



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

User Guide

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What's new in this edition?

No changes to this edition.

1. What is PEPPER?

The Office of Inspector General (OIG) encourages hospitals to develop and implement a compliance program to protect their operations from fraud and abuse.^{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 as "target areas"). Data are presented in graphs and tables that show 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), together with its partners Integrity Management Services, Inc. (IntegrityM) and GovCon Growth Solutions, LLC, develops and distributes PEPPER under contract with the Centers for Medicare & Medicaid Services (CMS).

All data tables, graphs, and reports in PEPPER are designed to help hospitals identify potential overpayments as well as potential underpayments.

PEPPER does not identify the presence of payment errors; however, it can be used as a guide for auditing and monitoring activities. Hospitals can use PEPPER to compare their 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 (LOS).

PEPPER is available for Short-Term Acute Care Hospitals (STACHs), Long-Term Acute Care Hospitals (LTACHs), 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 each hospital's results to three comparison groups: the nation, the Medicare Administrative Contractor (MAC) jurisdiction, and the state in which the hospital operates. These comparisons help hospitals determine whether they are outliers relative to other short-term acute care hospitals.

PEPPER determines outliers using preset control limits. The upper control limit for all target areas is the 80th percentile, and the lower control limit is the 20th percentile. PEPPER highlights any findings at or above the upper control limit (high outliers) or at or below the lower control limit.

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.](#)

In PEPPER, the term “outlier” refers to a hospital whose target area percent falls within the top 20 percent of all hospitals in the comparison group (i.e., at or above the 80th percentile) or within the bottom 20 percent (i.e., at or below the 20th percentile for coding-focused target areas). PEPPER does not use formal statistical significance testing to determine outlier status.

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 Advantage Plan.
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 identified as potentially problematic, and the denominator represents discharges from a broader comparison group. For admission necessity-focused target areas, the numerator generally includes the discharges or DRG(s) identified as prone to unnecessary admissions, while the denominator typically includes all discharges for the DRG(s) or all discharges overall. For DRG coding-focused target areas, the numerator generally includes the DRG(s) identified as prone to coding errors, while the denominator includes those DRGs plus the DRGs to which the original DRG is frequently changed.

Table 2 identifies the FY 2026 definitions for the ST PEPPER target areas. The 2024 and 2025 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), 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 (precerebral occlusion without infarction with MCC), • 068 (precerebral occlusion without infarction without MCC), and • 069 (transient ischemia without thrombolytic).
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).
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).

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 the DRG description. Numerator Exclusions: Exclude DRGs that can be assigned on the basis of a CC, MCC, or medication administration. For FY 2026, 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 2026, 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 the DRG description. Numerator Exclusions: Exclude DRGs that can be assigned on the basis of a CC, MCC, or a procedure. For Fiscal Year 2026, 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 antineoplastic 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 a procedure. For FY 2026, this includes DRGs 005, 023, 029, 041, 276, 321, 426, 447, 450, 469, or 518.

Target Area	Target Area Definition
Single CC or MCC⁴	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 Malnutrition⁵	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.

⁴ While the target area definitions remain the same, users may notice a decrease in their target area percentages compared with historical PEPPERS. This change results from an update to how historical PEPPERS calculated the target area. Beginning with the FY 2025 PEPPERS, the Single CC/MCC target area methodology has been revised to align with the formal definition and now counts only those claims in which a single diagnosis on the claim is a CC, an MCC, or a CC/MCC in the secondary diagnosis position toward the numerator.

⁵ While the target area definition remains the same, users may notice a decrease in their target area percentages compared with historical PEPPERS. This decrease results from a change in how historical PEPPERS calculated the target area. Beginning with the FY 2025 PEPPERS, the Severe Malnutrition target area methodology has been updated to align with the formal definition and now counts only those claims in which a single diagnosis on the claim is an MCC in the secondary diagnosis position toward the numerator.

Target Area	Target Area Definition
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).
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.

Target Area	Target Area Definition
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 the following 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 the following 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 the following 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.
3-Day Skilled Nursing Facility (SNF)-Qualifying Admissions	Numerator: Count of discharges to an SNF with a 3-day length of stay. 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.

Target Area	Target Area Definition
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: Exclude claims for the index admission 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 Refined (CCSR) diagnosis categories. Denominator: Count of all discharges. Denominator Exclusions: Exclude claims with patient discharge status codes: 02, 07, 20, or 82. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCSR diagnosis categories. (Refer to <i>Appendix B</i> for more specifics regarding how readmissions are identified.)
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: Exclude claims for the index admission 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 CCSR diagnosis categories. Denominator: Count of all discharges. Denominator Exclusions: Exclude claims with patient discharge status codes: 02, 07, 20, or 82. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCSR diagnosis categories. (Refer to <i>Appendix B</i> for more specifics regarding how readmissions are identified.)

Target Area	Target Area Definition
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 the 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.
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 the 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.

Target Area	Target Area Definition
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 the 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.
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 the 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, 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: DRGs and DRG definitions may change from one fiscal year to the next. Refer to the [Federal Register](#) for detailed information. A complete list of Medical and Surgical DRGs, including DRGs with and without CC, MCC, or CC/MCC designations, is available in the CMS MS-DRG Definitions Manual on the CMS website: [ICD-10-CM/PCS MS-DRG Definitions Manual](#).

The OIG found widespread miscoding of severe malnutrition in cases where hospitals should have assigned diagnosis codes for other forms of malnutrition or, in some instances, no malnutrition diagnosis code at all.⁶ Four ICD-10 diagnosis codes, E40, E41, E42, and E43, qualify as MCCs and can increase payment when reported as secondary diagnoses.

Effective January 1, 2018, total knee replacement procedures were removed from CMS' inpatient-only list, allowing them to be performed on either an inpatient or outpatient basis. CMS maintains that the decision to admit a patient as an inpatient is a complex medical decision based on the physician's clinical expectation of the anticipated duration of hospital care and the beneficiary's unique clinical circumstances. Analysis of 2019 claims data shows that approximately 30 percent of hospitals performed all total knee replacement procedures on an inpatient basis. Short inpatient hospital admissions, particularly one-day stays, have historically been associated with high rates of unnecessary admissions. CMS reported an improper payment rate of 24.3 percent for inpatient stays lasting one night or less in the *2024 Medicare Fee-for-Service Supplemental Payment Data Report*.⁷ The FY 2014 Inpatient Prospective Payment System (IPPS) Final Rule revised the admission and medical review criteria used by CMS contractors (i.e., MACs and RAs) when evaluating inpatient hospital admissions for payment purposes. Generally, an inpatient hospital admission is considered appropriate when the physician expects the beneficiary to require a stay that will span two midnights and admits the beneficiary based on that expectation.⁸

To assist hospitals in monitoring short stays, several PEPPER target areas focus specifically on one- and two-day stays. Under CMS admission and medical review criteria, one-day stays may not meet inpatient admission requirements, while two-day stays may be appropriate. Hospitals can review their statistics for these target areas to 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. PEPPER includes two target areas related to readmissions within 30 days of discharge: one that captures readmissions to any short-term acute care hospital (including the same hospital or another facility), and one that captures readmissions to the same hospital only. PEPPER readmission statistics do not incorporate risk adjustment or exclude planned readmissions due to the significant complexity and processing time required to generate such measures.

⁶ 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](#)

⁷ 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](#)

⁸ Department of Health and Human Services/Centers for Medicare & Medicaid Services. 2013. *Federal Register* 78, no. 160, August 19, 2013. Available at: [Federal Register/Vol. 78, No. 160/Monday, August 19, 2013/Rules and Regulations](#)

PEPPER does not include condition-specific readmission information because these readmissions occur too infrequently within a single quarter for most hospitals to have sufficient data for reporting.

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

Three-day Skilled Nursing Facility (SNF)-qualifying admissions have been identified as problematic with respect to admission necessity. Historical data show that these admissions have a higher incidence of unnecessary admissions compared with other three-day stays.

The coding of CCs, and more recently MCCs, has been identified as problematic. Oversight agencies have found coding errors in which a CC or MCC was added without sufficient documentation in the medical record to support the diagnosis.

Note: DRGs and DRG definitions may change from one fiscal year to the next. Details are available in the [Federal Register](#). Definitions for the FY 2024 and FY 2025 target areas are provided in *Appendix B*.

1.2 How Hospitals Can Use PEPPER Data

For Medicare data, the fiscal year runs from October 1 through September 30, with quarters defined 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*.) In PEPPER, “Reportable Data” means there are 11 or more numerator discharges for a given target area during a specific time period. Due to CMS data restrictions, PEPPER does not display statistics when a target area has fewer than 11 numerator discharges for that period.

Note: These are generalized suggestions and may not apply to all situations. For each target area, assess whether there is sufficient volume, typically 10 to 30 discharges per year, depending on the hospital’s total annual discharges, to justify 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, or 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 a physician.
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 a 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)
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, 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 a physician.
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, or 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 a 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.

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)
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 a 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 a 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 a 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 a 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 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 a 2-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 2-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 across multiple consecutive quarters can help identify whether a hospital’s target area percents have changed significantly from one quarter to the next. Such shifts may indicate changes in admitting, coding or billing practices; staff turnover; or modifications in medical staff. They may also reflect evolving business practices (e.g., new service lines) or broader changes in the external healthcare environment.

2. Using PEPPER

PEPPER is a Microsoft Excel workbook containing multiple worksheets. Users navigate through the report by selecting the worksheet tabs at the bottom of the screen. Each tab is labeled to indicate its contents (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 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 percentile values, compared with 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, the percentile appears in red bold text. When the hospital is a low outlier, the percentile appears in green italic text. If the hospital is not an outlier, the percentile is displayed in black text.

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. These percentile values allow a hospital to assess how its target area percent compares with 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 lower than the hospital's own target area percent.

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

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

When interpreting the Compare Targets Report, 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 comparison should be given the lowest priority because it represents 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 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, it might warrant higher priority for review.

2.2 National High Outlier Ranking Report

The National High Outlier Ranking Report compares a hospital to all other short-term acute care hospitals in the nation based on high outlier status (defined as being at or above the national 80th percentile). It also ranks each hospital according to the total number of target areas and time periods in which it is identified as 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 when compared with the nation but not when compared with its jurisdiction or state, and vice versa.

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

The report displays results by quarter for all target areas in a grid format. For each target area and time period, the corresponding cell will show a black "0" if the hospital is a low outlier or 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. For each target area, all quarters in which a hospital is at or above the national 80th percentile are counted and summed to determine the hospital’s total number of high outliers. Hospitals are then ranked nationally based on their total number of high outliers. The hospital with the highest total is assigned a rank of “1,” the hospital with the second highest total 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 11 fiscal quarters. These statistics include the percent (the proportion of numerator to denominator discharges), the numerator count of target area discharges, the denominator count of discharges, the average length of stay (ALOS), and Medicare payment data.

The “Outlier Status” column identifies when the hospital is a high outlier. In these cases, the hospital’s percentile is displayed in red bold text, 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 these cases, the hospital’s percent is displayed in green italic text, 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 “No data” when the hospital does not have reportable data for that target area and time period.

The “Target Sum Medicare Payments” column is calculated by adding the claim payment amounts for all claims that meet 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 in the data tables to help hospitals determine whether they should audit a sample of records. Suggested interventions tailored to each target area are also included in each data table.

Below the data tables are graphs that provide a visual representation of the hospital’s percentage for each target area over the previous nine fiscal quarters. These graphs allow hospitals to identify significant quarter-to-quarter changes, which may result from shifts in medical staff, coding or billing practices, utilization review processes, documentation improvement efforts, 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 80th percentile threshold, as well as the 20th percentile threshold for coding-focused target areas, for each of the three comparison groups: nation, jurisdiction, and state. These trend lines help hospitals easily identify when they are outliers relative to any comparison group. A table displaying these percentile values is included on each target area worksheet. State percentiles are shown as zero when fewer than 11 hospitals in the state have reportable data for the target area. Jurisdiction percentiles are shown as zero when

fewer than 11 hospitals in the jurisdiction have reportable data. If no reportable data exist for a given quarter, the table will display #N/A in the corresponding cell.

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

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. These reports list the top medical and surgical DRGs associated with same-day and one-day stays for your hospital and, separately, for your jurisdiction.

The Hospital Top DRGs table lists the top DRGs for same-day and one-day stays for your hospital during the most recent four fiscal quarters, excluding discharges with patient status codes **02**, **07**, **20**, and **82**, as well as claims containing occurrence span code **72** with a "through" date on or before the day prior to inpatient admission. The table also displays the total number of hospital discharges for each listed DRG, 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 during the most recent four fiscal quarters, excluding discharges with patient status codes **02**, **07**, **20**, and **82**, as well as claims with occurrence span code **72** with a "through" date on or before the day prior to an inpatient admission. The table also includes the total jurisdiction-wide discharges for each listed DRG, the proportion of same-day and one-day stays to total discharges, and the ALOS for each DRG.

Please note that these reports display only the top 20 ranked DRGs with 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 no DRGs meet the minimum threshold of 11 same-day and one-day stays, the table will not display any data.

2.4 System Requirements, Customer Support, and Technical Assistance

PEPPER is a Microsoft Excel spreadsheet, developed in Excel 2016, that can be opened and saved on a personal computer (PC). It is not intended for use on a network; however, it may be saved to multiple PCs as needed.

For assistance using PEPPER, submit a request through the [CMS CBR PEPPER website](#) by selecting the "Help/Contact Us" tab. The website also provides a variety of educational resources to support hospitals in using PEPPER.

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

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 Refined	CCSR	CCSR 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.
Health Maintenance Organization	HMO	An HMO is a type of Medicare managed care plan where a group of doctors, hospitals, and other healthcare providers agree to give healthcare to Medicare beneficiaries for a set amount of money from Medicare every month.
Healthcare Common Procedure Coding System	HCPCS	HCPCS is a set of healthcare procedure codes based on the American Medical Association (AMA) Current Procedural Terminology (commonly pronounced Hick-Picks).
Home Health Agency	HHA	An HHA is a public agency or private organization, or subdivision of such agency or organization that provides skilled nursing services and at least one other therapeutic service in the residence of the client.
Hospice	NA	Hospice is inpatient or outpatient supportive care given to a terminally ill client and the family. The focus of this care is to enable the client to remain in the familiar surroundings of their home for as long as they can.
Index Analytics	IA	Index provides data integration services, including data architecture, master data management, data quality, security, and data warehousing.
Inpatient 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.
Integrity Management Services, Inc.	IntegrityM	IntegrityM is a women-owned small business empowering Federal Government, State agencies, and private sector organizations to make more informed decisions.
International Classification of Diseases, 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.

Term	Abbreviation	Definition
Length of Stay	LOS	LOS refers to the duration of time a patient spends in a healthcare facility, measured from admission 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 for an episode of care (three days before, during, and 30 days after a hospital stay) with 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 2024 and FY 2025

Table 5: Historical Target Area Definitions for FY 2024 and FY 2025

Target Area	Target Area Definitions for Fiscal Year 2024	Target Area Definitions for Fiscal Year 2025
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 cerebrovascular accident (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 2024	Target Area Definitions for Fiscal Year 2025
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 2024	Target Area Definitions for Fiscal Year 2025
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 2024	Target Area Definitions for Fiscal Year 2025
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.⁹	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.¹⁰

⁹ As defined by the [2023 IPPS Final Rule Table 5](#)

¹⁰ As defined by the [2024 IPPS Final Rule Table 5](#)

Target Area	Target Area Definitions for Fiscal Year 2024	Target Area Definitions for Fiscal Year 2025
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 2024, 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 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 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 2024, 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 2024	Target Area Definitions for Fiscal Year 2025
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 2024	Target Area Definitions for Fiscal Year 2025
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 2024	Target Area Definitions for Fiscal Year 2025
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 and 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 and Healthcare Common Procedure Coding System (HCPCS) codes C9600, C9602, C9604, and C9607.
Total Knee Replacement	Numerator: Count of discharges with at least one ICD-10-PCS knee replacement procedure code. Denominator: Count of discharges with at least one ICD-10-PCS knee replacement procedure code and outpatient claims with CPT® code 27447.	Numerator: Count of discharges with at least one ICD-10-PCS knee replacement procedure code. Denominator: Count of discharges with at least one ICD-10-PCS knee replacement procedure code and outpatient claims with CPT® code 27447.

Target Area	Target Area Definitions for Fiscal Year 2024	Target Area Definitions for Fiscal Year 2025
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).
Other Circulatory System Diagnoses	Numerator: Count of discharges for the following 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 the following 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 the following 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 the following 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 the following 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 the following 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).

Target Area	Target Area Definitions for Fiscal Year 2024	Target Area Definitions for Fiscal Year 2025
Spinal Fusion	Numerator: Count of discharges with 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 with at least one ICD-10-PCS spinal procedure code and outpatient claims with at least one CPT® spinal procedure code.	Numerator: Count of discharges with 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 with at least one ICD-10-PCS spinal procedure code and outpatient claims with at least one CPT® spinal procedure code.
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 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 patient discharge status codes 03, 61, 83, and 89.

Target Area	Target Area Definitions for Fiscal Year 2024	Target Area Definitions for Fiscal Year 2025
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 PPS hospital for the same beneficiary (identified using the Health Insurance Claim number). Numerator Exclusions: Claims for the index admission where the patient discharge status is one of the following: • 02 (discharged/transferred), • 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 CCSR diagnosis categories. Denominator: Count of all discharges. Denominator Exclusions: Exclude claims where the patient discharge status is 02, 07, 20, or 82. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCSR 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 PPS hospital for the same beneficiary (identified using the Health Insurance Claim number). Numerator Exclusions: Claims for the index admission 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 CCSR diagnosis categories. Denominator: Count of all discharges. Denominator Exclusions: Exclude claims where the patient discharge status is 02, 07, 20, or 82. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCSR diagnosis categories.

Target Area	Target Area Definitions for Fiscal Year 2024	Target Area Definitions for Fiscal Year 2025
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 where the patient discharge status is one of the following: • 02 (discharged/transferred), • 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 CCSR diagnosis categories. Denominator: Count of all discharges. Denominator Exclusions: Exclude claims where the patient discharge status is 02, 07, 20, or 82. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCSR 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 where the patient discharge status is one of the following: • 02 (discharged/transferred), • 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 CCSR diagnosis categories. Denominator: Count of all discharges. Denominator Exclusions: Exclude claims where the patient discharge status is 02, 07, 20, or 82. Exclude claims with a diagnosis of rehabilitation and primary psychiatric as defined by the CCSR diagnosis categories.

Target Area	Target Area Definitions for Fiscal Year 2024	Target Area Definitions for Fiscal Year 2025
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 the following 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 the 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 codes 02, 07, 20, and 82, and 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 the following 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 the 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 codes 02, 07, 20, and 82, and 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 2024	Target Area Definitions for Fiscal Year 2025
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 the following 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 the 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 codes 02, 07, 20, and 82, and 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 the following 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 the 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 codes 02, 07, 20, and 82, and 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 2024	Target Area Definitions for Fiscal Year 2025
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 the following 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 the 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 codes 02, 07, 20, and 82, and 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 the 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 codes 02, 07, 20, and 82, and 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 2024	Target Area Definitions for Fiscal Year 2025
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 the following 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 the 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 codes 02, 07, 20, and 82, and 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 the following 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 the 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 codes 02, 07, 20, and 82, and claims with occurrence span 72 with the through date on or the day prior to the inpatient admission.

Appendix C: Rehabilitation and Primary Psychiatric CCSR Diagnosis Categories

Table 6: Rehabilitation and Primary Psychiatric CCSR Diagnosis Categories

CCSR Category	CCSR Category Description
FAC009	Implant, device or graft related encounter
INJ021	Effect of other external causes, initial encounter
INJ022	Poisoning by drugs, initial encounter
MBD001	Schizophrenia spectrum and other psychotic disorders
MBD002	Depressive disorders
MBD003	Bipolar and related disorders
MBD004	Other specified and unspecified mood disorders
MBD005	Anxiety and fear-related disorders
MBD006	Obsessive-compulsive and related disorders
MBD007	Trauma- and stressor-related disorders
MBD008	Disruptive, impulse-control and conduct disorders
MBD009	Personality disorders
MBD010	Feeding and eating disorders
MBD011	Somatic disorders
MBD012	Suicidal ideation/attempt/intentional self-harm
MBD013	Miscellaneous mental and behavioral disorders/conditions
MBD014	Neurodevelopmental disorders
MBD018	Opioid-related disorders
MBD019	Cannabis-related disorders
MBD020	Sedative-related disorders
MBD021	Stimulant-related disorders
MBD022	Hallucinogen-related disorders
MBD023	Inhalant-related disorders
MBD026	Mental and substance use disorders in remission
MBD027	Suicide attempt/intentional self-harm; subsequent encounter
MBD034	Mental and substance use disorders; sequela

For more information on these CCSR categories, please visit: [Clinical Classifications Software Refined \(CCSR\) for ICD-10-CM Diagnoses](#).

Appendix D: How Readmissions Are Identified

These examples are designed to help users understand 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, keep in mind that:

1. Readmissions are counted in the federal fiscal quarter in which the discharge date of the index (first) admission occurs. If the discharge date of the index admission falls between:
 - October 1 and December 31, the readmission is counted in Quarter 1 of that fiscal year.
 - January 1 and March 31, the readmission is counted in Quarter 2 of that fiscal year.
 - April 1 and June 30, the readmission is counted in Quarter 3 of that fiscal year.
 - July 1 and September 30, the readmission is counted in Quarter 4 of that fiscal year.
2. Each admission for a patient may serve as an index admission for a subsequent short-term acute care hospital admission if the subsequent admission occurs within 30 days of the index admission's discharge date.
3. Each admission for a patient can be identified as a readmission only for the short-term acute care hospital admission that immediately precedes it. 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), "20" (expired), 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 and cannot be used as index admissions for either readmission target area.
5. Admissions to other settings, such as skilled nursing facilities, swing beds, inpatient rehabilitation facilities, inpatient psychiatric facilities, critical access hospitals, or any other type of provider, are not considered for this measure. Only admissions to short-term acute care hospitals are included. 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., an inpatient rehabilitation or inpatient psychiatric facility unit) under the provider number for the short-term acute care hospital instead of the provider number assigned to the unit.
 - Incorrect coding of the patient discharge status code when a patient is discharged or transferred to another short-term acute care hospital. As noted in item number 4 above, index admissions with patient discharge status codes 02, 07, 20, or 82 are excluded from the numerator and cannot be used as index admissions.

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 subsequently admitted to Hospital #1 on April 15, 2024.
- The April 15, 2024, admission to Hospital #1 qualifies as a readmission for both the *30-Day Readmission to Same* and *30-Day Readmission to Same or Elsewhere* target areas relative to the March 25, 2024, index admission because it occurred within 30 days of the index admission discharge date of March 29, 2024.
- Row 2:** The beneficiary was admitted to Hospital #1 on April 15, 2024, and transferred (patient discharge status code 02) to Hospital #2 on April 17, 2024.

- The April 17, 2024, admission to Hospital #2 does not qualify as a readmission to Hospital #1's April 15, 2024, index admission for either target area because the index admission had patient discharge status code "02". Admissions with patient discharge status code "02" are excluded as index admissions for both target areas.
- **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.
- There are no subsequent admissions; therefore, no additional readmissions are identified.

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 Q3FY24	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 5, 2024, and was discharged home (patient discharge status code 01) on April 7, 2024. The beneficiary was subsequently admitted to Hospital #1 on May 1, 2024.
- The May 1, 2024, admission to Hospital #1 qualifies as a readmission to the April 5, 2024, index admission for both the *30-Day Readmission to Same* and *30-Day Readmission to Same or Elsewhere* target areas because the beneficiary was readmitted to Hospital #1 within 30 days of the index admission discharge date of April 7, 2024.

- **Row 2:** The beneficiary was admitted to Hospital #1 on May 1, 2024, and transferred to IRF #1 (patient discharge status code 62) on May 3, 2024. The admission to IRF #1 does not qualify as a readmission to Hospital #1's April 5, 2024, index admission because the beneficiary was transferred to an IRF. Only admissions to short-term acute care hospitals qualify as readmissions.
- **Row 3:** The beneficiary was admitted to IRF #1 on May 3, 2024, and transferred to Hospital #1 (patient discharge status code 02) on May 15, 2024. The May 15, 2024, admission to Hospital #1 qualifies as a readmission to the May 1, 2024, index admission for both readmission target areas because the beneficiary was readmitted to Hospital #1 within 30 days of discharge from the index admission.
- **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.
- No further admissions occurred, so no additional readmissions are identified.

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 subsequently admitted to Hospital #2 on November 2, 2024.
- The November 2, 2024, admission to Hospital #2 does not qualify as a readmission for the *30-Day Readmission to Same* target area because the readmission occurred at a different hospital.
- The November 2, 2024, admission to Hospital #2 qualifies as a readmission for the *30-Day Readmission to Same or Elsewhere* target area relative to Hospital #1’s October 10, 2024, index admission because the beneficiary was readmitted within 30 days of discharge from the index admission.
- **Row 2:** The beneficiary was admitted to Hospital #2 on November 2, 2024, and was discharged home (patient discharge status code 01) on November 12, 2024.
- No further admissions occurred, so no additional readmissions are identified.