Quality Payment
PROGRAM

2021 MIPS Performance Feedback Patient-Level Data Reports Supplement

Background and Purpose

Due to COVID-19's impact on cost measures, the Centers for Medicare and Medicaid Services (CMS) reweighted the cost performance category from 20% to 0% for the 2021 performance period. For additional information about this decision and its implications, please see Appendix A, the listserv distributed on April 25, 2022.

CMS recognizes that clinicians need more insight into and familiarity with their performance in the cost performance category. To support this need, we provided 2021 patient-level reports on administrative claims-based cost and quality measures for clinicians, groups, virtual groups, and APM Entities who met the case minimum for the measures.

This document provides additional information about these patient-level reports that are downloadable as part of 2021 performance feedback and is organized as follows:

Cost Performance Category

- General Questions
- Total Per Capita Costs (TPCC) Measure Patient-Level Report
- Medicare Spending Per Beneficiary Clinician (MSPB-C) Measure Patient-Level Report
- Episode-Based Cost Measures Patient-Level Reports

Quality Performance Category

- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups
- Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions for ACOs (MCC)

- **Please note**: Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) will be able to download only the HWR and MCC patient-level reports. If you're a Shared Savings Program ACO's QPP Security Official or QPP Staff User contact in the ACO Management System (ACO-MS), then you can sign in to the QPP website using your ACO-MS username and password.

- Where You Can Go for Help
- Version History

General Questions

What are the 2021 case minimums and measure IDs for each of the MIPS cost measures and administrative claims-based quality measures for which patient-level reports are generated?
The case minimums are 10 episodes for the procedural episode-based cost measures (EBCMs), 20 episodes for the acute inpatient medical condition episode-based measures, 35 episodes for the MSPB Clinician measure and 20 patients for the TPCC measure, as summarized in the table below:

Measure Name	Case Minimum	Measure Type	Measure ID[1]
Total per Capita Cost (TPCC)	20	Populated-based cost measure	TPCC_1
Medicare Spending per Beneficiary Clinician (MSPB-C)	35	Populated-based cost measure	MSPB_1
Elective Outpatient Percutaneous Coronary Intervention(PCI)/ Procedural	10	Procedural EBCM	COST_EOPCI_1
Knee Arthroplasty/Procedural	10	Procedural EBCM	COST_KA_1

[1] Measure ID used for purposes of labelling the patient-level report generated for this measure.

Measure Name	Case Minimum	Measure Type	Measure ID[1]
Revascularization for Lower Extremity Chronic Critical LimbIschemia/Procedural	10	Procedural EBCM	COST_CCLI_1
Routine Cataract Removal with Intraocular Lens (IOL)Implantation/Procedural	10	Procedural EBCM	COST_IOL_1
Screening/Surveillance Colonoscopy /Procedural	10	Procedural EBCM	COST_SSC_1
Acute Kidney Injury Requiring New Inpatient Dialysis	10	Procedural EBCM	COST_AKID_1
Elective Primary Hip Arthroplasty	10	Procedural EBCM	COST_PHA_1
Femoral or Inguinal Hernia Repair	10	Procedural EBCM	COST_FIHR_1
Hemodialysis Access Creation	10	Procedural EBCM	COST_HAC_1
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	10	Procedural EBCM	COST_LSFDD_1
Lumpectomy Partial Mastectomy, Simple Mastectomy	10	Procedural EBCM	COST_LPMSM_1
Non-Emergent Coronary Artery Bypass Graft (CABG)	10	Procedural EBCM	COST_NECABG_1
Renal or Ureteral Stone Surgical Treatment	10	Procedural EBCM	COST_RUSST_1
Intracranial Hemorrhage or Cerebral Infarction/AcuteInpatient Medical Condition	20	Acute inpatient medical condition EBCM	COST_IHCI_1
Simple Pneumonia with Hospitalization/ Acute InpatientMedical Condition	20	Acute inpatient medical condition EBCM	COST_SPH_1
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) / Acute InpatientMedical Condition	20	Acute inpatient medical condition EBCM	COST_STEMI_1
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	20	Acute inpatient medical condition EBCM	COST_COPDE_1

Measure Name	Case Minimum	Measure Type	Measure ID[1]
Lower Gastrointestinal Hemorrhage (applied to groups only)	20	Acute inpatient medical condition EBCM	COST_LGH_1
Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups	See measure methodology documents	High Priority Quality Measure: Outcome	Quality ID: 479
Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS)	See measure methodology documents	High Priority Quality Measure: Outcome	Quality ID: 480
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions for ACOs (MCC)	See measure methodology documents	High Priority Quality Measure:Outcome	Quality ID: MCC1

How should we interpret the Hierarchical Conditions Categories (HCC) Percentile Ranking figure in the TPCC, MSPB Clinician, and Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate Groups (Quality Measure ID #479) patient-level reports?

CMS generates HCC scores based on patient characteristics 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 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 beneficiaries' self-management. You may also look for opportunities to help patients 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 patients to whom your TIN or TIN-NPI provides care.

What data source is used for the patient-level cost reports?

The data source used is final action claims in the Integrated Data Repository (IDR).

How should we interpret the HCC figure in the episode-based cost measure patient-level reports?

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," also known as 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. This HCC risk score/figure is not used in the measure calculation and is provided for informational purposes. It should not be confused with the actual risk adjustment model which does include variables from the CMS-HCC model.

Are costs reflected in the patient-level cost report differentiated by costs of services provided by my TIN or TIN-NPI versus other TINs or TIN-NPIs?

No, 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 reflect the costs of services rendered to attributed patients by *all* providers/eligible professionals during either the episode of care or the performance period, not just costs for services rendered solely by the TIN/TIN-NPI to which the patient is attributed.

I see BETOS codes noted in calculation conditions below. What are BETOS codes?

The Restructured Berenson-Eggers Type of Service (BETOS) Classification System (RBCS) dataset is a taxonomy that allows researchers to group healthcare service codes for Medicare Part B services into clinically meaningful categories and subcategories. It's based on the original BETOS classification created in the 1980s and includes notable updates such as Part B non-physician services. The first version of the RBCS was released in 2020 and covers healthcare services between 2014 and 2018. For more information refer to the 2021 RBCS and BETOS Crosswalk and the full data set.

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.

Are payment-standardized costs used to compute the figures in the MIPS cost measure patient-level cost reports?

Yes, standardized Medicare-allowed amounts are used for the cost measures. For more information on payment standardization, please consult CMS Price (Payment) Standardization Resources.

TPCC Patient-Level Report

Which individual MIPS eligible clinicians and/or groups received a 2021 MIPS TPCC patient-level data report?

Only clinicians and groups who met the minimum case volume of 20 received a 2021 MIPS TPCC patient-level data report.

How are Medicare patients attributed to a TIN or TIN-NPI for purposes of including them and their costs in the TPCC patient-level report?

The TPCC attribution methodology is completed in 4 steps, summarized below. For more information, please refer to the 2 measure specifications documents available for each cost measure: Measure Information Form (MIF) in a PDF file, and measure codes list Excel file.

1. **Identify candidate events.** A candidate event identifies the start of a primary care relationship between a clinician and patient. A candidate event is defined using select evaluation and management (E&M) Current Procedural Terminology / Healthcare Common Procedure Coding System (CPT/HCPCS) codes for outpatient physician visit, termed E&M "primary care" service, paired with one or more additional service(s) indicative of general primary care that together trigger the opening of a risk window.
2. **Apply service category and specialty exclusions.** Clinicians are excluded from attribution if they meet the criteria for one or more service exclusions in the following categories: global surgery, anesthesia, therapeutic radiation, and chemotherapy. Clinicians are also excluded based on their Health Care Finance Administration (HCFA) Specialty designation, if they identify as one or more of the 56 specialties in the specialty exclusion list.
3. **Construct risk windows.** The risk window begins on the date of the candidate event and continues until one year after that date. A patient's costs are attributable to a clinician during months where the risk window and performance period overlap.
4. **Attribute months to TINs and TIN-NPIs.** After service category and specialty exclusions are applied, all costs occurring during the covered months are attributed to the remaining eligible TINs. For TIN-NPI attribution, only the TIN-NPI responsible for the majority share, or plurality, of candidate events provided to the patient within the TIN is attributed that patient's costs for their respective candidate events.

How can we interpret the information on the 4 chronic conditions 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 2020 Calendar Year (CY): diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and heart failure.

Please note: Diagnoses from the 2020 CY, not the 2021 MIPS performance period of 1/1/2021-12/31/2021, were used to identify these chronic condition data points. These conditions were identified independently of measure construction.

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

This number represents the total payment-standardized Medicare Parts A and B costs across all the patient's beneficiary months attributed to the TIN or TIN-NPI during the performance period. These costs are neither risk-adjusted nor specialty adjusted. The costs are annualized. As explained in the 2021 TPCC Measure Information Form: 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.

The table below includes detailed descriptions of the figures presented in the 2021 TPCC Patient-level Report for either a TIN or TIN-NPI

Please note the following:

- Dollar values, categorized by service type, in the TPCC patient-level report reflect attributable patient costs. A patient's costs are attributable to a clinician/group during months where the risk window and performance period overlap. A risk window is a year-long period that begins on the date of the candidate event. A candidate event is defined as a pair of services billed by the clinician to the patient within a short period of time. A candidate event marks the start of a primary care relationship between a patient and a clinician. The performance period is a static calendar year that is divided into 13 4-week blocks called beneficiary months. Beneficiary months that occur during a risk window and the performance period are counted towards a clinician's (or clinician group's) measure scores/included in this report. For TIN-level attribution, these beneficiary months are attributed to the TIN billing the initial E&M "primary care" service. For TIN-NPI-level attribution, only the TIN-NPI responsible for the plurality (largest share) of candidate events provided to the patient within the TIN is attributed the beneficiary months.
- Green column headers are consistent across patient-level reports generated for all MIPS cost measures.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
entityType	Entity Type	Description	N/A	Group, individual, etc. Depends on participation and reporting level.
entityId	Entity ID	Alpha-numeric	N/A	Applicable only to virtual groups/APM Entities
tin	TIN of the clinician or groupto which the patient's costs were attributed	Numeric	See 2021 MIPS TPCC Measure Information Form linked to above	N/A
npi	NPI of the individual clinician to which the patient's costs were attributed, for clinicians participating in MIPS as an individual in 2021	Numeric	See 2021 MIPS TPCC Measure Information Form linked to above	Presence of this field will depend upon the chosen 2021 MIPS participation level
measureId	Measure ID	Alpha-numeric	N/A	MIPS Measure ID
mbi	Medicare Beneficiary Identifier	Numeric	N/A	N/A
gender	Patient's gender	M=Male F=Female	N/A	N/A
dob	Patient's date of birth	Numeric Date	N/A	N/A
expired	Expired	Numeric Date		If the attributed patient died during the 2021 PY, the patient'sdate of death will be reflected here.
hccPercentileRanking (for TPCC and MSPB	HCC Percentile Ranking	Numeric	See Q&A above	This figure is an average of the patient's 2021 risk scores translated into a percentile. CMS HCC V22 was

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
Clinician Reports ONLY)				used to compute 2021 scores, which are based on 2020 claims.
Diabetes	Diabetes	Boolean (True orFalse Indicator)	N/A	If true, a diagnosis of diabetes (based on ICD-10 diagnoses codes) waslocated on Medicare administrative claims submitted on behalf of the patient between 1/1/2020-12/31/2020. **Please note:** data from the prior CY, not the 2021 performance period,are used to compute this particular T/F value.
Chronic Obstructive Pulmonary Disease	Chronic Obstructive Pulmonary Disease	Boolean (True orFalse 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 patient between 1/1/2020-12/31/2020. **Please note:** data from the prior CY, not the 2021 performance period, are used to compute this T/Fvalue.
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 patient between 1/1/2020-12/31/2020. **Please note:** data from the prior CY, not the 2021 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 1/1/2020-12/31/2020.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				Please note: data from the prior CY, not the 2021 performance period, are used to compute this T/F value.
ScaledCostTotals	Payment-Standardized Medicare FFS Costs	Dollar Amount	N/A	This number represents the total payment-standardized Medicare Parts A and B costs across all the patient's beneficiary months attributed to the TIN or TIN-NPI during the performance period. These costs are neither risk-adjusted nor specialty adjusted. The costs are annualized and outliers are excluded.
emServiceAmount	Evaluation & Management Services Billed by Eligible Professionals	Dollar Amount	hcpcsBetosCode4 in ('M1A', 'M1B', 'M2A', 'M2B', 'M2C', 'M4A', 'M4B', 'M5A', 'M5B', 'M5C', 'M5D') or substring(hcpcsBetosC ode, 1, 2) in ('M3', 'M6')) and placeOfServiceCode5 not in ('23', '21', '51') and NOT AmbulatoryCenterCondi tion 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: 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 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.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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[2]: 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

[2] https://resdac.org/sites/datadocumentation.resdac.org/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[3] 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)

[3] 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
				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) B5 = Ocularist C1 = Centralized Flu C2 = Indirect payment procedure
majorProcedureAmount	Major Procedures Billed byEligible Professionals	Dollar Amount	First two characters of hcpcsBetosCode in ('P1', 'P2', 'P3', 'P7') andNOT AmbulatoryCenterCondi tion and placeOfService NOT in ('23', '21', '51') and NOT TherapyCondition andNOT	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: 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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			SpecialtyCondition[4]	P2B = Major procedure, cardiovascular-Aneurysm repair P2C = Major Procedure, cardiovascular-Thromboendarterectomy P2D = Major procedure, cardiovascular-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 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:

[4] https://requests.resdac.org/sites/resdac.umn.edu/files/CMS_PRVDR_SPCLTY_TB_rev01242018_0.tx

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. (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)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 C1 = Centralized Flu C2 = Indirect payment procedure

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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				This figure doesn't include services provided in the following places of service: Emergency room of a hospital, inpatient hospital, Inpatient Psychiatric Facility, ambulatory surgical centers. This figure doesn't 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)

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. (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)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				A4 = HHA (DMERCs only) A5 = Pharmacy (DMERC) A6 = Medical supply company with respiratory therapist (DMERCs only) A7 = Department store (DMERC) A8 = Grocery store (DMERC)
therapyAmount[5]	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(hcpcsBetos Code, 1, 2) not in ('P9', 'P0') OR (Outpatient Claims Type Code (40)	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[6] for the following services: • 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

[5] Although the downloadable report indicates this value includes only outpatient therapy, the figure includes costs for therapy services submitted as BOTH professional claims and outpatient claims, as described in the "additional explanation" column.

[6] 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
			and TherapyCondition and hcpcsBetosCode not in('O1A', 'O1D', 'O1E', 'D1G') and substr(hcpcsBetos Code, 1, 2) not in ('P9', 'P0') and TypeOfBill not in ('22', '23', '33', '34', '72') and revenueCenterCod e NOT in ('0981', '0450', '0451', '0452', '0453', '0454', '0455', '0456', '0457', '0458', '0459')10	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)
ancillaryServicesAmo unt	Ancillary Services	Dollar Amount	OutpatientClaims (claimTypeCode = 40) and first 2 characters of hcpcsBetosCode in ('T1', 'T2','I1', 'I2', 'I3', 'I4') 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, AND costs for outpatient claim

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			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 hcpcsBetosCode in ('T1', 'T2','I1', 'I2', 'I3', 'I4') and placeOfService not in (21,23,51) and NOT TherapyCondition DmeClaims(81,82) and	type claims[7] AND costs for DMEPOS claims submitted to DMEPOS carrier for the following services: 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 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

[7] 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 NOT IN (O1D,O1E,O1G)	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
inpatientFacilityServicesAmount	Inpatient Hospital FacilityServices	Dollar Value	BillionProviderOscar (orCCN) ends in {0001-0899},{1300-1399},{4000-4499} or its third character is M or S	This figure includes costs for inpatient claim type[8] services in short-term (general and specialty) hospitals 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).
eligibleProfessionalServicesAmount	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 claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, provided to the patient in an inpatient hospital or an inpatient psychiatric facility. This value **does not** include: O1A = Ambulance O1D = Chemotherapy O1E = Other drugs D1G = Drugs Administered through DME

[8] 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
				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) 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)

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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				Thromboendarterectomy P2D = Major procedure, cardiovascular-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 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

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

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 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

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) This figure also includes costs for outpatient claim type

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				claims[9] for the services listed above provided to the patient during the 2021 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 0452-Emergency room - ER beyond EMTALA screening 0456-Emergency room-urgent care 0459-Emergency room-other 0981-Professional fees-emergency room

[9] 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
postAcuteServicesAmount	Post-Acute Services	Dollar Amount	Claim Type Code[10] 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: • 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.
hospiceAmount	Hospice	Dollar Amount	All hospice claims (claim type code 50)	This figure reflects attributable costs for hospice claims.
allOtherServicesAmount	All Other Services	Dollar Amount	TotalCost – sum (all categories above)	This figure reflects the attributable costs of other services provided to patient that are not captured in the categories above.

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

MSPB Clinician Patient-Level Report

Which individual MIPS eligible clinicians and/or groups received a 2021 MSPB Clinician Patient-Level Report?

Only clinicians and groups who met the minimum case volume of 35 received a 2021 MSPB Clinician patient-level report.

How is the MSPB Clinician measure attributed at the TIN/TIN-NPI levels?

Episodes ending during the performance period are included in the calculation of the MSPB Clinician measure. Episodes are attributed as follows:

- Episodes with Medical Medicare-Severity Diagnosis-Related Groups (MS-DRGs)
    - Attributed to any clinician group rendering at least 30% of E&M services on Medicare Part B Physician/Supplier claims during the inpatient stay, and to any clinician who bills at least one E&M service that was used to determine the episode's attribution to the clinician group.

- Episodes with Surgical MS-DRGs
    - Attributed to the clinician and clinician group rendering any main procedure determined to be clinically relevant to the index admission.

The table below includes detailed descriptions of the figures presented in the 2021 MSPB Clinician Patient-level Data Report for either a TIN or TIN-NPI

Please note:

- The episode trigger is an admission to an inpatient hospital. The MSPB Clinician cost measure can be triggered at acute care facility hospitals.
- Costs are measured from 3 days prior to the index admission through 30 days post discharge.
- The columns that are consistent across all patient-level cost measure reports are not duplicated in the table below (entity type, entityId, npi, tin, measureId, mbi, gender, dob, and expired)

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
inpatentAdmitDate	Inpatient Admission Date	Numeric Date	N/A	This is the date of the inpatient hospital admission that triggered the episode.
beneHCCrank	HCC Percentile Ranking	Numeric	See Q&A above	This figure is an average of the beneficiary's 2021 risk scores translated into a percentile. CMS HCC V22 was used to compute 2021 scores, which are based on 2020 claims.
totalCost	Episode Cost	Dollar Amnt		This figure represents the un-adjusted, price-standardized, observedcost of the episode. This figure is neither normalized nor Winsorized.
inpatientIndexAdmission	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[11] services provided in short-term (general and specialty) hospitals,[12] submitted on behalf of a patient in the time period beginning three days prior to the hospital admission and 30 days after hospital discharge. This figure does not include inpatient claims rendered during a repeat admission. A repeat admission is defined as any admission other thanthe index admission that occurs within 30 days of the index admission.

[11] See: https://www.resdac.org/cms-data/variables/nch-claim-type-code. Inpatient claims are identified by code 60.
[12] See: https://resdac.org/sites/datadocumentation.resdac.org/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
				Inpatient claims are fee-for-service (FFS) claims submitted by inpatient hospital providers for reimbursement of facility costs. Theseclaim records represent covered stays (Medicare paid FFS bills).
inpatientHospitalReadmission	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 patient 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 admissionthat occurs within 30 days of the index admission.
inpatientRehabLTCH	Inpatient Rehabilitation or Long-Term Care Hospital (LTCH) Services	Dollar Amnt	claimtype = 'INPATIENT[13]' 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 patient during the time period beginning 3 days prior to the index admission plus 30 days after discharge by the following providertypes/in the following places: Psychiatric Unit in Critical Access Hospital, Psychiatric unit (excludedfrom PPS), Rehabilitation Unit in Critical Access Hospital, Rehabilitation unit (excluded from PPS), Long-term hospitals, rehabilitation hospitals, and/or psychiatric hospitals.

[13] Claims submitted by inpatient hospital providers for reimbursement of facility costs.

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
physicianServicesPb	Other Physician or Supplier Part B Services Billed During Any Hospitalization	Dollar Amnt	claimtype = 'PROFESSIONAL' and placeOfService[14] in (21,51) and substring(hcpcsBetos Group,1,2) not in ('P0','P9') and hcpcsBetosCode[15] not in ('O1A','O1D','O1E','D1 G')[16]	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 patient 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. This figure does NOT include the following services: anesthesia, dialysis, ambulance, chemotherapy, other DME, nor drugs administered through DME.
homeHealth	Home Health Services	Dollar Amnt	claimtype = 'HOME_HEALTH_SE RVICES'	This figure includes costs for Home Health Agency (HHA) claim type claims for services provided to the patient in the time period beginning three days prior to the hospital admission and 30 days after hospital discharge.

[14] https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
[15] https://www.resdac.org/cms-data/variables/line-berenson-eggers-type-service-betos-code
[16] https://resdac.org/sites/datadocumentation.resdac.org/files/BETOS%20Table.txt

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
snf	Skilled Nursing Facility Services	Dollar Amnt	claimtype = 'SKILLED_NURSING _FACILITY'	This figure includes costs for swing-bed AND non-swing bed SkilledNursing Facility claim type claims for services provided to the patient in the time period beginning three days prior to the hospital admission and 30 days after hospital discharge.
therapy	Physical, Occupational, or Speech and Language Pathology Therapy, carrier costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and (hcpcsModiferCode1 in ('GN[17]','GO','GP') or hcpcsModiferCode2in ('GN','GO','GP') or hcpcsModiferCode3 in ('GN','GO','GP') or hcpcsModiferCode4 in ('GN','GO','GP') OR hcpcsModiferCode5 in ('GN','GO','GP'))	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 patient during the time period beginning 3days 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 occupational therapy plan of care, Services delivered under an outpatient physical therapy plan of care.

[17] 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
erEandMpb	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
erPRocsPb	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 patient 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, cardiovascular-Coronary angioplasty (PTCA) P2E = Major procedure, cardiovascular-Pacemaker insertion P2F = Major procedure, cardiovascular-Other

Abbreviated 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 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 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

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
erLabsPb	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 patient 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 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 =

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				Other tests – EKG monitoring T2D = Other tests – other
erImagingPb	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 patient 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 I3C = Echography/ultrasonography – heart

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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
dialysisPb	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 patient 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)
emNonErPb	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 patient 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:

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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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, cardiovascular-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
minorProcsAmbulatory Pb	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 patient during the time period beginning 3 days prior to the index

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 P8H = Endoscopy – laryngoscopy P8I = Endoscopy – other
ancillarylabsPb	Ancillary Laboratory, Pathology, and Other Tests,	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1,	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,

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
	carrier costs		1)='T'	clinical social workers, and nurse practitioners, for the following services provided to the patient 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
AncillaryimagingPb	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 patient 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 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 patient 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
				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 patient in the time period beginning three days prior to the hospital admission and 30 days after hospital discharge
Ambulancepb	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 patient during the time period beginning 3 days prior to the index admission plus 30 days after discharge: O1A = Ambulance
ChemoDrugsPbDme	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 patient during the time period beginning 3 days prior to the index admission plus 30

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				days after discharge: O1D = Chemotherapy O1E = Other drugs D1G = Drugs Administered through DME
Outpatient	Total Outpatient Cost	Dollar Amnt	claimType = 'OUTPATIENT'	This figure includes costs for outpatient claim type claims for services provided to the patient 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.
other	All Services Not Otherwise Classified	Dollar Amnt	else (anything else)	All Services Not Otherwise Classified

Episode-Based Cost Measures

The table below includes detailed descriptions of the figures presented in the 2021 EBCM Patient-level Reports for either a TIN or TIN-NPI

Note: Each service assigned to a patient episode is listed as a separate row in the report. For each assigned service, there's an associated episode trigger date, episode service category, episode service category description, service code(s), service code description, and standardized cost. Taken together, this information describes the service assignment rule(s) used to assign the cost of the service to the episode.

Column Header in Output File	Full Column Figure Description	Format	Additional Information/Explanation
entityType	Entity Type	Description	Group, individual, etc. Depends on participation and reporting level.
entityId	Entity ID	Alpha-numeric	Only applicable to virtual groups/APM Entities.
tin	TIN of the clinician or group to which the patient's costs were attributed	Numeric	Refer to the 2021 MIPS Cost Measure Information Forms and the 2021 MIPS Cost Measure Codes Lists for more information.
npi	NPI of the individual clinician to which the patient's costs were attributed, for clinicians participating in MIPS as an individual in 2021	Numeric	Presence of this field will depend upon the chosen 2021 MIPS participation level. Refer to the 2021 MIPS Cost Measure Information Forms and the 2021 MIPS Cost Measure Codes Lists for more information.
measureId	Measure ID	Alpha-numeric	MIPS Measure ID
mbi	Medicare Beneficiary Identifier	Numeric	N/A

Column Header in Output File	Full Column Figure Description	Format	Additional Information/Explanation
gender	Patient's gender	M=Male F=Female	N/A
dob	Patient's date of birth	Numeric Date	N/A
Hcc (not included in the TPCC or MSPB Clinician Reports)	HCC	Numeric	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.
Expired (or "beneDeathdate")	Expired	Numeric Date	If the attributed patient died during the 2021 PY, the patient's date of death will be reflected here.
episodeTriggerDate	Episode Trigger Date	Numeric Date	Certain codes open, or trigger, an episode. Please see the "Triggers" and "Triggers_Details" tabs of the measure's codes list file
serviceCategory	Episode Service Category	Description	
serviceCategoryDescription	Episode Service Category Description	Description	
serviceCode	Service Code(s)	Alpha-numeric codes	
serviceCodeDesciption	Service Code(s) Description	Description	
StandardizedCost	Standardized Cost	Dollar Amount	This figure represents the un-adjusted, price-standardized, observed cost of the service assigned to the episode. This figure is neither normalized nor Winsorized.

How are patient episodes assigned to clinicians/groups?

Acute inpatient medical condition episodes are attributed to clinician groups (identified by TIN) that bill at least 30% of the inpatient E&M claim lines during the trigger inpatient stay, and to clinicians (identified by TIN-NPI) who bill at least one E&M claim line under a TIN that met the 30% threshold. All TIN-NPIs who bill at least one inpatient E&M service within a TIN that met the 30% threshold will be attributed the episode. As a result, an acute inpatient medical condition episode can be attributed to more than one individual clinician.

Procedural episodes are attributed to any TIN-NPI who bills a trigger code, defined by CPT/HCPCS codes, on the date of the procedure or during a concurrent related inpatient stay. As a result, procedural episodes can be attributed to more than one clinician. Refer to the 2021 MIPS Cost Measure Information Forms and the 2021 MIPS Cost Measure Codes Lists for more information.

For patient-level reports generated for procedural EBCMs, how do I interpret the information contained in the "serviceCategory" and "ServiceCategoryDescription" columns?

The information in these columns describes the service category and related assignment rule used to assign the service and it's cost to the patient's episode.

How do I interpret the numeric codes contained in the "Service Code" column of the patient level reports for MIPS 2021 EBCMs?

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 2021 MIPS Cost Measure Codes Lists.

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 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 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."

Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS Patient-Level Report

The table below includes descriptions of the figures presented in the patient-level report for quality measure ID #479.

Please note:

- The columns that are consistent across all patient-level cost measure reports are not duplicated in the table below (entity type, entityId, npi, tin, measureId, mbi, gender, dob, and expired)
- There are no dollar values contained in this report.
- Refer to the MIPS 2021 Hospital-Wide All-Cause Unplanned Readmission Measure zip file containing three documents: MIPS Hospital Wide Readmission MIF, code tables, and methodology report.
- Eligible index admissions include acute care hospitalizations for Medicare Fee-for-Service (FFS) beneficiaries age 65 or older at non-federal, short-stay, acute-care or critical access hospitals that were discharged during the performance period. Beneficiaries must have been enrolled in Medicare FFS Part A for the 12 months prior to the date of admission and 30 days after discharge, discharged alive, and not transferred to another acute care facility. Admissions for all principal diagnoses are included unless identified as having a reason for exclusion

Column Header in Outpost File	Full Column Description	Format	Additional Information/Explanation
hccPercentileRanking	HCC Percentile Ranking	Numeric	This figure is an average of the patient's 2021 risk scores translated into a percentile. CMS HCC V22 was used to compute 2021 scores, which are based on 2020 claims.
Diabetes	Diabetes	Boolean (True or False Indicator)	If true, a diagnosis of diabetes (based on ICD-10 diagnoses codes) was located on Medicare administrative claims submitted on behalf of the patient between 1/1/2020-12/31/2020.

Column Header in Outpost File	Full Column Description	Format	Additional Information/Explanation
			Please note: data from the prior CY, not the 2021 performance period, are used to compute this particular T/F value.
chronicObstructivePulmonaryDisease	COPD	Boolean (True or False Indicator)	If true, a diagnosis of COPD (based on ICD-10 diagnoses codes) was located on Medicare administrative claims submitted on behalf of the patient between 1/1/2020-12/31/2020. **Please note:** data from the prior CY, not the 2021 performance period, are used to compute this particular T/F value.
coronaryArteryDisease	Coronary Artery Disease	Boolean (True or False Indicator)	If true, a diagnosis of coronary artery disease (based on ICD-10 diagnoses codes) was located on Medicare administrative claims submitted on behalf of the patient between 1/1/2020-12/31/2020. **Please note:** data from the prior CY, not the 2021 performance period,are used to compute this particular T/F value.
heartFailure	Heart Failure	Boolean (True or False Indicator)	If true, a diagnosis of heart failure (based on ICD-10 diagnoses codes) waslocated on Medicare administrative claims submitted on behalf of the patient between 1/1/2020-12/31/2020. **Please note:** data from the prior CY, not the

Column Header in Outpost File	Full Column Description	Format	Additional Information/Explanation
			2021 performance period,are used to compute this particular T/F value.
medicalCohort	Medical Cohort	Description	All admissions are classified into one of five different specialty cohorts: medicine, neurological, cardiovascular, cardiorespiratory, and surgical. Principal discharge diagnosis categories (as defined by AHRQ CCSs) are used to define the specialty cohorts
primaryIndexDiagnosis	Primary Index Diagnosis	Alpha-numeric code	ICD-10 Diagnosis code
indexAdmissionDate	Index Admission Date	Numeric Date	N/A
indexDischargeDate	Index Discharge Date	Numeric Date	N/A
primaryReadmissionDiagnosis	Primary Readmission Diagnosis	Alpha-numeric code	ICD-10 Diagnosis code
readmissionStayAdmissionDate	Readmission Stay Admission Date	Numeric Date	N/A
readmissionStayDischargeDate	Readmission Stay Discharge Date	Numeric Date	N/A

2021 Hip Arthroplasty and Knee Arthroplasty Complication Measure

The table below includes descriptions of the figures presented in the patient-level report for quality measure ID #480. Please note:

- The columns that are consistent across all patient-level cost measure reports are not duplicated in the table below (entity type, entityId, npi, tin, measureId, mbi, gender, dob, and expired)
- Refer to the 2021 Hip Arthroplasty and Knee Arthroplasty Complication Measure zip file, containing 3 documents: codes tables, MIF, and methodology report
- There are no dollar values in this report.

Column Header in Outpost File	Full Column Description	Format	Additional Information/Explanation
hccPercentileRanking	HCC Percentile Ranking	Numeric	This figure is an average of the patient's 2021 risk scores translated into a percentile. CMS HCC V22 was used to compute 2021 scores, which are based on 2020 claims.
indexAdmissionsDate	Index Admission Date	Numeric Date	Date of index admission. Eligible index admissions include Medicare Fee-For-Service (FFS) beneficiaries who are: • at least 65 years of age who have undergone a qualifying elective primary THA and/or TKA procedure at a non-federal, short-stay, acute-care or critical access hospital during the performance period. • Eligible index admissions must have been enrolled in Medicare FFS Part A and B for the 12 months prior to the date of admission and Part A during the index admission and 90 days after it.

Column Header in Outpost File	Full Column Description	Format	Additional Information/Explanation
			Eligible index admissions are identified using ICD-10 PCS procedure codes in Medicare inpatient claims data. Qualifying elective primary THA/TKA procedures are defined as those procedures without any of the following: • Femur, hip, or pelvic fractures; • Partial hip arthroplasty procedures (with a concurrent THA/TKA); • Revision procedures with a concurrent THA/TKA; • Resurfacing procedures with a concurrent THA/TKA; • Mechanical complication; • Malignant neoplasm of the pelvis, sacrum, coccyx, lower limbs, or bone/bone marrow or a disseminated malignant neoplasm; • Removal of implanted devises/prostheses.
procedureType	Procedure Type	Alpha-numeric code(s)	ICD-10 Procedure Code(s)
complicationAttributed	Complication Attributed	Comma separated descriptions	The measure defines a “complication” as: • Acute myocardial infarction (AMI), pneumonia, or sepsis/septicemia/shock during the index admission or a subsequent

Column Header in Outpost File	Full Column Description	Format	Additional Information/Explanation
			inpatient admission that occurs within seven days from the start of the index admission; • Surgical site bleeding or pulmonary embolism during the index admission or a subsequent inpatient admission within 30 days from the start of the index admission; • Death during the index admission or within 30 days from the start of the index admission; • Mechanical complication or periprosthetic joint infection/wound infection during the index admission or a subsequent inpatient admission that occurs within 90 days from the start of the index admission **Please note:** "comp" will always be present in this field, it signifies the existence of a complication The following are possible inputs and their meanings: • radmComp=complication required a readmission • iCm= complication occurred during the index admission • compPe= pulmonary embolism • compDeath=Death • compAmi= Acute Myocardial Infarction • CompSb= surgical bleeding

Column Header in Outpost File	Full Column Description	Format	Additional Information/Explanation
			• compSep=sepsis • compPn=Pneumonia • compInf=infection

All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions for ACOs (MCC)

This report provides ACOs with admission-level data for aligned/assigned patients who were included in the numerator of the calculation of the All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions for ACOs (MCC) quality measure for performance year 2021.

Please note:

- This list is at the admission-level where a patient may have more than one admission.
- This list includes the unplanned admissions for aligned/assigned patients with MCCs who met measurement inclusion criteria and had an unplanned admission in the measurement period.
- For more information on measurement specifications, please refer to the All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions for ACOs (MCC) Measure Information Form.

Data Element Label	Data Element Name	Data Element Description
entityId	ACO or APM Entity Identifier	Identifies the ACO or APM Entity to which the beneficiary with the unplanned admission is aligned/assigned
measureId	Measure identification number	Quality Payment Program Measure number identifier. This will be the same for all observations in this data file (MCC1)
mbi	Medicare Beneficiary Identifier (MBI)	11-digit alpha/numeric MBI
gender	Patient gender	Patient's gender; 0=female, 1=male

Data Element Label	Data Element Name	Data Element Description
dob	Patient date of birth (DOB)	Patient's DOB
expired	Patient date of death	Patient's date of death
ami	Acute myocardial infarction (AMI)	Indicator (value of 1 or 0) for whether a patient meets requirements for inclusion in the AMI chronic condition category
alz	Alzheimer's disease and related disorders or senile dementia	Indicator (value of 1 or 0) for whether a patient meets requirements for inclusion in the Alzheimer's disease and related disorders or senile dementia chronic condition category
atf	Atrial fibrillation	Indicator (value of 1 or 0) for whether a patient meets requirements for inclusion in the atrial fibrillation chronic condition category
ckd	Chronic kidney disease (CKD)	Indicator (value of 1 or 0) for whether a patient meets requirements for inclusion in the CKD chronic condition category
copd	Chronic obstructive pulmonary disease (COPD) and asthma	Indicator (value of 1 or 0) for whether a patient meets requirements for inclusion in the COPD and asthma chronic condition category
dep	Depression	Indicator (value of 1 or 0) for whether a patient meets requirements for inclusion in the depression condition category
hf	Heart failure	Indicator (value of 1 or 0) for whether a patient meets requirements for inclusion in the heart failure chronic condition category
tia	Stroke and transient ischemic attack (TIA)	Indicator (value of 1 or 0) for whether a patient meets requirements for inclusion in the stroke and TIA chronic condition category
diab	Diabetes	Indicator (value of 1 or 0) for whether a patient meets requirements for inclusion in the diabetes chronic condition category
admissionDate	Admission date	Date of unplanned admission

Data Element Label	Data Element Name	Data Element Description
dischargeDate	Discharge date	Date of unplanned discharge
primaryDiagnosis	Primary admission diagnosis	Primary diagnosis for unplanned admission

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	Change Description
8/18/2022	Original version

Appendix A

Listserv Distribution Date: April 25, 2022

Subject: CMS Reweighting 2021 MIPS Cost Performance Category
The Centers for Medicare & Medicaid Services (CMS) recognizes the impact that the COVID-19 pandemic public health emergency (PHE) continued to have on clinicians and the services they provided in the 2021 performance period.

Due to COVID-19's impact on cost measures, we're reweighting the cost performance category from 20% to 0% for the 2021 performance period. The 20% cost performance category weight will be redistributed to other performance categories in accordance with § 414.1380(c)(2)(ii)(E). Please see the table below for reweighting scenarios.

Why CMS is Reweighting the MIPS Cost Performance Category for 2021

Cost was already reweighted to 0% for all individual MIPS eligible clinicians, even if data were submitted for other performance categories, due to the automatic extreme and uncontrollable circumstances (EUC) policies under § 414.1380(c)(2)(i)(A)(6) and § 414.1380(c)(2)(i)(C). Our analysis of the underlying data for the 2021 performance period shows similar results at the group- and individual-level across measures. As a result, we believe that reweighting shouldn't depend on whether you choose to report as a group or individual.

Given these circumstances and in accordance with § 414.1380(c)(2), we'll assign a weight of 0% to the cost performance category for the 2021 performance period and redistribute the prescribed weight of 20% to another performance category or categories.

Specifically, we don't believe we can reliably calculate scores for some of the cost measures that would adequately capture and reflect the performance of MIPS eligible clinicians based on the following reasons, as shown by our analysis of the cost performance category data for the 2021 performance period:

- Most measures have higher observed and risk-adjusted costs at the episode-level. This indicates that risk adjustment at the episode-level doesn't entirely account for differences in resource use, particularly for broader measures or measures that are clinically proximate to respiratory disease and COVID-19.
- There's less of an effect at the provider-level for most measures where testing shows that scores don't appear to be adversely impacted by higher case-loads of episodes with a recent or concurrent COVID-19 diagnosis. However, there are a small number of measures where scores may be adversely affected by the volume of episodes with a COVID-19 diagnosis.

Please note that starting with the 2022 performance period, instead of reweighting the entire cost performance category, individual cost measures can be suppressed if the data used to calculate the score was impacted by significant changes

during the performance period, such that calculating the cost measure would lead to misleading or inaccurate results. This provision allowing greater flexibility was finalized in the CY 2022 Physician Fee Schedule Final Rule.

Clinicians don't need to take any action as a result of this decision because the cost performance category relies on administrative claims data.

MIPS Performance Category Weight Redistribution Policies Finalized for the 2021 Performance Period
The table below illustrates the MIPS performance category weights and reweighting policies that apply to MIPS eligible clinicians, groups and virtual groups in the 2021 performance period.

MIPS Performance Category Reweighting Scenario	Quality Performance Category Weight	Cost Performance Category Weight	Improvement Activities Performance Category Weight	Promoting Interoperability Performance Category Weight
Reweight the Cost Performance Category				
No Additional Reweighting Applies	55%	0%	15%	30%
Reweight 2 Performance Categories				
No Promoting Interoperability, No Cost	85%	0%	15%	0%
No Quality, No Cost	0%	0%	15%	85%
No Improvement Activities, No Cost	70%	0%	0%	30%

*This table can be found at § 414.1380(c)(2)(ii)(E).

This reweighting of the cost performance category applies in addition to the extreme and uncontrollable circumstances (EUC) policies under § 414.1380(c)(2)(i)(A)(6) and § 414.1380(c)(2)(i)(C).

- Cost was already reweighted to 0% for all individual MIPS eligible clinicians, even if data were submitted for other performance categories, due to the automatic EUC policy.

- Cost will now be reweighted to 0% for all groups and virtual groups, even if they didn't request reweighting through an EUC exception application.

As a reminder, under § 414.1380(c), if a MIPS eligible clinician is scored on fewer than 2 performance categories (meaning 1 performance category is weighted at 100% or all performance categories are weighted at 0%), they'll receive a final score equal to the performance threshold and a neutral MIPS payment adjustment for the 2023 MIPS payment year.

Cost Data in Performance Feedback for 2021

We recognize that this is the second year that we've had to reweight the cost performance category due to COVID-19, and that clinicians need more insight into and familiarity with their performance in this category. To support this need, we'll provide patient-level reports on the 2021 cost measures for which clinicians, groups and virtual groups met the case minimum. Patient-level reports will be available as part of the final performance feedback in August 2022.

Please note that we won't include measure-level scoring information in performance feedback. As previously mentioned, we don't believe we can reliably calculate" scores for the cost measures that would adequately capture and reflect the performance of MIPS eligible clinicians.