Quality Payment
PROGRAM

2022 MIPS Performance Feedback Patient-Level Data Reports Supplement

Background and Purpose

Patient-level reports on administrative claims-based cost and quality measures are provided to clinicians, groups, Alternative Payment Model (APM) entities, and virtual groups who met the case minimum for the measures. Please note: APM Entities aren't scored in the cost performance category. This document provides additional information about these patient-level reports that are downloadable as part of 2022 performance feedback and is organized as follows:

Cost Performance Category

Quality Performance Category

General Questions

What are the case minimums and measure IDs for the 2022 MIPS cost and administrative claims-based quality measures for which patient-level reports are generated?

The case minimums are:

- 10 episodes for all procedural episode-based cost measures (EBCMs), except the Colon and Rectal Resection measure (which has a case minimum of 20 episodes)
- 20 episodes for the acute inpatient medical condition EBCMs
- 20 episodes for chronic condition EBCMs
- 35 episodes for the MSPB Clinician measure
- 20 patients for the TPCC measure, as summarized in the table below:

Measure Name	Case Minimum	Measure Type	Measure ID
Total per Capita Cost (TPCC)	20	Population-based cost measure	TPCC_1
Medicare Spending per Beneficiary Clinician (MSPB-C)	35	Population-based cost measure	MSPB_1
Elective Outpatient Percutaneous Coronary Intervention (PCI)	10	Procedural EBCM	COST_EOPCI_1
Knee Arthroplasty	10	Procedural EBCM	COST_KA_1
Revascularization for Lower Extremity Chronic Critical LimbIschemia	10	Procedural EBCM	COST_CCLI_1
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	10	Procedural EBCM	COST_IOL_1
Screening/Surveillance Colonoscopy	10	Procedural EBCM	COST_SSC_1

Measure Name	Case Minimum	Measure Type	Measure ID
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	20	Acute inpatient medical condition EBCM	COST_IHCI_1
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	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
Lower Gastrointestinal Hemorrhage (applies 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 (ZIP, 778 KB)	High Priority Quality Measure: Outcome	Quality ID: 479

Measure Name	Case Minimum	Measure Type	Measure ID
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 (ZIP, 581 KB)	High Priority Quality Measure: Outcome	Quality ID: 480
Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	See measure methodology documents (ZIP, 36 MB)	High Priority Quality Measure: Outcome	Quality ID: 484
Asthma/COPD	20	Chronic Condition EBCM	COST_ACOPD_1
Colon and Rectal Resection	20	Procedural EBCM	COST_CRR_1
Diabetes	20	Chronic Condition EBCM	COST_D_1
Melanoma Resection	10	Procedural EBCM	COST_MR_1
Sepsis	20	Acute inpatient medical condition EBCM	COST_S_1

Note: CMS determined it will exclude only the Simple Pneumonia with Hospitalization measure for all MIPS eligible clinicians pursuant to § 414.1380(b)(2)(v)(A). Therefore, this measure wasn't included in CMS's calculation of MIPS eligible clinicians' scores under the cost performance category for the 2022 performance period. Patient-level reports weren't generated for this measure. For more information, refer to the 2022 MIPS Cost Measure Exclusion Fact Sheet (PDF, 226 KB)

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% 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 Tax Identification Number (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 isn't used in the measure calculation and is provided for informational purposes. It shouldn't 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 don't 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 health care 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 health care services between 2014 and 2018. For more information refer to the 2021 RBCS and BETOS Crosswalk (XLSX) 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 on this webpage.

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 2022 MIPS TPCC patient-level data report?

Only clinicians and groups who met the case minimum of 20 received a 2022 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 (ZIP, 10.4 MB), and measure codes list Excel file (ZIP, 10.6 MB).

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 should 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 2021 calendar year: diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and heart failure.

Please note: Diagnoses from the 2021 calendar year, not the 2022 MIPS performance period of 1/1/2022-12/31/2022, 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 2022 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 2022 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's 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, virtual group, or individual. Depends on participation and reporting level.
entityId	Entity ID	Alpha numeric	N/A	Applicable only to virtual groups
tin	TIN of the clinician or group to which the patient's costs were attributed	Numeric	See 2022 MIPS TPCC Measure Information Form linked above	N/A

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
npi	NPI of the individual clinician to which the patient's costs were attributed, for clinicians participating in MIPS as individuals in 2021	Numeric	See 2022 MIPS TPCC Measure Information Form linked above	Presence of this field will depend upon the 2022 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 2022 PY, the patient's date of death will be reflected here.
hccPercentileRanking (for TPCC and MSPB Clinician Reports ONLY)	HCC Percentile Ranking	Numeric	See Q&A above	This figure is an average of the patient's 2022 risk scores translated into a percentile. CMS HCC V22 was used to compute the 2022 scores, which are based on 2021 claims.
Diabetes	Diabetes	Boolean (True or False Indicator)	N/A	If true, a diagnosis of diabetes (based on ICD-10 diagnoses codes) was located on Medicare administrative claims

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				submitted on behalf of the patient between 1/1/2021-12/31/2021. **Please note:** data from the prior calendar year, not the 2022 performance period,are used to compute this particular T/F value.
Chronic Obstructive Pulmonary Disease	Chronic Obstructive Pulmonary Disease	Boolean (True or False Indicator)	N/A	If true, a diagnosis of COPD (based on ICD-10 diagnoses codes) was located on Medicare administrative claims submitted on behalf of the patient between 1/1/2021-12/31/2021. **Please note:** data from the prior calendar year, not the 2022 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 1/1/2021-12/31/2021.

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				Please note: data from the prior calendar year, not the 2022 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 1/1/2021-12/31/2021. **Please note:** data from the prior calendar year, not the 2022 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	Dollar Amount	hcpcsBetosCode4 in ('M1A', 'M1B', 'M2A', 'M2B', 'M2C', 'M4A',	This figure includes costs for local carrier non-Durable

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	Billed by Eligible Professionals		'M4B', 'M5A', 'M5B', 'M5C', 'M5D') or substring(hcpcsBetosC ode, 1, 2) in ('M3', 'M6')) and placeOfServiceCode 5 not in ('23', '21', '51') and NOT AmbulatoryCenterCondi tion and NOT SpecialtyCondition and NOT TherapyCondition	Medical Equipment, Prosthetics/Orthotics & 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 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.

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				This figure doesn't include services provided in: the emergency room of a hospital, an inpatient hospital, nor an Inpatient Psychiatric Facility. This figure doesn't 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 **doesn't** include services provided by providers with the following CMS specialty codes[1]: 31 = Intensive Cardiac Rehabilitation 45 = Mammography screening center 47 = Independent Diagnostic Testing Facility (IDTF)

[1] 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
				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

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				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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				A0 = Hospital (Durable Medical Equipment Regional Carriers (DMERCs) only) A1 = Skilled Nursing Facility (DMERCs only) A2 = Intermediate care nursing facility (DMERCs only) A3 = Nursing facility, other DMERCs only) A4 = Home Health Agency (DMERCs only) A5 = Pharmacy (DMERC) A6 = Medical supply company with respiratory therapist (DMERCs only) A7 = Department store (DMERC) A8 = Grocery store (DMERC) B1 = Supplier of oxygen and/or oxygen related equipment B2 = Pedorthic Personnel (eff. 10/2/07) B3 = Medical Supply Company with Pedorthic Personnel B4 = Doesn't meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations,

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				histocompatibility labs) (eff. 10/2/07) B5 = Ocularist C1 = Centralized Flu C2 = Indirect payment procedure
majorProcedureAmount	Major Procedures Billed byEligible Professionals	Dollar Amount	First 2 characters of hcpcsBetosCode in ('P1', 'P2', 'P3', 'P7') andNOT AmbulatoryCenterCondi tion and placeOfService NOT in ('23', '21', '51') and NOT TherapyCondition andNOT SpecialtyCondition[2]	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

[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
				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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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, ambulatory surgical center services, services delivered in an emergency department, inpatient hospital, nor inpatient psychiatric facility. This figure doesn't 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

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

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				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)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 = Doesn't meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) B5 = Ocularist C1 = Centralized Flu C2 = Indirect payment procedure
ambulatoryMinorProcedureAmount	Ambulatory/Minor Procedures Billed by Eligible Professionals	Dollar Amount	First 2 characters of HcpcsBetosCode in ('P4', 'P5', 'P6', 'P8') and placeOfService not	This figure includes costs for local carrier non-DMEPOS claim type claims, also referred to as "professional claims" submitted by professional

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			in ('23', '21', '51') and NOT (primarySpecialty='49' or AmbulatoryCenterCondition) and NOT SpecialtyCondition and NOT TherapyCondition	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 -

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				other (non-Medicare fee schedule) P8A = Endoscopy - arthroscopy P8B = Endoscopy - upper gastrointestinal P8C = Endoscopy - sigmoidoscopy P8D = Endoscopy - colonoscopy P8E = Endoscopy - cystoscopy P8F = Endoscopy - bronchoscopy P8G = Endoscopy - laparoscopic cholecystectomy P8H = Endoscopy - laryngoscopy P8I = Endoscopy – other This figure 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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 doesn't 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)

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				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)

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				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)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				A8 = Grocery store (DMERC)
therapyAmount[3]	Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	Dollar Amount	Carrier Claim Type code (71,72) and TherapyCondition ANDplaceOfService not in ('23', '21', '51') and hcpcsBetosCode not in('O1A', 'O1D', 'O1E', 'D1G') and substr(hcpcsBetosCode, 1, 2) not in ('P9', 'P0') OR (Outpatient Claims Type Code (40) and TherapyCondition and hcpcsBetosCode not in('O1A', 'O1D', 'O1E', 'D1G') and substr(hcpcsBetosC	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[4] 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.

[3] 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.

[4] 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
			ode, 1, 2) not in ('P9', 'P0') and TypeOfBill not in ('22', '23', '33', '34', '72') and revenueCenterCode NOT in ('0981', '0450', '0451', '0452', '0453', '0454', '0455', '0456', '0457', '0458', '0459')10	This figure doesn't include services provided in the following places of service: Emergency room of a hospital, inpatient hospital, Inpatient Psychiatric Facility, SNF, Home Health Agency. This figure doesn't 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)
ancillaryServicesAmount	Ancillary Services	Dollar Amount	OutpatientClaims (claimTypeCode = 40) and first 2 characters of hcpcsBetosCode in ('T1', 'T2','I1', 'I2', 'I3', 'I4') and NOT TherapyCondition and TypeOfBill not in ('22', '23', '33',	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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			'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 hcpcsBetosCode NOT IN	outpatient claim type claims[5] 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

[5] 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
			(O1D,O1E,O1G)	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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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 doesn't 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[6] services in short-term (general and specialty) hospitals. Short-term (general and specialty) hospitals where type of bill (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 prospective payment system (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

[6] 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
				(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 **doesn't** include: O1A = Ambulance O1D = Chemotherapy O1E = Other drugs D1G = Drugs Administered through DME P9A = Dialysis services (Medicare fee schedule) P9B = Dialysis services (non-Medicare fee schedule) This figure **doesn't** include services provided by providers with CMS specialty codes of: 31 = Intensive Cardiac

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

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)

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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				M4B = Nursing home visit M5A = Specialist - pathology M5B = Specialist - psychiatry M5C = Specialist - ophthalmology M5D = Specialist - other M6 = Consultations P1A = Major procedure – breast P1B = Major procedure - colectomy P1C = Major procedure - cholecystectomy P1D = Major procedure - turp P1E = Major procedure - hysterectomy P1F = Major procedure - explor/decompr/excisdisc P1G = Major procedure - Other P2A = Major procedure, cardiovascular-CABG P2B = Major procedure, cardiovascular-Aneurysm repair P2C = Major Procedure, cardiovascular-Thromboendarterectomy P2D = Major procedure, cardiovascular-Coronary

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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				P5E = Ambulatory procedures - other P6A = Minor procedures - skin P6B = Minor procedures - musculoskeletal P6C = Minor procedures - other (Medicare fee schedule) P6D = Minor procedures - other (non-Medicare fee schedule) P8A = Endoscopy - arthroscopy P8B = Endoscopy - upper gastrointestinal P8C = Endoscopy - sigmoidoscopy P8D = Endoscopy - colonoscopy P8E = Endoscopy - cystoscopy P8F = Endoscopy - bronchoscopy P8G = Endoscopy - laparoscopic cholecystectomy P8H = Endoscopy - laryngoscopy P8I = Endoscopy - other T1A = Lab tests - routine venipuncture (non-Medicare fee schedule)

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

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

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				other Carrier/professional claims for services AREN'T included in this figure if provided by providers with the following CMS specialty codes: 31 = Intensive Cardiac Rehabilitation 45 = Mammography screening center 47 = Independent Diagnostic Testing Facility (IDTF) 49 = Ambulatory surgical center 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics) 52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics) 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				54 = Medical supply company not included in 51, 52, or 53. 55= Individual certified orthotist 56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc. 60 = Public health or welfare agencies (federal, state, and local) 61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities) 63 = Portable X-ray supplier 69 = Clinical laboratory (billing independently) 73 = Mass Immunization Roster Biller 74 = Radiation Therapy Centers 75 = Slide Preparation

Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				Facilities 87 = All other suppliers (e.g., drug and department stores) 88 = Unknown supplier/provider specialty 95 = Competitive Acquisition Program (CAP) 96 = Optician A0 = Hospital (DMERCs only) A1 = SNF (DMERCs only) A2 = Intermediate care nursing facility (DMERCs only) A3 = Nursing facility, other DMERCs only) A4 = HHA (DMERCs only) This figure also includes costs for outpatient claim type claims[7] for the services listed above provided to the patient during the 2022 performance period if provided in locations with the following revenue center codes:

[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
				0450-Emergency room - general classification 0451-Emergency room - Emergency Medical Treatment and Labor Act (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

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[8] 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 aren't 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 aren't captured in the categories above.

[8] 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 2022 MSPB Clinician Patient-Level Report?

Only clinicians and groups who met the case minimum of 35 received a 2022 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 2022 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 aren't 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 2022 risk scores translated into a percentile. CMS HCC V22 was used to compute 2022 scores, which are based on 2021 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 nota repeat admission (no	This figure includes costs for inpatient claim type[9] services provided in short-term (general and specialty) hospitals,[10] submitted on behalf of a patient in the time period beginning 3 days prior to the hospital admission and 30 days after hospital discharge. This figure doesn't include inpatient claims rendered during a repeat admission. A repeat admission is

[9] See: https://www.resdac.org/cms-data/variables/nch-claim-type-code. Inpatient claims are identified by code 60.
[10] 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
			admission for the same beneficiary 30 days before the current admission)	defined as any admission other than the index admission that occurs within 30 days of the index admission. Inpatient claims are fee-for-service (FFS) claims submitted by inpatient hospital providers for reimbursement of facility costs. These claim records represent covered stays (Medicare paid FFS bills).
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 admission that occurs within 30 days of the index admission.

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
inpatientRehabLTCH	Inpatient Rehabilitation or Long-Term Care Hospital (LTCH) Services	Dollar Amnt	claimtype = 'INPATIENT[11]' 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 provider types/in the following places: Psychiatric Unit in Critical Access Hospital, Psychiatric unit (excluded from PPS), Rehabilitation Unit in Critical Access Hospital, Rehabilitation unit (excluded from PPS), Long-term hospitals, rehabilitation hospitals, and/or psychiatric hospitals.
physicianServicesPb	Other Physician or Supplier Part B Services Billed During Any Hospitalization	Dollar Amnt	claimtype = 'PROFESSIONAL' and placeOfService[12] in (21,51) and substring(hcpcsBetosGroup,1,2) not in ('P0','P9') and hcpcsBetosCode[13]	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

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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			not in ('O1A','O1D','O 1E','D1G')[14]	days after discharge, in an inpatient hospital and/or inpatient Psychiatric Facility. This figure **doesn't** include the following services: anesthesia, dialysis, ambulance, chemotherapy, other DME, nor drugs administered through DME.
homeHealth	Home Health Services	Dollar Amnt	claimtype = 'HOME_HEAL TH_SER VICES'	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.
snf	Skilled Nursing Facility Services	Dollar Amnt	claimtype = 'SKILLED_NU RSING_F ACILITY'	This figure includes costs for swing-bed AND non-swing bed Skilled Nursing 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.

[14] 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
therapy	Physical, Occupational, or Speech and Language Pathology Therapy, carrier costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and (hcpcsModiferCode1 in ('GN[15]','GO','GP') or hcpcsModiferCode2in ('GN','GO','GP') or hcpcsModiferCode3 in ('GN','GO','GP') or hcpcsModiferCode4 in ('GN','GO','GP') OR hcpcsModifer Code5 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.

[15] See: https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Downloads/2018-Alpha-Numeric-HCPCS-File.zip (1.1 MB), 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

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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				P5D = Ambulatory procedures – lithotripsy P5E = Ambulatory procedures – other P6A = Minor procedures – skin P6B = Minor procedures – musculoskeletal P6C = Minor procedures – other (Medicare fee schedule) P6D = Minor procedures – other (non-Medicare fee schedule) P7A = Oncology – radiation therapy P7B = Oncology – other P8A = Endoscopy – arthroscopy P8B = Endoscopy – upper gastrointestinal P8C = Endoscopy – sigmoidoscopy P8D = Endoscopy – colonoscopy P8E = Endoscopy – cystoscopy P8F = Endoscopy – bronchoscopy P8G = Endoscopy – laparoscopic cholecystectomy P8H = Endoscopy – laryngoscopy P8I = Endoscopy – other
erLabsPb	ER Laboratory, Pathology, and Other Tests, carrier cost	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring	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
			(hcpcsBetosCode, 1, 1)='T' and placeOfServiceCode = '23'	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 = 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	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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			placeOfService Code = '23'	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 I3D = Echography/ultrasonography –

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

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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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
minorProcsAmbulatoryPb	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 admission plus 30 days after discharge: P4C = Eye procedure – retinal detachment

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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
ancillarylabsPb	Ancillary Laboratory, Pathology, and Other Tests, carrier costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 1)='T'	This figure includes costs for local carrier non-DMEPOS claim type claims, also referred to as "professional claims" submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the 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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
AncillaryimagingPb	Ancillary Imaging Services, Carrier Costs	Dollar Amnt	claimtype = 'PROFESSIONAL' and substring(hcpcsBet osCode,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 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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
				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. This figure doesn't include the following costs: O1D = Chemotherapy O1E = Other drugs O1G = Immunizations/Vaccinations

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
Hospice	Hospice	Dollar Amnt	claimType = 'HOSPICE'	This figure includes costs for hospice claim type claims for services provided to the 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	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

Abbreviated Column Header in Output File	Full Column Figure Description	Format	Conditions/ Calculation Details	Additional Information/Explanation
			('O1D','O1 E','D1G')	patient during the time period beginning 3 days prior to the index admission plus 30 days after discharge: O1D = Chemotherapy O1E = Other drugs D1G = Drugs Administered through DME
Outpatient	Total Outpatient Cost	Dollar Amnt	claimType = 'OUTPATI ENT'	This figure includes costs for outpatient claim type claims for services provided to the patient in the time period beginning 3 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 Patient-Level Reports

The table below includes detailed descriptions of the figures presented in the 2022 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
tin	TIN of the clinician or group to which the patient's costs were attributed	Numeric	Refer to the 2022 MIPS Cost Measure Information Forms (ZIP, 10.4 MB) and the 2022 MIPS Cost Measure Codes Lists (ZIP, 10.6 MB) 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 2022	Numeric	Presence of this field will depend upon the chosen 2021 MIPS participation level. Refer to the 2022 MIPS Cost Measure Information Forms (ZIP, 10.4 MB) and the 2022 MIPS Cost Measure Codes Lists (ZIP, 10.6 MB) 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
reviseddob	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 2022 performance year, 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	Refer to the measure codes list file for service categories and descriptions
serviceCategoryDescription	Episode Service Category Description	Description	Refer to the measure codes list file for service categories and descriptions
serviceCode	Service Code(s)	Alpha numeric codes	Refer to the measure codes list file for service categories and descriptions
serviceCodeDesciption	Service Code(s) Description	Description	Refer to the measure codes list file for service categories and descriptions
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.

Chronic condition episodes are attributed to a clinician group when it performs 2 services indicating care for a particular condition within a certain number of days (e.g., 180 days). Both claims must have a diagnosis code for the relevant chronic condition. Each clinician (within the group) that rendered at least 30% of the qualifying services during the episode is considered for attribution. As a result, chronic condition episodes can be attributed to more than one clinician. Refer to the MIPS Chronic Condition Cost Measures Attribution Methodology Resources (ZIP, 1.6 MB) for more detailed information.

For patient-level reports generated for 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 2022 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 2022 MIPS Cost Measure Codes Lists (ZIP, 10.6 MB).

Consider the following entries in an *example* row in a downloadable report for the Knee Arthroplasty procedural episode-based cost measure:

Service Category	Service Category Description	Service Code	Service Code Description	Standardized Cost
POST_PB_OP	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

This row illustrates that a particular service/groups of services provided to a patient were assigned to an episode.

To interpret the 3 distinct service codes listed, navigate to the “Service_Assignment” tab of the Knee Arthroplasty code list file. This tab presents the codes for assigned services during the pre- and post-trigger periods of the episode window in each of the following service categories: Emergency Department (ED); Outpatient Facility and Clinician Services (OP Clinician); Inpatient - Medical, including Long-Term Care Hospital (IP Medical); Inpatient - Surgical, including Long-Term Care Hospital (IP Surgical); Inpatient Rehabilitation Facility - Medical (IRF Medical); Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DME); and Home Health (HH).

Apply the following filters: “OP Clinician” in the service category column, 213 in the “High Level Code” column.

Starting from left to right in the “Service Assignment” tab, you’ll find that the service 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 service code Z96 is an ICD-10 CM 3-Digit Diagnosis code with a label of “Presence Of Other Functional Implants.” The service code Z96652 is an ICD-10 CM Long Diagnosis code with a label of

“Presence Of Left Artificial Knee Joint.” This service and its cost was attributed to the episode because it was deemed clinically related to the attributed clinician’s role in managing patient care during the episode. In other words, a “Physical Therapy Exercises, Manipulation, And Other Procedures” service is attributed to a clinician when paired with a primary diagnosis of “Presence of Other Functional Implants” where there is the 5 digit diagnosis code for “Presence Of Left Artificial Knee Joint” because it’s clinically relevant to the clinician’s role in managing care for a knee arthroplasty procedure.

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

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 aren’t 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 2022 Hospital-Wide All-Cause Unplanned Readmission Measure ZIP (778 KB) containing 2 documents: MIPS Hospital Wide Readmission MIF and code tables.
- 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 2022 risk scores translated into a percentile. CMS HCC V22 was used to compute 2022 scores, which are based on 2021 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 1/1/2021-12/31/2021. **Please note:** data from the prior calendar year, not the 2022 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 1/1/2021-12/31/2021. **Please note:** data from the prior calendar year, not the 2022 performance period, are used to compute this particular T/F value.
coronaryArteryDisease	Coronary Artery Disease	Boolean (True or	If true, a diagnosis of coronary artery disease (based on ICD-10 diagnoses

Column Header in Outpost File	Full Column Description	Format	Additional Information/Explanation
		False Indicator)	codes) was located on Medicare administrative claims submitted on behalf of the patient between 1/1/2021-12/31/2021. **Please note:** data from the prior calendar year, not the 2022 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) was located on Medicare administrative claims submitted on behalf of the patient between 1/1/2021-12/31/2021. **Please note:** data from the prior calendar year, not the 2022 performance period, are used to compute this particular T/F value.
medicalCohort	Medical Cohort	Description	All admissions are classified into 1 of 5 different specialty cohorts: medicine, neurological, cardiovascular, cardiorespiratory, and surgical. Principal discharge diagnosis categories (as defined by Agency for Healthcare Research and Quality (AHRW) clinical classification software (CCS)) are used to define the specialty cohorts.

Column Header in Outpost File	Full Column Description	Format	Additional Information/Explanation
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

RSCR Following Elective Primary THA and/or TKA for MIPS

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 aren't duplicated in the table below (entity type, entityId, npi, tin, measureId, mbi, gender, dob, and expired)
- Refer to the 2022 Hip Arthroplasty and Knee Arthroplasty Complication Measure ZIP (492 KB), containing 2 documents: code tables and MIF.
- 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 2022 risk scores translated into a percentile. CMS HCC V22 was used to compute 2022 scores, which are based on 2021 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. 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;

Column Header in Outpost File	Full Column Description	Format	Additional Information/Explanation
			• 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 inpatient admission that occurs within 7 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

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

Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

The table below includes descriptions of the figures presented in the patient-level report for quality measure ID #484. Please note:

- The columns that are consistent across all patient-level cost measure reports aren't duplicated in the table below (entity type, entityId, npi, tin, measureId, mbi, gender, dob, and expired)
- For more information, please refer to the All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions for ACOs (MCC) Measure Specifications (ZIP, 13 MB).

Data Element Label	Data Element Name	Data Element Description
ami	Acute myocardial infarction (AMI)	Indicator (value of TRUE or FALSE) 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 TRUE or FALSE) 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 TRUE or FALSE) for whether a patient meets requirements for inclusion in the atrial fibrillation chronic condition category
ckd	Chronic kidney disease (CKD)	Indicator (value of TRUE or FALSE) 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 TRUE or FALSE) for whether a patient meets requirements for inclusion in the COPD and asthma chronic condition category
dep	Depression	Indicator (value of TRUE or FALSE) for whether a patient meets requirements for inclusion in the depression condition category

Data Element Label	Data Element Name	Data Element Description
hf	Heart failure	Indicator (value of TRUE or FALSE) 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 TRUE or FALSE) for whether a patient meets requirements for inclusion in the stroke and TIA chronic condition category
diab	Diabetes	Indicator (value of TRUE or FALSE) for whether a patient meets requirements for inclusion in the diabetes chronic condition category
admissionDate	Admission date	Date of unplanned admission
dischargeDate	Discharge date	Date of unplanned discharge
primaryDiagnosis	Primary admission diagnosis	Primary diagnosis for unplanned admission

Where Can You Go for Help?

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

Version History

Date	Change Description
08/10/2023	Original Posting.