Quality Payment PROGRAM

2018 MIPS Performance Feedback Beneficiary-Level Data Reports Supplement

General TPCC & MSPB Beneficiary-level Data Reports Questions

Why is CMS providing beneficiary-level data on the MIPS TPCC & MSPB cost measures and what is the purpose of doing so?

CMS is committed to maturing the MIPS feedback experience. In honoring that commitment, CMS is providing beneficiary-level cost data reports for viewing and download by clinicians and groups who were scored on the MIPS Total Per Capita Costs for All Attributed Beneficiaries (TPCC) measure and the MIPS Medicare Spending per Beneficiary (MSPB) cost measure in 2018.

Individuals and groups can compare their costs for each measure with the benchmark provided in the performance feedback user interface (UI) to better understand their performance relative to their peers, which include TINs or TIN-NPIs that had at least 20 eligible cases for TPCC and/or all TINs or TIN-NPIs that had at least 35 eligible cases for MSPB. These data may be used to identify care coordination opportunities for your beneficiaries and streamline resource use

What data are used to calculate the two 2018 MIPS TPCC & MSPB cost measures?

Both MIPS cost measures are calculated using administrative claims.

Cost data for the TPCC measure are based on Medicare-allowed charges for Medicare Part A and Medicare Part B claims during the performance period (January 1, 2018- December 31, 2018) that were submitted by *all* providers for Medicare beneficiaries attributed to your TIN (for groups who participated in MIPS as a group and reported to MIPS as a

group for the 2018 MIPS performance period) or TIN-NPI (for individual MIPS eligible clinicians who reported to MIPS as an individual for the 2018 MIPS performance period).

For the MIPS MSPB measure, per episode costs are based on Medicare Part A and Medicare Part B allowed amounts surrounding specific inpatient hospital stays for episodes attributed to your TIN or TIN-NPI.

How should we interpret and use the Hierarchical Conditions Categories (HCC) Percentile Ranking figure in the MIPS beneficiary-level TPCC and MSPB cost reports?

CMS generates HCC scores based on beneficiary characteristics (such as age) and prior health conditions identified on previous Medicare claims. The percentile ranking shows how that beneficiary's risk score compares to all other Medicare Fee-for-Service (FFS) beneficiaries nationwide, with 1 being low and 100 being high (for example, a percentile ranking of 83 means that 83 percent of beneficiaries nationwide had lower risk scores). Higher percentile rankings tend to be associated with more serious health conditions, including multiple chronic conditions. These beneficiaries may benefit from more intensive efforts to manage their care, including closer monitoring of the beneficiary's condition, actively coordinating care with other providers, and supporting beneficiaries' self-management. You may also look for opportunities to help beneficiaries at lower risk avoid the need for high-cost services (for example, outpatient emergency services).

You can sort data by HCC percentile ranking, in descending order, to see the high and low-risk beneficiaries to whom your TIN or TIN-NPI provides care.

Are costs reflected in the MIPS TPCC and MSPB beneficiary-level cost report further differentiated by costs of services provided by my TIN or TIN-NPI versus other TINs or TIN-NPIs?

No. Unlike past Annual Quality and resource Use Reports (QRURs) provided to illustrate how groups and solo practitioners performed on quality and cost measures used to calculated the Value-Based Payment Modifier, the MIPS beneficiary-level cost data reports do not indicate which services included in the measure calculations were provided by your specific TIN or TIN-NPI versus other TINs/TIN-NPIs, unless otherwise specified in the tables below. The costs computed reflect costs of services rendered to your attributed beneficiaries by *all* providers/eligible professionals during

either the MSPB episode or the performance year, not just costs for services rendered solely by the TIN/TIN-NPI to which the beneficiary is attributed.

What are BETOS codes?

BETOS codes are Berenson-Eggers Type of Service (BETOS) codes present in non-institutional Medicare Part B Carrier claims. The BETOS classification scheme maps HCPCS codes into major categories (such as physician evaluation and management, procedures, imaging, tests, durable medical equipment, other services, and exceptions/unclassified services), with additional sub-categories within each. In summary, BETOS codes are clinically understood categories that can be used for analysis of patient care[1]. See: https://www.resdac.org/sites/resdac.umn.edu/files/BETOS%20Table.txt

What are place of service (POS) codes?

POS codes are used on noninstitutional professional claims to specify the entity where services were rendered. The place of service code set is available here: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Are payment-standardized costs used to compute the figures in the MIPS TPCC & MSPB beneficiary-level cost reports?

Yes, standardized Medicare allowed charges are used for the cost measures. These data associate a standardized amount with each actual allowed amount for each service billed by Medicare providers. For more information on payment standardization, please consult the document entitled CMS Price (Payment) Standardization-Detailed Methods.

[1] https://www.ccwdata.org/documents/10280/19002248/ccw-technical-guidance-getting-started-with-cms-medicare-administrative-research-files.pdf

TPCC

Which individual MIPS eligible clinicians and/or groups received a 2018 MIPS TPCC score and associated beneficiary-level data report?

Only clinicians and groups who met the 2018 minimum case volume of 20 received a 2018 MIPS TPCC score and associated beneficiary-level data report.

How are Medicare beneficiaries attributed to a TIN or TIN-NPI for purposes of calculating MIPS TPCC measure performance?

CMS attributes beneficiaries to a TIN or TIN-NPI through a two-step process that takes into account the level of primary care services received (as measured by Medicare allowed charges) and the provider specialties that performed these services. methodology. For detailed attribution methodology information, please refer to Step 1 on page 5 of the 2018 TPCC Measure Information Form.

How can we interpret/use the information on the four chronic condition subgroups in the TPCC beneficiary-level cost report?

The TPCC beneficiary-level cost report indicates which of your attributed beneficiaries had one or more of the following chronic conditions during the 2017 Calendar Year (CY): diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and heart failure. These chronic conditions are widespread among Medicare beneficiaries and for which enhanced management may improve beneficiary outcomes as well as efficiency of care.[2] You can use this information to identify individual beneficiaries with these conditions who may benefit from such enhanced management and coordination activities. For example, a beneficiary with congestive heart failure and relatively high costs attributable to

[2] Bodenheimer, T., E. Wagner, K. Grumbach. “Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2.” *Journal of the American Medical Association*, vol. 288, no. 15, 2002, pp. 1909-1914.

inpatient stays may represent an opportunity to re-examine how you manage such beneficiaries. You may decide to update or change beneficiaries' preventive care, self-management support, monitoring, or medical treatment plans.

Please note: Diagnoses from the 2017 CY, not the 2018 MIPS performance period of 1/1/2018-12/31/2018, were used to identify these chronic condition data points.

How can we interpret and use the data in the "Total Costs by Category of Services Furnished by All Providers" subcategories in the MIPS TPCC beneficiary-level cost report, which include: Evaluation & Management Services Billed by Eligible Professionals, Major Procedures Billed by Eligible Professionals, Ambulatory/Minor Procedures Billed by Eligible Professionals, Outpatient Physical, Occupational, or Speech and Language Pathology Therapy, Ancillary Services, Inpatient Hospital Facility Services, Eligible Professional Services During Hospitalization, Emergency Services Not Included in a Hospital Admission, Post-Acute Services, Hospice, and All Other Services?

You can use data presented in these subcategories to understand what type(s) of services contribute most to the total scaled costs incurred by each of your attributed beneficiaries and to identify opportunities to improve efficiencies. For example, if skilled nursing facility expenses for your TIN or TIN-NPI's attributed beneficiaries are high, consider options for arranging needed support at home or other, less costly venues.

What is the meaning of the beneficiary-specific "Total Scaled Cost" value in the MIPS TPCC beneficiary-level cost report?

This number represents the total payment-standardized Medicare Fee-for-Service (FFS) costs associated with the care of each beneficiary over the performance period. Payment standardization removes differences in payments due to geographic location, incentive payments, and other add-on payments that support specific Medicare program goals. These costs are neither risk-adjusted nor specialty adjusted. The costs are annualized. As explained on page 6 of the 2018 TPCC Measure Information Form: In performance year 2018, part year beneficiaries (those who were enrolled in Medicare Part A and Part B for only part of the year) may be attributed to TIN-NPIs if the reason for their part year

enrollment was either that they were new enrollees in Medicare at some time other than the start of the calendar year or they died during the calendar year.

What is the data source used for the figures presented in the 2018 TPCC Beneficiary-level Cost Data Report?

The data source used to compute figures presented in this report is final action claims in the Integrated Data Repository (IDR).

The table below includes detailed descriptions of the figures presented in the 2018 TPCC Beneficiary-level Cost Data Report for either a TIN or TIN-NPI

Please note: all values in the table below reflect costs of services rendered by all providers/eligible professionals during the relevant time period for the measure, including costs of services rendered by your group's TIN or your individual TIN-NPI.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
HICN or MBI[3]	Attributed Beneficiary's Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI)	Numeric or alpha-numeric, depending on identifier used	N/A	This column will include the beneficiary's HICN, MBI or RRB identifier
beneIdType	Beneficiary ID Type	MBI, HICN or RRB	N/A	This column will indicate whether to beneficiary ID type listed is a HICN or MBI or RRB
Gender	Beneficiary's Gender	1=Male 2=Female	N/A	N/A

[3] https://www.cms.gov/medicare/new-medicare-card/

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
Attributed TIN	TIN of the clinician or group or TIN-NPI of the individual clinician (depending on the level of 2018 MIPS reporting) to which the beneficiary's costs were attributed	Numeric	See 2018 MIPS TPCC Measure Information Form linked to above	Presence of this field will depend upon the chosen 2018 MIPS reporting level.
Attributed NPI	NPI of the individual clinician to which the beneficiary's costs were attributed, for individual clinicians participating in and reporting to MIPS as an individual in 2018	Numeric	See 2018 MIPS TPCC Measure Information Form linked to above	Presence of this field will depend upon the chosen 2018 MIPS reporting level.
DOB	Beneficiary's Date of Birth	Numeric	N/A	N/A
HCC Percentile Ranking	HCC Percentile Ranking	Numeric	See Q&A above	This figure is an average of the beneficiary's 2018 risk scores translated into a percentile. CMS HCC V22 was used to compute 2018 scores, which are based on 2017 claims.
Expired	Expired	Numeric Date	N/A	If the attributed beneficiary died during the 2018 PY, the beneficiary's date of death will be reflected here.
Diabetes	Diabetes	Boolean (True or False Indicator)	N/A	If true, a diagnosis of diabetes (based on ICD-10 diagnoses codes) was located on Medicare administrative claims submitted on behalf of the beneficiary between 1/1/2017-12/31/2017. Please note: data from the prior CY, not the 2018 performance period, are used to compute this particular T/F value.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
Chronic Obstructive Pulmonary Disease	Chronic Obstructive Pulmonary Disease	Boolean (True or False Indicator)	N/A	If true, a diagnosis of COPD (based on ICD-10 diagnoses codes) was located on Medicare administrative claims submitted on behalf of the beneficiary between 1/1/2017-12/31/2017. Please note: data from the prior CY, not the 2018 performance period, are used to compute this T/F value.
Coronary Artery Disease	Coronary Artery Disease	Boolean (True or False Indicator)	N/A	If true, a diagnosis of CAD (based on ICD-10 diagnoses codes) was located on Medicare administrative claims submitted on behalf of the beneficiary between 1/1/2017-12/31/2017. Please note: data from the prior CY, not the 2018 performance period, are used to compute this T/F value.
Heart Failure	Heart Failure	Boolean (True or False Indicator)	N/A	If true, a diagnosis of heart failure (based on ICD-10 diagnoses codes) was located on Medicare administrative claims submitted on behalf of the beneficiary between 1/1/2017-12/31/2017. Please note: data from the prior CY, not the 2018 performance period, are used to compute this particular T/F value.
Total Scaled Cost	Payment-Standardized Medicare FFS Costs	Dollar Amount	N/A	This value represents the total amount of payment-standardized, Medicare FFS allowed amount costs incurred by the beneficiary during the 2018 performance period. This value is neither risk adjusted, nor specialty adjusted. It is annualized and Winsorized (meaning outliers are excluded).
Evaluation & Management Services Billed by Eligible Professionals	Evaluation & Management Services Billed by Eligible Professionals	Dollar Amount	hcpcsBetosCode[4] in ('M1A', 'M1B', 'M2A', 'M2B', 'M2C', 'M4A', 'M4B', 'M5A', 'M5B', 'M5C', 'M5D') or substring(hcpcsBetosCode, 1, 2) in ('M3', 'M6')) and	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary during the 2018 Performance Period: M1A = Office visits - new M1B = Office visits - established M2A = Hospital visit - initial M2B = Hospital visit - subsequent M2C = Hospital visit - critical care

[4] https://www.resdac.org/sites/resdac.umn.edu/files/BETOS%20Table.txt

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			placeOfServiceCode[5] not in ('23', '21', '51') and NOT AmbulatoryCenterCondition and NOT SpecialtyCondition and NOT TherapyCondition	M4A = Home visit M4B = Nursing home visit M5A = Specialist - pathology M5B = Specialist - psychiatry M5C = Specialist - ophthalmology M5D = Specialist - other M6 = Consultations M3 = Emergency room visit. This figure does not include services provided in: the emergency room of a hospital, an inpatient hospital, nor an Inpatient Psychiatric Facility. This figure does not include ambulatory surgical center services, services delivered under an outpatient speech language pathology plan of care, services delivered under an outpatient occupational therapy plan of care, nor services delivered under an outpatient physical therapy plan of care. This figure **does not** include services provided by providers with the following CMS specialty codes[6]: 31 = Intensive Cardiac Rehabilitation 45 = Mammography screening center 47 = Independent Diagnostic Testing Facility (IDTF) 49 = Ambulatory surgical center 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics) 52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics)

[5] https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.
[6] https://www.resdac.org/sites/resdac.umn.edu/files/CMS_PRVDR_SPCLTY_TB_rev01242018_0.txt

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 54 = Medical supply company not included in 51, 52, or 53. 55= Individual certified orthotist 56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g. private ambulance companies, funeral homes, etc. 60 = Public health or welfare agencies (federal, state, and local) 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities) 63 = Portable X-ray supplier 69 = Clinical laboratory (billing independently) 73 = Mass Immunization Roster Biller 74 = Radiation Therapy Centers 75 = Slide Preparation Facilities 87 = All other suppliers (e.g. drug and department stores) 88 = Unknown supplier/provider specialty 95 = Competitive Acquisition Program (CAP) 96 = Optician A0 = Hospital (DMERCs[7] only) A1 = SNF (DMERCs only) A2 = Intermediate care nursing facility (DMERCs only) A3 = Nursing facility, other DMERCs only) A4 = HHA (DMERCs only) A5 = Pharmacy (DMERC) A6 = Medical supply company with respiratory therapist (DMERCs only)

[7] Durable Medical Equipment Regional Carrier. See: https://www.cms.gov/center/provider-type/durable-medical-equipment-dme-center.html

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				A7 = Department store (DMERC) A8 = Grocery store (DMERC) B1 = Supplier of oxygen and/or oxygen related equipment B2 = Pedorthic Personnel (eff. 10/2/07) B3 = Medical Supply Company with Pedorthic Personnel B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/07) B5 = Ocularist C1 = Centralized Flu C2= Indirect payment procedure
Major Procedures Billed by Eligible Professionals	Major Procedures Billed by Eligible Professionals	Dollar Amount	First two characters of hcpcsBetosCode in ('P1', 'P2', 'P3', 'P7') and NOT AmbulatoryCenterCondition and placeOfService NOT in ('23', '21', '51') and NOT TherapyCondition and NOT SpecialtyCondition[8]	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary during the 2018 Performance Period: P1A = Major procedure - breast P1B = Major procedure - colectomy P1C = Major procedure - cholecystectomy P1D = Major procedure - turp P1E = Major procedure - hysterectomy P1F = Major procedure - explor/decompr/excisdisc P1G = Major procedure - Other P2A = Major procedure, cardiovascular-CABG P2B = Major procedure, cardiovascular-Aneurysm repair P2C = Major Procedure, cardiovascular-Thromboendarterectomy P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA) P2E = Major procedure, cardiovascular-Pacemaker insertion P2F = Major procedure, cardiovascular-Other

[8] https://www.resdac.org/sites/resdac.umn.edu/files/CMS_PRVDR_SPCLTY_TB_rev01242018_0.txt

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				P3A = Major procedure, orthopedic - Hip fracture repair P3B = Major procedure, orthopedic - Hip replacement P3C = Major procedure, orthopedic - Knee replacement P3D = Major procedure, orthopedic – other P7A = Oncology - radiation therapy P7B = Oncology - other This figure does not include: services delivered under an outpatient speech language pathology plan of care, services delivered under an outpatient occupational therapy plan of care, services delivered under an outpatient physical therapy plan of care, ambulatory surgical center services, services delivered in an emergency department, inpatient hospital, nor inpatient psychiatric facility. This figure does not include services rendered by the following specialty providers: 31 = Intensive Cardiac Rehabilitation 45 = Mammography screening center 47 = Independent Diagnostic Testing Facility (IDTF) 49 = Ambulatory surgical center 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics) 52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics) 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 54 = Medical supply company not included in 51, 52, or 53. (Revised to mean medical supply company for DMERC) 55 = Individual certified orthotist

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc. 60 = Public health or welfare agencies (federal, state, and local) 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities) 63 = Portable X-ray supplier 69 = Clinical laboratory (billing independently) 73 = Mass Immunization Roster Biller 74 = Radiation Therapy Centers 75 = Slide Preparation Facilities 87 = All other suppliers (e.g. drug and department stores) 88 = Unknown supplier/provider specialty 95 = Competitive Acquisition Program (CAP) 96 = Optician A0 = Hospital (DMERCs only) A1 = SNF (DMERCs only) A2 = Intermediate care nursing facility (DMERCs only) A3 = Nursing facility, other DMERCs only) A4 = HHA (DMERCs only) A5 = Pharmacy (DMERC) A6 = Medical supply company with respiratory therapist (DMERCs only) A7 = Department store (DMERC) A8 = Grocery store (DMERC) B1 = Supplier of oxygen and/or oxygen related equipment B2 = Pedorthic Personnel B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) B5 = Ocularist

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				C1 = Centralized Flu C2= Indirect payment procedure
Ambulatory/Minor Procedures Billed by Eligible Professionals	Ambulatory/Minor Procedures Billed by Eligible Professionals	Dollar Amount	First 2 characters of HcpcsBetosCode in ('P4', 'P5', 'P6', 'P8') and placeOfService not in ('23', '21', '51') and NOT (primarySpecialty='49' or AmbulatoryCenterCondition) and NOT SpecialtyCondition and NOT TherapyCondition	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary during the 2018 Performance Period: P4B = Eye procedure - cataract removal/lens insertion P4C = Eye procedure - retinal detachment P4D = Eye procedure - treatment of retinal lesions P4E = Eye procedure - other P5A = Ambulatory procedures - skin P5B = Ambulatory procedures - musculoskeletal P5C = Ambulatory procedures - inguinal hernia repair P5D = Ambulatory procedures - lithotripsy P5E = Ambulatory procedures - other P6A = Minor procedures - skin P6B = Minor procedures - musculoskeletal P6C = Minor procedures - other (Medicare fee schedule) P6D = Minor procedures - other (non-Medicare fee schedule) P8A = Endoscopy - arthroscopy P8B = Endoscopy - upper gastrointestinal P8C = Endoscopy - sigmoidoscopy P8D = Endoscopy - colonoscopy P8E = Endoscopy - cystoscopy P8F = Endoscopy - bronchoscopy P8G = Endoscopy - laparoscopic cholecystectomy P8H = Endoscopy - laryngoscopy P8I = Endoscopy – other This figure does not include services provided in the following places of service: Emergency room of a hospital, inpatient

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				hospital, Inpatient Psychiatric Facility, ambulatory surgical centers. This figure does not include: services delivered under an outpatient speech language pathology plan of care, services delivered under an outpatient occupational therapy plan of care, services delivered under an outpatient physical therapy plan of care. This figure does not include services rendered by the following specialty providers: 31 = Intensive Cardiac Rehabilitation 45 = Mammography screening center 47 = Independent Diagnostic Testing Facility (IDTF) 49 = Ambulatory surgical center 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics) 52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics) 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 54 = Medical supply company not included in 51, 52, or 53. (Revised to mean medical supply company for DMERC) 55 = Individual certified orthotist 56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g.,private ambulance companies, funeral homes, etc. 60 = Public health or welfare agencies (federal, state, and local) 61 = Voluntary health or charitable agencies (e.g.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				National Cancer Society, National Heart Association, Catholic Charities) 63 = Portable X-ray supplier 69 = Clinical laboratory (billing independently) 73 = Mass Immunization Roster Biller 74 = Radiation Therapy Centers 75 = Slide Preparation Facilities 87 = All other suppliers (e.g. drug and department stores) 88 = Unknown supplier/provider specialty 95 = Competitive Acquisition Program (CAP) 96 = Optician A0 = Hospital (DMERCs only) A1 = SNF (DMERCs only) A2 = Intermediate care nursing facility (DMERCs only) A3 = Nursing facility, other DMERCs only) A4 = HHA (DMERCs only) A5 = Pharmacy (DMERC) A6 = Medical supply company with respiratory therapist (DMERCs only) A7 = Department store (DMERC) A8 = Grocery store (DMERC) B1 = Supplier of oxygen and/or oxygen related equipment B2 = Pedorthic Personnel Pedorthic Personnel B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) B5 = Ocularist C1 = Centralized Flu C2= Indirect payment procedure
Outpatient Physical, Occupational, or Speech and	Outpatient Physical, Occupational, or Speech and	Dollar Amount	Carrier Claim Type code (71,72) and TherapyConditi	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, AND

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
Language Pathology Therapy[9]	Language Pathology Therapy		on AND placeOfService not in ('23', '21', '51') and hcpcsBetosCode not in ('O1A', 'O1D', 'O1E', 'D1G') and substr(hcpcsBetosCode, 1, 2) not in ('P9', 'P0') OR (Outpatient Claims Type Code (40) and TherapyCondition and hcpcsBetosCode not in ('O1A', 'O1D', 'O1E', 'D1G') and substr(hcpcsBetosCode, 1, 2) not in ('P9', 'P0') and	costs for outpatient claim type claims[11] for the following services provided to the beneficiary during the 2018 Performance Period: • services delivered under an outpatient speech language pathology plan of care, • services delivered under an outpatient occupational therapy plan of care • services delivered under an outpatient physical therapy plan of care. This figure does not include services provided in the following places of service: Emergency room of a hospital, inpatient hospital, Inpatient Psychiatric Facility, SNF, Home Health Agency. This figure does not include the following service types: O1A = Ambulance O1D = Chemotherapy O1E = Other drugs D1G = Drugs Administered through DME P9A = Dialysis services (Medicare fee schedule) P9B = Dialysis services (non-Medicare fee schedule)

[9] Although the downloadable report indicates this value includes only outpatient therapy, the figure includes costs for including therapy services submitted as BOTH professional claims and outpatient claims, as described in the “additional explanation” column.
[11] This includes FFS claims submitted by institutional outpatient providers. Examples of institutional outpatient providers include hospital outpatient departments, rural health clinics, renal dialysis facilities, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, Federally Qualified Health Centers and community mental health centers.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			TypeOfBill not in ('22', '23', '33', '34', '72') and revenueCenter Code NOT in ('0981', '0450', '0451', '0452', '0453', '0454', '0455', '0456', '0457', '0458', '0459')[10]	
Ancillary Services	Ancillary Services	Dollar Amount	OutpatientClaims (claimTypeCode = 40) and first 2 characters of hcpcsBetosCode in ('T1', 'T2','I1', 'I2', 'I3', 'I4') and NOT TherapyCondition and TypeOfBill not in ('22', '23', '33', '34', '72') and revenueCenter Code NOT in	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as "professional claims" submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, AND costs for outpatient claim type claims[12] AND costs for DMEPOS claims submitted to DMEPOS carrier for the following services provided to the beneficiary during the 2018 Performance Period: T1E = Lab tests - glucose T1F = Lab tests - bacterial cultures T1G = Lab tests - other (Medicare fee schedule) T1H = Lab tests - other (non-Medicare fee schedule) T2A = Other tests - electrocardiograms T2B = Other tests - cardiovascular stress tests T2C = Other tests - EKG monitoring T2D = Other tests – other I1A = Standard imaging - chest

[10] https://bluebutton.cms.gov/resources/variables/rev_cntr/

[12] This includes FFS claims submitted by institutional outpatient providers. Examples of institutional outpatient providers include hospital outpatient departments, rural health clinics, renal dialysis facilities, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, Federally Qualified Health Centers and community mental health centers.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			('0981', '0450', '0451', '0452', '0453', '0454', '0455', '0456', '0457', '0458', '0459') CarrierClaims(71,72) and first 2 characters of hcpcsBetosCode in ('T1', 'T2','I1', 'I2', 'I3', 'I4') and placeOfService not in (21,23,51) and NOT TherapyCondition DmeClaims(81, 82) and hcpcsBetosCode NOT IN (O1D,O1E,O1G)	I1B = Standard imaging - musculoskeletal I1C = Standard imaging - breast I1D = Standard imaging - contrast gastrointestinal I1E = Standard imaging - nuclear medicine I1F = Standard imaging - other I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck I2B = Advanced imaging - CAT/CT/CTA: other I2C = Advanced imaging - MRI/MRA: brain/head/neck I2D = Advanced imaging - MRI/MRA: other I3A = Echography/ultrasonography - eye I3B = Echography/ultrasonography - abdomen/pelvis I3C = Echography/ultrasonography - heart I3D = Echography/ultrasonography - carotid arteries I3E = Echography/ultrasonography - prostate, transrectal I3F = Echography/ultrasonography - other I4A = Imaging/procedure - heart including cardiac catheterization I4B = Imaging/procedure – other. AS noted above, this value **does** include durable medical equipment claims (excluding chemotherapy, other drugs, and immunizations/vaccinations). This value **does not** include the following services: SNF, Home Health, dialysis, emergency department, inpatient hospital, inpatient psychiatric facility, services delivered under an outpatient speech language pathology plan of care, services delivered under an outpatient occupational therapy plan of care, nor services delivered under an outpatient physical therapy plan of care.
Inpatient Hospital Facility Services	Inpatient Hospital Facility Services	Dollar Value	BillionProviderOscar (or CCN)	This figure includes costs for inpatient claim type[13] services provided in short-term (general and specialty) hospitals

[13] See: https://www.resdac.org/cms-data/variables/nch-claim-type-code. Inpatient claims are identified by code 60.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			ends in {0001-0899},{1300-1399},{4000-4499} or its third character is M or S	submitted on behalf of a beneficiary during the performance period, by the following provider types: Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X, hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X, Rural Primary Care Hospital (RCPH), Psychiatric hospitals, Psychiatric Unit in Critical Access Hospital, and/or a Psychiatric unit (excluded from PPS) Inpatient claims are fee-for-service (FFS) claims submitted by inpatient hospital providers for reimbursement of facility costs. These claim records represent covered stays (Medicare paid FFS bills).
Eligible Professional Services During Hospitalization	Eligible Professional Services During Hospitalization	Dollar Amount	placeOfService in ('21','51') and hcpcsBetosCode not in ('O1A', 'O1D', 'O1E', 'D1G') and first 2 characters of HcpcsBetosCode not in ('P9', 'P0') and NOT SpecialtyCondition	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, provided to the beneficiary in an inpatient hospital or an inpatient psychiatric facility during the 2018 Performance Period. This value **does not** include: O1A = Ambulance O1D = Chemotherapy O1E = Other drugs D1G = Drugs Administered through DME P9A = Dialysis services (Medicare fee schedule) P9B = Dialysis services (non-Medicare fee schedule) This figure **does not** include services provided by providers with CMS specialty codes of: 31 = Intensive Cardiac Rehabilitation 45 = Mammography screening center 47 = Independent Diagnostic Testing Facility (IDTF)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				49 = Ambulatory surgical center 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics) 52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics) 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 54 = Medical supply company not included in 51, 52, or 53. 55= Individual certified orthotist 56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc. 60 = Public health or welfare agencies (federal, state, and local) 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities) 63 = Portable X-ray supplier 69 = Clinical laboratory (billing independently) 73 = Mass Immunization Roster Biller 74 = Radiation Therapy Centers 75 = Slide Preparation Facilities 87 = All other suppliers (e.g. drug and department stores) 88 = Unknown supplier/provider specialty 95 = Competitive Acquisition Program (CAP) 96 = Optician A0 = Hospital (DMERCs only) A1 = SNF (DMERCs only) A2 = Intermediate care nursing facility (DMERCs only) A3 = Nursing facility, other DMERCs only) A4 = HHA (DMERCs only)
Emergency Services Not	Emergency Services Not	Dollar Amount	Carrier Claims and	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
Included in a Hospital Admission	Included in a Hospital Admission		placeOfService = 23 and first 2 characters of hcpcsBetosCode in (M1-M6, P1-P8, T1,T2,I1-I4) and NOT SpecialtyCondition Outpatient Claims and first 2 characters of hcpcsBetosCode in (M1-M6, P1-P8, T1,T2,I1-I4) and revenueCenter Code in ('0981', '0450', '0451', '0452', '0453', '0454', '0455', '0456', '0457', '0458', '0459')	by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, provided in the emergency room of a hospital, and including the following services: M1A = Office visits - new M1B = Office visits - established M2A = Hospital visit - initial M2B = Hospital visit - subsequent M2C = Hospital visit - critical care M4A = Home visit M4B = Nursing home visit M5A = Specialist - pathology M5B = Specialist - psychiatry M5C = Specialist - ophthalmology M5D = Specialist - other M6 = Consultations P1A = Major procedure – breast P1B = Major procedure - colectomy P1C = Major procedure - cholecystectomy P1D = Major procedure - turp P1E = Major procedure - hysterectomy P1F = Major procedure - explor/decompr/excisdisc P1G = Major procedure - Other P2A = Major procedure, cardiovascular-CABG P2B = Major procedure, cardiovascular-Aneurysm repair P2C = Major Procedure, cardiovascular-Thromboendarterectomy P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA) P2E = Major procedure, cardiovascular-Pacemaker insertion P2F = Major procedure, cardiovascular-Other P3A = Major procedure, orthopedic - Hip fracture repair P3B = Major procedure, orthopedic - Hip replacement P3C = Major procedure, orthopedic - Knee replacement P3D = Major procedure, orthopedic - other

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				P4B = Eye procedure - cataract removal/lens insertion P4C = Eye procedure - retinal detachment P4D = Eye procedure - treatment of retinal lesions P4E = Eye procedure - other P5A = Ambulatory procedures - skin P5B = Ambulatory procedures - musculoskeletal P5C = Ambulatory procedures - inguinal hernia repair P5D = Ambulatory procedures - lithotripsy P5E = Ambulatory procedures - other P6A = Minor procedures - skin P6B = Minor procedures - musculoskeletal P6C = Minor procedures - other (Medicare fee schedule) P6D = Minor procedures - other (non-Medicare fee schedule) P8A = Endoscopy - arthroscopy P8B = Endoscopy - upper gastrointestinal P8C = Endoscopy - sigmoidoscopy P8D = Endoscopy - colonoscopy P8E = Endoscopy - cystoscopy P8F = Endoscopy - bronchoscopy P8G = Endoscopy - laparoscopic cholecystectomy P8H = Endoscopy - laryngoscopy P8I = Endoscopy - other T1A = Lab tests - routine venipuncture (non-Medicare fee schedule) T1B = Lab tests - automated general profiles T1C = Lab tests - urinalysis T1D = Lab tests - blood counts T1E = Lab tests - glucose T1F = Lab tests - bacterial cultures T1G = Lab tests - other (Medicare fee schedule) T1H = Lab tests - other (non-Medicare fee schedule) T2A = Other tests - electrocardiograms T2B = Other tests - cardiovascular stress tests T2C = Other tests - EKG monitoring

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				T2D = Other tests – other I1A = Standard imaging - chest I1B = Standard imaging - musculoskeletal I1C = Standard imaging - breast I1D = Standard imaging - contrast gastrointestinal I1E = Standard imaging - nuclear medicine I1F = Standard imaging - other I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck I2B = Advanced imaging - CAT/CT/CTA: other I2C = Advanced imaging - MRI/MRA: brain/head/neck I2D = Advanced imaging - MRI/MRA: other I3A = Echography/ultrasonography - eye I3B = Echography/ultrasonography - abdomen/pelvis I3C = Echography/ultrasonography - heart I3D = Echography/ultrasonography - carotid arteries I3E = Echography/ultrasonography - prostate, transrectal I3F = Echography/ultrasonography - other I4A = Imaging/procedure - heart including cardiac catheterization I4B = Imaging/procedure - other Carrier/professional claims for services are **NOT** included in this figure if provided by providers with the following CMS specialty codes: 31 = Intensive Cardiac Rehabilitation 45 = Mammography screening center 47 = Independent Diagnostic Testing Facility (IDTF) 49 = Ambulatory surgical center 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics) 52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics) 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				54 = Medical supply company not included in 51, 52, or 53. 55= Individual certified orthotist 56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc. 60 = Public health or welfare agencies (federal, state, and local) 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities) 63 = Portable X-ray supplier 69 = Clinical laboratory (billing independently) 73 = Mass Immunization Roster Biller 74 = Radiation Therapy Centers 75 = Slide Preparation Facilities 87 = All other suppliers (e.g. drug and department stores) 88 = Unknown supplier/provider specialty 95 = Competitive Acquisition Program (CAP) 96 = Optician A0 = Hospital (DMERCs only) A1 = SNF (DMERCs only) A2 = Intermediate care nursing facility (DMERCs only) A3 = Nursing facility, other DMERCs only) A4 = HHA (DMERCs only) This figure also includes costs for outpatient claim type claims[14] for the services listed above provided to the beneficiary during the 2018 Performance Period if provided in locations with the following revenue center codes:

[14] This includes FFS claims submitted by institutional outpatient providers. Examples of institutional outpatient providers include hospital outpatient departments, rural health clinics, renal dialysis facilities, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, Federally Qualified Health Centers and community mental health centers.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				0450-Emergency room - general classification 0451-Emergency room - EMTALA emergency medical screening services 0452-Emergency room - ER beyond EMTALA screening 0456-Emergency room-urgent care 0459-Emergency room-other 0981-Professional fees-emergency room
Post-Acute Services	Post-Acute Services	Dollar Amount	Claim Type Code[15] 10 [HHA claim], 20 [non swing bed SNF claim] or 30 [swing bed SNF claim] or Claim Type Code 60 [inpatient claim] and Provider CCN ends in 2000-2299 or 3025-3099 or its third character is R or T	This figure includes cost of the following claims for services rendered to the attributed beneficiary during the 2018 performance period: • all home health claims • all SNF claims • Inpatient claims for services provided in: Long-term hospitals, rehabilitation hospitals, Rehabilitation Units in Critical Access Hospitals, and/or in Rehabilitation units (excluded from PPS). Outpatient SNF claims and outpatient home health claims are not included in this figure.
Hospice	Hospice	Dollar Amount	All hospice claims (claim type code 50)	This figure reflects costs for all hospice claims submitted on behalf of the attributed beneficiary during the 2018 performance period.
All Other Services	All Other Services	Dollar Amount	TotalCost – sum (all categories above)	This figure reflects the costs of all other services provided to the attributed beneficiary during the performance period that are not captured in the categories above.

[15] https://www.resdac.org/cms-data/variables/nch-claim-type-code

MSPB

Which individual MIPS eligible clinicians and/or groups received a 2018 MIPS MSPB score?

Only clinicians and groups who met the 2018 minimum case volume of 35 received a 2018 MIPS MSPB score and associated beneficiary-level data report.

What is the data source used for the figures presented in the 2018 MSPB Beneficiary-level Cost Data Report?

The data source used to compute figures presented in this report is final action claims in the Integrated Data Repository (IDR). For outpatient claims, header-level outpatient claims data from the IDR were used.

The table below includes detailed descriptions of the figures presented in the 2018 MSPB Beneficiary-level Cost Data Report for either a TIN or TIN-NPI

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
HICN or MBI[16]	Attributed Beneficiary's Health Insurance Claim Number (HICN) or Medicare	Numeric or alpha-numeric, depending on identifier used	N/A	This column will include the beneficiary's HICN, MBI, or RRB identifier.

[16] https://www.cms.gov/medicare/new-medicare-card/

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
	Beneficiary Identifier (MBI)			
beneIdType	Beneficiary ID Type	MBI, HICN or RRB	N/A	This column will indicate whether to beneficiary ID type listed is a HICN or MBI or RRB.
Gender	Beneficiary's Gender	F or M	N/A	N/A
Attributed TIN	TIN of the clinician or group (depending on the level of 2018 MIPS reporting) to which the beneficiary MSPB episode was attributed	Numeric	See 2018 MIPS MSPB Measure Information Form linked to above	N/A
Attributed NPI	NPI of the individual clinician to which the beneficiary MSPB episode was attributed, for individual clinicians participating in and reporting to	Numeric	See 2018 MIPS MSPB Measure Information Form linked to above.	N/A

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
	MIPS as an individual in 2018			
DOB	Beneficiary's Date of Birth	Numeric	N/A	N/A
Admission Date	Index Inpatient Admission Date	Numeric	See 2018 MIPS MSPB Measure Information Form linked to above for information for index admission inclusion and exclusion criteria.	This is the date of the index admission that triggered the beneficiary MSPB episode.
HCC Percentile Ranking	HCC Percentile Ranking	Numeric	See Q&A above	This figure is an average of the beneficiary's 2018 risk scores translated into a percentile. CMS HCC V22 was used to compute 2018 scores, which are based on 2017 claims.
Episode Cost	Episode Cost	Dollar Amnt		This figure represents the un-adjusted, price-standardized, observed cost of the beneficiary episode. It reflects aggregated standardized payments for the subcategories of services reflected in this report. This figure is neither normalized nor Winsorized.

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
Acute Inpatient Hospital: Index Admission	Inpatient Hospital index admission	Dollar Amnt	claimType = 'INPATIENT' (Inpatient claims) and acute provider (3rd character of provider is '0' and not a repeat admission (no admission for the same beneficiary 30 days before the current admission)	This figure includes costs for inpatient claim type[17] services provided in short-term (general and specialty) hospitals,[18] submitted on behalf of a beneficiary in the time period beginning three days prior to the hospital admission and 30 days after hospital discharge, which is the acute inpatient hospitalization that triggered the MSPB episode. This figure does not include inpatient claims rendered during a repeat admission. A repeat admission is defined as any admission other than the index admission that occurs within 30 days of the index admission. Inpatient claims are fee-for-service (FFS) claims submitted by inpatient hospital providers for reimbursement of facility costs. These claim records represent covered stays (Medicare paid FFS bills).
Acute Inpatient Hospital: Readmission	Inpatient Hospital: Readmission	Dollar Amnt	claimType = 'INPATIENT' and patient at acute provider and repeat admission	This figure includes costs for inpatient claim type services provided to the beneficiary at an acute hospital, critical access hospital, psychiatric hospital, psychiatric unit in a critical access hospital, and/or in a psychiatric unit excluded from the prospective payment system (PPS) only if rendered during a repeat admission which is any hospitalization other than the one that triggered the episode. A repeat admission is defined as any

[17] See: https://www.resdac.org/cms-data/variables/nch-claim-type-code. Inpatient claims are identified by code 60.
[18] See: https://www.resdac.org/sites/resdac.umn.edu/files/Provider%20Number%20Table.txt. The first two digits of the "provider number variable" indicate the state where the provider is located, using the SSA state codes; the middle two characters indicate the type of provider; and the last two digits are used as a counter for the number of providers within that state and type of provider (i.e., this is a unique but not necessarily sequential number).

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				admission other than the index admission that occurs within 30 days of the index admission.
Inpatient Rehabilitation or Long-Term Care Hospital	Inpatient Rehabilitation or Long-Term Care Hospital (LTCH) Services	Dollar Amnt	claimtype = 'INPATIENT[19]' and 3rd character of provider is in ('M','S','R','T') or 3-6 characters of ipProvider are in 2000-2299 or 3025-3099 or 4000-4499	This figure includes costs for inpatient claim type services provided to the beneficiary during the time period beginning 3 days prior to the index admission plus 30 days after discharge by the following provider types/in the following places: Psychiatric Unit in Critical Access Hospital, Psychiatric unit (excluded from PPS), Rehabilitation Unit in Critical Access Hospital, Rehabilitation unit (excluded from PPS), Long-term hospitals, rehabilitation hospitals, and/or psychiatric hospitals.
Other Physician or Supplier Part B Services Billed During Any Hospitalization	Other Physician or Supplier Part B Services Billed During Any Hospitalization	Dollar Amnt	claimtype = 'PROFESSIONAL' and placeOfService[20] in (21,51) and substring(hcpcsBetosGroup,1,2) not in ('P0','P9') and hcpcsBetosCode [21] not in	This figure includes costs for local carrier non-durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for services provided to the beneficiary during the time period beginning 3 days prior to the index admission plus 30 days after discharge, in an inpatient hospital and/or inpatient Psychiatric Facility.

[19] Claims submitted by inpatient hospital providers for reimbursement of facility costs.
[20] https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
[21] https://www.resdac.org/cms-data/variables/line-berenson-eggers-type-service-betos-code

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			('O1A','O1D','O1E','D1G')[22]	This figure does NOT include the following services: anesthesia, dialysis, ambulance, chemotherapy, other DME, nor drugs administered through DME.
Home Health	Home Health Services	Dollar Amnt	claimtype = 'HOME_HEALTH_SERVICES'	This figure includes costs for Home Health Agency (HHA) claim type claims for services provided to the beneficiary in the time period beginning three days prior to the hospital admission and 30 days after hospital discharge.
Skilled Nursing Facility	Skilled Nursing Facility Services	Dollar Amnt	claimtype = 'SKILLED_NURSING_FACILITY'	This figure includes costs for swing-bed AND non-swing bed Skilled Nursing Facility claim type claims for services provided to the beneficiary in the time period beginning three days prior to the hospital admission and 30 days after hospital discharge.
Physical, Occupational, or Speech and Language Pathology Therapy, carrier	Physical, Occupational, or Speech and Language Pathology Therapy, carrier costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and (hcpcsModifierCode1 in ('GN[23]','GO','GP') or hcpcsModifer Code2 in ('GN','GO','GP') or	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary during the time period beginning 3 days prior to the index admission plus 30 days after discharge: Services delivered under an outpatient speech language pathology plan of care, Services delivered under an outpatient

[22] https://www.resdac.org/sites/resdac.umn.edu/files/BETOS%20Table.txt

[23] See: https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Downloads/2018-Alpha-Numeric-HCPCS-File.zip, file entitled “HCPC2018_CONTR_ANWEB_DISC.xlsx”

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			hcpcsModiferCode3 in ('GN','GO','GP') or hcpcsModiferCode4 in ('GN','GO','GP') OR hcpcsModiferCode5 in ('GN','GO','GP'))	occupational therapy plan of care, Services delivered under an outpatient physical therapy plan of care.
ER Evaluation & Management Services, carrier cost	ER Evaluation & Management Services, carrier cost	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 1) ='M' and placeOfServiceCode = '23'	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following evaluation and management (E&M) services provided to the beneficiary in an emergency room of a hospital during the time period beginning 3 days prior to the index admission plus 30 days after discharge: M1A = Office visits - new M1B = Office visits - established M2A = Hospital visit - initial M2B = Hospital visit - subsequent M2C = Hospital visit - critical care M3 = Emergency room visit M4A = Home visit M4B = Nursing home visit M5A = Specialist - pathology M5B = Specialist - psychiatry M5C = Specialist - ophthalmology M5D = Specialist - other

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				M6 = Consultations
ER Procedures, carrier cost	Emergency Room Procedures, carrier costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 2) in ('P0'-'P8')) and placeOfServiceCode = '23'	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary in an emergency room of a hospital during the time period beginning 3 days prior to the index admission plus 30 days after discharge: P0 = Anesthesia P1A = Major procedure - breast P1B = Major procedure - colectomy P1C = Major procedure - cholecystectomy P1D = Major procedure - turp P1E = Major procedure - hysterectomy P1F = Major procedure explor/decompr/excisdisc P1G = Major procedure - Other P2A = Major procedure, cardiovascular-CABG P2B = Major procedure, cardiovascular-Aneurysm repair P2C = Major Procedure, cardiovascular-Thromboendarterectomy P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA) P2E = Major procedure, cardiovascular-Pacemaker insertion P2F = Major procedure, cardiovascular-Other P3A = Major procedure, orthopedic - Hip fracture repair P3B = Major procedure, orthopedic - Hip replacement P3C = Major procedure, orthopedic - Knee replacement P3D = Major procedure, orthopedic - other P4A = Eye procedure - corneal transplant P4B = Eye procedure - cataract removal/lens insertion

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				P4C = Eye procedure - retinal detachment P4D = Eye procedure - treatment of retinal lesions P4E = Eye procedure - other P5A = Ambulatory procedures - skin P5B = Ambulatory procedures - musculoskeletal P5C = Ambulatory procedures - inguinal hernia repair P5D = Ambulatory procedures - lithotripsy P5E = Ambulatory procedures - other P6A = Minor procedures - skin P6B = Minor procedures - musculoskeletal P6C = Minor procedures - other (Medicare fee schedule) P6D = Minor procedures - other (non-Medicare fee schedule) P7A = Oncology - radiation therapy P7B = Oncology - other P8A = Endoscopy - arthroscopy P8B = Endoscopy - upper gastrointestinal P8C = Endoscopy - sigmoidoscopy P8D = Endoscopy - colonoscopy P8E = Endoscopy - cystoscopy P8F = Endoscopy - bronchoscopy P8G = Endoscopy - laparoscopic cholecystectomy P8H = Endoscopy - laryngoscopy P8I = Endoscopy - other
ER Laboratory, Pathology, and Other Tests, carrier cost	ER Laboratory, Pathology, and Other Tests, carrier cost	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 1) ='T' and placeOfServiceCode = '23'	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary in an emergency room of a hospital during the time period beginning 3 days prior to the index admission plus 30 days after discharge:

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				T1A = Lab tests - routine venipuncture (non-Medicare fee schedule) T1B = Lab tests - automated general profiles T1C = Lab tests - urinalysis T1D = Lab tests - blood counts T1E = Lab tests - glucose T1F = Lab tests - bacterial cultures T1G = Lab tests - other (Medicare fee schedule) T1H = Lab tests - other (non-Medicare fee schedule) T2A = Other tests - electrocardiograms T2B = Other tests - cardiovascular stress tests T2C = Other tests - EKG monitoring T2D = Other tests - other
ER Imaging Services, carrier cost	Emergency Room Imaging Services, carrier costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 1) ='I' and placeOfServiceCode = '23'	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary in an emergency room of a hospital during the time period beginning 3 days prior to the index admission plus 30 days after discharge: I1A = Standard imaging - chest I1B = Standard imaging - musculoskeletal I1C = Standard imaging - breast I1D = Standard imaging - contrast gastrointestinal I1E = Standard imaging - nuclear medicine I1F = Standard imaging - other I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck I2B = Advanced imaging - CAT/CT/CTA: other I2C = Advanced imaging - MRI/MRA: brain/head/neck I2D = Advanced imaging - MRI/MRA: other

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				I3A = Echography/ultrasonography - eye I3B = Echography/ultrasonography - abdomen/pelvis I3C = Echography/ultrasonography - heart I3D = Echography/ultrasonography - carotid arteries I3E = Echography/ultrasonography - prostate, transrectal I3F = Echography/ultrasonography - other I4A = Imaging/procedure - heart including cardiac catheterization I4B = Imaging/procedure - other
Dialysis, carrier outpatient costs	Dialysis, carrier outpatient costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode,1,2) = 'P9' and PlaceOfService NOT ‘23’	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary during the time period beginning 3 days prior to the index admission plus 30 days after discharge: P9A = Dialysis services (Medicare fee schedule) P9B = Dialysis services (non-Medicare fee schedule)
Evaluation and Management Services, carrier cost & non ER carrier	Evaluation and Management Services, carrier cost & non Emergency-Room carrier costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 1) ='M'	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following evaluation and management services provided to the beneficiary in places of service NOT including the emergency room during the time period beginning 3 days prior to the index admission plus 30 days after discharge: M1A = Office visits - new M1B = Office visits - established

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				M2A = Hospital visit - initial M2B = Hospital visit - subsequent M2C = Hospital visit - critical care M3 = Emergency room visit M4A = Home visit M4B = Nursing home visit M5A = Specialist - pathology M5B = Specialist - psychiatry M5C = Specialist - ophthalmology M5D = Specialist - other M6 = Consultations
Major Procedures and Anesthesia, carrier costs	Major Procedures and Anesthesia, carrier costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 2) ='P0,P1,P2,P3,P7'	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary during the time period beginning 3 days prior to the index admission plus 30 days after discharge: P0 = Anesthesia P1A = Major procedure - breast P1B = Major procedure - colectomy P1C = Major procedure - cholecystectomy P1D = Major procedure - turp P1E = Major procedure - hysterectomy P1F = Major procedure - explor/decompr/excisdisc P1G = Major procedure - Other P2A = Major procedure, cardiovascular-CABG P2B = Major procedure, cardiovascular-Aneurysm repair P2C = Major Procedure, cardiovascular-Thromboendarterectomy

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA) P2E = Major procedure, cardiovascular-Pacemaker insertion P2F = Major procedure, cardiovascular-Other P3A = Major procedure, orthopedic - Hip fracture repair P3B = Major procedure, orthopedic - Hip replacement P3C = Major procedure, orthopedic - Knee replacement P3D = Major procedure, orthopedic - other P7A = Oncology - radiation therapy P7B = Oncology - other
Ambulatory/Minor Procedures, carrier costs	Ambulatory/Minor Procedures, carrier costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 2) ='P4, P5,P6,P8'	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary during the time period beginning 3 days prior to the index admission plus 30 days after discharge: P4C = Eye procedure - retinal detachment P4D = Eye procedure - treatment of retinal lesions P4E = Eye procedure – other P5B = Ambulatory procedures - musculoskeletal P5C = Ambulatory procedures - inguinal hernia repair P5D = Ambulatory procedures - lithotripsy P5E = Ambulatory procedures – other P6A = Minor procedures - skin P6B = Minor procedures - musculoskeletal P6C = Minor procedures - other (Medicare fee schedule) P6D = Minor procedures - other (non-Medicare fee schedule) P8A = Endoscopy - arthroscopy P8B = Endoscopy - upper gastrointestinal

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				P8C = Endoscopy - sigmoidoscopy P8D = Endoscopy - colonoscopy P8E = Endoscopy - cystoscopy P8F = Endoscopy - bronchoscopy P8G = Endoscopy - laparoscopic cholecystectomy P8H = Endoscopy - laryngoscopy P8I = Endoscopy - other
Ancillary Laboratory, Pathology, and Other Tests, carrier costs	Ancillary Laboratory, Pathology, and Other Tests, carrier costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 1) ='T'	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary during the time period beginning 3 days prior to the index admission plus 30 days after discharge: T1A = Lab tests - routine venipuncture (non-Medicare fee schedule) T1B = Lab tests - automated general profiles T1C = Lab tests - urinalysis T1D = Lab tests - blood counts T1E = Lab tests - glucose T1F = Lab tests - bacterial cultures T1G = Lab tests - other (Medicare fee schedule) T1H = Lab tests - other (non-Medicare fee schedule) T2A = Other tests - electrocardiograms T2B = Other tests - cardiovascular stress tests T2C = Other tests - EKG monitoring T2D = Other tests - other

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
Ancillary Imaging Services, carrier costs	Ancillary Imaging Services, Carrier Costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring(hcpcsBetosCode,1,1) = 'I'	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary during the time period beginning 3 days prior to the index admission plus 30 days after discharge: I1A = Standard imaging - chest I1B = Standard imaging - musculoskeletal I1C = Standard imaging - breast I1D = Standard imaging - contrast gastrointestinal I1E = Standard imaging - nuclear medicine I1F = Standard imaging - other I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck I2B = Advanced imaging - CAT/CT/CTA: other I2C = Advanced imaging - MRI/MRA: brain/head/neck I2D = Advanced imaging - MRI/MRA: other I3A = Echography/ultrasonography - eye I3B = Echography/ultrasonography - abdomen/pelvis I3C = Echography/ultrasonography - heart I3D = Echography/ultrasonography - carotid arteries I3E = Echography/ultrasonography - prostate, transrectal I3F = Echography/ultrasonography - other I4A = Imaging/procedure - heart including cardiac catheterization I4B = Imaging/procedure - other
Durable Medical Equipment and Supplies	Durable Medical Equipment and Supplies	Dollar Amnt	claimType = 'DURABLE_MEDICAL_EQUIPMENT' and	This figure includes costs for local carrier DMEPOS claims, which are FFS claims submitted by DME suppliers to the DME Medicare Administrative Contractor, on behalf of the beneficiary

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			hcpcsBetosCode not in ('O1D','O1E','D1G') (not chemo and drugs)	during the time period beginning 3 days prior to the index admission plus 30 days after discharge. This figure does not include the following costs: O1D = Chemotherapy O1E = Other drugs O1G = Immunizations/Vaccinations
Hospice	Hospice	Dollar Amnt	claimType = 'HOSPICE'	This figure includes costs for hospice claim type claims for services provided to the beneficiary in the time period beginning three days prior to the hospital admission and 30 days after hospital discharge
Ambulance Services, carrier	Ambulance Services, carrier	Dollar Amnt	claimtype = 'PROFESSIONAL' and hcpcsBetosCode = 'O1A'	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the beneficiary during the time period beginning 3 days prior to the index admission plus 30 days after discharge: O1A = Ambulance
Chemotherapy and Other Part B-Covered Drugs, carrier	Chemotherapy and Other Part B-Covered Drugs, DME and carrier	Dollar Amnt	claimtype in ('DURABLE_MEDICAL_EQUIPMENT','PROFESSIONAL') and hcpcsBetosCode in	This figure includes costs for local carrier non DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, AND costs for local carrier DMEPOS claims, which are FFS claims submitted by DME suppliers to the DME Medicare Administrative Contractor, for the following services provided to

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			('O1D','O1E','D1G')	the beneficiary during the time period beginning 3 days prior to the index admission plus 30 days after discharge: O1D = Chemotherapy O1E = Other drugs D1G = Drugs Administered through DME
Outpatient claims cost	Total Outpatient Cost	Dollar Amnt	claimType = 'OUTPATIENT'	This figure includes costs for outpatient claim type claims for services provided to the beneficiary in the time period beginning three days prior to the hospital admission and 30 days after hospital discharge. This includes FFS claims submitted by institutional outpatient providers. Examples of institutional outpatient providers include hospital outpatient departments, rural health clinics, renal dialysis facilities, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, Federally Qualified Health Centers and community mental health centers.
All Other Services Not Otherwise Classified	All Services Not Otherwise Classified	Dollar Amnt	else (anything else)	All Services Not Otherwise Classified

ACR Beneficiary-level Data Reports Questions

What is CMS providing beneficiary-level data on the 30-Day All-Cause Readmission measure and what is the purpose of doing so?

As with the TPCC and MSPB measures, CMS is committed to maturing the MIPS feedback experience. The beneficiary-level data that we provide for the 30-Day All-Cause Readmission measure includes information about your attributed patients' hospitalizations and shows whether there was a readmission within 30 days of discharge from the original hospital stay. The purpose of this data is to provide groups and clinicians a starting point for ways to improve the quality of care provided to their attributed patients.

Which beneficiaries are included in the beneficiary-level table?

The tables include patients attributed to the group (as identified by the Taxpayer Identification Number [TIN]) that had at least one hospital admission and were readmitted for an unplanned or planned within 30 days of discharge from the original hospital stay. Patients are attributed to the group's TIN via the two-step attribution methodology. For more information on how the 30-Day All-Cause Readmission measure is calculated, please refer to the 2018 30-day All-Cause Hospital Readmission Measure Specifications.

Who is the TIN-NPI to which the beneficiary is assigned?

In the beneficiary-level data, each beneficiary is assigned to an NPI within the TIN. The beneficiary is assigned to an NPI using the following multi-step process:

1. If a beneficiary was treated by one primary care physician in the TIN, then the beneficiary will be assigned to that primary care physician;
2. If a beneficiary was treated by more than one primary care physician in the TIN, the beneficiary is assigned to the primary care physician who provided the plurality of services (based on allowed charges);

3. If a beneficiary was not seen by a primary care physician but seen by one non-primary care physician in the TIN, the beneficiary will be associated with that non-primary care physician;
4. If a beneficiary was not seen by a primary care physician but seen by more than one non-primary care physician in the TIN, the beneficiary will be associated with the non-primary care physician who provided the plurality of services (based on allowed charges).

How should the Hierarchical Condition Category (HCC) Risk Score Percentile be interpreted?

The "HCC Percentile Ranking" column in the ACR beneficiary-level data is calculated in the same manner as the HCC Risk Score Percentiles presented in the beneficiary-level data for the MIPS TPCC and MSPB cost measures. The HCC Percentile Ranking" column shows how that beneficiary's risk score compares to all other Medicare Fee-for-Service (FFS) beneficiaries nationwide, with 1 being low and 100 being high (for example, a percentile ranking of 83 means that 83 percent of beneficiaries nationwide had lower risk scores). Higher percentile rankings tend to be associated with more serious health conditions, including multiple chronic conditions. These beneficiaries may benefit from more intensive efforts to manage their care, including closer monitoring of the beneficiary's condition, actively coordinating care with other providers, and supporting beneficiaries' self-management. You may also look for opportunities to help beneficiaries at lower risk avoid the need for high-cost services (for example, outpatient emergency services).

What happens if a beneficiary is identified as "Expired"?

If a beneficiary expired during the period of performance, the date of death will be shown in the "Expired" column. Please note that beneficiaries that expired during the admission will not be included in the calculation of the 30-Day All-Cause Readmission measure.

What does it mean for a patient to have one or more chronic condition?

The tables identify whether beneficiaries had one or more of four common chronic conditions among the Medicare population, including diabetes, Chronic Obstructive Pulmonary Disease (COPD), Chronic Artery Disease (CAD), and Congestive Heart Failure (CHF). The information in these columns can be used to identify those patients that may require improved or additional chronic condition-management.

What does the “Primary Index Diagnosis” column represent?

This column displays the principal diagnosis associated with the index admission. This column may allow clinicians and groups to more closely review the conditions that were the drivers behind patients’ hospitalizations.

What is the difference between the “Medical Cohort” and “Category” columns?

Each admission is categorized into clinically coherent groups of conditions/procedures (condition categories or procedure categories) by using the Agency for Healthcare Research and Quality (AHRQ) Clinical Classifications System (CCS). Each admission is assigned to one of five mutually exclusive “Medical Cohorts”: medicine, surgery/gynecology, cardiorespiratory, cardiovascular, and neurology. The “Category” column identifies whether the admission was assigned to the surgical cohort.

Admissions with an eligible surgical procedure category are assigned to the surgical cohort, regardless of the diagnosis code of the admission. All other admissions are assigned to the medical cohort under the “Category” column and are assigned to cohorts based on the principal diagnosis.

What information is available for beneficiaries who have been readmitted within 30 days of discharge?

The table provides information about whether your attributed beneficiaries had a 30-day readmission, including information on the (1) date of admission and discharge for that readmission, (2) the principal diagnosis associated with the readmission; and (3) whether the readmission was unplanned or planned.

What is the difference between a planned and unplanned readmission?

Planned readmissions are identified as certain types of care such as obstetrical delivery, transplant surgery, maintenance chemotherapy or non-acute scheduled procedures. Unplanned readmissions include admissions for acute illness or for complications of care. Planned readmissions are not included in the calculation of the 30-day All-cause Readmission measure. For more information on procedures and diagnoses that are considered planned, please see the 2018 30-day All-Cause Hospital Readmission Measure Specifications.