Partial Hospitalization Program
Program for Evaluating Payment Patterns Electronic Report

User's Guide

Seventh Edition

Partial Hospitalization Program
Program for Evaluating Payment Patterns Electronic Report User's Guide
Seventh Edition, effective with the Q4CY18 release and current with the Q4CY22 release

Introduction 3
What Is PEPPER? 3
PHP PEPPER CMS Target Areas 6
How PHPs Can Use PEPPER Data 7
Using PEPPER 9
Compare Targets Report 9
Target Area Reports 10
PHP Top Diagnoses Report 11
Nationwide PHP Top Diagnoses Report 11
System Requirements, Customer Support, and Technical Assistance 11
Acronyms and Abbreviations 13
Appendix 1: How Target Area Average Lengths of Stay and Average Payments Are Calculated 14

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 its compliance program, a hospital should conduct regular audits to ensure charges for Medicare services are correctly documented and billed. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) can help guide auditing and monitoring activities.

National partial hospitalization program (PHP) claims data were analyzed to identify areas within the PHP benefit that could be at risk for improper Medicare payment. These areas are referred to as "target areas." PEPPER is a data report that contains a single PHP's claims data statistics, which are obtained from the UB-04 or the CMS-1450 claim submitted to the Medicare Administrative Contractor (MAC) for these target areas. Each PHP receives a PEPPER, which contains statistics for these target areas, regardless of whether the PHP's data is of concern. The report shows how a PHP's data compares to jurisdiction, state, and national statistics. Data in PEPPER is presented in tabular form and in graphs that depict the PHP's target area percentages over time. All of the data tables, graphs, and reports in PEPPER were designed to assist PHPs 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 the Centers for Medicare & Medicaid Services (CMS).

Beginning in 2012, PEPPER is available for PHPs and for hospices. PEPPERs are also available for short- and long-term acute care inpatient prospective payment system hospitals, critical access hospitals, inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities, and home health agencies (the format of the reports and the target areas are customized for each type of provider). The *PHP PEPPER* is the version of PEPPER specifically developed for PHPs.

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

PHPs provide intensive psychiatric care in an organized outpatient psychiatric setting. The treatment may be provided by a hospital outpatient department (through a short- or long-term acute care hospital, an IPF, an IRF, or a children's hospital) or a community mental health center (CMHC) for patients who may otherwise require inpatient care. **In the *PHP PEPPER* and throughout this guide, PHPs administered through short- and long-term acute care hospitals, IPFs, IRFs, children's hospitals, and CMHCs are grouped together and referred to collectively as PHPs.**

[1] Department of Health and Human Services/Office of Inspector General. 1998. "Compliance Program Guidance for Hospitals," *Federal Register* 63, no. 35, Feb. 23, 1998, 8987–8998. 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, Jan. 31, 2005, 4858–4876. Available at: http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf

The *PHP PEPPER* for CMHCs, free-standing IPFs and IRFs, long-term acute care hospitals, and children's hospitals is available to the PHP's Chief Executive Officer, Administrator, President, Compliance Officer, or Quality Assurance/Performance Improvement Officer through a secure portal accessed through the PEPPER.CBRPEPPER.org website. PHPs that are administered by short-term acute care hospitals, as well as those administered by IPFs or IRFs that are distinct part units of short-term acute care hospitals, receive their PEPPER electronically through a secure file exchange in QualityNet. The PEPPER files will be sent to the short-term acute care hospitals' QualityNet administrators and to those who have QualityNet basic user accounts (i.e., anyone with in the PEPPER recipient role and File Exchange and Search role). Each PHP 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 *PHP PEPPER* contains claims data statistics for the most recent three federal calendar years. A PHP is compared to other PHPs in three comparison groups: the nation, MAC jurisdiction, and state. These comparisons enable PHPs to determine whether their results differ from other PHPs and whether they are at 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. Note that the *PHP PEPPER* does not contain any coding-focused target areas; therefore, the *PHP PEPPER* only draws attention to findings that are at or above the national 80th percentile.

In order to be included in the *PHP PEPPER*, claims must meet the specifications shown below.

Claims Specifications for Outpatient Hospital PHPs

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Claim facility type equal to "1"	UB-04 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 1 (Hospital)
Include claim service classification type of "Outpatient"	UB-04 FL 04 Type of Bill, third digit (Bill Classification) = 3 (Outpatient)
Condition code equal to "41"	UB-04 FL 19 – 28, Condition Code = 41 (Partial hospitalization - Effective 3/92, indicates claim is for partial hospitalization services. For outpatient [OP] services, this includes a variety of psych programs.)
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.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Services provided during the time period used to create the episode of care	Claim "From Date" and claim "Through Date" fall within the three calendar years included in the report. Additional claims for the previous calendar year will be included for episodes of care beginning prior to the reporting period. Please see below for more explanation of the episode of care. Note: for the *30-Day Readmissions* target area, the index episode must occur during the reporting period. A resumption of care is identified by an episode of care with a "From Date" within 30 days of the previous episode's "Through Date."
Medicare claim payment amount greater than zero	The PHP 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

Claims Specifications for CMHC PHPs

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Claim facility type equal to "7"	CMS-1450 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 7 (Clinic or hospital-based renal dialysis facility)
Claim service classification type of "Community Mental Health Center"	CMS-1450 FL 04 Type of Bill, third digit (Bill Classification) = 6 (CMHC)
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.
Services provided during the time period used to create the episode of care	Claim "From Date" and claim "Through Date" fall within the three calendar years included in the report. Additional claims for the previous calendar year will be included for episodes of care beginning prior to the reporting period. Note: for the *30-Day Readmissions* target area, the index episode must occur during the reporting period. A resumption of care is identified by an episode of care with a "From Date" within 30 days of the previous episode's "Through Date."
Medicare claim payment amount greater than zero	The PHP 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

A beneficiary may receive PHP services for varying lengths of time; it could be anywhere from one day to several months. The PEPPER target areas were designed to report on the services provided to beneficiaries whose service ends during the specified time period (the calendar year). An episode of care is created from the claims submitted by a provider for a beneficiary to represent one episode of treatment.

All claims submitted by a provider for a beneficiary are collected and sorted from the earliest "Claim From" date to the latest. There must be no break in service of more than seven days between one claim and the next. If there is a gap between one claim's "Through Date" to the next claim's "From Date" of

more than seven days, then that is considered a new episode of care. If the last claim in an episode has a "Through Date" in the time period, then that episode is included. Claims are collected for one year prior to each time period so that the longer episodes of care may be evaluated.

PHP PEPPER CMS Target Areas

In general, the target areas are constructed as ratios and expressed as percents; the numerator represents claims that may be identified as problematic, and the denominator represents a larger comparison group. The *PHP PEPPER* target areas are defined in the table below.

TARGET AREA (Full and Abbreviated Title)	TARGET AREA DEFINITION
Group Therapy (Group Tx)	*Numerator (N):* count of episodes of care ending in the report period with only group therapy (Healthcare Common Procedure Coding System [HCPCS] codes G0410 or G0411) billed *Denominator (D):* count of all episodes of care ending in the report period Note: An episode of care is defined as a series of claims from a provider for a beneficiary, where the difference between the "Through Date" of one claim and the "From Date" of the subsequent claim is less than or equal to seven days. The "From" and "Through" dates in form locator 6 (statement covers period) on the claim identify the span of service dates included in a particular bill; the "From" date is the earliest date of service on the claim.
No Individual Psychotherapy (No Indiv Psychotx)	*N:* count of episodes of care ending in the report period with no units of individual psychotherapy (HCPCS codes 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90865, or 90880) *D:* count of all episodes of care ending in the report period
60+ Days of Service (GE60 DOS)	*N*: count of episodes of care ending in the report period with greater than or equal to 60 days of service provided by the PHP *D*: count of all episodes of care ending in the report period
30-Day Readmissions (30-Day Readm)	*N:* count of all index (first) episodes of care ending in the report period for which a resumption of care occurred within 30 days to the same or to another partial hospitalization program. Any episode of care that begins ("From Date") more than 30 days after a previous episode of care ends ("Through Date") becomes a new index episode of care. *D:* count of all episodes of care ending in the report period

These PEPPER target areas were approved by CMS because they have been identified as potentially prone to improper Medicare payments in PHPs.

Group therapy is less costly to provide than individual therapy; therefore, there may be a financial incentive for PHPs to provide group therapy when individual therapy may be more appropriate for a beneficiary. The *PHP PEPPER* identifies the proportion of all episodes of care during which the beneficiary received only group therapy. Similarly, the *PHP PEPPER* identifies the proportion of PHP episodes of care where the beneficiary did not receive any individual psychotherapy. While the provision

of individual psychotherapy is not a Medicare requirement, since the PHP is "in lieu of inpatient psychiatric hospitalization," there is a general expectation that PHPs provide some amount of individual psychotherapy, in addition to a range of services during a Medicare beneficiary's course of treatment.

There is no limit on the length of time a beneficiary may receive PHP services; therefore, there is a risk that PHPs may continue PHP services beyond the point where those services are necessary. The *PHP PEPPER* identifies the proportion of all episodes of care during which the beneficiary received more than 60 days of service.

The *PHP PEPPER* identifies the proportion of Medicare beneficiaries who were readmitted to the same PHP or to another PHP within 30 days of the last date of an episode of care. This could indicate that the beneficiary was discharged prematurely or that the discharge planning process could be strengthened.

How PHPs Can Use PEPPER Data

The *PHP PEPPER* allows PHPs to compare their billing statistics with national, jurisdiction, and state percentile values for each target area with reportable data for the most recent three calendar years.

"Reportable data" in PEPPER means there are 11 or more numerator episodes for a given target area for a given time period. When there are fewer than 11 numerator episodes for a target area for a time period, statistics are not displayed in PEPPER due to CMS data restrictions.

To calculate percentiles, the target area percents for all PHPs with reportable data for each target area and each time period are ordered from highest to lowest. The target area percent below which 80% of all PHPs' target area percents fall is identified as the 80th percentile. PHPs whose target percents 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, MAC jurisdiction, and state).

The PEPPER Team has developed suggested interventions that PHPs may consider when assessing their risk for improper Medicare payments. Please note that these are generalized suggestions and will not apply to all situations. For all areas, assess whether there is sufficient volume (i.e., numerator count of 10 to 30 for the time period, depending on the PHP's total denominator count) to warrant a review. The following table can assist PHPs with interpreting their percentile values, which are indications of possible risk of improper Medicare payments.

TARGET AREA (Full and Abbreviated Title)	SUGGESTED INTERVENTIONS FOR PHPs AT RISK FOR IMPROPER PAYMENTS (IF AT/ABOVE 80TH PERCENTILE)
Group Therapy (Group Tx)	This could indicate that the PHP is not providing the individualized plan of care necessary to address beneficiaries' needs or that the PHP is not correctly including all services on the claim. The PHP should ensure that beneficiary plans of care are appropriate and individualized to meet the beneficiary's condition. The PHP should ensure that all services provided are correctly documented in the medical record and included on the claim.
No Individual Psychotherapy (No Indiv Psychotx)	This could indicate that the PHP is not providing the intensity of services necessary to address beneficiaries' needs or that the PHP is not correctly including all services on the claim. The PHP should ensure that beneficiary plans of care are appropriate and individualized to meet the beneficiary's condition. The PHP should ensure that all services provided are correctly documented in the medical record and included on the claim.
60+ Days of Service (GE60 DOS)	This could indicate that the PHP is continuing treatment beyond the point where those services are necessary. The PHP should review documentation for beneficiary episodes of care with 60 or more days of service to ensure that beneficiaries' continued care is appropriate for a PHP. The PHP should review plans of care for appropriateness and assess appropriateness of discharge plans.
30-Day Readmissions (30-Day Readm)	This could indicate that the PHP is discharging beneficiaries prematurely or that the discharge planning process could be strengthened. The PHP should review documentation for beneficiaries readmitted to their PHP to assess appropriateness of discharge and discharge planning processes.

Comparative data for the three consecutive years can be used to help identify whether the PHP's target area percents changed significantly in either direction from one year to the next. This could be an indication of a procedural change in admitting or billing practices, staff turnover or a change in medical staff.

Using PEPPER

Compare Targets Report

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

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

The Compare Targets Report provides the PHP'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 PHP to judge how its target area percent compares to all PHPs in each respective comparison group.

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

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

The PHP's state percentile indicates the percentage of all other PHPs in the state that have a target area percent less than the PHP's target area percent. The state percentile will be blank if there are fewer than 11 PHPs 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 PHP 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, PHPs should consider their target area percentile values for the nation, jurisdiction, and state. Percentile values at or above the 80th percentile indicate that the PHP is at risk for improper Medicare payments. Providers should place the highest priority with their national percentile, as this percentile represents how the PHP compares to all PHPs 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 "Sum of Payments" and "Target (Numerator) Count" 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 calendar 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 PHP's target area percent over three calendar years. The PHP's data is represented on the graph in bar format, and each bar represents a calendar year. PHPs can identify significant changes from one time period to the next, which could be a result of changes in medical staff or utilization review processes, for example. PHPs 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 that are at the 80th percentile for the three comparison groups (i.e., nation, jurisdiction, and state), which the PHP 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 percents (i.e., "Comparative Data") is included under the PHP's data table. To learn more about how percents differ from percentiles, see the "Training and Resources" page in the PHP section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

A PHP'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 PHPs with reportable data for a target area in a state, there will not be a trend line for the state comparison group in the graph. If there are fewer than 11 PHPs with reportable data for a target area in a jurisdiction, there will not be a trend line for the jurisdiction comparison group in the graph.

Target Area PHP Data Table

PEPPER Target Area Reports also include a PHP data table. Statistics in each data table include the numerator count for the target area, the denominator count, the proportion of the numerator and denominator (percent), the average length of stay (ALOS) for the numerator and for the denominator, and the average and sum of Medicare payment data. The PHP's percent will be shown in red bold print if it is at or above the national 80th percentile (suggesting a higher risk of improper Medicare payments). For each time period, a PHP'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 percentile for the three comparison groups: 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 PHPs with reportable data for the target area in the state. Jurisdiction percentiles are zero when there are fewer than 11 PHPs with reportable data for the 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 PHPs in considering whether they should audit a sample of records. Suggested interventions for providers, whose results suggest a higher risk for improper Medicare payments, are tailored to each target area and are also included at the bottom of each worksheet.

PHP Top Diagnoses Report

The PHP Top Diagnoses Report lists the top Clinical Classifications Software (CCS) diagnosis categories[3] by volume of episodes of care at the PHP 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 (identified using the principal diagnosis code on the first claim for each beneficiary's episode of care) mapping to that category, the proportion of episodes for the diagnosis category to total episodes, and the ALOS for the diagnosis category. Please note that this report is limited to the top diagnosis categories (up to ten) for which there are at least 11 episodes of care (for the respective diagnosis category) during the most recent calendar year.

Nationwide PHP Top Diagnoses Report

The Nationwide PHP Top Diagnoses report lists the top CCS diagnosis categories by volume of episodes of care in the nation ending in the most recent calendar year. For each diagnosis category listed, the report includes the total number of episodes in the nation that have a principal diagnosis code (identified using the principal diagnosis code on the first claim for each beneficiary's episode of care) mapping to that category, the national proportion of episodes for the diagnosis category to total episodes, and the national ALOS for the diagnosis category. Please note that this report is limited to displaying the top diagnosis categories (up to ten) for which there are at least 11 episodes of care during the most recent calendar year.

System Requirements, Customer Support, and Technical Assistance

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 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 contains many educational resources to assist PHPs with PEPPER in the PHP "Training and Resources" section.

[3] 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

Please do not contact your state Medicare Quality Improvement Organization or any other association for help 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 based on the episode of care. It is computed by dividing the total number of days within all episodes of care by the total number of episodes of care at the PHP within a given time period (see Appendix 1). It represents the arithmetic average, or mean, and includes a count of all days for episodes that end within the last calendar year of the report.
CMHC	Community mental health center (CMHC)
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 prospective payment system inpatient hospitals in areas at risk for improper payment using Medicare administrative claims data.
HCPCS	Healthcare Common Procedure Coding System (HCPCS)
IPF	Inpatient psychiatric facility (IPF)
IRF	Inpatient rehabilitation facility (IRF)
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.
OP	Outpatient (OP)
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.
PHP	Partial hospitalization program (PHP)
UB-04 and CMS 1450	Standard uniform bills used by health care providers to submit claims for services. Claims for Medicare reimbursement are submitted to the provider's MAC.

Appendix 1: How Target Area Average Lengths of Stay and Average Payments Are Calculated

The tables shown below provide the numerator and denominator used to calculate the "Target Average Length of Stay," "Denominator Average Length of Stay," and "Target Average Payment" as found on the target area worksheet for each respective target area. To calculate the respective averages, the numerator is divided by the denominator. The numerator and denominator counts represent statistics obtained from a PHP's claims that meet the claims specifications (as found on pages 4 and 5).

Target Area	"Target ALOS" Numerator	"Target ALOS" Denominator	"Denominator ALOS" Numerator	"Denominator ALOS" Denominator
Group Therapy (Group Tx)	Sum of episode of care days for episodes that end in the calendar year, with only group therapy billed.	Number of episodes of care that end in the calendar year, with only group therapy billed.	Sum of episode of care days for all episodes of care that end in the calendar year.	Total number of episodes of care that end in the calendar year.
No Individual Psychotherapy (No Indiv Psychotx)	Sum of episode of care day for episodes that end in the calendar year, with no individual psychotherapy billed.	Number of episodes of care that end in the calendar year, with no individual psychotherapy billed.	Sum of episode of care days for all episodes of care that end in the calendar year.	Total number of episodes of care that end in the calendar year.
60+ Days of Service (GE60 DOS)	Sum of episode of care days for episodes that end in the calendar year, with 60 or more days of service billed.	Number of episodes of care that end in the calendar year, with 60 or more days of service billed.	Sum of episode of care days for all episodes of care that end in the calendar year.	Total number of episodes of care that end in the calendar year.
30-Day Readmissions (30-Day Readm)	Sum of episode of care days for episodes that end in the calendar year, with at least one readmission (see target area definition).	Number of episodes of care that end in the calendar year, with at least one readmission.	Sum of episode of care days for all episodes of care that end in the calendar year.	Total number of episodes of care that end in the calendar year.

Target Area	"Target Average Payment" Numerator	"Target Average Payment" Denominator
Group Therapy (Group Tx)	Sum of payments for episodes of care that end in the calendar year, with only group therapy billed.	Number of episodes of care that end in the calendar year, with only group therapy billed.
No Individual Psychotherapy (No Indiv Psychotx)	Sum of payments for episodes of care that end in the calendar year, with no individual psychotherapy billed.	Number of episodes of care that end in the calendar year, with no individual psychotherapy billed.
60+ Days of Service (GE60 DOS)	Sum of payments for episodes of care that end in the calendar year, with 60 or more days of service billed.	Number of episodes of care that end in the calendar year, with 60 or more days of service billed.
30-Day Readmissions (30-Day Readm)	Sum of payments for episodes of care that end in the calendar year, with at least one readmission.	Number of episodes of care that end in the calendar year, with at least one readmission.