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

User's Guide

Tenth Edition

Prepared by

PEPPER

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Introduction

What Is PEPPER?

The Office of Inspector General encourages hospitals to develop and implement a compliance program to protect their operations from fraud and abuse.[1,2] As part of a 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 the hospital's 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 (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 twelve federal fiscal quarters for each area at risk for improper payments (referred to in the report as "target areas"). Data in PEPPER are presented in tabular form, as well as in graphs that depict the hospital's target area percentages over time. PEPPER also includes reports on the hospital's top medical and surgical DRGs for one-day stays. PEPPER is developed and distributed by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS).

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

Beginning in 2011, PEPPER is available for short- and long-term acute care inpatient Prospective Payment System (PPS) hospitals, critical access hospitals and inpatient psychiatric and rehabilitation facilities. ST PEPPER is the version of PEPPER designed specifically for short-term acute care hospitals. In ST PEPPER, a hospital is compared to other short-term acute care hospitals in three comparison groups: state, Medicare Administrative Contractor/Fiscal Intermediary jurisdiction and nation. These comparisons enable a hospital to determine if it is an outlier, differing from other short-term acute care hospitals.

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

- Significant changes in billing practices
- Possible over- or under-coding
- Increasing length of stays

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

[1] Department of Health and Human Services/Office of Inspector General. 1998. "Compliance Program Guidance for Hospitals," *Federal Register* 63, no. 35, February 23, 1998, 8987–8998. Available at: http://oig.hhs.gov/authorities/docs/cpghosp.pdf

[2] Department of Health and Human Services/Office of Inspector General. 2005. "Supplementing the Compliance Program Guidance for Hospitals," *Federal Register* 70, no. 19, January 31, 2005, 4858–4876. Available at: http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf

Specifications for claims included in ST PEPPER are shown in the table below.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Acute care providers only	Third position of the CMS Certification Number = "0"
Claim facility type of "Hospital"	UB04 Form Locator (FL) 4 Type of Bill, second digit (Type of Facility) = 1 (Hospital) or 4 (Religious Nonmedical (Hospital))
Include claim service classification type of "Inpatient"	UB04 FL 04 Type of Bill, third digit (Bill Classification) = 1 (Inpatient Part A)
Claim with valid medical record number	UB04 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 UB04 FL 17
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Health Maintenance Organization
Exclude cancelled claims	Exclude claims cancelled by the Fiscal Intermediary or Medicare Administrative Contractor

Short-term acute care hospitals will receive PEPPER files through a My QualityNet secure file exchange on a quarterly basis. The PEPPER files are sent to the hospital's QualityNet Administrators and to those who have QualityNet basic user accounts with the PEPPER recipient role.

ST PEPPER CMS Target Areas

In general, the target areas are constructed as ratios and expressed as percents, with the numerators representing discharges that have been identified as problematic. For example, admission necessity-focused target areas generally include in the numerator the DRG(s) that have been identified as prone to unnecessary admissions, and the denominator generally includes all discharges for the DRG(s) or all discharges. DRG-coding related target areas generally include in the numerator the DRG(s) that have been identified as prone to DRG coding errors, and the denominator includes these DRGs as well as DRGs to which the original DRG is frequently changed.

The ST PEPPER target areas are defined in the table on the following pages.

TARGET AREA Full and Abbreviated Title	TARGET AREA DEFINITION
Stroke Intracranial Hemorrhage (Stroke ICH)	*Numerator (N):* count of discharges for DRGs 061 (acute ischemic stroke with use of thrombolytic agent with MCC), 062 (acute ischemic stroke with use of thrombolytic agent with CC), 063 (acute ischemic stroke with use of thrombolytic agent without CC/MCC), 064 (intracranial hemorrhage or cerebral infarction with MCC), 065 (intracranial hemorrhage or cerebral infarction with CC), 066 (intracranial hemorrhage or cerebral infarction without CC/MCC) *Denominator (D):* count of discharges for DRGs 061, 062, or 063, 064, 065, 066, 067 (nonspecific CVA and precerebral occlusion without infarct with MCC), 068 (nonspecific CVA and precerebral occlusion without infarct without MCC), 069 (transient ischemia)
Respiratory Infections (Resp Inf)	*N:* count of discharges for DRGs 177 (respiratory infections and inflammations with MCC), 178 (respiratory infections and inflammations with CC) *D:* count of discharges for DRGs 177, 178, 179 (respiratory infections and inflammations w/o CC/MCC), 193 (simple pneumonia and pleurisy with MCC), 194 (simple pneumonia and pleurisy with CC), 195 (simple pneumonia and pleurisy without CC/MCC)
Simple Pneumonia (Simp Pne)	*N:* count of discharges for DRGs 193, 194 *D:* count of discharges for DRGs 190 (chronic obstructive pulmonary disease with MCC), 191 (chronic obstructive pulmonary disease with CC), 192 (chronic obstructive pulmonary disease without CC/MCC), 193, 194, 195
Septicemia (Septicemia)	*N:* count of discharges for DRGs 870 (septicemia or severe sepsis with mechanical ventilation 96+ hours), 871 (septicemia or severe sepsis without mechanical ventilation 96+ hours with MCC), 872 (septicemia or severe sepsis without mechanical ventilation 96+ hours without MCC) *D:* count of discharges for DRGs 689 (kidney and urinary tract infections with MCC), 690 (kidney and urinary tract infections without MCC), 870, 871, 872
Unrelated OR Procedure (Unrel OR Px)	*N*: count of discharges for DRGs 981 (extensive OR procedure unrelated to principal diagnosis with MCC), 982 (extensive OR procedure unrelated to principal diagnosis with CC), 983 (extensive OR procedure unrelated to principal diagnosis without CC/MCC), 987 (non-extensive OR procedure unrelated to principal diagnosis with MCC), 988 (non-extensive OR procedure unrelated to principal diagnosis with CC), 989 (non-extensive OR procedure unrelated to principal diagnosis without CC/MCC) *D*: count of all discharges for surgical DRGs
Medical DRGs with CC or MCC (Med CC MCC)	*N:* count of discharges from medical DRGs in groups 1, 2 or 3 with a CC or MCC *D:* count of discharges from medical DRGs in groups 1, 2 or 3[3] (see Appendix 1)

[3] In the MS-DRGs, there are three "groups" of DRGs with CCs and/or MCCs:

Group 1: MS-DRGs broken out into three tiers: with MCC, with CC, without CC or MCC
Group 2: MS-DRGs broken out into two tiers: with MCC, without MCC
Group 3: MS-DRGs are broken out into two tiers: with CC or MCC, without CC or MCC

TARGET AREA Full and Abbreviated Title	TARGET AREA DEFINITION
Surgical DRGs with CC or MCC (Surg CC MCC)	*N:* count of discharges from surgical DRGs in groups 1, 2 or 3 with a CC or MCC, excluding discharges from DRGs 005 (liver transplant with MCC or intestinal implant), 023 (craniotomy with major device implant/acute complex CNS principal diagnosis with MCC or chemo implant), 029 (spinal procedures with CC or spinal neurostimulators), 041 (peripheral/cranial nerve and other nervous system procedure with CC or peripheral neurostimulator), 129 (major head and neck procedures with CC/MCC or major device), 237 (major cardiovascular procedures with MCC or thoracic aortic aneurysm repair), 246 (percutaneous cardiovascular procedure with drug-eluting stent with MCC or 4+ vessels/stents), 248 (percutaneous cardiovascular procedure with non-drug-eluting stent with MCC or 4+ vessels/stents), 490 (back and neck procedures except spinal fusion with CC/MCC or disc device/neurostimulator) (Note: These DRGs are structured such that they may be assigned on the basis of a procedure being performed.) *D:* count of all discharges for surgical DRGs with or without CC/MCC, excluding discharges for DRGs 005, 023, 029, 041, 129, 237, 246, 248, 490 (see Appendix 2)
Excisional Debridement (Excis Deb)	*N:* count of discharges for 43 DRGs (46 DRGs prior to FY 2012) affected by procedure code 86.22 that have procedure code 86.22 coded on the claim *D:* count of discharges for the 43 (46 DRGs prior to FY 2012) DRGs (see Appendix 3)
Ventilator Support (Vent Sup)	*N*: count of discharges for DRGs 003 (ECMO 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), 933 (extensive burns or full thickness burns with mechanical ventilation 96+ hours without skin graft), with procedure code 96.72 (ventilator support 96+ hours) on the claim *D*: count of discharges for 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, 934 (full thickness burn without skin graft or inhalation injury)
Transient Ischemic Attack (TIA)	*N*: count of discharges for DRG 069 (transient ischemia) *D*: count of discharges for DRGs 061 (acute ischemic stroke with use of thrombolytic agent with MCC), 062 (acute ischemic stroke with use of thrombolytic agent with CC), 063 (acute ischemic stroke with use of thrombolytic agent without CC/MCC), 064 (intracranial hemorrhage or cerebral infarction with MCC), 065 (intracranial hemorrhage or cerebral infarction with CC), 066 (intracranial hemorrhage or cerebral infarction without CC/MCC), 067 (nonspecific CVA and precerebral occlusion without infarct with MCC), 068 (nonspecific CVA and precerebral occlusion without infarct without MCC), 069

TARGET AREA Full and Abbreviated Title	TARGET AREA DEFINITION
Chronic Obstructive Pulmonary Disease (COPD)	*N*: count of discharges for DRGs 190 (chronic obstructive pulmonary disease with MCC) 191 (chronic obstructive pulmonary disease with CC), 192 (chronic obstructive pulmonary disease without CC/MCC) *D*: count of all discharges for medical DRGs in MDC 04 (respiratory system) (DRGs 175 through 208)
PTCA with Stent (PTCA)	*N:* count of discharges for DRGs 246 (percutaneous cardiovascular procedure with drug-eluting stent with MCC or 4+ vessels/stents), 247 (percutaneous cardiovascular procedure with drug-eluting stent without MCC), 248 (percutaneous cardiovascular procedure with non-drug eluting stent with MCC or 4+ vessels/stents), 249 (percutaneous cardiovascular procedure with non-drug-eluting stent without MCC) *D:* count of discharges for DRGs 246, 247, 248, 249 plus outpatient claims with CPT code 92980 (transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) or with HCPCS code G0290 (transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel)
Syncope (Syncope)	*N*: count of discharges for DRG 312 (syncope and collapse) *D*: count of discharges for medical DRGs in MDC 05 (circulatory system) (DRGs 280 through 316)
Other Circulatory System Diagnoses (Circ Sys Dx)	*N*: count of discharges for DRGs 314 (other circulatory system diagnoses with MCC), 315 (other circulatory system diagnoses with CC), 316 (other circulatory system diagnoses without CC/MCC) *D*: count of discharges for medical DRGs in MDC 05 (circulatory system) (DRGs 280 through 316)
Other Digestive System Diagnoses (Dig Sys Dx)	*N*: count of discharges for DRGs 393 (other digestive system diagnoses with MCC), 394 (other digestive system diagnoses with CC), 395 (other digestive system diagnoses without CC/MCC) *D*: count of discharges for medical DRGs in MDC 06 (digestive system) (DRGs 368 through 395)
Medical Back Problems (Med Back)	*N:* count of discharges for DRGs 551 (medical back problems with MCC), 552 (medical back problems without MCC) *D:* count of all discharges for medical DRGs in Major Diagnostic Category (MDC) 08 (Musculoskeletal System and Connective Tissue) (DRGs 533 through 566)

TARGET AREA Full and Abbreviated Title	TARGET AREA DEFINITION
Spinal Fusion (Spinal Fusion)	*N:* count of discharges that have any of the following spinal fusion procedure codes on the claim: 81.00, 81.01, 81.02, 81.03, 81.04, 81.05, 81.06, 81.07, 81.08 *D:* count of discharges that have any of the following procedure codes on the claim: 03.01 through 03.29, 03.32 through 03.79, 03.93, 03.94, 03.97 through 03.99, 80.50, 80.51, 80.53 through 80.59, 81.00 through 81.08, 81.30 through 81.39, 81.65, 81.66, 84.59, 84.60 through 84.69, 84.80, 84.82, 84.84. (See Appendix 4 for complete listing and description of numerator and denominator procedure codes)
Three-day Skilled Nursing Facility-qualifying Admissions (3-Day SNF)	*N:* count of discharges to a SNF with a three-day length of stay *D:* count of all discharges to a SNF (identified by patient discharge status code of 03 (discharged or transferred to a SNF) or 61 (discharged or transferred to a swing bed))
30-day Readmissions to Same Hospital or Elsewhere (Readm)	*N:* 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); patient discharge status of the index admission is not equal to 02 (discharged/transferred to a short-term general hospital for inpatient care); principal diagnosis code of the second admission (readmission) does not begin with "V57." For Maryland claims only: exclude claims if the second admission has a psychiatric principal discharge diagnosis code (ICD-9-CM codes 290-319), and if the index admission has a patient discharge status code of 65 (discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital), and if the readmission occurred during the same day as or the day following the index admission discharge. *D*: count of all discharges excluding patient discharge status 20 (see Appendix 5 for more specifics regarding how readmissions are identified)
30-day Readmissions to Same Hospital (Readm Same)	*N:* 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); patient discharge status of the index admission is not equal to 02 (discharged/transferred to a short-term general hospital for inpatient care); principal diagnosis code of the second admission (readmission) does not begin with "V57." For Maryland claims only: exclude claims if the second admission has a psychiatric principal discharge diagnosis code (ICD-9-CM codes 290-319) and if the index admission has a patient discharge status code of 65 (discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) and if the readmission occurred during the same day as or the day following the index admission discharge. *D*: count of all discharges excluding patient discharge status 20 (see Appendix 5 for more specifics regarding how readmissions are identified)

TARGET AREA Full and Abbreviated Title	TARGET AREA DEFINITION
Two-day Stays for Other Vascular Procedures (2DS Vasc Px)	*N*: count of discharges for DRGs 252 (other vascular procedures with MCC), 253 (other vascular procedures with CC), 254 (other vascular procedures without CC/MCC) with a LOS of less than or equal to two days, excluding patient discharge status codes 02, 20, 07 *D*: count of discharges for DRGs 252, 253, 254
Two-day Stays for Heart Failure and Shock (2DS HF)	*N*: count of discharges for DRGs 291 (heart failure and shock with MCC) , 292 (heart failure and shock with CC), 293 (heart failure and shock without CC/MCC) with a LOS of less than or equal to two days, excluding patient discharge status codes 02, 20, 07 *D*: count of discharges for DRGs 291, 292, 293
Two-day Stays for Cardiac Arrhythmia (2DS Card Arrhy)	*N*: count of discharges for DRGs 308 (cardiac arrhythmia and conduction disorders with MCC), 309 (cardiac arrhythmia and conduction disorders with CC), 310 (cardiac arrhythmia and conduction disorders without CC/MCC) with a LOS of less than or equal to two days, excluding patient discharge status codes 02, 20, 07 *D*: count of discharges for DRGs 308, 309, 310
Two-day Stays for Esophagitis Gastroenteritis (2DS Eso Gastro)	*N*: count of discharges for DRGs 391 (esophagitis, gastroenteritis and miscellaneous digestive disorders with MCC), 392 (esophagitis, gastroenteritis and miscellaneous digestive disorders without MCC) with a LOS of less than or equal to two days, excluding patient discharge status codes 02, 20, 07 *D*: count of discharges for DRGs 391, 392
Two-day Stays for Nutritional and Metabolic Disorders (2DS Nutri Meta)	*N*: count of discharges for DRGs 640 (nutritional and miscellaneous metabolic disorders with MCC) and 641 (nutritional and miscellaneous metabolic disorders without MCC) with a LOS of less than or equal to two days, excluding patient status codes 02, 20, 07 *D*: count of discharges for DRGs 640, 641
Two-day Stays for Renal Failure (2DS Renal Fail)	*N*: count of discharges for DRGs 682 (renal failure with MCC), 683 (renal failure with CC), 684 (renal failure without CC/MCC) with a LOS of less than or equal to two days, excluding patient discharge status codes 02, 20, 07 *D*: count of discharges for DRGs 682, 683, 684
Two-day Stays for Kidney and Urinary Tract Infections (2DS Kidney UTI)	*N*: count of discharges for DRGs 689 (kidney and urinary tract infections with MCC), 690 (kidney and urinary tract infections without MCC) with a LOS of less than or equal to two days, excluding patient status codes 02, 20, 07 *D*: count of discharges for DRGs 689, 690
One-day Stays Excluding Transfers (1DS Excl Trans)	*N:* count of discharges with length of stay less than or equal to one day excluding patient discharge status of 02, 07 or 20 and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours *D:* count of all discharges excluding patient discharge status 02

TARGET AREA Full and Abbreviated Title	TARGET AREA DEFINITION
One-day Stays for Medical DRGs (1DS Med DRGs)	*N:* count of discharges for medical DRGs with length of stay less than or equal to one day excluding patient discharge status of 02, 07 or 20 and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours *D:* count of all discharges for medical DRGs
One-day Stays for Chest Pain and Atherosclerosis (1DS CP Athero)	*N:* count of discharges for DRGs 302 (atherosclerosis with MCC), 303 (atherosclerosis without MCC), 313 (chest pain) with length of stay less than or equal to one day excluding patient discharge status of 02, 07 or 20, and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours *D:* count of discharges for DRGs 302, 303, 313

These ST PEPPER target areas were approved by CMS because they have been identified as prone to improper Medicare payments. Historically, many of these target areas were the focus of Office of Inspector General audits, while others were identified through the now defunct Payment Error Prevention Program and Hospital Payment Monitoring Program, which were implemented by state Medicare Quality Improvement Organizations in 1999 through 2008. More recently, the Recovery Audit Contractor (RAC) demonstration project and the RAC permanent program have identified additional areas prone to improper payments.

Short inpatient hospital admissions, in particular one- and two-day stays, have had high rates of unnecessary admissions. Several target areas in PEPPER focus on one- and two-day stays. The target areas focusing on two-day stays were structured to increase the number of hospitals that have reportable data (numerator and/or denominator greater than 11 for a time period) as well as to assist hospitals with focusing on potentially unnecessary admissions.

Readmissions have been associated with billing errors, premature discharge, incomplete care and inappropriate readmission. There are two target areas relating to readmissions within 30 days of discharge—one including statistics for patients who were readmitted to either the same hospital or to another short-term acute care hospital, and the other including statistics for patients who were readmitted to the same hospital.

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

The coding of complications and comorbidities (CCs) and more recently major complications and comorbidities (MCCs) has been found to be problematic. Oversight agencies have identified coding errors related to the addition of a CC or MCC that was not substantiated by documentation in the medical record. The target areas relating to medical and surgical DRGs with a CC or MCC focus on this issue.

Please note there are changes in DRGs and DRG definitions from one fiscal year (FY) to the next that should be considered:

- Changes for FY 2012 are documented in the *Federal Register*, Volume 76, number 157, August 18, 2011, pages 51476-51846.
- Changes for FY 2011 are documented in the *Federal Register*, Volume 75, number 157, August 16, 2010, pages 50042 – 50677.
- Changes for FY 2010 are documented in the *Federal Register*, Volume 74, number 165, August 27, 2009, pages 43787 – 44236.
- Changes for FY 2009 are documented in the *Federal Register*, Volume 73, number 161, August 19, 2008, pages 48434 – 49083.

How Hospitals Can Use PEPPER Data

ST PEPPER provides short-term acute care hospitals with their jurisdiction, state and national percentile values for each target area with reportable data for the most recent fiscal year quarter included in PEPPER (see Compare Worksheet on page 20). "Reportable data" in PEPPER means there are 11 or more numerator discharges for a given target area for a given time period. When there are fewer than 11 numerator discharges for a target area for a time period, statistics are not displayed in PEPPER due to CMS data restrictions. The following table can assist hospitals with interpreting these values.

Please note that these are generalized suggestions and will not apply to all situations. For all areas, assess whether there is sufficient volume (10 to 30 cases for the fiscal year, depending on the hospital's total discharges for the fiscal year) to warrant a review of cases.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Stroke Intracranial Hemorrhage (Stroke ICH)	This could indicate potential over-coding. A sample of medical records for DRGs 061, 062, 063, 064, 065 and 066 should be reviewed to determine if coding errors exist.	This could indicate that there are coding or billing errors related to under-coding of DRGs 061, 062, 063, 064, 065 and 066. A sample of medical records for other DRGs, such as DRGs 067, 068 and 069 should be reviewed to determine if coding errors exist. Remember to ensure that the documentation supports the principal diagnosis. A coder should not code based on radiological findings without seeking clarification from the physician.
Respiratory Infections (Resp Inf)	This could indicate that there are coding or billing errors related to over-coding for DRGs 177 or 178. A sample of medical records for these DRGs should be reviewed to determine if coding errors exist. Hospitals may generate data profiles to identify cases with principal diagnosis codes of 507.x (aspiration	This could indicate that there are coding or billing errors related to under-coding for DRGs 177 or 178. A sample of medical records for other DRGs, such as DRGs 179, 193, 194 or 195, should be reviewed to determine if coding errors exist. Remember that a diagnosis of pneumonia must be determined by the

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
	pneumonia), 482.83 (pneumonia due to other gram negative pneumonia) or 482.89 (pneumonia due to other specified bacteria) to ensure that documentation supports the principal diagnosis.	physician. A coder should not code based on a laboratory or radiological finding without seeking clarification from the physician.
Simple Pneumonia (Simp Pne)	This could indicate that there are coding or billing errors related to DRGs 193 or 194. A sample of medical records for these DRGs should be reviewed to determine if coding errors exist. Hospitals should ensure documentation supports the principal diagnosis.	This could indicate that there are coding or billing errors related to under-coding for DRGs 193 or 194. A sample of medical records for other DRGs, such as DRGs 177, 178 and 189 (pulmonary edema and respiratory failure), should be reviewed to determine if coding errors exist. Remember that a diagnosis of pneumonia must be determined by the physician. A coder should not code based on a laboratory or radiological finding without seeking clarification from the physician.
Septicemia (Septicemia)	This could indicate that there are coding or billing errors related to over-coding of DRGs 870, 871 or 872. A sample of medical records for these DRGs should be reviewed to determine if coding errors exist. Hospitals may generate data profiles to identify cases with a principal diagnosis code of 038.9 (unspecified septicemia) to ensure documentation supports the principal diagnosis.	This could indicate that there are coding or billing errors related to under-coding of DRGs 870, 871 or 872. A sample of medical records for other DRGs, such as DRGs 689 and 690, should be reviewed to determine if coding errors exist. Remember that a diagnosis of septicemia/sepsis must be determined by the physician. A coder should not code based on a laboratory finding without seeking clarification from the physician.
Unrelated OR Procedure (Unrel OR Px)	This could indicate that there are coding or billing errors related to over-coding of DRGs 981, 982, 983, 987, 988 or 989. A sample of medical records for these DRGs should be reviewed to determine if the principal diagnosis is correct.	This could indicate that the principal diagnosis is being billed with the related procedures. No intervention is necessary.
Medical DRGs with CC or MCC (Med CC MCC) **Surgical DRGs with CC or MCC** (Surg 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 and/or surgical DRGs with CCs or MCCs should be reviewed to determine if coding errors exist. Hospitals may generate data profiles to identify proportions of their CCs or MCCs to determine if there are any particular	This could indicate that there are coding or billing errors related to under-coding for CCs or MCCs. A sample of medical and/or surgical records for medical and/or surgical DRGs without a CC or MCC should be reviewed to determine if 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

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
	medical and/or surgical DRGs on which to focus. Remember that a diagnosis of a CC or MCC must be determined by the physician. A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. If particular diagnoses are found to be problematic, provide education.	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.
Excisional Debridement (Excis Deb)	This could indicate that there are coding or billing errors related to use of procedure code 86.22. A sample of medical records including this procedure code should be reviewed to ensure that the coding is supported by the documentation. Refer to *Coding Clinic* for specific guidelines regarding the use of procedure code 86.22.	If your facility does not perform excisional debridement, low numbers in this target area would be expected. If the excisional debridement number is lower than expected, this could indicate that there are coding or billing errors related to under-coding for procedure code 86.22. A sample of medical records including procedure code 86.28 (nonexcisional debridement) should be reviewed to ensure that the coding is supported by the documentation. Refer to *Coding Clinic* for specific guidelines regarding the use of procedure code 86.22.
Ventilator Support (Vent Sup)	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 if 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 procedure code 96.71 (mechanical ventilation less than 96 hours) to verify that the number of continuous invasive mechanical ventilation hours was coded accurately.
Transient Ischemic Attack (TIA)	This could indicate that there are unnecessary admissions related to failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRG 069. A sample of medical records for DRG 069 should be reviewed to determine 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	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Chronic Obstructive Pulmonary Disease (COPD)	This could indicate that there are unnecessary admissions related to failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRGs 190, 191 or 192. A sample of medical records for these DRGs should be reviewed to determine if inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). Note: These DRGs are also vulnerable to coding errors.	Not applicable, as this is an admission-necessity focused target area.
PTCA with Stent (PTCA)	This could indicate that there are unnecessary admissions related to use of outpatient observation or inappropriate use of admission screening criteria associated with DRGs 246, 247, 248 or 249. A sample of medical records for these DRGs should be reviewed to determine if care could have been provided more efficiently on an outpatient basis. Documentation should support the need for an inpatient admission.	Not applicable, as this is an admission-necessity focused target area.
Syncope (Syncope)	This could indicate that there are unnecessary admissions related to failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRG 312. A sample of medical records for DRG 312 should be reviewed to determine if 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 (Circ Syst Dx)	This could indicate that there are unnecessary admissions related to 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 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	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Other Digestive System Diagnoses (Digest Syst Dx)	This could indicate that there are unnecessary admissions related to failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRGs 393, 394 and 395. A sample of medical records for these DRGs should be reviewed to determine 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.
Medical Back Problems (Med Back)	This could indicate that there are unnecessary admissions related to failure to use outpatient observation or inappropriate use of admission screening criteria associated with DRGs 551 and 552. A sample of medical records for these DRGs should be reviewed to determine if 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 (Spinal Fusion)	This could indicate that there are unnecessary admissions related to performance of unnecessary spinal fusion procedures. A sample of medical records for spinal fusion cases 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.
Three-day Skilled Nursing Facility-qualifying Admissions (3-Day SNF)	This could indicate that there are admission necessity issues related to unnecessary admissions to qualify patients for a SNF admission. A sample of medical records with three-day lengths of stay and patient discharge status codes of “03” or “61” should be reviewed to determine if the admission	Not applicable, as this is an admission-necessity focused target area.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
	was necessary.	
30-day Readmissions to Same Hospital or Elsewhere (Readm) **30-day Readmissions to Same Hospital** (Readm Same)	A sample of readmission cases should be reviewed to identify appropriateness of admission, discharge, quality of care and DRG assignment and billing errors. The hospital is encouraged to generate data profiles for readmissions, such as patients readmitted the same day or next day after discharge. Suggested data elements to include in these profiles are: patient identifier, date of admission, date of discharge, patient discharge status code, principal and secondary diagnoses, procedure code(s) and DRG. Evaluate these profiles for the following indications of potential improper payments: • Patients discharged home (patient discharge status code 01) and readmitted the same or next day may indicate a potential premature discharge or incomplete care. • Patients readmitted for the same principal diagnosis as the first admission may indicate a potential premature discharge or incomplete care. Same-day readmissions for related medical conditions are combined by the MAC/FI, and the hospital is reimbursed for one admission. Hospitals should utilize condition code B4 when the patient is readmitted on the same day to treat a condition that was not related to the first admission. • Hospitals that have exempt units (i.e., swing beds, rehabilitation units or psychiatric units) should verify that the correct provider number was billed (exempt unit number vs. acute care number) for same-day readmissions. The	Not applicable, as these are admission-necessity focused target areas.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
	second admission to an exempt unit should be billed to the exempt unit number, whereas a readmission for acute care should be billed to the acute care number. There is a high probability of billing error when the following patient discharge status codes are billed on the first admission of a same-day readmission to the same hospital: 03, 61, 62, 65 or 70. Note that it is possible for a patient discharged to another hospital's exempt unit for rehabilitation or psychiatric services to be identified as a readmission if the receiving hospital bills the admission to an acute care number.	
All one- and two-day stay target areas: **Two-day Stays for Other Vascular Procedures** (2DS Vasc Px) **Two-day Stays for Heart Failure and Shock** (2DS HF) **Two-day Stays for Cardiac Arrhythmia** (2DS Card Arrhy) **Two-day Stays for Esophagitis Gastroenteritis** (2DS Eso Gastro) **Two-day Stays for Nutritional and Metabolic Disorders** (2DS Nutri Meta) **Two-day Stays for Renal Failure** (2DS Renal Fail)	This could indicate that there are unnecessary admissions related to inappropriate use of admission screening criteria or outpatient observation. A sample of one and/or two-day stay cases should be reviewed to determine if 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 one and/or two-day stays sorted by DRG, physician or admission source to assist in identification of any patterns related to one and/or two-day stays. Hospitals should not review one and/or two-day stays that are associated with procedures designated by CMS as "inpatient only." For target areas of two-day or less lengths of stay it is recommended that the hospital start with a review of the one-day stays.	Not applicable, as these are admission-necessity focused target areas.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS (IF AT/ABOVE 80TH PERCENTILE)	SUGGESTED INTERVENTIONS FOR LOW OUTLIERS (IF AT/BELOW 20TH PERCENTILE)
Two-day Stays for Kidney and Urinary Tract Infections (2DS Kidney UTI) **One-day Stays Excluding Transfers** (1DS Excl Trans) **One-day Stays for Medical DRGs** (1DS Med DRGs) **One-day Stays for Chest Pain and Atherosclerosis** (1DS CP Athero)		

Comparative data for several consecutive quarters can be used to help identify whether the hospital's target area percents changed significantly in either direction from one quarter to the next. This could be an indication of a procedural change in admitting, coding or billing practices, staff turnover or a change in medical staff. It could also reflect changing business practices (e.g. new lines of service) or changes in the external healthcare environment.

Installation

System Requirements

PEPPER is a Microsoft Excel spreadsheet program that can be opened and saved to a PC. It is not intended for use on a network but may be saved to as many PCs as necessary.

Technical Assistance

For help using PEPPER, please submit a request for assistance at PEPPERresources.org by clicking on the “Help/Contact Us” tab. This website also contains many educational resources to assist hospitals with PEPPER.

Please do **not** contact your state Medicare Quality Improvement Organization for assistance with PEPPER, as these organizations are no longer involved in the production or distribution of PEPPER.

Using PEPPER

PEPPER is a Microsoft Excel Workbook that contains numerous worksheets. Users will navigate through PEPPER by clicking on the worksheet tabs at the bottom of the screen. Each tab is labeled to identify the contents of each worksheet (e.g., Compare Worksheet, target area data tables, target area graphs).

Compare Worksheet

Hospitals can use the Compare Worksheet to help prioritize areas for auditing and monitoring. The Compare Worksheet includes all target areas with reportable data for the most recent fiscal year quarter included in PEPPER. For each target area, the Compare Worksheet displays the hospital's number of target discharges; percent; percentiles as compared to the nation, jurisdiction and state; and the "Sum of Payments."

The Compare Worksheet is the only report in PEPPER which allows hospitals to assess 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 Worksheet. When the hospital is a high outlier for a target area, the hospital percent is printed in **red bold**. When the hospital is a low outlier (for coding-focused target areas only), the hospital percent is printed in *green italics*. When the hospital is not an outlier, the hospital's percent is printed in black.

The Compare Worksheet provides the hospital's percentile value for the nation, jurisdiction and state for all target areas with reportable data in the most recent quarter. The percentile value allows a hospital to judge how its target area percent compares to all hospitals in each respective comparison group.

The jurisdiction percentile indicates the percentage of all other hospitals in the jurisdiction that have a target area percent less than the hospital's target area percent.

The state percentile indicates the percentage of all other hospitals in the state within the MAC/FI jurisdiction that have a target area percent less than the hospital's target area percent. The state percentile will be blank if there are fewer than 11 hospitals in a state within the MAC/FI jurisdiction.

The national percentile indicates the percentage of all other hospitals in the nation that have a target area percent less than the hospital's target area percent.

For more on percents versus percentiles, please see the "Frequently Asked Questions" section or the "Training and Resources" section for each respective setting on PEPPERresources.org for a short slide presentation with visuals to assist in the understanding of these terms.

When interpreting the Compare Worksheet findings, hospitals should consider their target area percentile values for the nation, jurisdiction and state. Percentile values at or above the 80th percentile (for all target areas) or at or below the 20th percentile (for coding-focused target areas) indicate that the hospital is an outlier. Outlier status should be evaluated in the priority order of 1) nation, 2) jurisdiction and 3) state. If a hospital is an outlier for nation (compared to all hospitals in the nation), this should be interpreted as the highest priority. If a hospital is an outlier for jurisdiction (compared to all short-term acute care hospitals

in the jurisdiction), this is somewhat of a lower priority. Lastly, if a hospital is an outlier for the state (compared to all short-term acute care hospitals in the state), this would be the lowest priority as the state has the smallest comparison group.

The "Sum of Payments" and "Number of Target Discharges" can also be used to help prioritize areas for review. For example, the Compare Worksheet may show that the Septicemia target area has the highest "Sum of Payments" and "Number of Target Discharges" but the hospital's percent is at the 80th percentile as compared to the jurisdiction and at the 65th percentile as compared to the nation. The One-day Stays for Chest Pain and Atherosclerosis target area may have a smaller "Sum of Payments" and "Number of Target Discharges" but is at the 80th percentile for jurisdiction and 90th percentile for nation. In this scenario, the One-day Stays for Chest Pain and Atherosclerosis target area might be given priority.

National High Outlier Ranking Report

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

Outlier status in the National High Outlier Ranking Report is determined using the national percentile, not the MAC/FI jurisdiction percentile.

The report displays all 29 target areas and 12 time periods in a grid format. For each target area and time period, the respective cell will contain a black "0" if the hospital is a low outlier or is not an outlier, a red "1" if the hospital is a high outlier or it will be blank if the hospital does not have reportable data for that target area and time period. All quarters for which a hospital is at or above the national 80th percentile are added up for the target areas, and for time periods, and are summed to provide the total number of high outliers. All hospitals in the nation are ranked by the total number of high outliers. The hospital with the greatest total number of high outliers is assigned a rank of "1," the hospital with the second greatest number of high outliers is assigned a rank of "2," and so on.

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

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

Target Area Data Tables

PEPPER data tables display a variety of statistics for each target area summarized over the previous 12 fiscal quarters. Statistics in each data table include the total number of discharges for the target area (target area discharge count, which is the numerator), the denominator count of discharges, the proportion of the numerator and denominator (percent), average length of stay and Medicare payment data. The

hospital's percent will be shown in **red bold print** if it is at or above the jurisdiction-wide 80th percentile. For coding-focused target areas it will be shown in *green italics* if it is at or below the jurisdiction-wide 20th percentile (see "Percentile" in the Glossary, page 24). Interpretive guidance is included on the data tables to assist hospitals in considering whether they should audit a sample of records. Suggested interventions tailored to each target area are also included on each data table.

For each time period, a hospital's data will not be displayed if the numerator for the target area is less than 11. This is due to data use restrictions established by CMS, effective with the January 2010 release of PEPPER.

Target Area Graphs

The PEPPER graphs provide a visual representation of the hospital's percent for each target area over the previous 12 fiscal quarters. Hospitals can identify significant changes from one quarter to the next, which could be a result of changes in the medical staff, coding staff, utilization review processes or hospital services. Hospitals are encouraged to identify root causes of major changes to ensure that payment errors are prevented.

The graphs include trend lines for the percents that are at the 80th percentile (and the 20th percentile for coding-focused target areas) for the three comparison groups (state, jurisdiction and nation) so the hospital can easily identify when they are an outlier as compared to any of these groups. A table of these percents is included on each target area graph worksheet. State percentile limits are not calculated if there are fewer than 11 hospitals in a state within the MAC/FI jurisdiction; a zero will be displayed for the state percentile limit(s) in this instance. For more on percents versus percentiles, please see the "Frequently Asked Questions" section or the "Training and Resources" section for each respective setting on PEPPERresources.org for a short slide presentation with visuals to assist in the understanding of these terms.

If there is no reportable data for a given time period due to CMS data use restrictions (see "Target Area Data Tables" above), there will not be a data point on the graph for that respective time period. If there are fewer than 11 hospitals in a state within the MAC/FI jurisdiction, there will not be a trend line for the state in the graph.

Hospital Top Medical DRGs for One-Day Stay Discharges Report

This report lists the top medical DRGs for one-day stays for your hospital in the most recent four fiscal quarters (excluding patient discharge status codes 02, 07 and 20 and excluding claims with prior observation of 24 hours or greater). It also includes the total hospital discharges for each of the top DRGs listed, the proportion of one-day stays to total discharges and the average hospital length of stay for each DRG. Please note that this report is limited to the top DRGs (up to 20) for which there are a total of at least 11 one-day stays (for the respective DRG) during the most recent four fiscal quarters.

Hospital Top Surgical DRGs for One-Day Stay Discharges Report

This report lists the top surgical DRGs for one-day stays for your hospital in the most recent four fiscal quarters (excluding patient discharge status codes 02, 07 and 20 and excluding claims with prior

observation of 24 hours or greater). It also includes the total hospital discharges for each of the top DRGs listed, the proportion of one-day stays to total discharges and the average hospital length of stay for each DRG. Please note that this report is limited to the top DRGs (up to 20) for which there are a total of at least 11 one-day stays (for the respective DRG) during the most recent four fiscal quarters.

Jurisdiction Top Medical DRGs for One-Day Stay Discharges Report

This report lists the top medical DRGs for one-day stays for all hospitals in your jurisdiction in the most recent four fiscal quarters (excluding patient discharge status codes 02, 07 and 20 and excluding claims with prior observation of 24 hours or greater). It also includes the total jurisdiction-wide discharges for each of the top DRGs listed, the proportion of one-day stays to total discharges and the average length of stay for each DRG. Please note that this report is limited to displaying the top medical DRGs (up to 20) for which there are a total of at least 11 one-day stays during the most recent four fiscal quarters.

Jurisdiction Top Surgical DRGs for One-Day Stay Discharges Report

This report lists the top surgical DRGs for one-day stays for all hospitals in your jurisdiction in the most recent four fiscal quarters (excluding patient discharge status codes 02, 07 and 20 and excluding claims with prior observation of 24 hours or greater). It also includes the total jurisdiction-wide discharges for each of the top DRGs listed, the proportion of one-day stays to total discharges and the average length of stay for each DRG. Please note that this report is limited to displaying the top medical DRGs (up to 20) for which there are a total of at least 11 one-day stays during the most recent four fiscal quarters.

Glossary

Average Length of Stay

The average length of stay (ALOS) is calculated as an arithmetic average or mean. It is computed by dividing the total number of hospital (or inpatient) days by the total number of discharges within a given time period. Hospital (or inpatient) days are calculated by counting the difference between admission and discharge dates for each discharge. Same-day admission and discharges are counted as one hospital (or inpatient) day. For the 30-day Readmissions to Same Hospital or Elsewhere and the 30-day Readmissions to Same Hospital target area, the ALOS is calculated using the first (index) admission's length of stay, not the second (readmission) admission's length of stay.

Data Table

The statistical findings for a hospital are presented in tabular form, labeled by time period and indicator.

Fiscal Year

For Medicare data, the fiscal year starts October 1 and ends September 30.

- Quarter 1 is from October 1 through December 31.
- Quarter 2 is from January 1 through March 31.
- Quarter 3 is from April 1 through June 30.
- Quarter 4 is from July 1 through September 30.

Graph

In PEPPER, a graph shows a hospital's percentages for the previous 12 quarters. The hospital's percentages are compared to the 80th percentiles for the state, jurisdiction and nation for all target areas and also to the 20th percentiles for the state, jurisdiction and nation for coding-focused target areas. See *Percentile*.

Percentile

A number that corresponds to one of 100 equal divisions of a range of values in a group. In PEPPER, the percentile represents the hospital's position in the group compared to all other hospitals in the comparison group for that target area. For example, suppose a hospital has a target area percent of 2.3 and 80 percent of the hospitals in the comparison group have a percent for that target area that is less than 2.3. Then we can say the hospital is at the 80th percentile.

Percentiles in PEPPER are calculated from the hospitals' percents so that each hospital percent can be compared to the statewide, jurisdiction-wide or nationwide distribution of hospital percents.

For more on percents versus percentiles, please see the "Frequently Asked Questions" section or the "Training and Resources" section for each respective setting on PEPPERresources.org for a short slide presentation with visuals to assist in the understanding of these terms.

Prioritize To arrange or sort items into an order according to some rule or characteristic to reflect importance or need. The Compare Worksheet was designed to assist hospitals with prioritizing data findings.

Acronyms and Abbreviations

Acronyms and Abbreviations	
ACRONYM/ ABBREVIATION	**ACRONYM/ABBREVIATION DEFINITION**
ALOS	The average length of stay (ALOS) is calculated as an arithmetic average or mean. It is computed by dividing the total number of hospital (or inpatient) days by the total number of discharges within a given time period.
CAH	Critical Access Hospital
CC	Complication or Comorbidity (CC). Patients who are more seriously ill tend to require more hospital resources than patients who are less seriously ill, even though they are admitted to the hospital for the same reason. Recognizing this, the diagnosis-related group (DRG) manual splits certain DRGs based on the presence of secondary diagnoses for specific complications or comorbidities.
CMS	The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for oversight of Medicare and Medicaid. CMS is a division of the U.S. Department of Health and Human Services.
DRG	The Diagnosis Related Group (DRG) is a system that was developed for Medicare in 1980, becoming effective in 1983, as a part of the prospective payment system to classify hospital cases expected to have similar hospital resource use.
DS	Used in conjunction with ST PEPPER one- and two-day stay (DS) target areas (e.g., 1DS Excl Trans, 2DS Kidney UTI)
FATHOM	First-look Analysis Tool for Hospital Outlier Monitoring (FATHOM) is a Microsoft Access application. It was designed to help Medicare Administrative Contractors (MACs) and Fiscal Intermediaries (FIs) compare ST and LT acute care prospective payment system (PPS) inpatient hospitals, CAHs, IPFs and IRFs in areas at risk for improper payment using Medicare administrative claims data.
FI	The fiscal intermediary (FI) is being replaced by the Medicare Administrative Contractor (MAC) in performing Medicare Fee-For-Service, Part A claims processing activities.
FY	Fiscal Year. The Medicare federal fiscal year begins October 1 and ends September 30. For example, Q2FY10 (or Q2FY2010) refers to the second quarter of federal fiscal year 2010, which begins January 1, 2010, and ends March 31, 2010.
IPF	Inpatient Psychiatric Facility
IPPS	The inpatient prospective payment system (IPPS) sets forth a system of reimbursement for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.
IRF	Inpatient Rehabilitation Facility
LT	Long-term, refers to Long-term Acute Care Hospital
MAC	The Medicare Administrative Contractor (MAC) is the contracting authority replacing the fiscal intermediary (FI) and carrier in performing Medicare Fee-For-Service claims processing activities.

MCC	Major Complication or Comorbidity (MCC). Before the introduction of MS-DRG system version 25, many CMS-DRG classifications were "paired" to reflect the presence of complications or comorbidities (CCs). A significant refinement of version 25 was to replace this pairing, in many instances, with a design that created a tiered system of the absence of CCs, the presence of CCs and a higher level of presence of Major CCs. As a result of this change, the historical list of diagnoses that qualified for membership on the CC list was substantially redefined and replaced with a new standard CC list and a new MCC list.
PEPPER	Program for Evaluating Payment Patterns Electronic Report (PEPPER) is an electronic data report in Microsoft Excel format that contains a single hospital's claims data statistics for DRGs and discharges at high risk for improper payments due to billing, coding and/or admission necessity issues.
SNF	Skilled Nursing Facility (SNF). One of the Short-term Acute Care Hospital PEPPER target areas is the 3-Day SNF, or Three-Day Skilled Nursing Facility-Qualifying Admissions.
ST	Short-term, refers to Short-term Acute Care Hospital
TMF	TMF Health Quality Institute (TMF) is the Quality Improvement Organization for the state of Texas. TMF is under contract with the Centers for Medicare & Medicaid Services (CMS) to develop and distribute PEPPER to short-term and long-term acute care hospitals, critical access hospitals, inpatient psychiatric and rehabilitation facilities, and to develop and distribute FATHOM to CMS and MAC/FIs.

Appendix 1: DRG Listing for the Medical DRGs with CC or MCC Target Area (FY 2012)

DRG	Description
052	Spinal disorders & injuries w CC or MCC
053	Spinal disorders & injuries w/o CC or MCC
054	Nervous system neoplasms w MCC
055	Nervous system neoplasms w/o MCC
056	Degenerative nervous system disorders w MCC
057	Degenerative nervous system disorders w/o MCC
058	Multiple sclerosis & cerebellar ataxia w MCC
059	Multiple sclerosis & cerebellar ataxia w CC
060	Multiple sclerosis & cerebellar ataxia w/o CC or MCC
061	Acute ischemic stroke w use of thrombolytic agent w MCC
062	Acute ischemic stroke w use of thrombolytic agent w CC
063	Acute ischemic stroke w use of thrombolytic agent w/o CC or MCC
064	Intracranial hemorrhage or cerebral infarction w MCC
065	Intracranial hemorrhage or cerebral infarction w CC
066	Intracranial hemorrhage or cerebral infarction w/o CC or MCC
067	Nonspecific CVA & precerebral occlusion w/o infarct w MCC
068	Nonspecific CVA & precerebral occlusion w/o infarct w/o MCC
070	Nonspecific cerebrovascular disorders w MCC
071	Nonspecific cerebrovascular disorders w CC
072	Nonspecific cerebrovascular disorders w/o CC or MCC
073	Cranial & peripheral nerve disorders w MCC
074	Cranial & peripheral nerve disorders w/o MCC
075	Viral meningitis w CC or MCC
076	Viral meningitis w/o CC or MCC
077	Hypertensive encephalopathy w MCC
078	Hypertensive encephalopathy w CC
079	Hypertensive encephalopathy w/o CC or MCC
080	Nontraumatic stupor & coma w MCC
081	Nontraumatic stupor & coma w/o MCC
082	Traumatic stupor & coma, coma > 1 hr w MCC
083	Traumatic stupor & coma, coma > 1 hr w CC
084	Traumatic stupor & coma, coma > 1 hr w/o CC or MCC
085	Traumatic stupor & coma, coma < 1 hr w MCC
086	Traumatic stupor & coma, coma < 1 hr w CC
087	Traumatic stupor & coma, coma < 1 hr w/o CC or MCC
088	Concussion w MCC
089	Concussion w CC
090	Concussion w/o CC or MCC
091	Other disorders of nervous system w MCC
092	Other disorders of nervous system w CC
093	Other disorders of nervous system w/o CC or MCC
094	Bacterial & tuberculous infections of nervous system w MCC
095	Bacterial & tuberculous infections of nervous system w CC
096	Bacterial & tuberculous infections of nervous system w/o CC or MCC
097	Non-bacterial infect of nervous sys exc viral meningitis w MCC
098	Non-bacterial infect of nervous sys exc viral meningitis w CC

099 Non-bacterial infect of nervous sys exc viral meningitis w/o CC or MCC
100 Seizures w MCC
101 Seizures w/o MCC
102 Headaches w MCC
103 Headaches w/o MCC
121 Acute major eye infections w CC or MCC
122 Acute major eye infections w/o CC or MCC
124 Other disorders of the eye w MCC
125 Other disorders of the eye w/o MCC
146 Ear, nose, mouth & throat malignancy w MCC
147 Ear, nose, mouth & throat malignancy w CC
148 Ear, nose, mouth & throat malignancy w/o CC or MCC
150 Epistaxis w MCC
151 Epistaxis w/o MCC
152 Otitis media & URI w MCC
153 Otitis media & URI w/o MCC
154 Other ear, nose, mouth & throat diagnoses w MCC
155 Other ear, nose, mouth & throat diagnoses w CC
156 Other ear, nose, mouth & throat diagnoses w/o CC or MCC
157 Dental & Oral Diseases w MCC
158 Dental & Oral Diseases w CC
159 Dental & Oral Diseases w/o CC or MCC
175 Pulmonary embolism w MCC
176 Pulmonary embolism w/o MCC
177 Respiratory infections & inflammations w MCC
178 Respiratory infections & inflammations w CC
179 Respiratory infections & inflammations w/o CC or MCC
180 Respiratory neoplasms w MCC
181 Respiratory neoplasms w CC
182 Respiratory neoplasms w/o CC or MCC
183 Major chest trauma w MCC
184 Major chest trauma w CC
185 Major chest trauma w/o CC or MCC
186 Pleural effusion w MCC
187 Pleural effusion w CC
188 Pleural effusion w/o CC or MCC
190 Chronic obstructive pulmonary disease w MCC
191 Chronic obstructive pulmonary disease w CC
192 Chronic obstructive pulmonary disease w/o CC or MCC
193 Simple pneumonia & pleurisy w MCC
194 Simple pneumonia & pleurisy w CC
195 Simple pneumonia & pleurisy w/o CC or MCC
196 Interstitial lung disease w MCC
197 Interstitial lung disease w CC
198 Interstitial lung disease w/o CC or MCC
199 Pneumothorax w MCC
200 Pneumothorax w CC
201 Pneumothorax w/o CC or MCC
202 Bronchitis & asthma w CC or MCC
203 Bronchitis & asthma w/o CC or MCC
205 Other respiratory system diagnoses w MCC
206 Other respiratory system diagnoses w/o MCC

280 Acute myocardial infarction, discharged alive w MCC
281 Acute myocardial infarction, discharged alive w CC
282 Acute myocardial infarction, discharged alive w/o CC or MCC
283 Acute myocardial infarction, expired w MCC
284 Acute myocardial infarction, expired w CC
285 Acute myocardial infarction, expired w/o CC or MCC
286 Circulatory disorders except AMI, w card cath w MCC
287 Circulatory disorders except AMI, w card cath w/o MCC
288 Acute & subacute endocarditis w MCC
289 Acute & subacute endocarditis w CC
290 Acute & subacute endocarditis w/o CC or MCC
291 Heart failure & shock w MCC
292 Heart failure & shock w CC
293 Heart failure & shock w/o CC or MCC
294 Deep vein thrombophlebitis w CC or MCC
295 Deep vein thrombophlebitis w/o CC or MCC
296 Cardiac arrest, unexplained w MCC
297 Cardiac arrest, unexplained w CC
298 Cardiac arrest, unexplained w/o CC or MCC
299 Peripheral vascular disorders w MCC
300 Peripheral vascular disorders w CC
301 Peripheral vascular disorders w/o CC or MCC
302 Atherosclerosis w MCC
303 Atherosclerosis w/o MCC
304 Hypertension w MCC
305 Hypertension w/o MCC
306 Cardiac congenital & valvular disorders w MCC
307 Cardiac congenital & valvular disorders w/o MCC
308 Cardiac arrhythmia & conduction disorders w MCC
309 Cardiac arrhythmia & conduction disorders w CC
310 Cardiac arrhythmia & conduction disorders w/o CC or MCC
314 Other circulatory system diagnoses w MCC
315 Other circulatory system diagnoses w CC
316 Other circulatory system diagnoses w/o CC or MCC
368 Major esophageal disorders w MCC
369 Major esophageal disorders w CC
370 Major esophageal disorders w/o CC or MCC
371 Major gastrointestinal disorders & peritoneal infections w MCC
372 Major gastrointestinal disorders & peritoneal infections w CC
373 Major gastrointestinal disorders & peritoneal infections w/o CC or MCC
374 Digestive malignancy w MCC
375 Digestive malignancy w CC
376 Digestive malignancy w/o CC or MCC
377 G.I. hemorrhage w MCC
378 G.I. hemorrhage w CC
379 G.I. hemorrhage w/o CC or MCC
380 Complicated peptic ulcer w MCC
381 Complicated peptic ulcer w CC
382 Complicated peptic ulcer w/o CC or MCC
383 Uncomplicated peptic ulcer w MCC
384 Uncomplicated peptic ulcer w/o MCC
385 Inflammatory bowel disease w MCC

386 Inflammatory bowel disease w CC
387 Inflammatory bowel disease w/o CC or MCC
388 G.I. obstruction w MCC
389 G.I. obstruction w CC
390 G.I. obstruction w/o CC or MCC
391 Esophagitis, gastroent & misc digest disorders w MCC
392 Esophagitis, gastroent & misc digest disorders w/o MCC
393 Other digestive system diagnoses w MCC
394 Other digestive system diagnoses w CC
395 Other digestive system diagnoses w/o CC or MCC
432 Cirrhosis & alcoholic hepatitis w MCC
433 Cirrhosis & alcoholic hepatitis w CC
434 Cirrhosis & alcoholic hepatitis w/o CC or MCC
435 Malignancy of hepatobiliary system or pancreas w MCC
436 Malignancy of hepatobiliary system or pancreas w CC
437 Malignancy of hepatobiliary system or pancreas w/o CC or MCC
438 Disorders of pancreas except malignancy w MCC
439 Disorders of pancreas except malignancy w CC
440 Disorders of pancreas except malignancy w/o CC or MCC
441 Disorders of liver except malig, cirr ,alc hepa w MCC
442 Disorders of liver except malig, cirr ,alc hepa w CC
443 Disorders of liver except malig, cirr, alc hepa w/o CC or MCC
444 Disorders of the biliary tract w MCC
445 Disorders of the biliary tract w CC
446 Disorders of the biliary tract w/o CC or MCC
533 Fractures of femur w MCC
534 Fractures of femur w/o MCC
535 Fractures of hip & pelvis w MCC
536 Fractures of hip & pelvis w/o MCC
537 Sprains, strains, & dislocations of hip, pelvis & thigh w CC or MCC
538 Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC or MCC
539 Osteomyelitis w MCC
540 Osteomyelitis w CC
541 Osteomyelitis w/o CC or MCC
542 Pathological fractures & musculoskelet & conn tiss malig w MCC
543 Pathological fractures & musculoskelet & conn tiss malig w CC
544 Pathological fractures & musculoskelet & conn tiss malig w/o CC or MCC
545 Connective tissue disorders w MCC
546 Connective tissue disorders w CC
547 Connective tissue disorders w/o CC or MCC
548 Septic arthritis w MCC
549 Septic arthritis w CC
550 Septic arthritis w/o CC or MCC
551 Medical back problems w MCC
552 Medical back problems w/o MCC
553 Bone diseases & arthropathies w MCC
554 Bone diseases & arthropathies w/o MCC
555 Signs & symptoms of musculoskeletal system & conn tissue w MCC
556 Signs & symptoms of musculoskeletal system & conn tissue w/o MCC
557 Tendonitis, myositis & bursitis w MCC
558 Tendonitis, myositis & bursitis w/o MCC
559 Aftercare, musculoskeletal system & connective tissue w MCC

560 Aftercare, musculoskeletal system & connective tissue w CC
561 Aftercare, musculoskeletal system & connective tissue w/o CC or MCC
562 Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC
563 Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC
564 Other musculoskeletal sys & connective tissue diagnoses w MCC
565 Other musculoskeletal sys & connective tissue diagnoses w CC
566 Other musculoskeletal sys & connective tissue diagnoses w/o CC or MCC
592 Skin ulcers w MCC
593 Skin ulcers w CC
594 Skin ulcers w/o CC or MCC
595 Major skin disorders w MCC
596 Major skin disorders w/o MCC
597 Malignant breast disorders w MCC
598 Malignant breast disorders w CC
599 Malignant breast disorders w/o CC or MCC
600 Non-malignant breast disorders w CC or MCC
601 Non-malignant breast disorders w/o CC or MCC
602 Cellulitis w MCC
603 Cellulitis w/o MCC
604 Trauma to the skin, subcut tiss & breast w MCC
605 Trauma to the skin, subcut tiss & breast w/o MCC
606 Minor skin disorders w MCC
607 Minor skin disorders w/o MCC
637 Diabetes w MCC
638 Diabetes w CC
639 Diabetes w/o CC or MCC
640 Nutritional & misc metabolic disorders w MCC
641 Nutritional & misc metabolic disorders w/o MCC
643 Endocrine disorders w MCC
644 Endocrine disorders w CC
645 Endocrine disorders w/o CC or MCC
682 Renal failure w MCC
683 Renal failure w CC
684 Renal failure w/o CC or MCC
686 Kidney & urinary tract neoplasms w MCC
687 Kidney & urinary tract neoplasms w CC
688 Kidney & urinary tract neoplasms w/o CC or MCC
689 Kidney & urinary tract infections w MCC
690 Kidney & urinary tract infections w/o MCC
691 Urinary stones w ESW lithotripsy w CC/MCC
692 Urinary stones w ESW lithotripsy w/o CC or MCC
693 Urinary stones w/o ESW lithotripsy w MCC
694 Urinary stones w/o ESW lithotripsy w/o MCC
695 Kidney & urinary tract signs & symptoms w MCC
696 Kidney & urinary tract signs & symptoms w/o MCC
698 Other kidney & urinary tract diagnoses w MCC
699 Other kidney & urinary tract diagnoses w CC
700 Other kidney & urinary tract diagnoses w/o CC or MCC
722 Malignancy, male reproductive system w MCC
723 Malignancy, male reproductive system w CC
724 Malignancy, male reproductive system w/o CC or MCC
725 Benign prostatic hypertrophy w MCC

726 Benign prostatic hypertrophy w/o MCC
727 Inflammation of the male reproductive system w MCC
728 Inflammation of the male reproductive system w/o MCC
729 Other male reproductive system diagnoses w CC or MCC
730 Other male reproductive system diagnoses w/o CC or MCC
754 Malignancy, female reproductive system w MCC
755 Malignancy, female reproductive system w CC
756 Malignancy, female reproductive system w/o CC or MCC
757 Infections, female reproductive system w MCC
758 Infections, female reproductive system w CC
759 Infections, female reproductive system w/o CC or MCC
760 Menstrual & other female reproductive system disorders w CC or MCC
761 Menstrual & other female reproductive system disorders w/o CC or MCC
808 Major hematol/immun diag exc sickle cell crisis & coagul w MCC
809 Major hematol/immun diag exc sickle cell crisis & coagul w CC
810 Major hematol/immun diag exc sickle cell crisis & coagul w/o CC or MCC
811 Red blood cell disorders w MCC
812 Red blood cell disorders w/o MCC
814 Reticuloendothelial & immunity disorders w MCC
815 Reticuloendothelial & immunity disorders w CC
816 Reticuloendothelial & immunity disorders w/o CC or MCC
834 Acute leukemia w/o major O.R. procedure w MCC
835 Acute leukemia w/o major O.R. procedure w CC
836 Acute leukemia w/o major O.R. procedure w/o CC or MCC
837 Chemo w acute leukemia as sdx or w high dose chemo agent w MCC
838 Chemo w acute leukemia as sdx w CC or high dose chemo agent
839 Chemo w acute leukemia as sdx w/o CC or MCC
840 Lymphoma & non-acute leukemia w MCC
841 Lymphoma & non-acute leukemia w CC
842 Lymphoma & non-acute leukemia w/o CC or MCC
843 Other myeloprolif dis or poorly diff neopl diag w MCC
844 Other myeloprolif dis or poorly diff neopl diag w CC
845 Other myeloprolif dis or poorly diff neopl diag w/o CC or MCC
846 Chemotherapy w/o acute leukemia as secondary diagnosis w MCC
847 Chemotherapy w/o acute leukemia as secondary diagnosis w CC
848 Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC or MCC
862 Postoperative & post-traumatic infections w MCC
863 Postoperative & post-traumatic infections w/o MCC
865 Viral illness w MCC
866 Viral illness w/o MCC
867 Other infectious & parasitic diseases diagnoses w MCC
868 Other infectious & parasitic diseases diagnoses w CC
869 Other infectious & parasitic diseases diagnoses w/o CC or MCC
871 Septicemia or severe sepsis w/o MV 96+ hours w MCC
872 Septicemia or severe sepsis w/o MV 96+ hours w/o MCC
896 Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC
897 Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC
913 Traumatic injury w MCC
914 Traumatic injury w/o MCC
915 Allergic reactions w MCC
916 Allergic reactions w/o MCC
917 Poisoning & toxic effects of drugs w MCC

918	Poisoning & toxic effects of drugs w/o MCC
919	Complications of treatment w MCC
920	Complications of treatment w CC
921	Complications of treatment w/o CC or MCC
922	Other injury, poisoning & toxic effect diag w MCC
923	Other injury, poisoning & toxic effect diag w/o MCC
945	Rehabilitation w CC or MCC
946	Rehabilitation w/o CC or MCC
947	Signs & symptoms w MCC
948	Signs & symptoms w/o MCC
949	Aftercare w CC or MCC
950	Aftercare w/o CC or MCC
963	Other multiple significant trauma w MCC
964	Other multiple significant trauma w CC
965	Other multiple significant trauma w/o CC or MCC
974	HIV w major related condition w MCC
975	HIV w major related condition w CC
976	HIV w major related condition w/o CC or MCC

Appendix 2: DRG Listing for the Surgical DRGs with CC or MCC Target Area (FY 2012)

DRG	Description
001	Heart transplant or implant of heart assist system w MCC
002	Heart transplant or implant of heart assist system w/o MCC
005	Liver transplant w MCC or intestinal transplant
006	Liver transplant w/o MCC
011	Tracheostomy for face, mouth & neck diagnoses w MCC
012	Tracheostomy for face, mouth & neck diagnoses w CC
013	Tracheostomy for face, mouth & neck diagnoses w/o CC/MCC
016	Autologous bone marrow transplant w CC/MCC
017	Autologous bone marrow transplant w/o CC/MCC
020	Intracranial vascular procedures w PDx hemorrhage w MCC
021	Intracranial vascular procedures w PDx hemorrhage w CC
022	Intracranial vascular procedures w PDx hemorrhage w/o CC/MCC
023	Cranio w major dev impl/acute complex cns PDx w MCC or chemo implant
024	Cranio w major dev impl/acute complex cns PDx w/o MCC
025	Craniotomy & endovascular intracranial procedures w MCC
026	Craniotomy & endovascular intracranial procedures w CC
027	Craniotomy & endovascular intracranial procedures w/o CC/MCC
028	Spinal procedures w MCC
029	Spinal procedures w CC or spinal neurostimulators
030	Spinal procedures w/o CC/MCC
031	Ventricular shunt procedures w MCC
032	Ventricular shunt procedures w CC
033	Ventricular shunt procedures w/o CC/MCC
034	Carotid artery stent procedure w MCC
035	Carotid artery stent procedure w CC
036	Carotid artery stent procedure w/o CC/MCC
037	Extracranial procedures w MCC
038	Extracranial procedures w CC
039	Extracranial procedures w/o CC/MCC
040	Periph/cranial nerve & other nerv syst proc w MCC
041	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim
042	Periph/cranial nerve & other nerv syst proc w/o CC/MCC
113	Orbital procedures w CC/MCC
114	Orbital procedures w/o CC/MCC
116	Intraocular procedures w CC/MCC
117	Intraocular procedures w/o CC/MCC
129	Major head & neck procedures w CC/MCC or major device
130	Major head & neck procedures w/o CC/MCC
131	Cranial/facial procedures w CC/MCC
132	Cranial/facial procedures w/o CC/MCC
133	Other ear, nose, mouth & throat OR procedures w CC/MCC
134	Other ear, nose, mouth & throat OR procedures w/o CC/MCC
135	Sinus & mastoid procedures w CC/MCC
136	Sinus & mastoid procedures w/o CC/MCC

137	Mouth procedures w CC/MCC
138	Mouth procedures w/o CC/MCC
163	Major chest procedures w MCC
164	Major chest procedures w CC
165	Major chest procedures w/o CC/MCC
166	Other resp system OR procedures w MCC
167	Other resp system OR procedures w CC
168	Other resp system OR procedures w/o CC/MCC
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC
222	Cardiac defib implant w cardiac cath w AMI/hf/shock w MCC
223	Cardiac defib implant w cardiac cath w AMI/hf/shock w/o MCC
224	Cardiac defib implant w cardiac cath w/o AMI/hf/shock w MCC
225	Cardiac defib implant w cardiac cath w/o AMI/hf/shock w/o MCC
226	Cardiac defibrillator implant w/o cardiac cath w MCC
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC
228	Other cardiothoracic procedures w MCC
229	Other cardiothoracic procedures w CC
230	Other cardiothoracic procedures w/o CC/MCC
231	Coronary bypass w PTCA w MCC
232	Coronary bypass w PTCA w/o MCC
233	Coronary bypass w cardiac cath w MCC
234	Coronary bypass w cardiac cath w/o MCC
235	Coronary bypass w/o cardiac cath w MCC
236	Coronary bypass w/o cardiac cath w/o MCC
237	Major cardiovasc procedures w MCC
238	Major cardiovasc procedures w/o MCC
239	Amputation for circ sys disorders exc upper limb & toe w MCC
240	Amputation for circ sys disorders exc upper limb & toe w CC
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC
242	Permanent cardiac pacemaker implant w MCC
243	Permanent cardiac pacemaker implant w CC
244	Permanent cardiac pacemaker implant w/o CC/MCC
246	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents
247	Perc cardiovasc proc w drug-eluting stent w/o MCC
248	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents
249	Perc cardiovasc proc w non-drug-eluting stent w/o MCC
250	Perc cardiovasc proc w/o coronary artery stent w MCC
251	Perc cardiovasc proc w/o coronary artery stent w/o MCC
252	Other vascular procedures w MCC
253	Other vascular procedures w CC
254	Other vascular procedures w/o CC/MCC
255	Upper limb & toe amputation for circ system disorders w MCC
256	Upper limb & toe amputation for circ system disorders w CC
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC

258	Cardiac pacemaker device replacement w MCC
259	Cardiac pacemaker device replacement w/o MCC
260	Cardiac pacemaker revision except device replacement w MCC
261	Cardiac pacemaker revision except device replacement w CC
262	Cardiac pacemaker revision except device replacement w/o CC/MCC
326	Stomach, esophageal & duodenal proc w MCC
327	Stomach, esophageal & duodenal proc w CC
328	Stomach, esophageal & duodenal proc w/o CC/MCC
329	Major small & large bowel procedures w MCC
330	Major small & large bowel procedures w CC
331	Major small & large bowel procedures w/o CC/MCC
332	Rectal resection w MCC
333	Rectal resection w CC
334	Rectal resection w/o CC/MCC
335	Peritoneal adhesiolysis w MCC
336	Peritoneal adhesiolysis w CC
337	Peritoneal adhesiolysis w/o CC/MCC
338	Appendectomy w complicated principal diag w MCC
339	Appendectomy w complicated principal diag w CC
340	Appendectomy w complicated principal diag w/o CC/MCC
341	Appendectomy w/o complicated principal diag w MCC
342	Appendectomy w/o complicated principal diag w CC
343	Appendectomy w/o complicated principal diag w/o CC/MCC
344	Minor small & large bowel procedures w MCC
345	Minor small & large bowel procedures w CC
346	Minor small & large bowel procedures w/o CC/MCC
347	Anal & stomal procedures w MCC
348	Anal & stomal procedures w CC
349	Anal & stomal procedures w/o CC/MCC
350	Inguinal & femoral hernia procedures w MCC
351	Inguinal & femoral hernia procedures w CC
352	Inguinal & femoral hernia procedures w/o CC/MCC
353	Hernia procedures except inguinal & femoral w MCC
354	Hernia procedures except inguinal & femoral w CC
355	Hernia procedures except inguinal & femoral w/o CC/MCC
356	Other digestive system OR procedures w MCC
357	Other digestive system OR procedures w CC
358	Other digestive system OR procedures w/o CC/MCC
405	Pancreas, liver & shunt procedures w MCC
406	Pancreas, liver & shunt procedures w CC
407	Pancreas, liver & shunt procedures w/o CC/MCC
408	Biliary tract proc except only cholecyst w or w/o CDE w MCC
409	Biliary tract proc except only cholecyst w or w/o CDE w CC
410	Biliary tract proc except only cholecyst w or w/o CDE w/o CC/MCC
411	Cholecystectomy w CDE w MCC
412	Cholecystectomy w CDE w CC
413	Cholecystectomy w CDE w/o CC/MCC
414	Cholecystectomy except by laparoscope w/o CDE w MCC
415	Cholecystectomy except by laparoscope w/o CDE w CC

416	Cholecystectomy except by laparoscope w/o CDE w/o CC/MCC
417	Laparoscopic cholecystectomy w/o CDE w MCC
418	Laparoscopic cholecystectomy w/o CDE w CC
419	Laparoscopic cholecystectomy w/o CDE w/o CC/MCC
420	Hepatobiliary diagnostic procedures w MCC
421	Hepatobiliary diagnostic procedures w CC
422	Hepatobiliary diagnostic procedures w/o CC/MCC
423	Other hepatobiliary or pancreas OR procedures w MCC
424	Other hepatobiliary or pancreas OR procedures w CC
425	Other hepatobiliary or pancreas OR procedures w/o CC/MCC
453	Combined anterior/posterior spinal fusion w MCC
454	Combined anterior/posterior spinal fusion w CC
455	Combined anterior/posterior spinal fusion w/o CC/MCC
456	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w MCC
457	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w CC
458	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w/o CC/MCC
459	Spinal fusion except cervical w MCC
460	Spinal fusion except cervical w/o MCC
461	Bilateral or multiple major joint procs of lower extremity w MCC
462	Bilateral or multiple major joint procs of lower extremity w/o MCC
463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC
464	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC
466	Revision of hip or knee replacement w MCC
467	Revision of hip or knee replacement w CC
468	Revision of hip or knee replacement w/o CC/MCC
469	Major joint replacement or reattachment of lower extremity w MCC
470	Major joint replacement or reattachment of lower extremity w/o MCC
471	Cervical spinal fusion w MCC
472	Cervical spinal fusion w CC
473	Cervical spinal fusion w/o CC/MCC
474	Amputation for musculoskeletal sys & conn tissue dis w MCC
475	Amputation for musculoskeletal sys & conn tissue dis w CC
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC
477	Biopsies of musculoskeletal system & connective tissue w MCC
478	Biopsies of musculoskeletal system & connective tissue w CC
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC
480	Hip & femur procedures except major joint w MCC
481	Hip & femur procedures except major joint w CC
482	Hip & femur procedures except major joint w/o CC/MCC
483	Major joint & limb reattachment proc of upper extremity w CC/MCC
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC
485	Knee procedures w PDx of infection w MCC
486	Knee procedures w PDx of infection w CC
487	Knee procedures w PDx of infection w/o CC/MCC
488	Knee procedures w/o PDx of infection w CC/MCC
489	Knee procedures w/o PDx of infection w/o CC/MCC
490	Back & neck proc exc spinal fusion w CC/MCC or disc device/neurostim
491	Back & neck proc exc spinal fusion w/o CC/MCC

492	Lower extrem & humer proc except hip,foot,femur w MCC
493	Lower extrem & humer proc except hip,foot,femur w CC
494	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC
495	Local excision & removal int fix devices exc hip & femur w MCC
496	Local excision & removal int fix devices exc hip & femur w CC
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC
498	Local excision & removal int fix devices of hip & femur w CC/MCC
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC
500	Soft tissue procedures w MCC
501	Soft tissue procedures w CC
502	Soft tissue procedures w/o CC/MCC
503	Foot procedures w MCC
504	Foot procedures w CC
505	Foot procedures w/o CC/MCC
507	Major shoulder or elbow joint procedures w CC/MCC
508	Major shoulder or elbow joint procedures w/o CC/MCC
510	Shoulder,elbow or forearm proc,exc major joint proc w MCC
511	Shoulder,elbow or forearm proc,exc major joint proc w CC
512	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC
515	Other musculoskelet sys & conn tiss OR proc w MCC
516	Other musculoskelet sys & conn tiss OR proc w CC
517	Other musculoskelet sys & conn tiss OR proc w/o CC/MCC
570	Skin debridement w MCC
571	Skin debridement w CC
573	Skin graft for skn ulcer or cellulitis w MCC
574	Skin graft for skn ulcer or cellulitis w CC
575	Skin graft for skn ulcer or cellulitis w/o CC/MCC
576	Skin graft exc for skin ulcer or cellulitis w MCC
577	Skin graft exc for skin ulcer or cellulitis w CC
578	Skin graft exc for skin ulcer or cellulitis w/o CC/MCC
579	Other skin, subcut tiss & breast proc w MCC
580	Other skin, subcut tiss & breast proc w CC
581	Other skin, subcut tiss & breast proc w/o CC/MCC
582	Mastectomy for malignancy w CC/MCC
583	Mastectomy for malignancy w/o CC/MCC
584	Breast biopsy, local excision & other breast procedures w CC/MCC
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC
614	Adrenal & pituitary procedures w CC/MCC
615	Adrenal & pituitary procedures w/o CC/MCC
616	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC
617	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC
618	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC
619	OR procedures for obesity w MCC
620	OR procedures for obesity w CC
621	OR procedures for obesity w/o CC/MCC
622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC
623	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC

624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC
625	Thyroid, parathyroid & thyroglossal procedures w MCC
626	Thyroid, parathyroid & thyroglossal procedures w CC
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC
628	Other endocrine, nutrit & metab OR proc w MCC
629	Other endocrine, nutrit & metab OR proc w CC
630	Other endocrine, nutrit & metab OR proc w/o CC/MCC
653	Major bladder procedures w MCC
654	Major bladder procedures w CC
655	Major bladder procedures w/o CC/MCC
656	Kidney & ureter procedures for neoplasm w MCC
657	Kidney & ureter procedures for neoplasm w CC
658	Kidney & ureter procedures for neoplasm w/o CC/MCC
659	Kidney & ureter procedures for non-neoplasm w MCC
660	Kidney & ureter procedures for non-neoplasm w CC
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC
662	Minor bladder procedures w MCC
663	Minor bladder procedures w CC
664	Minor bladder procedures w/o CC/MCC
665	Prostatectomy w MCC
666	Prostatectomy w CC
667	Prostatectomy w/o CC/MCC
668	Transurethral procedures w MCC
669	Transurethral procedures w CC
670	Transurethral procedures w/o CC/MCC
671	Urethral procedures w CC/MCC
672	Urethral procedures w/o CC/MCC
673	Other kidney & urinary tract procedures w MCC
674	Other kidney & urinary tract procedures w CC
675	Other kidney & urinary tract procedures w/o CC/MCC
707	Major male pelvic procedures w CC/MCC
708	Major male pelvic procedures w/o CC/MCC
709	Penis procedures w CC/MCC
710	Penis procedures w/o CC/MCC
711	Testes procedures w CC/MCC
712	Testes procedures w/o CC/MCC
713	Transurethral prostatectomy w CC/MCC
714	Transurethral prostatectomy w/o CC/MCC
715	Other male reproductive system OR proc for malignancy w CC/MCC
716	Other male reproductive system OR proc for malignancy w/o CC/MCC
717	Other male reproductive system OR proc exc malignancy w CC/MCC
718	Other male reproductive system OR proc exc malignancy w/o CC/MCC
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC
739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC
740	Uterine,adnexa proc for non-ovarian/adnexal malig w CC

741	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC
742	Uterine & adnexa proc for non-malignancy w CC/MCC
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC
744	D&C, conization, laparoscopy & tubal interruption w CC/MCC
745	D&C, conization, laparoscopy & tubal interruption w/o CC/MCC
746	Vagina, cervix & vulva procedures w CC/MCC
747	Vagina, cervix & vulva procedures w/o CC/MCC
749	Other female reproductive system OR procedures w CC/MCC
750	Other female reproductive system OR procedures w/o CC/MCC
765	Cesarean section w CC/MCC
766	Cesarean section w/o CC/MCC
799	Splenectomy w MCC
800	Splenectomy w CC
801	Splenectomy w/o CC/MCC
802	Other OR proc of the blood & blood forming organs w MCC
803	Other OR proc of the blood & blood forming organs w CC
804	Other OR proc of the blood & blood forming organs w/o CC/MCC
820	Lymphoma & leukemia w major OR procedure w MCC
821	Lymphoma & leukemia w major OR procedure w CC
822	Lymphoma & leukemia w major OR procedure w/o CC/MCC
823	Lymphoma & non-acute leukemia w other OR proc w MCC
824	Lymphoma & non-acute leukemia w other OR proc w CC
825	Lymphoma & non-acute leukemia w other OR proc w/o CC/MCC
826	Myeloprolif disord or poorly diff neopl w maj OR proc w MCC
827	Myeloprolif disord or poorly diff neopl w maj OR proc w CC
828	Myeloprolif disord or poorly diff neopl w maj OR proc w/o CC/MCC
829	Myeloprolif disord or poorly diff neopl w other OR proc w CC/MCC
830	Myeloprolif disord or poorly diff neopl w other OR proc w/o CC/MCC
853	Infectious & parasitic diseases w OR procedure w MCC
854	Infectious & parasitic diseases w OR procedure w CC
855	Infectious & parasitic diseases w OR procedure w/o CC/MCC
856	Postoperative or post-traumatic infections w OR proc w MCC
857	Postoperative or post-traumatic infections w OR proc w CC
858	Postoperative or post-traumatic infections w OR proc w/o CC/MCC
901	Wound debridements for injuries w MCC
902	Wound debridements for injuries w CC
903	Wound debridements for injuries w/o CC/MCC
904	Skin grafts for injuries w CC/MCC
905	Skin grafts for injuries w/o CC/MCC
907	Other OR procedures for injuries w MCC
908	Other OR procedures for injuries w CC
909	Other OR procedures for injuries w/o CC/MCC
928	Full thickness burn w skin graft or inhal inj w CC/MCC
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC
939	OR proc w diagnoses of other contact w health services w MCC
940	OR proc w diagnoses of other contact w health services w CC
941	OR proc w diagnoses of other contact w health services w/o CC/MCC
957	Other OR procedures for multiple significant trauma w MCC
958	Other OR procedures for multiple significant trauma w CC

959	Other OR procedures for multiple significant trauma w/o CC/MCC
969	HIV w extensive OR procedure w MCC
970	HIV w extensive OR procedure w/o MCC
981	Extensive OR procedure unrelated to principal diagnosis w MCC
982	Extensive OR procedure unrelated to principal diagnosis w CC
983	Extensive OR procedure unrelated to principal diagnosis w/o CC/MCC
984	Prostatic OR procedure unrelated to principal diagnosis w MCC
985	Prostatic OR procedure unrelated to principal diagnosis w CC
986	Prostatic OR procedure unrelated to principal diagnosis w/o CC/MCC
987	Non-extensive OR proc unrelated to principal diagnosis w MCC
988	Non-extensive OR proc unrelated to principal diagnosis w CC
989	Non-extensive OR proc unrelated to principal diagnosis w/o CC/MCC

Appendix 3: DRGs Affected by Procedure Code 86.22 (FY 2012)

DRG	Description
040	Periph & cranial nerve & other nerv syst proc w MCC
041	Periph & cranial nerve & other nerv syst proc w CC or periph neurostim
042	Periph & cranial nerve & other nerv syst proc w/o CC or MCC
115	Extraocular procedures except orbit
133	Other ear, nose, mouth & throat O.R. procedures w CC or MCC
134	Other ear, nose, mouth & throat O.R. procedures w/o CC or MCC
166	Other resp system O.R. procedures w MCC
167	Other resp system O.R. procedures w CC
168	Other resp system O.R. procedures w/o CC or MCC
264	Other circulatory system O.R. procedures
356	Other digestive system O.R. procedures w MCC
357	Other digestive system O.R. procedures w CC
358	Other digestive system O.R. procedures w/o CC or MCC
423	Other hepatobiliary or pancreas O.R. procedures w MCC
424	Other hepatobiliary or pancreas O.R. procedures w CC
425	Other hepatobiliary or pancreas O.R. procedures w/o CC or MCC
463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC
464	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC or MCC
570	Skin debridement w MCC
571	Skin debridement w CC
572	Skin debridement w/o CC or MCC
622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC
623	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC or MCC
673	Other kidney & urinary tract procedures w MCC
674	Other kidney & urinary tract procedures w CC
675	Other kidney & urinary tract procedures w/o CC or MCC
715	Other male reproductive system O.R. proc for malignancy w CC or MCC
716	Other male reproductive system O.R. proc for malignancy w/o CC or MCC
717	Other male reproductive system O.R. proc exc malignancy w CC or MCC
718	Other male reproductive system O.R. proc exc malignancy w/o CC or MCC
749	Other female reproductive system O.R. procedures w CC or MCC
750	Other female reproductive system O.R. procedures w/o CC or MCC
802	Other O.R. proc of the blood & blood forming organs w MCC
803	Other O.R. proc of the blood & blood forming organs w CC
804	Other O.R. proc of the blood & blood forming organs w/o CC or MCC
901	Wound debridements for injuries w MCC
902	Wound debridements for injuries w CC
903	Wound debridements for injuries w/o CC or MCC
957	Other O.R. procedures for multiple significant trauma w MCC
958	Other O.R. procedures for multiple significant trauma w CC
959	Other O.R. procedures for multiple significant trauma w/o CC or MCC

DRGs Affected by Procedure Code 86.22 (prior to FY 2012)

DRG	Description
040	Periph & cranial nerve & other nerv syst proc w MCC
041	Periph & cranial nerve & other nerv syst proc w CC or periph neurostim
042	Periph & cranial nerve & other nerv syst proc w/o CC or MCC
115	Extraocular procedures except orbit
133	Other ear, nose, mouth & throat O.R. procedures w CC or MCC
134	Other ear, nose, mouth & throat O.R. procedures w/o CC or MCC
166	Other resp system O.R. procedures w MCC
167	Other resp system O.R. procedures w CC
168	Other resp system O.R. procedures w/o CC or MCC
264	Other circulatory system O.R. procedures
356	Other digestive system O.R. procedures w MCC
357	Other digestive system O.R. procedures w CC
358	Other digestive system O.R. procedures w/o CC or MCC
423	Other hepatobiliary or pancreas O.R. procedures w MCC
424	Other hepatobiliary or pancreas O.R. procedures w CC
425	Other hepatobiliary or pancreas O.R. procedures w/o CC or MCC
463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC
464	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC or MCC
573	Skin graft &/or debrid for skn ulcer or cellulitis w MCC
574	Skin graft &/or debrid for skn ulcer or cellulitis w CC
575	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC or MCC
576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC
577	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC
622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC
623	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC or MCC
673	Other kidney & urinary tract procedures w MCC
674	Other kidney & urinary tract procedures w CC
675	Other kidney & urinary tract procedures w/o CC or MCC
715	Other male reproductive system O.R. proc for malignancy w CC or MCC
716	Other male reproductive system O.R. proc for malignancy w/o CC or MCC
717	Other male reproductive system O.R. proc exc malignancy w CC or MCC
718	Other male reproductive system O.R. proc exc malignancy w/o CC or MCC
749	Other female reproductive system O.R. procedures w CC or MCC
750	Other female reproductive system O.R. procedures w/o CC or MCC
802	Other O.R. proc of the blood & blood forming organs w MCC
803	Other O.R. proc of the blood & blood forming organs w CC
804	Other O.R. proc of the blood & blood forming organs w/o CC or MCC
901	Wound debridements for injuries w MCC
902	Wound debridements for injuries w CC
903	Wound debridements for injuries w/o CC or MCC
957	Other O.R. procedures for multiple significant trauma w MCC
958	Other O.R. procedures for multiple significant trauma w CC
959	Other O.R. procedures for multiple significant trauma w/o CC or MCC

Appendix 4: Spinal Fusion Target Area Numerator and Denominator Procedure Codes

Numerator Procedure Codes:

81.00 Spinal fusion, NOS
81.01 Atlas-axis spinal fusion
81.02 Other cervical, fusion of the anterior column, anterior technique
81.03 Other cervical fusion of the posterior column, posterior technique
81.04 Dorsal and dorsolumbar fusion of the anterior column, anterior technique
81.05 Dorsal and dorsolumbar fusion of the posterior column, posterior technique
81.06 Lumbar and lumbosacral fusion of the anterior column, anterior technique
81.07 Lumbar and lumbosacral fusion of the posterior column, posterior technique
81.08 Lumbar and lumbosacral fusion of the anterior column, posterior technique

Denominator Procedure Codes:

03.01 Removal of foreign body from spinal canal
03.02 Reopening of laminectomy site
03.09 Other exploration and decompression of spinal canal
03.1 Division of intraspinal nerve root
03.21 Percutaneous chordotomy
03.29 Other chordotomy
03.32 Biopsy of spinal cord or spinal meninges
03.39 Other diagnostic procedures on spinal cord and spinal canal structures
03.4 Excision or destruction of lesion of spinal cord or spinal meninges
03.51 Repair of spinal meningocele
03.52` Repair of spinal myelomeningocele
03.53 Repair of vertebral fracture
03.59 Other repair and plastic operations on spinal cord structures
03.6 Lysis of adhesions of spinal cord and nerve roots
03.71 Spinal subarchnoid-peritoneal shunt
03.72 Spinal subarchnoid-ureteral shunt
03.79 Other shunt of spinal theca
03.93 Implantation or replacement of spinal neurostimulator lead(s)
03.94 Removal of spinal neurostimulator lead(s)
03.97 Revision of spinal thecal shunt
03.98 Removal of spinal thecal shunt
03.99 Other operations on spinal cord and spinal canal structures, other
80.50 Excision or destruction of intervertebral disc, unspecified
80.51 Excision of intervertebral disc
80.53 Repair of the anulus fibrosus with graft or prosthesis
80.54 Other and unspecified repair of the annulus fibrosus
80.59 Other destruction of intervertebral disc
81.00 Spinal fusion, NOS
81.01 Atlas-axis spinal fusion

81.02 Other cervical, fusion of the anterior column, anterior technique
81.03 Other cervical fusion of the posterior column, posterior technique
81.04 Dorsal and dorsolumbar fusion of the anterior column, anterior technique
81.05 Dorsal and dorsolumbar fusion of the posterior column, posterior technique
81.06 Lumbar and lumbosacral fusion of the anterior column, anterior technique
81.07 Lumbar and lumbosacral fusion of the posterior column, posterior technique
81.08 Lumbar and lumbosacral fusion of the anterior column, posterior technique
81.30 Refusion of spine, NOS
81.31 Refusion of atlas-axis
81.32 Refusion of other cervical spine, anterior column, anterior technique
81.33 Refusion of other cervical spine, posterior column, posterior technique
81.34 Refusion of dorsal and dorsolumbar spine, anterior column, anterior technique
81.35 Refusion of dorsal and dorsolumbar spine, posterior column, posterior technique
81.36 Refusion of lumbar and lumbosacral spine, anterior column, anterior technique
81.37 Refusion of lumbar and lumbosacral spine, posterior column, posterior technique
81.38 Refusion of lumbar and lumbosacral spine, anterior column, posterior technique
81.39 Refusion of spine, NEC
81.65 Percutaneous vertebroplasty
81.66 Percutaneous vertebral augmentation (includes kyphoplasty)
84.59 Insertion of other spinal devices
84.60 Insertion of spinal disc prosthesis, NOS
84.61 Insertion of partial spinal disc prosthesis, cervical
84.62 Insertion of total spinal disc prosthesis, cervical
84.63 Insertion of spinal disc prosthesis, thoracic
84.64 Insertion of partial spinal disc prosthesis, lumbosacral
84.65 Insertion of total spinal disc prosthesis, lumbosacral
84.66 Revision or replacement of artificial spinal disc prosthesis, cervical
84.67 Revision or replacement of artificial spinal disc prosthesis, thoracic
84.68 Revision or replacement of artificial spinal disc prosthesis, lumbosacral
84.69 Revision or replacement of artificial spinal disc prosthesis, NOS
84.80 Insertion or replacement or interspinous process device(s)
84.82 Insertion or replacement of pedicle-based dynamic stabilization device(s)
84.84 Insertion or replacement of facet replacement device(s)

Appendix 5: How Readmissions are Identified

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

1. Readmissions are counted in the federal fiscal quarter during which the discharge date of the index (first) admission occurs. If the discharge date of the index admission occurs between:
   - October 1 and December 31, the readmission would be counted in Quarter 1
   - January 1 and March 31, the readmission would be counted in Quarter 2
   - April 1 and June 30, the readmission would be counted in Quarter 3
   - July 1 and September 30, the readmission would be counted in Quarter 4

2. Each admission of a patient could serve as an index admission for a subsequent admission to short-term acute care hospitals if it occurs within 30 days of the discharge date of the index admission.

3. Each admission of a patient could be identified as a readmission only for the short-term acute care hospital admission directly preceding it in time (see Example 1, Claim3).

4. Index admissions with a patient discharge status code of "02" (discharged/transferred to a short-term acute care hospital) are excluded from the numerator count and cannot be identified as an index admission.

5. Any admissions of beneficiaries to other settings, such as SNF, swing bed, inpatient rehabilitation facility, inpatient psychiatric facility, critical access hospital or any other type of provider are not considered for this measure. Only admissions to short-term acute care hospitals are considered.

6. Common billing errors that may result in claims being identified as readmissions include:
   - Billing an admission to a distinct part unit of your short-term acute care hospital (e.g., inpatient rehabilitation or inpatient psychiatric facility unit) to the provider number for the short-term acute care hospital, instead of the provider number for the unit.
   - Incorrect coding of the patient discharge status code when the patient is discharged/transferred to another short-term acute care hospital. As noted in #3 above, index admissions with a patient discharge status code of "02" are excluded from the numerator count and cannot be identified as an index admission.

Example 1

Below is a table showing claims for one beneficiary; the claims are sorted in date order.

Claims for One Beneficiary	Admission Date	Discharge Date	Hospital	Patient Discharge Status Code	Counts as Readm within 30 Days to Same?	Counts as Readm within 30 Days to Same or Elsewhere?
Claim1	March 25	March 29	Hospital A	01	No, this is the index (first) admission	No; this is the index admission
Claim2	April 15	April 17	Hospital A	02	Yes, in Quarter 2 for Hospital A	Yes, in Quarter 2 for Hospital A
Claim3	April 17	April 20	Hospital B	01	No	No

Detailed discussion:

- Claim1: The beneficiary is shown as discharged from Hospital A with a patient discharge status code of "01" (discharged to home or self care (routine discharge)).
- Claim2: Counts as a readmission to Hospital A against index admission Claim1. The beneficiary was discharged from Hospital A on March 29 and readmitted to Hospital A within 30 days on April 15.
- Claim3: Does not count as a readmission to Hospital A against index admission Claim1 because there was an intervening short-term acute care hospital admission (Claim2) that directly preceded the Claim3. Because the patient discharge status code for Claim2 was "02" (discharged/transferred to a short-term acute care hospital) Claim3 is not counted as a readmission to Hospital A against index admission Claim2.

Example 2

Below is a table showing claims submitted for one beneficiary; the claims are sorted in date order.

Claims for One Beneficiary	Admission Date	Discharge Date	Hospital	Patient Status Code	Counts as Readm in 30 Days to Same?	Counts as Readm in 30 days to Same or Elsewhere?
Claim1	April 5	April 7	Hospital A	01	No; this is the index (first) admission	No; this is the index admission
Claim2	May 1	May 3	Hospital A	62	Yes, to Hospital A in Quarter 3	Yes, to Hospital A in Quarter 3
Claim3	May 3	May 15	IRF A	02	No	No
Claim4	May 15	May 17	Hospital A	01	Yes, to Hospital A in Quarter 3	Yes, to Hospital A in Quarter 3

Detailed discussion:

- Claim1: The beneficiary is shown as discharged from Hospital A with a patient discharge status code of "01" (discharged to home or self care (routine discharge)).
- Claim2: Counts as a readmission to Hospital A against index admission Claim1, as the beneficiary was readmitted to Hospital A within 30 days of discharge from the index admission discharge date of April 7. The beneficiary is shown as discharged from Hospital A with a patient discharge status code of "62" (discharged or transferred to an inpatient rehabilitation facility or distinct part unit).
- Claim3: The beneficiary is admitted to Inpatient Rehabilitation Facility A. The beneficiary is shown as discharged from IRF A with a patient discharge status code of "02" (discharged or transferred to a short-term acute care hospital). Note that an admission to another setting, such as SNF, swing bed, inpatient rehabilitation facility, inpatient psychiatric facility, critical access hospital or any other type of provider cannot serve as an index admission or be counted as a readmission; only admissions to short-term acute care hospitals are considered.
- Claim4: Counts as a readmission to Hospital A against index admission Claim2, as the beneficiary was readmitted to Hospital A on May 15 which is within 30 days of discharge from the May 3 discharge date. The beneficiary is shown as discharged from Hospital A with a patient discharge status code of "01."

Example 3

Below is a table showing claims submitted for one beneficiary; the claims are sorted in date order.

Claims for One Beneficiary	Admission Date	Discharge Date	Hospital	Patient Status Code	Counts as Readm in 30 Days to Same?	Counts as Readm in 30 days to Same or Elsewhere?
Claim1	October 10	October 17	Hospital A	01	No; this is the index (first) admission	No; this is the index admission
Claim2	November 2	November 12	Hospital B	01	No	Yes, to Hospital A in Quarter 1

Detailed discussion:

- Claim1: The beneficiary is shown as discharged from Hospital A with a patient discharge status code of “01” (discharged to home or self care (routine discharge)).
- Claim2: Counts as a readmission to Elsewhere for Hospital A against index admission Claim1, as the beneficiary was readmitted to Hospital B within 30 days of discharge from the index admission discharge date of October 17. The beneficiary is shown as discharged from Hospital B with a patient discharge status code of “01” (discharged to home or self care (routine discharge)).