Quality Payment PROGRAM

2019 MIPS Performance Feedback Patient-Level Data Reports FAQs

Background and Purpose

The Centers for Medicare and Medicaid Services (CMS) is committed to maturing the Merit-based Incentive Payment System (MIPS) feedback experience. In honoring that commitment, we are providing patient-level reports for download by those who were scored on a 2019 MIPS cost measure and/or the 2019 30-Day All-Cause Readmission (ACR) measure.

Individuals, groups and virtual groups can compare their performance on each measure with the benchmark provided in performance feedback to better understand their performance relative to their peers, to identify care coordination and quality of care opportunities and streamline resource use for their attributed patients.

The following questions & answers provide additional information about these patient-level reports that are displayed and downloadable in the 2019 performance feedback.

Cost Performance Category

Quality Performance Category

General Questions

What are the 2019 case minimums for each MIPS cost measure?

The case minimums are as follows: 10 episodes for the procedural measures, 20 episodes for the acute inpatient medical condition measures, 35 episodes for the MSPB measure and 20 beneficiaries for the TPCC measure, as summarized in the table below:

Cost Measure Name/Episode Type, if Applicable	Case Minimum
Total per Capita Costs (TPCC)	20
Medicare Spending per Beneficiary (MSPB)	35
Elective Outpatient Percutaneous Coronary Intervention (PCI)/ Procedural	10
Knee Arthroplasty/Procedural	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia/Procedural	10
Routine Cataract Removal with Intraocular Lens (IOL) Implantation/Procedural	10
Screening/Surveillance Colonoscopy /Procedural	10
Intracranial Hemorrhage or Cerebral Infarction/Acute Inpatient Medical Condition	20
Simple Pneumonia with Hospitalization/ Acute Inpatient Medical Condition	20
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) / Acute Inpatient Medical Condition	20

What data are used to calculate the 2019 MIPS cost measures?

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, 2019- December 31, 2019) 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 2019 MIPS performance period) or TIN-NPI (for individual MIPS eligible clinicians who reported to MIPS as an individual for the 2019 MIPS performance period).

For the MSPB measure, per episode costs are based on Medicare Part A and Medicare Part B Medicare-allowed amounts surrounding specific inpatient hospital stays for episodes attributed to your TIN or TIN-NPI. Episodes included in the 2019 Measure score calculation are those ending in the performance period (January 1, 2019 – December 31, 2019).

Each episode-based measure includes Medicare Part A and Medicare Part B allowed amounts for services that are clinically related to the attributed clinician's role in managing care during the defined episode window. Episodes included in the 2019 Measure score calculation are those ending in the performance period (January 1, 2019 – December 31, 2019).

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

CMS generates HCC scores based on patient characteristics (such as age) and prior health conditions identified on previous Medicare claims. The percentile ranking shows how that patient's risk score compares to all other Medicare Fee-for-Service (FFS) patients 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 patient'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 patient-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 patient-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 episode of care or the performance year, not just costs for services rendered solely by the TIN/TIN-NPI to which the patient 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 non-institutional 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.

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

Are payment-standardized costs used to compute the figures in the MIPS cost measure patient-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.

TPCC

Which individual MIPS eligible clinicians and/or groups received a 2019 MIPS TPCC score and associated patient-level data report?

Only clinicians and groups who met the 2019 minimum case volume of 20 received a 2019 MIPS TPCC score and associated patient-level data report.

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

CMS attributes patients 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. For detailed attribution methodology information, please refer to Step 1 on page 5 of the 2019 TPCC Measure Information Form.

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

The TPCC patient-level cost report indicates which of your attributed patients had one or more of the following chronic conditions during the 2018 Calendar Year (CY): diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and heart failure. These chronic conditions are widespread among Medicare patients and for which

enhanced management may improve patient outcomes as well as efficiency of care.[2] You can use this information to identify individual patients with these conditions who may benefit from such enhanced management and coordination activities. For example, a patient with congestive heart failure and relatively high costs attributable to inpatient stays may represent an opportunity to re-examine how you manage such patients. You may decide to update or change patients' preventive care, self-management support, monitoring, or medical treatment plans.

Please note: Diagnoses from the 2018 CY, not the 2019 MIPS performance period of 1/1/2019-12/31/2019, 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 patient-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 patients and to identify opportunities to improve efficiencies. For example, if skilled nursing facility expenses for your TIN or TIN-NPI's attributed patients are high, consider options for arranging needed support at home or other, less costly venues.

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

This number represents the total payment-standardized Medicare Fee-for-Service (FFS) costs associated with the care of each patient 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

[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.

neither risk-adjusted nor specialty adjusted. The costs are annualized. As explained on page 6 of the 2019 TPCC Measure Information Form: In performance year 2019, part year patients (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 2019 TPCC Patient-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 2019 TPCC Patient-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

[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
Gender	Beneficiary's Gender	1=Male 2=Female	N/A	N/A
Attributed TIN	TIN of the clinician or group or TIN-NPI of the individual clinician (depending on the level of 2019 MIPS reporting) to which the beneficiary's costs were attributed	Numeric	See 2019 MIPS TPCC Measure Information Form linked to above	Presence of this field will depend upon the chosen 2019 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 2019	Numeric	See 2019 MIPS TPCC Measure Information Form linked to above	Presence of this field will depend upon the chosen 2019 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 2019 risk scores translated into a percentile. CMS HCC V22 was used to compute 2019 scores, which are based on 2018 claims.
Expired	Expired	Numeric Date	N/A	If the attributed beneficiary died during the 2019 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 1/1/2018-12/31/2018. Please note: data from the prior CY, not the 2019 performance period, are used to compute this particular T/F value.
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 1/1/2018-12/31/2018. Please note: data from the prior CY, not the 2019 performance period, are used to compute this T/F value.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
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 1/1/2018-12/31/2018. Please note: data from the prior CY, not the 2019 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 1/1/2018-12/31/2018. Please note: data from the prior CY, not the 2019 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 2019 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 placeOfServiceCode[5] not in ('23', '21', '51') and NOT 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 2019 Performance Period: 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

[4] https://www.resdac.org/sites/resdac.umn.edu/files/BETOS%20Table.txt
[5] https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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) 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

[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
				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) 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)

[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
				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 2019 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 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

[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
				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 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)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 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	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 2019 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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			SpecialtyCondition and NOT TherapyCondition	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 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)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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. 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)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 Language Pathology Therapy[9]	Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	Dollar Amount	Carrier Claim Type code (71,72) and TherapyCondition 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	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[11] for the following services provided to the beneficiary during the 2019 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.

[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
			substr(hcpcsBetosCode , 1, 2) not in ('P9', 'P0') and TypeOfBill not in ('22', '23', '33', '34', '72') and revenueCenterCode NOT in ('0981', '0450', '0451', '0452', '0453', '0454', '0455', '0456', '0457', '0458', '0459')[10]	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)
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 revenueCenterCode NOT in ('0981', '0450', '0451', '0452', '0453', '0454', '0455', '0456', '0457', '0458', '0459') CarrierClaims(71,72) and first 2 characters of	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 2019 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
			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.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
Inpatient Hospital Facility Services	Inpatient Hospital Facility Services	Dollar Value	BillionProviderOscar (or CCN) ends in {0001-0899},{1300-1399},{4000-4499} or its third character is M or S	This figure includes costs for inpatient claim type[13] services provided in short-term (general and specialty) hospitals 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 2019 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:

[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
				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. 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)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
Emergency Services Not Included in a Hospital Admission	Emergency Services Not Included in a Hospital Admission	Dollar Amount	Carrier Claims and 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 revenueCenterCode in ('0981', '0450', '0451', '0452', '0453', '0454', '0455', '0456', '0457', '0458', '0459')	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 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 T2D = Other tests – other

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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) 54 = Medical supply company not included in 51, 52, or 53. 55= Individual certified orthotist 56 = Individual certified prosthetist

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 2019 Performance Period if provided in locations with the following revenue center codes: 0450-Emergency room - general classification 0451-Emergency room - EMTALA emergency medical screening services

[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
				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 2019 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 2019 MIPS MSPB score?

Only clinicians and groups who met the 2019 minimum case volume of 35 received a 2019 MIPS MSPB score and associated patient-level data report.

What is the data source used for the figures presented in the 2019 MSPB Patient-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 2019 MSPB Patient-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 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.

[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
Gender	Beneficiary's Gender	F or M	N/A	N/A
Attributed TIN	TIN of the clinician or group (depending on the level of 2019 MIPS reporting) to which the beneficiary MSPB episode was attributed	Numeric	See 2019 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 MIPS as an individual in 2019	Numeric	See 2019 MIPS MSPB Measure Information Form linked to above.	N/A
DOB	Beneficiary's Date of Birth	Numeric	N/A	N/A
Admission Date	Index Inpatient Admission Date	Numeric	See 2019 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.

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
HCC Percentile Ranking	HCC Percentile Ranking	Numeric	See Q&A above	This figure is an average of the beneficiary's 2019 risk scores translated into a percentile. CMS HCC V22 was used to compute 2019 scores, which are based on 2018 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.
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).

[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
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 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	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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			hcpcsBetosCode[21] not in ('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 (hcpcsModiferCode 1 in ('GN[23]','GO','GP') or hcpcsModiferCode2 in ('GN','GO','GP') or hcpcsModiferCode3 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:

[21] https://www.resdac.org/cms-data/variables/line-berenson-eggers-type-service-betos-code
[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
			hcpcsModiferCode4 in ('GN','GO','GP') OR hcpcsModiferCode5 in ('GN','GO','GP'))	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.
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 M6 = Consultations

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
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, 33ardiovascular-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 P4C = Eye procedure – retinal detachment P4D = Eye procedure – treatment of retinal lesions P4E = Eye procedure – other

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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: T1A = Lab tests – routine venipuncture (non-Medicare fee schedule) T1B = Lab tests – automated general profiles

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 I3A = Echography/ultrasonography – eye I3B = Echography/ultrasonography – abdomen/pelvis

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 M2A = Hospital visit – initial M2B = Hospital visit – subsequent M2C = Hospital visit – critical care M3 = Emergency room visit

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 P2D = Major procedure, 37ardiovascular-Coronary angioplasty (PTCA) P2E = Major procedure, cardiovascular-Pacemaker insertion P2F = Major procedure, cardiovascular-Other P3A = Major procedure, orthopedic – Hip fracture repair

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 P8C = Endoscopy – sigmoidoscopy P8D = Endoscopy – colonoscopy P8E = Endoscopy – cystoscopy P8F = Endoscopy – bronchoscopy P8G = Endoscopy – laparoscopic cholecystectomy

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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
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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 hcpcsBetosCode not in ('O1D','O1E','D1G') (not chemo and drugs)	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 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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
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 ('O1D','O1E','D1G')	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 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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
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

Episode-Based Cost Measures

What are the 2019 episode-based cost measures?

There are 8 episode-based cost measures for the 2019 performance period.

Cost Measure Name/Type	Case Minimum
Elective Outpatient Percutaneous Coronary Intervention (PCI)/Procedural	10
Intracranial Hemorrhage or Cerebral Infarction/Acute Inpatient Medical Condition	20
Knee Arthroplasty/Procedural	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia/Procedural	10
Routine Cataract Removal with Intraocular Lens (IOL) Implantation/Procedural	10
Screening/Surveillance Colonoscopy /Procedural	10
Simple Pneumonia with Hospitalization/ Acute Inpatient Medical Condition	20
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) / Acute Inpatient Medical Condition	20

What are the possible values for the "beneIDtype" column in the patient-level episode-based cost measure reports and what do they mean?

This column will be populated with either an "H" for Health Insurance Claim Number (HICN) or an "M" for Medicare Beneficiary Identifier (MBI), indicating which type of identifier is contained in the "beneID" column.

What are the possible values for the "benesexcode" column in the patient-level episode-based cost measure reports and what do they mean?

This column will be populated with either a "1" for male or "2" for female, reflecting the sex of the patient.

How do I interpret the numeric codes contained in the "Service Code" column of the downloadable report for the MIPS 2019 episode-based measures?

Each row of the downloadable report pertains to a unique service a patient received during an episode of care. The codes listed in the "service code" column for a specific row in the report depend on the "service category" and the service category assignment rules for the service in question. Service category assignment rules for each episode-based measure are found in the 2019 cost measure code list files.

Consider the following *example* data pertaining to the Knee Arthroplasty ("KA") procedural episode-based measure that a clinician may find in her downloadable report.

Service Category	Service Code(s)	Service Category Description	Standardized Cost
Post-trigger costs for outpatient facility services.	213; Z96; Z96652	Physical therapy exercises, manipulation, and other procedures; Presence Of Other Functional Implants; Presence Of Left Artificial Knee Joint	1385.00

To interpret the 3 distinct service codes listed, navigate to the "SA_Post_OP_Clinician" tab of the KA code list file. This tab presents the services assigned to the episode group for the Outpatient (OP) Facility and Clinician Services service categories during the post-trigger period of the episode window. Assigned services are categorized into a Clinical Theme for the purposes of presenting metrics in coherent categories of episode costs. For Knee Arthroplasty, the 5 Clinical Themes are Deep Venous Thrombosis / Pulmonary Embolism, Pre-Operative Evaluation, Post-Procedural Joint Bleeding, Post-Trigger Joint Procedures, and Wound Care and Infections.

Starting from left to right in the "SA_Post_OP_Clinician" tab, you'll find that the first numerical code, 213, is a Clinical Classifications Software (CCS) category[24] with a category label of "Physical therapy exercises, manipulation, and other procedures." Continuing to navigate through the columns, the second code, Z96, is a ICD-10 CM 3-Digit Diagnosis[25] code with a label of "Presence Of Other Functional Implants." The third code, Z96652, is an ICD-10 CM Long Diagnosis code with a label of "Presence Of Left Artificial Knee Joint."

What is an episode window, a trigger date, a pre-trigger period and a post-trigger period?

An **episode window** is the time period during which certain costs incurred by a patient are identified for purposes of calculating an episode-based measure.

Episodes are defined by the codes that trigger (or open) the episode group and determine the patient cohort included in the episode group. To find the codes for clinical events that trigger an episode, navigate to the "Triggers" tab of the measure's code list file. The date on which an episode was triggered is contained in the column labeled "episode **trigger date**" in the downloadable report for episode-based measures.

An episode window may (but not always) include a period of time before the triggering clinical event, referred to as a "**pre-trigger period**," plus a period of time after the triggering clinical event, referred to as a "**post-trigger period**". Some episode windows begin when the triggering event occurs and do not include a pre-trigger period (therefore, they have a pre-trigger period of 0 days). To find the measure-specific episode window for a measure, refer to Section 2.0 of the measure's 2019 measure information form (MIF).

For example, for the knee arthroplasty episode-based measure, the episode window starts 30 days before the trigger and ends 90 days after the trigger. Two clinical events can trigger an episode for this measure, defined by the Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes of 27446 and 27447, both of which are defined as "repair of knee joint."

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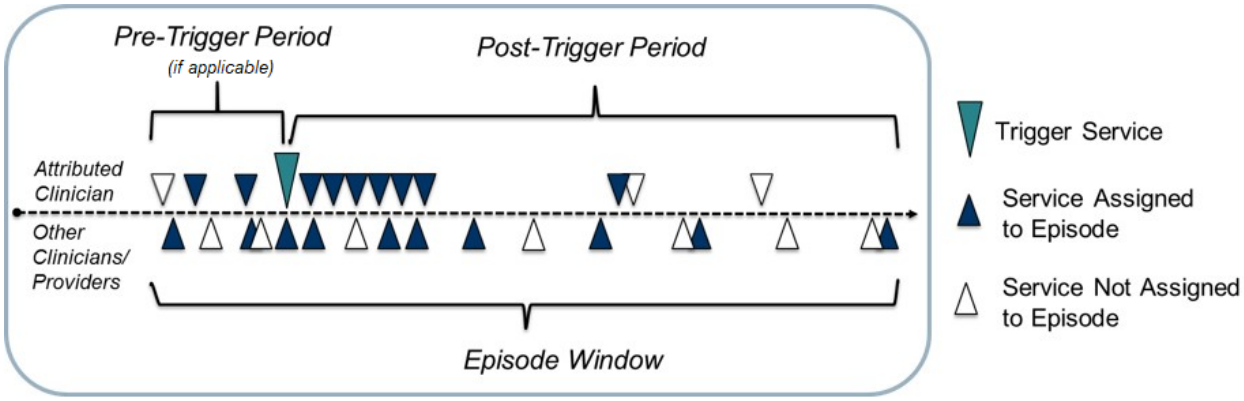
[24] For a list of CCS-Services and Procedures Procedure Categories, see: https://www.hcup-us.ahrq.gov/toolssoftware/ccs_svcsproc/ccssvcproc.jsp#table1

[25] International Classification of Disease, Tenth Revision, Clinical Modification. To browse the classification, navigate to: https://icd.who.int/browse10/2019/en



In the downloadable report for the MIPS 2019 episode-based measures, how do I interpret the service codes in the "service code" column categorized under the "concurrent_IP" and "PB_DME_during_concurrent_IP" service categories?

Procedural episode-based cost measures are triggered by a specific list of CPT/HCPCS trigger codes that can often occur during an inpatient (IP) admission. In these cases, the facility component for the concurrent IP stay during which the trigger procedure occurred is grouped and categorized as the "concurrent_IP". Any additional Part B physician/supplier services or durable medical equipment (DME) provided during the stay are assigned to the episode and categorized as "PB_DME_during_concurrent_IP." To view the triggers for an episode-based measure, navigate to the "Triggers" tab in the episode's Measure codes list file.

How do I interpret the value contained in the "HCC" column of the downloadable report for the MIPS 2019 episode-based measures?

The figure displayed in this column is meant to convey information about the patient's relative acuity. The figure is a patient's HCC risk score calculated in the month in which the episode was triggered and then rescaled based on the patient's "risk score factor code," aka a "rescaling factor" for that month.

A risk score factor code/rescaling factor is based on the segment a patient is assigned to in the risk adjustment model used to calculate the risk score. Risk scores are calculated with distinct sets of coefficients depending on which segment, or group of patients, a patient is assigned to. Coefficients are estimated for each segment separately to reflect the unique cost and utilization patterns of patients within the segment. For example, the rescaling factor for a patient categorized in the "dialysis/kidney transplant" segment is much higher than the rescaling factor for a patient in the "community" segment as patients receiving dialysis care and/or patients who have undergone a kidney transplant are expected to be much costlier than patients residing in the community.

What is a CCS category code?

A CCS code is a code specifying a Clinical Classifications Software Services and Procedures category created by the Agency for Healthcare Research and Quality (AHRQ).

What is the national average observed episode cost for each episode-based cost measure?

See table below.

Episode-based Cost Measure (Abbreviation)	National Average Observed Episode Cost for all TINs	National Average Observed Episode Cost for individual TIN-NPIs
Elective Outpatient Percutaneous Coronary Intervention (eo-pci)	$11,129.76	$11,130.44
Intracranial Hemorrhage or Cerebral Infarction (ich-cva)	$23,904.35	$27,070.67
Knee Arthroplasty (knee-arthro)	$17,555.25	$17,487.45
Simple Pneumonia with Hospitalization (pna-hosp)	$10,506.28	$11,089.56

Episode-based Cost Measure (Abbreviation)	National Average Observed Episode Cost for all TINs	National Average Observed Episode Cost for individual TIN-NPIs
Routine Cataract Removal with Intraocular Lens (IOL) Implantation (rcr-iol)	$3,149.27	$3,149.29
Revascularization for Lower Extremity Chronic Critical Limb Ischemia (rle-cli)	$22,815.24	$23,053.45
Screening/Surveillance Colonoscopy (ss-clnscpy)	$957.52	$957.53
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) (stemi-pci)	$20,452.98	$21,764.15

What is the 2019 national average payment-standardized observed MSPB episode cost?

The national average payment-standardized observed MSPB episode cost is $22,274.00.

What is the 2019 national average TPCC Average Cost Per Beneficiary?

The national payment-standardized average TPCC average cost per beneficiary is $14,282.70.

All-Cause Readmission (ACR) Patient-Level Data Reports Questions

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

The patient-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 patients are included in the patient-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 2019 30-day All-Cause Hospital Readmission Measure Specifications..

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

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

1. If a patient was treated by one primary care physician in the TIN, then the patient will be assigned to that primary care physician;
2. If a patient was treated by more than one primary care physician in the TIN, the patient is assigned to the primary care physician who provided the plurality of services (based on allowed charges);
3. If a patient was not seen by a primary care physician but seen by one non-primary care physician in the TIN, the patient will be associated with that non-primary care physician;
4. If a patient was not seen by a primary care physician but seen by more than one non-primary care physician in the TIN, the patient 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 patient-level data is calculated in the same manner as the HCC Risk Score Percentiles presented in the patient-level data for the MIPS TPCC and MSPB cost measures. The HCC Percentile Ranking” column shows how that patient’s risk score compares to all other Medicare Fee-for-Service (FFS) patients’ nationwide, with 1 being low and 100 being high (for example, a percentile ranking of 83 means that 83 percent of patients nationwide had lower risk scores). Higher percentile rankings tend to be associated with more serious health conditions, including multiple chronic conditions. These patients may benefit from more intensive efforts to manage their care, including closer monitoring of the patient’s condition, actively coordinating care with other providers, and supporting patients’ 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 patient is identified as “Expired”?

If a patient expired during the period of performance, the date of death will be shown in the “Expired” column. Please note that patients 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 patients 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 patients who have been readmitted within 30 days of discharge?

The table provides information about whether your attributed patients 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 an unplanned and planned readmission?

Unplanned readmissions include admissions for acute illness or for complications of care.

Planned readmissions are identified as certain types of care such as obstetrical delivery, transplant surgery, maintenance chemotherapy or non-acute scheduled procedures. The measure identifies planned readmissions with an algorithm that is a set of criteria using Medicare claims to classify readmissions as planned. This algorithm identifies admissions that are typically planned and may occur within 30 days of discharge from the hospital. Readmissions meeting the criteria of a planned readmission are not counted in the outcome of the 30-day All-cause Readmission measure. For more information on procedures and diagnoses that are considered planned, please see the 2019 30-day All-Cause Hospital Readmission Measure Specifications.

Where You Can Go for Help

- Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 a.m. - 8:00 p.m. ET or by e-mail at: QPP@cms.hhs.gov.
    - Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.
- Connect with your local technical assistance organization. We provide no-cost technical assistance to **small, underserved, and rural practices** to help you successfully participate in the Quality Payment Program.
- Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Version History

Date	Comment
8/5/2020	Original version