NEWS & INSIGHTS

CMS relaunches PEPPER for short-term acute care hospitals

January 7, 2026
News & Insights

CMS recently relaunched the Program for Evaluating Payment Patterns Electronic Report (PEPPER) for short-term acute care hospitals, restoring these facilities' access to a valuable data tool that assists with claim accuracy.

First developed in 2002, PEPPER can be used by facilities to identify problematic billing patterns, areas that require additional auditing or monitoring, under-coded or over-coded diagnosis-related groups, length of stay trends, and more. CMS paused the program in 2023 to make improvements, but it released a limited version of the report in August 2025.

Only authorized officials (AO) and access managers (AM) with active Identify & Access Management System accounts can download their report from the PEPPER Portal at this time, according to CMS. Staff end users are expected to gain access in April 2026, but until then, they can coordinate with their AO or AM to get their report.

Revenue cycle professionals at short-term acute care hospitals can view CMS' PEPPER user guide for more information.

***Editor's note**: A version of this article originally appeared in* Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Related Topics:
Auditing and monitoring, Billing and reimbursement, Medicare news

Q&A: ICD-10-CM coding for poisoning with resulting manifestations

January 14, 2026
News & Insights

Q: What is the correct ICD-10-CM coding approach for poisoning cases that include documented manifestations, and how are these cases reflected in code selections and sequencing?

A: Let's look at two examples of poisoning, one accidental and the other intentional self-harm, to understand the best approach for coding poisonings with manifestations.

First consider a patient who accidentally takes double the prescribed dose of amitriptyline, a generic prescription classified as a tricyclic antidepressant. Not taking their medication exactly as prescribed causes the patient to feel dizzy and confused. This scenario is classified as a poisoning because the drug was taken incorrectly (i.e., wrong dose), even though the intent was not malicious. ICD-10-CM codes for poisonings are found in categories T36-T50 and are reported first, followed by codes for any resulting clinical manifestations. The code must specify the intent with fifth/sixth character 1, 2, 3, or 4, depending on whether it is accidental, intentional, assault, or undetermined. The intent in this scenario is accidental, so the sixth character would be 1. If the intent was unclear, coders would need to query the provider to avoid making assumptions.

Because a wide variety of medications, illicit substances, and chemicals can be associated with poisoning, it is not practical for the ICD-10-CM Alphabetic Index to list each drug in depth. As a result, many substances are either listed in a limited manner or not individually detailed within the main index entries for the intent. Coders must therefore consult the ICD-10-CM Table of Drugs and Chemicals, which systemically organizes substances by name and identifies the appropriate subcategories based on intent. Locating antidepressant followed by tricyclic leads to a row of subcategories found under T43.01-. The subcategory listed under unintentional poisoning is T43.011-, where the seventh character would be A to represent the initial encounter. All poisoning codes require a seventh character to indicate the encounter type.

Codes for dizziness and disorientation are coded as secondary diagnoses. According to the 2026 ICD-10-CM Alphabetic Index, dizziness is reported with R42, and disorientation is reported with R41.0.

Now consider a teenager who ingests a full bottle of ibuprofen in a suicide attempt, resulting in acute kidney injury. When a poisoning is intentional, it should be classified as a self-harm poisoning, and the external cause must be clearly documented, or else the coder will need to query for further clarification. The poisoning is again sequenced first. Ibuprofen is classified as a propionic acid derivative, but the medication is listed as its own substance in the Table of Drugs and Chemicals. The row of subcategories for ibuprofen is under T39.31-. The subcategory listed under intentional self-harm poisoning is T39.312-, where the seventh character would be A to represent the initial encounter.

The secondary code for this scenario would be for acute kidney failure. Looking up "Failure, renal, acute" in the alphabetic index, coders will find N17.9 (acute kidney failure, unspecified) as the assignable code.

Editor's note: *This article originally appeared on JustCoding, and the answer was provided by* ***Leigh Poland, RHIA, CCS, CDIP, CIC****, vice president of coding services at AGS Health during the HCPro webinar,* "Beyond the Bottle: ICD-10-CM Coding Poisoning, Adverse Effects, and Underdosing with Accuracy and Clarity."

Related Topics:
Coding, Documentation improvement, Medicare news

CMS publishes FY 2025 improper payment figures

January 21, 2026
News & Insights

CMS recently published a fact sheet detailing improper payments across Medicare and Medicaid programs in fiscal year (FY) 2025, including overpayments, underpayments, and payments that lacked sufficient documentation.

The estimated fee-for-service improper payment rate was 6.55% ($28.83 billion) in FY 2025, signaling a decrease from the FY 2024 reported rate of 7.66% ($31.70 billion). CMS noted that the FY 2025 rate marks the ninth consecutive year that the figure has fallen below the 10% compliance threshold.

The estimated FY 2025 Part C improper payment rate was 6.09% ($23.67 billion), slightly higher than the reported rate of 5.61% ($19.07 billion) in the previous year. CMS attributed most of these improper payments to situations where Medicare Advantage Organizations failed to submit documentation that substantiated the diagnoses submitted for payment. For Part D, the estimated improper payment was 4.00% ($4.23 billion), a slight increase from the FY 2024 reported rate of 3.70% ($3.58 billion).

Revenue cycle professionals can find more information on CMS' Improper Payments Measurement Programs here.

Related Topics:
Billing and reimbursement, Documentation improvement, Medicare news

Examining diagnosis reportability

January 28, 2026
News & Insights

Regardless of the record format, the provider's goal should be to accurately document all acute, exacerbated, and/or chronic conditions that required evaluation, diagnostics, monitoring, and/or treatment during the episode of care. A diagnosis can be reported whenever resources (services, supplies, attention, time, and medical judgment) have been expended to care for the patient. The documentation should support the fact that the condition was addressed or considered during the patient's care.

[The Uniform Hospital Discharge Data Set] has identified criteria that allow conditions to be coded. Documentation must demonstrate that a condition affects patient care by requiring one or more of the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring

Due to the brevity of outpatient encounters and their associated documentation, reportability can be difficult to determine in the outpatient environment. Coders must consider this carefully when reviewing records.

Many people use acronyms to remind them of what is needed to support the reporting of a diagnosis. Common acronyms for this purpose include MEAT (was the diagnosis **M**onitored, **E**valuated, **A**ssessed, or **T**reated?) and TAMPER (did the provider **T**reat, **A**ssess, **M**onitor, **P**lan, **E**valuate, or **R**efer related to the diagnosis?).

These acronyms reinforce that a mere statement that a diagnosis is present is not enough; the record must also demonstrate the thought process behind the diagnosis. This thought process may not be clear with a quick review of the record, so coders must look at interventions given by not only the provider but also the ancillary staff, including nurses and therapists.

Providers must draw clear relationships between related diagnoses and speak to the conditions considered in the planning of their care. Their medical decision-making must be evident within their documentation. Many providers fail to include this information, and they must be educated as to why its inclusion is so important.

Editor's note: *This article is an excerpt from the "2026 Just Coding Pocket Guide." Purchase your copy today to gain insights on diagnostic criteria, official coding guidelines, and documentation requirements.*

Related Topics:
Coding, Documentation improvement

"Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, or the Copyright Clearance Center at 978-750-8400. Opinions expressed are not necessarily those of CRCJ/MSB. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions."