



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

User's Guide

Sixth Edition

Prepared by





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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 high risk for improper payments due to billing, coding and/or admission necessity issues. Each PEPPER contains statistics for the most recent three federal fiscal years for each area at risk for payment errors (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 DRGs for one-day stays and top medical 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 (CAHs), inpatient psychiatric facilities (IPFs) and inpatient rehabilitation facilities (IRFs). LT PEPPER is the version of PEPPER developed specifically for long-term acute care hospitals. In LT PEPPER, a hospital is compared to other long-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 long-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 national 80th percentile. Coding-focused target areas also have a lower control limit, which is the national 20th percentile. PEPPER draws attention to any findings that are at or above the upper control limit (high outliers) or at or below the lower control limit (low outliers, for coding-focused areas only).

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 LT PEPPER are shown in the table below.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Long-term acute care providers only	Third – sixth position of the CMS Certification Number is between “2000” and “2299”
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 (<i>Note that Medicare Secondary Payer claims are included.</i>)
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

Beginning in 2011, LT PEPPER data, previously displayed in 12 federal fiscal quarters, will be aggregated into three federal fiscal years. LT PEPPER will be burned on CD and mailed to hospitals annually.

To receive LT PEPPER, visit PEPPERresources.org, click on Help/Contact Us and submit a request through the Help Desk. Please include in the request a name, position title and complete mailing address. LT PEPPER will continue to be distributed electronically to long-term acute care hospitals that had previously obtained QualityNet accounts.

LT 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 LT PEPPER target areas are defined in the table on the following page.

TARGET AREA	TARGET AREA DEFINITION
Septicemia (Septicemia)	<p><i>Numerator (N):</i> 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)</p> <p><i>Denominator (D):</i> count of discharges for DRGs 689 (kidney and urinary tract infections with MCC), 690 (kidney and urinary tract infections without MCC), 870, 871, 872</p>
Excisional Debridement (Excis Deb)	<p><i>N:</i> count of discharges for 46 DRGs affected by procedure code 86.22 that have procedure code 86.22 coded on the claim</p> <p><i>D:</i> count of discharges for the 46 DRGs</p> <p><i>See Appendix 1 for a list of DRGs included in this target area.</i></p>
Rehabilitation (Rehabilitation)	<p><i>N:</i> count of discharges for DRGs 945 (rehabilitation with CC or MCC) and 946 (rehabilitation without CC or MCC)</p> <p><i>D:</i> count of all discharges</p>
Short Stays (Short Stays)	<p><i>N:</i> count of discharges that were discharged on or the day after the short stay outlier threshold was met</p> <p><i>D:</i> count of all discharges</p>
Outlier Payments (Outlier Pmts)	<p><i>N:</i> count of discharges with a DRG outlier approved amount of greater than \$0</p> <p><i>D:</i> count of all discharges</p>
30-day Readmissions to Same Hospital or Elsewhere (Readm)	<p><i>N:</i> count of index (first) admissions during the 12-month time period for which a readmission occurred within 30 days to the same hospital or to another long-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 63 (discharged/transferred to a long-term acute care hospital)</p> <p><i>D:</i> count of all discharges excluding patient discharge status code 20 (expired)</p>

These LT PEPPER target areas were approved by CMS because they have been identified as prone to improper Medicare payments. Historically, some of these target areas were the focus of Office of Inspector General audits, while others were identified through the former Payment Error Prevention Program and Hospital Payment Monitoring Program, which were implemented by state Medicare Quality Improvement Organizations in 1999 through 2008.

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 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.
- Changes for FY 2008 are documented in the *Federal Register*, Volume 72, number 162, August 22, 2007, pages 47130 – 48157.

How Hospitals Can Use PEPPER Data

LT PEPPER provides long-term acute care hospitals with their national, state and jurisdiction percentile values for each target area with reportable data for the most recent three fiscal years. 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 IF AT/ABOVE 80 TH PERCENTILE	SUGGESTED INTERVENTIONS IF AT/BELOW 20 TH PERCENTILE
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.
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 <i>Coding Clinic</i> 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 <i>Coding Clinic</i> for specific guidelines regarding the use of procedure code 86.22.
Rehabilitation (Rehab)	This could indicate that there are unnecessary admissions related to inappropriate use of admission screening criteria. A sample of medical records for DRGs 945 or 946 should be reviewed to determine if inpatient admission was necessary or if care could have been provided more efficiently in another setting.	Not applicable, as this is an admission-necessity focused target area.

TARGET AREA	SUGGESTED INTERVENTIONS IF AT/ABOVE 80 TH PERCENTILE	SUGGESTED INTERVENTIONS IF AT/BELOW 20 TH PERCENTILE
Short Stays (Short Stays)	<p>This could indicate that there are unnecessary admissions related to inappropriate use of admission screening criteria. A sample of medical records for the appropriate DRG(s) should be reviewed to determine if inpatient admission was necessary or if care could have been provided more efficiently in another setting.</p>	<p>Not applicable, as this is an admission-necessity focused target area.</p>
Outlier Payments (Outlier Pmts)	<p>This indicates that the hospital is submitting a high percentage of claims with outlier payments. Claims with outlier payments should be reviewed to ensure treatment provided was medically necessary.</p>	<p>Not applicable, as this is an admission-necessity focused target area.</p>
30-day Readmissions to Same Hospital or Elsewhere (Readm)	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>LTCHs that are within a short-term acute care hospital should verify that the correct provider number was billed (LTCH number vs. acute care number) for same-day readmissions. The second admission to a short-term acute care hospital should be billed to the short-term acute care hospital's number.</p>	<p>Not applicable, as this is an admission-necessity focused target area.</p>

Comparative data for consecutive years can be used to help identify whether the hospital's proportions changed significantly in either direction from one year 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.

Installation

System Requirements

PEPPER is a Microsoft Excel workbook 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

Target Area Worksheets

PEPPER Target Area Worksheets display a variety of statistics for each target area summarized over three fiscal years. Each worksheet includes a target area graph, a target area data table, comparative data, interpretive guidance and suggested interventions.

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., Target Area Worksheets, Compare).

Target Area Graph

Each worksheet includes a target area graph, which provides a visual representation of the hospital's target area percent over three fiscal years. The hospital's data is represented on the graph in bar format, with each bar representing a fiscal year. Hospitals can identify significant changes from one year 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 improper payments are prevented.

The graph includes 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 ("Comparative Data") is included under the hospital's data table. For more on percents versus percentiles, see the "Frequently Asked Questions" section on PEPPERresources.org for a short slide presentation with visuals to assist in the understanding of these terms.

For each time period, a hospital's data will not be displayed in the graph 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. 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 comparison group in the graph.

Target Area Hospital Data Table

PEPPER Target Area Worksheets also include a data table. 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 national 80th percentile (high outlier); for coding-focused target areas it will be shown in *green italics* if it is at or below the national 20th percentile (low outlier) (see "Percentile" in the Glossary, page 12). For each time period, a hospital's data will not be displayed if the numerator for the target area is less than 11.

Comparative Data Table

The Comparative Data Table provides the target area percents that are at the 80th and 20th percentiles (for coding-focused areas only) for the three comparison groups of nation, jurisdiction and state. These are the percent values that are graphed as trend lines on the Target Area Graph. State percentiles are zero when

there are fewer than 11 hospitals in the jurisdiction's state or when there are no hospitals with at least 11 target (numerator) discharges.

Interpretive Guidance and Suggested Interventions

Interpretive guidance is included on the target area worksheet (to the left of the graph) to assist hospitals in considering whether they should audit a sample of records. Suggested interventions tailored to each target area are also included at the bottom of each worksheet.

Compare Worksheet

Hospitals can use the Compare Worksheet to help them prioritize areas for auditing and monitoring. The Compare Worksheet includes all target areas with reportable data for the most recent fiscal year 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 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. LT PEPPER identifies outliers as compared to all hospitals in the nation.

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 fiscal year. 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 jurisdiction percentile will be blank if there are fewer than 11 hospitals in the MAC/FI jurisdiction.

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, see the "Frequently Asked Questions" section 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 long-term acute care hospitals in the nation), this should be interpreted as the highest priority. If a hospital is an outlier for jurisdiction (compared to all long-term acute care hospitals in the jurisdiction) but not for nation, this is somewhat of a lower priority. Lastly, if a hospital is an outlier for the state (compared to all long-term acute care hospitals in the state) but not for nation or jurisdiction, this would be the lowest priority, as the state has the smallest comparison group.

The “Sum of Payments” can also be used to help prioritize areas for review. For example, the Compare Worksheet may show that the Short Stays target area has the highest “Sum of Payments,” 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 Septicemia target area may rank third in “Sum of Payments,” but is at the 80th percentile for the jurisdiction and the 90th percentile for the nation. In this scenario, the Septicemia target area might be given priority.

Top DRGs Report

This report lists the top DRGs for all discharges for your hospital for the most recent fiscal year. It also includes the number of short-stay outliers, total hospital discharges, the proportion of short-stay outliers 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 discharges (for the respective DRG) during the most recent fiscal year.

Nationwide Top DRGs Report

This report lists the top DRGs for all discharges in the nation for the most recent fiscal year. It also includes the number of short-stay outliers, total discharges, the proportion of short-stay outliers to total discharges and the average length of stay for each DRG. Please note that this report is limited to displaying the top DRGs (up to 20) for which there are a total of at least 11 discharges during the most recent fiscal year.

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.
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.
Graph	In LT PEPPER, a graph shows a hospital's percentages for the previous three years. The hospital's percentages are compared to the 80 th percentile for the state, jurisdiction and nation for all target areas, and also to the 20 th percentile for the state, jurisdiction and nation for coding-focused target areas. See <i>Percentile</i> .
Outlier	In LT PEPPER, hospitals are identified as an outlier if their target area percent is at or above the national 80 th percentile (high outlier) or at or below the national 20 th percentile (low outlier) (coding-focused target areas only).
Percentile	<p>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 percentile value compared to all values 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 <i>less</i> than 2.3. Then we can say that the hospital is at the 80th percentile.</p> <p>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.</p> <p>For more on percents versus percentiles, please see the "Frequently Asked Questions" section on PEPPERresources.org for a short slide presentation with visuals to assist in the understanding of these terms.</p>
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

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.
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 acute care prospective payment system (PPS) inpatient hospitals 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.
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 MACs/FIs.

Appendix 1: DRGs Affected by Procedure Code 86.22

<u>DRG</u>	<u>Description</u>
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/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