **208** (respiratory system diagnosis with ventilator support < 96 hours), • **870,** • **871** (septicemia or severe sepsis without mechanical ventilation >96 hours with MCC), • **872** (septicemia or severe sepsis without mechanical ventilation >96 hours without MCC), • **927**, • **928** (full thickness burns with skin graft or inhalation injury with CC or MCC),

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
Ventilator Support (Continued)	• **929** (full thickness burns with skin graft or inhalation injury without CC or MCC), • **933**, and • **934** (full thickness burn without skin graft or inhalation injury).	• **929** (full thickness burns with skin graft or inhalation injury without CC or MCC), • **933**, and • **934** (full thickness burn without skin graft or inhalation injury).
Percutaneous Cardiovascular (CV) Procedures	**Numerator**: Count of discharges for the following DRGs: • **246** (Percutaneous cardiovascular procedures with non-drug-eluting stent with MCC or 4+ arteries or stents), • **247** (Percutaneous cardiovascular procedures with drug-eluting stent without MCC), • **248** (Percutaneous cardiovascular procedures with non-drug eluting stent with MCC or 4+ arteries or stents), and • **249** (Percutaneous cardiovascular procedures with non-drug eluting stent without MCC). **Denominator**: Count of discharges for the following DRGs: **246, 247, 248**, and **249**. Including outpatient claims with Current Procedural Terminology® (CPT®) codes **92928**, **92933**, **92937**, and **92943**. or with Healthcare Common Procedure Coding System (HCPCS) codes **C9600**, **C9602**, **C9604**, and **C9607**.	**Numerator**: Count of discharges for the following DRGs: • **321** (Percutaneous cardiovascular procedures with intraluminal device with MCC or 4+ Arteries/Intraluminal Devices), and • **322** (Percutaneous cardiovascular procedures with intraluminal device without MCC). **Denominator**: Count of discharges for the following DRGs: **321** and **322**. Including outpatient claims with Current Procedural Terminology® (CPT®) codes **92928**, **92933**, **92937**, and **92943**. or with Healthcare Common Procedure Coding System (HCPCS) codes **C9600**, **C9602**, **C9604**, and **C9607**.
Total Knee Replacement	**Numerator**: Count of discharges with at least one of the ICD-10-PCS knee replacement procedure codes. **Denominator**: Count of discharges with at least one of the ICD-10-PCS knee replacement procedure codes, and outpatient claims with CPT® code **27447**.	**Numerator**: Count of discharges with at least one of the ICD-10-PCS knee replacement procedure codes. **Denominator**: Count of discharges with at least one of the ICD-10-PCS knee replacement procedure codes, and outpatient claims with CPT® code **27447**.
Syncope	**Numerator**: Count of discharges for DRG **312** (syncope and collapse). **Denominator**: Count of discharges for medical DRGs in Major Diagnostic Category (MDC) **05** (circulatory system).	**Numerator**: Count of discharges for DRG **312** (syncope and collapse). **Denominator**: Count of discharges for medical DRGs in Major Diagnostic Category (MDC) **05** (circulatory system).

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
Other Circulatory System Diagnoses	**Numerator**: Count of discharges for DRGs: • **314** (other circulatory system diagnoses with MCC), • **315** (other circulatory system diagnoses with CC), and • **316** (other circulatory system diagnoses without CC/MCC). **Denominator**: Count of discharges for medical DRGs in MDC **05** (circulatory system).	**Numerator**: Count of discharges for DRGs: • **314** (other circulatory system diagnoses with MCC), • **315** (other circulatory system diagnoses with CC), and • **316** (other circulatory system diagnoses without CC/MCC). **Denominator**: Count of discharges for medical DRGs in MDC **05** (circulatory system).
Other Digestive System Diagnosis	**Numerator**: Count of discharges for DRGs: • **393** (other digestive system diagnoses with MCC), • **394** (other digestive system diagnoses with CC), and • **395** (other digestive system diagnoses without CC/MCC). **Denominator**: Count of discharges for medical DRGs in MDC **06** (digestive system).	**Numerator**: Count of discharges for DRGs: • **393** (other digestive system diagnoses with MCC), • **394** (other digestive system diagnoses with CC), and • **395** (other digestive system diagnoses without CC/MCC). **Denominator**: Count of discharges for medical DRGs in MDC **06** (digestive system).
Medical Back Problems	**Numerator**: Count of discharges for DRGs: • **551** (medical back problems with MCC), and • **552** (medical back problems without MCC). **Denominator**: Count of all discharges for medical DRGs in MDC **08** (musculoskeletal system and connective tissue).	**Numerator**: Count of discharges for DRGs: • **551** (medical back problems with MCC), and • **552** (medical back problems without MCC). **Denominator**: Count of all discharges for medical DRGs in MDC **08** (musculoskeletal system and connective tissue).
Spinal Fusion	**Numerator**: Count of discharges that have at least one ICD-10-PCS spinal fusion procedure code, and outpatient claims with at least one CPT® spinal fusion procedure code. **Denominator**: Count of discharges that have at least one ICD-10-PCS spinal procedure code and outpatient claims with at least one CPT® spinal procedure code.	**Numerator**: Count of discharges that have at least one ICD-10-PCS spinal fusion procedure code, and outpatient claims with at least one CPT® spinal fusion procedure code. **Denominator**: Count of discharges that have at least one ICD-10-PCS spinal procedure code and outpatient claims with at least one CPT® spinal procedure code.

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
3-Day Skilled Nursing Facility (SNF)-Qualifying Admissions	**Numerator**: Count of discharges to an SNF with a 3-day LOS. Discharges to an SNF are identified by the following patient discharge status codes: • **03** (discharged or transferred to an SNF), • **61** (discharged or transferred to a swing bed), • **83** (discharged or transferred to an SNF with a planned acute care hospital inpatient admission), and • **89** (discharged or transferred to a swing bed with a planned acute care hospital inpatient admission). **Denominator**: Count of all discharges to an SNF, identified by the following patient discharge status codes: **03**, **61**, **83**, and **89**.	**Numerator**: Count of discharges to an SNF with a 3-day LOS. Discharges to an SNF are identified by the following patient discharge status codes: • **03** (discharged or transferred to an SNF), • **61** (discharged or transferred to a swing bed), • **83** (discharged or transferred to an SNF with a planned acute care hospital inpatient admission), and • **89** (discharged or transferred to a swing bed with a planned acute care hospital inpatient admission). **Denominator**: Count of all discharges to an SNF, identified by the following patient discharge status codes: **03**, **61**, **83**, and **89**.

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
30-Day Readmissions to the Same Hospital or Elsewhere	**Numerator**: Count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the same hospital or to another short-term acute care prospective payment system (PPS) hospital for the same beneficiary (identified using the Health Insurance Claim number). **Numerator Exclusions**: Claims for the index admission or readmission where the patient discharge status is one of the following: • **02** (discharged/transferred), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software (CCS) diagnosis categories. **Denominator**: Count of all discharges. **Denominator Exclusions**: Exclude claims for the index admission or readmission where the patient discharge status is one of the following: **02**, **07**, **20**, and **82**. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software (CCS) diagnosis categories.	**Numerator**: Count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the same hospital or to another short-term acute care prospective payment system (PPS) hospital for the same beneficiary (identified using the Health Insurance Claim number). **Numerator Exclusions**: Claims for the index admission or readmission where the patient discharge status is one of the following: • **02** (discharged/transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software (CCS) diagnosis categories. **Denominator**: Count of all discharges. **Denominator Exclusions**: Exclude claims for the index admission or readmission where the patient discharge status is one of the following: **02**, **07**, **20**, and **82**. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software (CCS) diagnosis categories.

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
30-Day Readmissions to the Same Hospital	**Numerator**: Count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the same hospital for the same beneficiary (identified using the Health Insurance Claim number). **Numerator Exclusions**: Claims for the index admission or readmission where the patient discharge status is one of the following: • **02** (discharged/transferred), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software (CCS) diagnosis categories. **Denominator**: Count of all discharges. **Denominator Exclusions**: Exclude claims for the index admission or readmission where the patient discharge status is one of the following: **02**, **07**, **20**, and **82**. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software (CCS) diagnosis categories.	**Numerator**: Count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the same hospital for the same beneficiary (identified using the Health Insurance Claim number). **Numerator Exclusions**: Claims for the index admission or readmission where the patient discharge status is one of the following: • **02** (discharged/transferred), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software (CCS) diagnosis categories. **Denominator**: Count of all discharges. **Denominator Exclusions**: Exclude claims for the index admission or readmission where the patient discharge status is one of the following: **02**, **07**, **20**, and **82**. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the Clinical Classifications Software (CCS) diagnosis categories.

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
2-Day Stays for Medical DRGs	**Numerator**: Count of discharges for medical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days). **Numerator Exclusions**: Claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for medical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, and **82**, and exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.	**Numerator**: Count of discharges for medical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days). **Numerator Exclusions**: Claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for medical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, and **82**, and exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
2-Day Stays for Surgical DRGs	**Numerator**: Count of discharges for surgical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days). **Numerator Exclusions**: Claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for surgical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, and **82**, and exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.	**Numerator**: Count of discharges for surgical DRGs with an LOS equal to 2 days (through date minus admission date = 2 days). **Numerator Exclusions**: Claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for surgical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, and **82**, and exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
1-Day Stays for Medical DRGs	**Numerator:** Count of discharges for medical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day). **Numerator Exclusions**: Claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for medical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, and **82**, and exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.	**Numerator**: Count of discharges for medical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day). **Numerator Exclusions**: Claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for medical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, and **82**, and exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.

Target Area	Target Area Definitions for Fiscal Year 2023	Target Area Definitions for Fiscal Year 2024
1-Day Stays for Surgical DRGs	**Numerator**: Count of discharges for surgical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day). **Numerator Exclusions**: Claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for surgical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, and **82**, and exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.	**Numerator**: Count of discharges for surgical DRGs with an LOS equal to 1 day (through date minus admission date = 1 day). **Numerator Exclusions**: Claims with patient discharge status codes: • **02** (discharged or transferred to a short-term general hospital for inpatient care), • **07** (left against medical advice), • **20** (expired), and • **82** (discharged or transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission). Exclude claims with occurrence span code **72** (identifying outpatient time associated with an inpatient admission) with through date on or the day prior to the inpatient admission. **Denominator**: Count of discharges for surgical DRGs. **Denominator Exclusions**: Exclude claims with patient discharge status code **02**, **07**, **20**, and **82**, and exclude claims with occurrence span **72** with the through date on or the day prior to the inpatient admission.

Appendix C: Rehabilitation and Primary Psychiatric CCS Diagnosis Categories

Table 6: Rehabilitation and Primary Psychiatric CCS Diagnosis Categories

CCS	Description
254	Rehabilitation care
650	Adjustment disorders
651	Anxiety disorders
652	Attention-deficit, conduct, and disruptive behavior disorders
654	Developmental disorders
655	Disorders usually diagnosed in infancy, childhood, or adolescence
656	Impulse control disorders, not elsewhere classified
657	Mood disorders
658	Personality disorders
659	Schizophrenia and other psychotic disorders
662	Suicide and intentional self-inflicted injury
670	Miscellaneous mental health disorders

Appendix D: How Readmissions Are Identified

These examples have been developed to assist users in understanding how readmissions are identified and counted in PEPPER's *30-Day Readmissions to Same* and *30-Day Readmissions to Same or Elsewhere* target areas. When reviewing these examples, remember that:

1. Readmissions are counted in the federal fiscal quarter during which the discharge date of the index (first) admission occurs. If the discharge date of the index admission occurs between:
   - October 01 and December 31, the readmission would be counted in Quarter 1 of the respective fiscal year.
   - January 01 and March 31, the readmission would be counted in Quarter 2 of the respective fiscal year.
   - April 01 and June 30, the readmission would be counted in Quarter 3 of the respective fiscal year.
   - July 01 and September 30, the readmission would be counted in Quarter 4 of the respective fiscal year.
2. Each admission of a patient could serve as an index admission for a subsequent admission to short-term acute care hospitals if it occurs within 30 days of the discharge date of the index admission.
3. Each admission of a patient could be identified as a readmission only for the short-term acute care hospital admission directly preceding it in time. Refer to the second row in *Table 7*.
4. Index admissions with a patient discharge status code of "02" (discharged/transferred to a short-term acute care hospital), "07" (left against medical advice) or "82" (discharged/transferred to a short-term acute care hospital for inpatient care with a planned acute care hospital inpatient readmission) are excluded from the numerator count and cannot be identified as an index admission for both readmission target areas.
5. Any admissions of beneficiaries to other settings, such as skilled nursing facility, swing bed, inpatient rehabilitation facility, inpatient psychiatric facility, critical access hospital, or any other type of provider are not considered for this measure. Only admissions to short-term acute care hospitals are considered. Common billing errors that may result in claims being identified as readmissions include the following:
   - Billing an admission to a distinct part unit of your short-term acute care hospital (e.g., inpatient rehabilitation or inpatient psychiatric facility unit) to the provider number for the short-term acute care hospital, instead of the provider number for the unit.
   - Incorrect coding of the patient discharge status code when the patient is discharged/transferred to another short-term acute care hospital. As noted in #4 above, index admissions with a patient discharge status code of 02, 07, or 82 are excluded from the numerator count and cannot be identified as an index admission.

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

The following table displays claims submitted for one beneficiary. The table sorts the claims in date order from 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 as a readmission. The next admission on one row becomes the index admission on the following row.

Table 7: Example 1

# (Index)	Index Adm. Provider	Index Adm. Date	Discharge Date	Patient Discharge Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Next Adm. Counts as 30-Day Readm. to Same?	Next Adm. Counts as 30-Day Readm. to Same or Elsewhere?
1	Hospital #1	03/25/2024	03/29/2024	01	2	Hospital #1	04/15/2024	04/17/2024	Yes, to Hospital #1 in Q2FY24	Yes, to Hospital #1 in Q2FY24
2	Hospital #1	04/15/2024	04/17/2024	02	3	Hospital #2	04/17/2024	04/20/2024	No	No
3	Hospital #2	04/17/2024	04/20/2024	01	NA	No further admissions	No further admissions	No further discharge dates	NA	NA

Detailed Discussion:

- **Row 1**: The beneficiary was admitted to Hospital #1 on March 25, 2024, and discharged home (patient discharge status code 01) on March 29, 2024. The beneficiary was admitted to Hospital #1 on April 15, 2024. The April 15, 2024 admission to Hospital #1 counts as a *30-Day Readmission to Same* and as a *30-Day Readmission to Same or Elsewhere* to Hospital #1 against the March 25, 2024 index admission, because it occurred within 30 days of the March 25, 2024 index admission discharge date of March 29, 2024.
- **Row 2**: The beneficiary was admitted to Hospital #1 on April 15, 2024, and was transferred (patient discharge status code 02) to Hospital #2 on April 17, 2024.

- The April 17, 2024, admission to Hospital #2 does not count as a *30-Day Readmission to Same or Elsewhere* against the April 15, 2024, index admission for Hospital #1 because the April 15, 2024, index admission had a patient discharge status code “02”.
- The April 17, 2024 admission to Hospital #2 does not count as a *30-Day Readmission to Same or Elsewhere* against the March 25, 2024 index admission for Hospital #1 because there was an intervening short-term acute care hospital admission (April 15, 2024 admission to Hospital #1) that directly preceded the April 17, 2024 admission to Hospital #2.
- Row 3: The beneficiary was admitted to Hospital #2 on April 17, 2024, and discharged home (patient discharge status code 01) on April 20, 2024.

D.2 Example 2 - Four Hospital Stays, Two Qualifying Readmissions for Readmission Same and Readmission Same or Elsewhere Target Areas

The following table displays claims submitted for one beneficiary. The table sorts the claims in date order from 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 as a readmission. The next admission on one row becomes the index admission on the following row.

Table 8: Example 2

# (Index)	Index Adm. Provider	Index Adm. Date	Discharge Date	Patient Discharge Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Next Adm. Counts as 30-Day Readm. to Same?	Next Adm. Counts as 30-Day Readm. to Same or Elsewhere?
1	Hospital #1	04/05/2024	04/07/2024	01	2	Hospital #1	05/01/2024	05/03/2024	Yes, to Hospital #1 in Q3FY2024	Yes, to Hospital #1 in Q3FY24
2	Hospital #1	05/01/2024	05/03/2024	62	3	IRF #1	05/03/2024	05/15/2024	No	No
3	IRF #1	05/03/2024	05/15/2024	02	4	Hospital #1	05/15/2024	05/17/2024	Yes, to Hospital #1 in Q3FY24	Yes, to Hospital #1 in Q3FY24
4	Hospital #1	05/15/2024	05/17/2024	01	NA	No further admissions	No further admissions	No further discharge dates	NA	NA

Detailed Discussion:

- **Row 1**: The beneficiary was admitted to Hospital #1 on April 05, 2024, and was discharged home (patient discharge status code 01) on April 07, 2024. The beneficiary was admitted to Hospital #1 on May 01, 2024. The May 01, 2024 admission to Hospital #1 counts as a *30-Day Readmission to Same* and as a *30-Day Readmission to Same or Elsewhere* for Hospital #1 against the

April 05, 2024 index admission, because the beneficiary was readmitted to Hospital #1 within 30 days of discharge from the April 05, 2024 index admission discharge date of April 07, 2024.

- **Row 2**: The beneficiary was admitted May 01, 2024, to Hospital #1 and was transferred to IRF #1 (patient discharge status code 62) on May 03,2024. The admission to IRF #1 does not count as a *30-Day Readmission to Same* or as a *30-Day Readmission to Same or Elsewhere* against the April 05, 2024, index admission for Hospital #1 because the patient was transferred to an IRF. Only admissions to short-term acute care hospitals can be considered as a readmission.
- **Row 3**: The beneficiary was admitted to IRF #1 on May 03, 2024, and was transferred to Hospital #1 (patient discharge status code 02) on May 15, 2024. The May 15, 2024 admission to Hospital #1 counts as a *30-Day Readmission to Same* and as a *30-Day Readmission to Same or Elsewhere* to Hospital #1 against the May 01, 2024 index admission, as the beneficiary was readmitted to Hospital #1 on May 13, 2024 which is within 30 days of discharge from the May 01, 2024 index admission discharge date of May 03, 2024.
- **Row 4**: The beneficiary was admitted to Hospital #1 on May 15, 2024, and was discharged home (patient discharge status code 01) on May 17, 2024.

D.3 Example 3 - Two Hospital Stays, One Qualifying Readmission for Readmission Same or Elsewhere Target Area

The following table displays claims submitted for one beneficiary. The table sorts the claims in date order from 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 as a readmission. The next admission on one row becomes the index admission on the following row.

Table 9: Example 3

# (Index)	Index Adm. Provider	Index Adm. Date	Discharge Date	Patient Discharge Status Code	# (Next)	Next Adm. Provider	Next Adm. Date	Discharge Date	Next Adm. Counts as 30-Day Readm. to Same?	Next Adm. Counts as 30-Day Readm. to Same or Elsewhere?
1	Hospital #1	10/10/2024	10/17/2024	01	2	Hospital #2	11/02/2024	11/12/2024	No	Yes, to Hospital #1 in Q1FY24
2	Hospital #1	11/02/2024	11/12/2024	01	NA	No further admissions	No further admissions	No further discharge dates	NA	NA

Detailed Discussion:

- **Row 1**: The beneficiary was admitted to Hospital #1 on October 10, 2024, and was discharged home (patient discharge status code 01) on October 17, 2024. The beneficiary was admitted to Hospital #2 on November 11, 2024.
  - The November 02, 2024, admission to Hospital #2 does not count as a *30-Day Readmission to Same*.
  - The November 02, 2024, admission to Hospital #2 counts as a *30-Day Readmission to Same or Elsewhere* against the October 10, 2024, index admission for Hospital #1 because the beneficiary was readmitted to Hospital #2 within 30 days of discharge from the index admission discharge date of October 17, 2024.
- **Row 2**: The beneficiary was admitted to Hospital #2 on November 02, 2024, and was discharged home (patient discharge status code 01) on November 12, 2024.