Home Health Agency
Program for Evaluating Payment
Patterns Electronic Report

User's Guide

Fifth Edition

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Fifth Edition, effective with the Q4CY19 release

Introduction

The Government Accountability Office has designated Medicare as a program at high risk for fraud, waste, and abuse.[1] Medicare spending for home health care has increased dramatically in recent years,[2,3] and home health agencies (HHAs) have been designated as providing Medicare services that have a high risk for fraud, waste, and abuse.[4] The Office of Inspector General (OIG) recommended that the Centers for Medicare & Medicaid Services (CMS) increase its monitoring of billing for home health services.[4] In 1999, the OIG encouraged health care providers to develop and implement a compliance program to protect their operations from fraud and abuse.[5] As part of their compliance programs, HHAs 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 a provider's auditing and monitoring activities with the goal of preventing improper Medicare payments.

What Is PEPPER?

PEPPER is a comparative data report that summarizes a single provider's Medicare claims data statistics in areas identified as at risk for improper Medicare payments. To develop the *HHA PEPPER*, Medicare claims data for all HHAs in the nation (obtained from the UB-04 claims submitted to the Medicare Administrative Contractor [MAC]) were analyzed to identify areas which could be at risk for improper Medicare payment. These areas are referred to as "target areas."

PEPPER does not identify the presence of improper payments, but it can be used as a guide for auditing and monitoring efforts. A HHA can use PEPPER to compare its claims data over time to identify areas of potential concern and to identify changes in billing practices.

Each HHA with sufficient data to generate a report receives a PEPPER, which summarizes statistics for these target areas regardless of whether the HHA's data are of concern. The report shows how an agency's data compares to national, jurisdiction, and state statistics. Data in PEPPER is presented in tabular form and in graphs that depict the HHA's target area percentages/rates over time. All of the data tables, graphs, and reports in PEPPER were designed to assist HHAs with identifying potentially improper payments. PEPPER is developed and distributed by the RELI Group, along with its partners TMF® Health Quality Institute and CGS, under contract with CMS.

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[1] Government Accountability Office. "Medicare Fraud, Waste and Abuse: Challenges and Strategies for Preventing Improper Payments." June 15, 2012. Available at: http://www.gao.gov/new.items/d10844t.pdf.

[2] Medicare Payment Advisory Commission. Medicare Payment Policy Report to Congress, March 2015, chapter 9, available at http://www.medpac.gov/documents/reports/mar2015_entirereport_revised.pdf?sfvrsn=0

[3] Medicare and Medicaid Research Review 2013 Statistical Supplement, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2013_Section7.pdf#Table7.1

[4] Office of Inspector General. "Inappropriate and Questionable Billing by Medicare Home Health Agencies. 2012. Available at http://oig.hhs.gov/oei/reports/oei-04-11-00240.asp

[5] Department of Health and Human Services/Office of Inspector General. 1998. "Publication of the OIG Compliance Program, Guidance for Home Health Agencies," *Federal Register* 63, no. 152, August 7, 1998, 42410–42426. Available at: http://oig.hhs.gov/authorities/docs/cpghome.pdf

In 2015, PEPPER became available for HHAs. PEPPER is also available for short- and long-term acute care inpatient prospective payment system (IPPS) hospitals, critical access hospitals, inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs), partial hospitalization programs, hospices, and skilled nursing facilities (SNFs) (the format of the reports and the target areas are customized for each setting). The *HHA PEPPER* is the version of PEPPER specifically developed for HHAs. The *HHA PEPPER* is available to the HHA's Chief Executive Officer, Administrator, President, Compliance Officer, or Quality Assurance/Performance Improvement Officer through the PEPPER Portal (accessible through PEPPER.CBRPEPPER.org).

Each HHA receives only its PEPPER. The PEPPER Team does not provide PEPPERs to other contractors, although it does provide a Microsoft Access database (the First-Look Analysis Tool for Hospital Outlier Monitoring [FATHOM]) to MACs and Recovery Auditors. FATHOM can be used to produce a PEPPER.

Each *HHA PEPPER* summarizes claims data statistics (obtained from paid home health Medicare UB-04 claims) for the most recent three calendar years (the calendar year begins on Jan. 1 and ends on Dec. 31). A HHA is compared to other HHAs in three comparison groups: the nation, MAC jurisdiction, and state. These comparisons enable HHAs to determine whether their billing statistics differ from other HHAs and whether they may be at higher risk for improper Medicare payments.

PEPPER identifies areas at risk for improper Medicare payments 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. Currently, the *HHA PEPPER* does not contain any coding-focused target areas; therefore, the *HHA PEPPER* only draws attention to findings that are at or above the national 80th percentile.

In order to be eligible for inclusion in the *HHA PEPPER*, claims must meet the specifications shown below.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Claim facility type equal to "3"	UB-04 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 3 (Home health agency)
Include claim service classification type of "Home health visits"	UB-04 FL 04 Type of Bill, third digit (Bill Classification) = 2 (Home health visits under Part B) or 3 (Home health visits Part A)
Services provided during the time periods included in the report	Claim "Through Date" falls within the three calendar years included in the report.
Exclude non-payment and interim claims	UB-04 FL 04 Type of Bill, fourth digit (Frequency) ≠ 0 (Non-payment/zero claim) or 2 (Interim – first claim)
Final action claim	A final action claim is a non-rejected claim for which a payment has been made. All disputes and adjustments have been resolved and details clarified.
Medicare claim payment amount greater than zero	The home health agency received a payment amount greater than zero on the claim (Note that Medicare Secondary Payer claims are included).
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Advantage (Health Maintenance Organization) plan
Exclude cancelled claims	Exclude claims cancelled by the MAC

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. After October 2000, HHAs have been paid under a Home Health Prospective Payment System (HH PPS) for 60-day episodes of care that include all covered home health services. The 60-day payment amount is adjusted for case-mix and area wage differences. The case-mix adjustment under this system included a clinical dimension, a functional dimension, and a service dimension, in which payment would increase if certain thresholds of therapy visits were met. If fewer than five visits were delivered during a 60-day episode, the low-utilization payment adjustment (LUPA) rate was applied and the HHA was paid per visit by visit type. The HH PPS included a partial episode payment (PEP) adjustment for when a beneficiary elected to transfer to another HHA or when a beneficiary was discharged and readmitted to the same HHA during the 60-day episode. Medicare makes additional payments, which are known as outlier payments, to HHAs that provide services to beneficiaries who incur unusually high costs.

CMS finalized a new case-mix classification model, the Patient-Driven Groupings Model (PDGM), which came into effect on Jan. 1, 2020. The PDGM eliminates the use of therapy thresholds for case-mix adjustments and changes the 60-day unit of payment to a 30-day unit of payment. LUPA payments, partial payments, and outlier payments are included in the model. For more on the PDGM, see MLN Matters SE 19027 and MLN Matters SE 19028, or visit the CMS HH PPS page on the CMS website.

A beneficiary can receive an unlimited number of episodes as long as they meet the coverage criteria. For home health services, an episode is represented by one claim submitted to the MAC for Medicare reimbursement. The PEPPER target areas are designed to report on beneficiary episodes (i.e., claims) that end during the respective calendar year.

HHA PEPPER CMS Target Areas

In general, the target areas are constructed as ratios and expressed as percents (when the numerator and denominator are expressed as the same unit, e.g., episodes) or rates (when the numerator is expressed as a different unit than the denominator, e.g., beneficiaries and episodes). Generally, the numerator represents episodes that may be identified as problematic (in terms of their risk for improper Medicare payment), and the denominator represents a larger comparison group. The *HHA PEPPER* target areas are defined in the table below.

TARGET AREA (Full and Abbreviated Title)	TARGET AREA DEFINITION
Average Case Mix (Avg Case Mix)	*N:* sum of case mix weight for all episodes paid to the HHA during the report period, excluding LUPAs (identified by Part A National Claims History [NCH] HHA LUPA code) and PEPs (identified as patient discharge status code equal to '06') *D:* count of episodes paid to the HHA during the report period, excluding LUPAs and PEPs Note: Reported as a rate, not a percent.

TARGET AREA (Full and Abbreviated Title)	TARGET AREA DEFINITION
Average Number of Episodes (Nbr Episodes)	*N*: count of episodes paid to the HHA during the report period *D*: count of unique beneficiaries served by the HHA during the report period Note: Reported as a rate, not a percent.
Episodes with 5 or 6 Visits (5 or 6 visits)	*N*: count of episodes with five or six visits paid to the HHA during the report period *D*: count of episodes paid to the HHA during the report period
Non-LUPA Payments (NonLUPA)	*N*: count of episodes paid to the HHA that did not have a LUPA payment during the report period *D*: count of episodes paid to the HHA during the report period
High Therapy Utilization Episodes (Hi Therapy Utiliz)	*N*: count of episodes with 20+ therapy visits paid to the HHA during the report period (first digit of Home Health Resource Groups [HHRG] equal to '5') *D*: count of episodes paid to the HHA during the report period
Outlier Payments (Outlier)	*N:* sum of dollar amount of outlier payments (identified by the amount where Value Code equal to '17') for episodes paid to the HHA during the report period *D:* sum of dollar amount of total payments for episodes paid to the HHA during the report period

These PEPPER target areas were approved by CMS because they were identified as being potentially at risk for improper Medicare payments in the HH PPS, prior to Jan. 1, 2020.

The PEPPER Team coordinated with CMS to evaluate changes to the *HHA PEPPER* related to the transition to the PDGM. The PDGM considers the following factors:

- Admission source: If the beneficiary was treated in an institutional setting (e.g., short-term acute care hospital, long-term acute care hospital, IRF, IPF, or SNF) within 14 days prior to the HHA admission, the HHA receives a higher adjustment than it would if the beneficiary was admitted to the HHA directly from the community setting.
- Comorbidity adjustment:
    - High comorbidity adjustment: There are two or more secondary diagnoses that are associated with higher resource use when they are both reported together, rather than separately. These two diagnoses may interact with one another, resulting in higher resource use.
    - Low comorbidity adjustment: There is a reported secondary diagnosis that is associated with higher resource use.
    - No comorbidity adjustment: There are no reported secondary diagnoses that could be considered either a low or high comorbidity adjustment.

CMS evaluated and approved three new target areas designed to assess the potential for circumventing these new payment adjustments:

- *High Comorbidity*

  - Numerator: Count of periods with two or more secondary diagnoses that interact with one another and, therefore, qualify for a high comorbidity adjustment
  - Denominator: Count of all periods
- *Low Comorbidity*
  - Numerator: Count of periods with one or more secondary diagnoses that are associated with higher resource use and, therefore, qualify for a low comorbidity adjustment (excluding periods that also qualify for a high comorbidity adjustment)
  - Denominator: Count of all periods
- *Admission Source*
  - Numerator: Count of periods with discharge from short-term acute care hospitals, long-term acute care hospitals, critical access hospitals, IRFs, IPFs, or SNFs in the 14 days prior to the home health admission
  - Denominator: Count of all periods

The *HHA PEPPER* will include these new target areas after one year of PDGM claims. The Q4CY20 *HHA PEPPER* release (scheduled for distribution in July 2021) will reflect these changes. Any current target areas that are no longer applicable will be retired.

How HHAs Can Use PEPPER Data

The *HHA PEPPER* allows HHAs to compare their billing statistics with national, jurisdiction, and state percentile values for each target area for which they have "reportable data" for the most recent three years.

"Reportable data" in PEPPER means the numerator count is 11 or more for a given target area for a given time period or the denominator count is 11 or more for the *Average Case Mix* and *Average Number of Episodes* target areas. When the numerator or denominator count is less than 11 for a target area and time period, statistics are not displayed in PEPPER due to CMS data restrictions.

To calculate percentiles, the target area percents/rates for all HHAs with reportable data for each target area and each time period in the respective comparison group (i.e., nation, jurisdiction, or state) are ordered from highest to lowest. The target area percent/rate below which 80% of all HHAs' target area percents/rates falls is identified as the 80th percentile. HHAs whose target percents/rates are at or above the 80th percentile (i.e., the top 20%) are considered at risk for improper Medicare payments.

Percentiles are calculated for each of the three comparison groups (i.e., nation, jurisdiction, and state). The greater a HHA's percentile, the greater risk for improper payments. The PEPPER Team has developed suggested interventions that HHAs could consider when assessing their risk for improper Medicare payments for each of the target areas. Please note that these are generalized suggestions and will not apply to all situations. The following table can assist HHAs with interpreting their percentile values, which are indications of possible risk of improper Medicare payments.

TARGET AREA (Full and Abbreviated Title)	SUGGESTED INTERVENTIONS FOR HHAs AT RISK FOR IMPROPER PAYMENTS (IF AT/ABOVE 80TH PERCENTILE)
Average Case Mix (Case Mix)	This could indicate a risk of potential over-coding of beneficiaries' clinical and functional status. The HHA should determine whether beneficiaries' clinical and functional status as reported on the Outcome and Assessment Information Set (OASIS) is supported and consistent with medical record documentation.
Average Number of Episodes (Nbr Episodes)	This could indicate that the HHA is continuing treatment beyond the point where services are necessary. The HHA should review documentation for beneficiaries with a high number of episodes to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. If the individualized assessment of the patient does not demonstrate the need for skilled care, such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, these services are not covered under the home health benefit. The HHA should review plans of care for appropriateness and assess the appropriateness of discharge plans.
Episodes with 5 or 6 Visits (5 or 6 visits)	This could indicate that the HHA is considering the minimum number of visits (i.e., five) to obtain an HHRG payment instead of a LUPA payment when there are less than five visits. The HHA should review documentation for episodes with five or six visits to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. If the individualized assessment of the patient does not demonstrate the need for skilled care, such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, these services are not covered under the home health benefit. The HHA should review plans of care to ensure they are individualized and appropriate for the beneficiaries' condition.
Non-LUPA Payments (NonLUPA)	This could indicate that the HHA is considering the minimum number of visits (i.e., five) to obtain an HHRG payment instead of a LUPA payment where there are less than five visits. The HHA should review documentation to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. If the individualized assessment of the patient does not demonstrate the need for skilled care, such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, these services are not covered under the home health benefit. The HHA should review plans of care to ensure they are individualized and appropriate for the beneficiaries' condition.
High Therapy Utilization Episodes (Hi Therapy Utiliz)	This could indicate that the HHA is improperly billing for therapy services. The HHA should review documentation for episodes with 20+ therapy visits to ensure that it clearly substantiates that skilled therapy services were reasonable and necessary. This includes ensuring that the specialized judgement, knowledge, and skills of a qualified therapist (i.e., "skilled care") were necessary to prevent deterioration and/or to preserve the beneficiary's existing capabilities. The HHA should ensure that the amount of therapy reported is supported by documentation in the medical record.

TARGET AREA (Full and Abbreviated Title)	SUGGESTED INTERVENTIONS FOR HHAs AT RISK FOR IMPROPER PAYMENTS (IF AT/ABOVE 80TH PERCENTILE)
Outlier Payments (Outlier)	This could indicate a risk of potential over-coding of beneficiaries' clinical and functional status. The HHA should determine whether beneficiaries' clinical and functional status, as reported on the OASIS, is supported and consistent with medical record documentation.

Comparative data for the three consecutive years can be used to help identify whether a HHA's target area percents/rates changed significantly in either direction from one year to the next. This could be an indication of a changes in admission or treatment practices, staff turnover, a change in medical staff, or changes in the external health care environment.

Using PEPPER

Compare Targets Report

HHAs can use the Compare Targets Report to help prioritize areas for auditing and monitoring. The Compare Targets Report lists all target areas with reportable data for the most recent year included in PEPPER. For each target area, the Compare Targets Report displays the HHA's numerator count, percent/rate, HHA's percentiles as compared to the nation, jurisdiction and state, and the "Sum of Payments" (where applicable).

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 Reports, Compare Targets Report).

The *HHA PEPPER* identifies providers whose data results (percentiles) suggest they are at risk for improper Medicare payments as compared to all HHAs in the nation. The HHA's risk status is indicated by the color of the target area percent/rate on the Compare Targets Report. When the HHA's percent/rate is at or above the national 80th percentile for a target area, the HHA's percent/rate is printed in **red bold**. When the HHA's percent/rate is below the national 80th percentile, the HHA's percent/rate is printed in black.

The Compare Targets Report provides the HHA's percentile value for the nation, jurisdiction, and state for all target areas with reportable data in the most recent year. The percentile value allows a HHA to judge how its target area percent/rate compares to all HHAs in each respective comparison group.

The HHA's national percentile indicates the percentage of all other HHAs in the nation that have a target area percent/rate less than the HHA's target area percent/rate.

The HHA's jurisdiction percentile indicates the percentage of all other HHAs in the MAC jurisdiction that have a target area percent/rate less than the HHA's target area percent/rate. The HHA's jurisdiction percentile for a target area will be blank if there are fewer than 11 HHAs with reportable data for the target area in a jurisdiction.

The HHA's state percentile indicates the percentage of all other HHAs in the state that have a target area percent/rate less than the HHA's target area percent/rate. The HHA's state percentile for a target area will be blank if there are fewer than 11 HHAs with reportable data for the target area in a state

To learn more about how percents differ from percentiles, see the "Training and Resources" page in the HHA section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

When interpreting the Compare Targets Report findings, HHAs should consider their target area percentile values for the nation, jurisdiction, and state. Percentile values at or above the 80th percentile indicate that the HHA is at risk for improper Medicare payments. Providers should place the highest priority with their national percentile, as this percentile represents how the HHA compares to all HHAs in the nation.

Percentile values at or above the jurisdiction's 80th percentile or state's 80th percentile should be considered as well, though they should be given lower priority. The jurisdiction and state comparison groups are smaller; therefore, these percentiles may be less meaningful. In addition, regional differences in practice patterns may be reflected in jurisdiction and state percentiles.

The "Target Count/Amount" and "Sum of Payments" (available for target areas based on episodes) can also be used to help prioritize areas for review. Areas in which a provider is at/above the 80th percentile that have a high sum of payment and/or numerator count may be given higher priority than target areas for which a provider is at/above the 80th percentile that have a lower sum of payments/numerator count.

Target Area Reports

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

Target Area Graph

Each report includes a target area graph, which provides a visual representation of the HHA's target area percent or rate over three years. The HHA's data is represented on the graph in bar format, and each bar represents a calendar year. HHAs can identify changes in the target area percent/rate from one time period to the next, which could be a result of changes in patient population, medical/therapy staff, or utilization review processes, for example. HHAs are encouraged to identify root causes of major changes to ensure that improper payments are prevented.

The graph includes red trend lines for the percents/rates that are at the 80th percentile for the three comparison groups (i.e., nation, jurisdiction, and state), which the HHA can use to easily identify when its results suggest that it is at risk for improper Medicare payments when compared to any of these groups. A table of these values (i.e., "Comparative Data") is included under the HHA's data table. To learn more about how percents differ from percentiles, see the "Training and Resources" page in the HHA section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

An HHA's data will not be displayed in the graph if the numerator count for the target area is less than 11 for any time period. This is due to data restrictions established by CMS. If there are fewer than 11 HHAs with reportable data for a target area in a state for any time period, there will not be a data point/trend line for the state comparison group in the graph. If there are fewer than 11 HHAs with reportable data for a target area in a jurisdiction for any time period, there will not be a data point/trend line for the jurisdiction comparison group in the graph.

Target Area HHA Data Table

PEPPER Target Area Reports also include an HHA data table. Statistics in each data table include the target (numerator) count for the target area, the denominator count, the proportion of the numerator and denominator (percent or rate), the average length of stay (ALOS) for the numerator and for the

denominator (where available), and the average and sum of Medicare payment data (available for episode-based target areas).

For the *Average Case Mix* target area, the numerator ALOS, the average Medicare payments, and the sum of Medicare payments cannot be calculated for the numerator, which is the sum of case mix weights for episodes paid to the HHA during the report period (excluding LUPAs and PEPs).

For the *Average Number of Episodes* target area, the denominator ALOS cannot be calculated because the denominator is the count of unique beneficiaries served by the HHA during the report period.

For the *Outlier Payments* target area, the average and sum of Medicare payments are not reported to avoid duplication in reporting these measures. Instead, the average outlier payment amount for each calendar year is calculated and reported.

The HHA's percent/rate will be shown in **red bold print** if it is at or above the national 80th percentile; this suggests that there is a risk of improper Medicare payments. For each time period, an HHA's data will not be displayed if the numerator count for the target area is less than 11.

Comparative Data Table

The comparative data table provides the target area percents/rates that are at the 80th percentile for the three comparison groups: nation, jurisdiction, and state. These are the values that are graphed as red trend lines on the target area graph. State percentiles are zero when there are fewer than 11 HHAs with reportable data for a target area in the state. Jurisdiction percentiles are zero when there are fewer than 11 HHAs with reportable data for a target area in the jurisdiction.

Interpretive Guidance and Suggested Interventions

Interpretive guidance is included on the target area report (to the left of the graph) to assist HHAs in considering whether they should audit a sample of records. Suggested interventions for providers, whose results suggest a risk for improper Medicare payments, are tailored to each target area and are included at the bottom of each report.

HHA Top Diagnoses Report

The HHA Top Diagnoses Report lists the top Clinical Classifications Software (CCS) diagnosis categories[6] (up to 20) for episodes at the HHA ending in the most recent calendar year. For each diagnosis category listed, the report includes the total number of episodes that have a principal diagnosis code mapping to that category, the proportion of episodes for the diagnosis category to total episodes, the number of visits, and the average number of visits. Please note that this report is limited to displaying the top diagnosis categories (up to 20) for which there are a total of at least 11 episodes ending in the most recent calendar year.

[6] Diagnoses and procedures have been collapsed into general categories using CCS. More information on CCS can be found at http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp

HHA Top Therapy Episodes Report

The HHA Top Therapy Episodes Report lists the top CCS diagnosis categories (up to five) for five groups of episodes: Early 0 – 13 therapy visits episodes, Early 14 – 19 therapy visits episodes, Late 0 – 13 therapy visits episodes, Late 14 – 19 therapy visits episodes, and All 20+ therapy visits episodes for episodes at the HHA ending in the most recent calendar year. (Note: Episodes are categorized into a therapy episode group based on the first digit in the Health Insurance Prospective Payment System [HIPPS] code as reported on the claim.)

For each therapy group, the report includes the number of episodes, the proportion of all episodes, the total number of therapy visits, and the average number of therapy visits for the HHA for the most recent calendar year. The top diagnosis categories (up to five) for each therapy group are listed, along with the number of episodes for the diagnosis category, the proportion of episodes for the diagnosis category within each therapy group, the number of therapy visits, and the average number of therapy visits. Please note that this report is limited to displaying statistics for the therapy groups and/or diagnosis categories for which there were at least 11 episodes ending in the most recent calendar year.

Jurisdiction-Wide Top Diagnoses Report

The Jurisdiction-Wide Top Diagnoses Report lists the top CCS diagnosis categories (up to 20) for episodes in the MAC jurisdiction ending in the most recent calendar year. For each diagnosis category listed, the report includes the total number of episodes that have a principal diagnosis code mapping to that category, the proportion of episodes for the diagnosis category to total episodes, the number of visits, and the average number of visits.

Jurisdiction-Wide Top Therapy Episodes Report

The Jurisdiction-Wide Top Therapy Episodes Report lists the top CCS diagnosis categories (up to five) for five groups of therapy episodes: Early 0 – 13 therapy visits episodes, Early 14 – 19 therapy visits episodes, Late 0 – 13 therapy visits episodes, Late 14 – 19 therapy visits episodes, and All 20+ therapy visits episodes for episodes in the MAC jurisdiction ending in the most recent calendar year. For each therapy group, the report includes the number of episodes, the proportion of all episodes, the total number of therapy visits, and the average number of therapy visits in the MAC jurisdiction for the most recent calendar year. The top diagnosis categories (up to five) for each therapy group are listed, along with the number of episodes for the diagnosis category, the proportion of episodes for the diagnosis category within each therapy group, the number of therapy visits, and the average number of therapy visits.

System Requirements, Customer Support, and Technical Assistance

PEPPER is a Microsoft Excel workbook that can be opened and saved to a personal computer (PC). It is not intended for use on a network, but it may be saved to as many PCs as necessary.

For help using PEPPER, please submit a request for assistance at PEPPER.CBRPEPPER.org by clicking on the "Help/Contact Us" tab. This website also provides many educational resources to assist HHAs with PEPPER in the HHA "Training and Resources" section.

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

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 days on claims ending during the report period at the HHA by the total number of claims submitted by the HHA during the time period.
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.
FATHOM	First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) is a Microsoft Access application. It was designed to help MACs compare acute care PPS inpatient hospitals in areas at risk for improper payment using Medicare administrative claims data.
HIPPS	Health Insurance Prospective Payment System (HIPPS)
HHA	Home health agencies (HHAs)
HHRG	Home Health Resource Groups (HHRG)
HH PPS	Home Health Prospective Payment System (HH PPS)
IPF	Inpatient psychiatric facility (IPF)
IRF	Inpatient rehabilitation facility (IRF)
IPPS	Inpatient prospective payment system (IPPS)
LOS	The length of stay (LOS) is the total number of HHA days for the claim submitted by an HHA for a beneficiary's episode. It is computed by subtracting the admission date ("From Date") on the claim from the discharge date ("Through Date") of the claim before then adding one.
LUPA	Low-utilization payment adjustment (LUPA)
MAC	The Medicare Administrative Contractor (MAC) is the contracting authority that replaced the fiscal intermediary and carrier in performing Medicare Fee-for-Service claims processing activities.
NCH	National Claims History (NCH)
OASIS	Outcome and Assessment Information Set (OASIS)
OIG	Office of Inspector General (OIG)
PEP	Partial episode payment (PEP)
PEPPER	Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a data report that contains a single provider's claims data statistics for claims for service at risk for improper Medicare payments.
SNF	Skilled nursing facility (SNF)
UB-04	Standard uniform bill used by health care providers to submit claims for services. Claims for Medicare reimbursement are submitted to the provider's MAC.