Quality Payment
PROGRAM

2024 MIPS Performance Feedback: Supplemental and Patient-Level Data Reports Guide

Background and Purpose

This guide provides context and details about the information provided in supplemental cost reports and patient-level reports for administrative claims-based measures.

- **Supplemental cost reports** are a new set of reports that compare your costs to the national observed for certain types of services. **(Begins on page 2.)**
- **Patient-level reports** are reports that we've provided in prior years with details about the patients included in the calculation of cost and quality administrative claims measures. **(Begins on page 15.)**

Supplemental Cost Reports

As part of the 2024 MIPS performance year performance feedback, informational reports, referred to as "supplemental cost reports," are provided to clinicians, groups and virtual groups who met the case minimum for the MIPS episode-based cost measures (EBCMs). This section provides additional information about these downloadable supplemental cost reports in 2024 performance feedback.

General Questions

What are the case minimums and measure IDs for the 2024 MIPS cost measures for which supplemental cost 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
- 20 episodes for the Emergency Medicine measure

Measure Name	Case Minimum	Measure Type	Measure ID
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 Limb Ischemia	10	Procedural EBCM	COST_CCLI_1
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	10	Procedural EBCM	COST_IOL_1

Measure Name	Case Minimum	Measure Type	Measure ID
Screening/Surveillance Colonoscopy	10	Procedural EBCM	COST_SSC_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	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

Measure Name	Case Minimum	Measure Type	Measure ID
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
Depression	20	Chronic Condition EBCM	COST_DEP_1
Heart Failure	20	Chronic Condition EBCM	COST_HF_1
Low Back Pain	20	Chronic Condition EBCM	COST_LBP_1
Emergency Medicine	20	Care Setting EBCM	COST_EDV_1
Psychoses and Related Conditions	20	Acute inpatient medical condition EBCM	COST_PRC_1

Note: CMS has determined it will exclude the Acute Kidney Injury Requiring New Inpatient Dialysis measure for all MIPS eligible clinicians pursuant to §414.1380(b)(2)(v)(B) and, therefore, this measure won't be included in CMS' calculation of MIPS eligible clinicians' scores under the cost performance category for the 2024 performance period/2026 MIPS payment year. Patient-level reports weren't generated for this measure. For more information, refer to the 2024 MIPS Cost Measure Exclusion Fact Sheet (PDF, 186 KB).

What data source is used for the supplemental cost reports?

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

Are payment-standardized costs used to compute the figures in the supplemental 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.

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. The 2021 and 2022 versions cover HCPCS codes over a 5-year period with the timeframe dropping the earliest year and adding the most recent year of data. Starting in 2023, the RBCS Taxonomy covers HCPCS codes over a 6-year period. For more information, refer to the 2023 RBCS and BETOS Crosswalk (ZIP, 55.5 KB) and the full data set.

How can clinicians use these supplemental cost reports to understand and improve cost measure performance?

Clinicians can use these reports to help identify differences between the characteristics of the national average episode for the measure and their attributed episodes. Differences could signify billing and care patterns that warrant additional investigation. For example, viewing your Compared Observed Costs to National Expected: Values that are outside of the expected with high variation may indicate services that are being billed are increasing your assigned cost score and associated point assignment for the measure. Viewing your Compared Episodes with Service with Observed Services: Values that are billed more frequently that aren't expected (based on measure calculations) can indicate that more services and /or more expensive episodes are being assigned to your attributed episodes as compared to the national average episode.

Supplemental Cost Report Figures and Descriptions

Column Name	Column Description
TIN	The Taxpayer Identification Number of the report recipient; this field is blank for virtual groups.
QSC Group	The specific Quality and Resource Use Report Service Category (QSC) code or a header code encompassing multiple QSC codes. Individual codes are numeric while header categories start with "A".
Provider Percent Episodes With Service	The percentage of this provider's episodes that include the given QSC code(s).

Column Name	Column Description
Provider Number Episodes With Service	The number of distinct episodes for this measure used in this provider's analysis.
Provider Average Service Cost Per Episode	The average observed cost per episode for the given QSC code for all of the provider's episodes. No risk-adjustment is applied to these costs. Episodes with outlier costs have been excluded. When a code is billed multiple times in an episode, the cost per episode is the sum of those occurrences, not the cost of an individual occurrence.
NPI	The clinician's National Provider Identifier; this field is blank for groups and virtual groups.
National Percent Episodes With Service	The percentage of all episodes nationwide for this measure that include the given QSC code(s).
Medicare Setting and Service Category	A high-level description of the QSC Group; further details provided in the table "Accessory Definitions" table.
Measure ID	Episode Based Measure ID.
Entity Type	Stating if report is for a "Group", "Individual", "Virtual Group", or "Subgroup" participant.
Entity ID	An identifying code for Virtual Groups or Subgroups; this field is blank for individuals and groups.
Diff Percent Episodes National and Provider	"National Pct Episodes With Service" minus "Provider Percent Episodes With Service".
Cost Diff Adj National and Provider	"Adjusted National Average Service Cost Per Episode" minus "Provider Average Service Cost Per Episode".
Adjusted National Average Service Cost Per Episode	The adjusted average observed cost per episode for the given QSC code(s) across all episodes nationwide. • Modifications before averaging are: episodes with outlier costs have been excluded, episodes with zero attribution have been excluded.

Column Name	Column Description
	• Post-processing adjustment factor: the raw observed cost is multiplied by an adjustment factor derived from 2 ratios: 1) National Average Cost * (Ratio_A / Ratio_B) ○ Ratio_A = the provider's average observed cost of all services per episode / the raw national average observed cost of all services per episode. ○ Ratio_B = the provider's average ratio, as provided in the measure score. This is the average ratio of observed_cost : final_expected_cost.

How Services are Defined in the Supplemental Cost Reports

Asterisk (*) = see "Accessory Definition" table for details

Label In Supplemental Cost Report	Service Types	General Criteria	Restructured BETOS Classification System (RBCS) criteria: primary	BETOS criteria: secondary
Overall Aggregate: All Services	N/A	Aggregate of all QSC codes 00-23	N/A	N/A
Aggregate: OP Eval and Management Services, Procedures, and Therapy (excluding Emergency Department)	N/A	Outpatient (OP) Physical, Occupational, or Speech and Language Pathology Therapy OP Evaluation and Management Services Major Procedures Ambulatory/Minor Procedures	N/A	N/A
OP Physical, Occupational, or Speech and Language Pathology Therapy	Part B, Outpatient Services	OP Physician*	N/A	N/A

Label In Supplemental Cost Report	Service Types	General Criteria	Restructured BETOS Classification System (RBCS) criteria: primary	BETOS criteria: secondary
OP Evaluation and Management Services	Part B, Outpatient Services	1. Service Type is Outpatient, and has the following RBCS or BETOS criteria, OR 2. Service Type is Part B and (the claim is coded as an Eligible Specialty* OR an Eligible Facility*), and has the following RBCS or BETOS criteria	RBCS starts with "E"	BETOS starts with "M"
Major Procedures	Part B, Outpatient Services	1. Service Type is Outpatient, and has the following RBCS or BETOS criteria, OR 2. Service Type is part B and (the claim is coded as an Eligible Specialty* OR an Eligible Facility*), and has the following RBCS or BETOS criteria	(RBCS starts with "P" and RBCS 6th character = "M") or RBCS starts with "RR"	BETOS starts with "P1", "P2", "P3", or "P7"
Ambulatory/Minor Procedures	Part B, Outpatient Services	1. Service Type is Outpatient, and has the following RBCS or BETOS criteria, OR 2. Service Type is part B and (the claim is coded as an Eligible Specialty* OR an Eligible Facility*), and has the	RBCS starts with "P" and RBCS 6th character = "O"	BETOS starts with "P4", "P5", "P6", "P8"

Label In Supplemental Cost Report	Service Types	General Criteria	Restructured BETOS Classification System (RBCS) criteria: primary	BETOS criteria: secondary
		following RBCS or BETOS criteria		
Aggregate: Ancillary Services	Part B, Outpatient Services	Laboratory, Pathology, and Other Tests Imaging Services Dural Medical Equipment (DME) and Supplies	N/A	N/A
Laboratory, Pathology, and Other Tests	Part B, Outpatient Services	N/A	RBCS starts with "T"	BETOS starts with "T"
Imaging Services	Part B, Outpatient Services	N/A	RBCS starts with "I"	BETOS starts with "I"
DME and Supplies	Durable Medical Equipment	N/A	RBCS does NOT start with ("RH", "RI", "DG") and RBCS does NOT ="RX029N"	BETOS does NOT = "O1D", "O1E", "D1G"
Aggregate: Hospital Inpatient Services	N/A	Inpatient Hospital: Trigger Chronic Measures = Inpatient Hospital; Acute and Proc Measures = Inpatient Hospital: Non-Trigger Physician Services During Hospitalization	N/A	N/A

Label In Supplemental Cost Report	Service Types	General Criteria	Restructured BETOS Classification System (RBCS) criteria: primary	BETOS criteria: secondary
Inpatient Hospital: Trigger	Inpatient Stay	Inpatient (IP) stay flagged as part of a trigger claim for an episode (applicable to Acute and Proc measures only; not Chronic)	N/A	N/A
Chronic Measures = Inpatient Hospital; Acute and Proc Measures = Inpatient Hospital: Non-Trigger	Inpatient Stay	IP stay at acute hospital (Critical Access Hospital (CAH), Inpatient Prospective Payment System (IPPS), Inpatient Psychiatric Facility (IPF)) determined by 3rd and 4th digit of CCN = (00-08, 13, 40-44) or 3rd character of CCN = (M, S)	N/A	N/A
Physician Services During Hospitalization	Part B Services	This Part B claim occurred during an Overlapping IP stay* and the clinician has an Eligible Specialty*	N/A	N/A
Aggregate: Emergency Room Services	N/A	Emergency Evaluation and Management Services Emergency Procedures Emergency Laboratory, Pathology, and Other Tests Emergency Imaging Services	N/A	N/A
Emergency Evaluation and Management Services	Part B, Outpatient Services	Emergency Room (ER) Service* and has the following RBCS or BETOS criteria	RBCS starts with "E"	BETOS starts with "M"

Label In Supplemental Cost Report	Service Types	General Criteria	Restructured BETOS Classification System (RBCS) criteria: primary	BETOS criteria: secondary
Emergency Procedures	Part B, Outpatient Services	ER Service* and has the following RBCS or BETOS criteria	RBCS starts with "P"	BETOS starts with any of "P1" through "P8"
Emergency Laboratory, Pathology, and Other Tests	Part B, Outpatient Services	ER Service* and has the following RBCS or BETOS criteria	RBCS starts with "T"	BETOS starts with "T"
Emergency Imaging Services	Part B, Outpatient Services	ER Service* and has the following RBCS or BETOS criteria	RBCS starts with "I"	BETOS starts with "I"
Aggregate: Post-Acute Services	N/A	Home Health Skilled Nursing Facility Inpatient Rehabilitation Facility (IRF) or Long-Term Care Hospital (LTCH)	N/A	N/A
Home Health	Outpatient, Home Health Services	1. Service Type is Home Health, OR 2. Service Type is Outpatient, AND (bill_type = 32, 33, or 34, indicating Home Health Services not under a Plan of Treatment)	N/A	N/A
Skilled Nursing Facility	Outpatient, Skilled Nursing Facility	1. Service Type is "SN" or "SN stay", OR 2. Service Type is Outpatient, AND 2a) bill_type = 22, indicating beneficiaries are in Medicare non-certified part of the institution, or	N/A	N/A

Label In Supplemental Cost Report	Service Types	General Criteria	Restructured BETOS Classification System (RBCS) criteria: primary	BETOS criteria: secondary
		2b) bill_type = 23, indicating beneficiaries are Skilled Nursing Facility (SNF) residents in non-covered stays but in Medicare-certified parts of an SNF		
IRF or LTCH	Inpatient Stay	LTCH or IRF stay	N/A	N/A
Aggregate: Hospice	N/A	Header category comprising QSC code 18	N/A	N/A
Hospice	Hospice	No criteria beyond Service Type	N/A	N/A
Aggregate: All Other Services	N/A	Dialysis Ambulance Services Chemotherapy and Other Part B-Covered Drugs All Other Services Not Otherwise Classified	N/A	N/A
Dialysis	N/A	bill_type = 72, indicating a claim for an End Stage Renal Disease (ESRD) facility; OR has the following RBCS or BETOS criteria	RBCS starts with "RD"	BETOS starts with "P9"
Ambulance Services	Part B, Outpatient Services	N/A	RBCS starts with "OA"	BETOS starts with "O1A"

Label In Supplemental Cost Report	Service Types	General Criteria	Restructured BETOS Classification System (RBCS) criteria: primary	BETOS criteria: secondary
Chemotherapy and Other Part B-Covered Drugs	Durable Medical Equipment	N/A	RBCS starts with ("RH", "RI", "DG") or RBCS="RX029N"	BETOS = "O1D", "O1E", "D1G"
All Other Services Not Otherwise Classified	Inpatient Stay, Part B Services, Outpatient	claims of Service Type as IP stay, Part B, or Outpatient that don't meet any other QSC criteria	N/A	N/A
Anesthesia Services	Part B Services, Outpatient	N/A	RBCS starts with "A"	BETOS starts with "P0" (zero, not letter O)
Aggregate: Part D Services	N/A	Header category comprising QSC code 23	N/A	N/A
Part-D Drugs	Part D	No criteria beyond Service Type	N/A	N/A

Accessory Definitions of Terms in Supplemental Cost Reports

Term	Definition	Source: of descriptors used in "Definition" column → i.e. that Type Service Code "F" means "ambulatory surgical center"
Eligible Facility	The claim is of type PB and the Line CMS Type Service Code ("F") OR the Line CMS Provider Specialty Code (49) indicates an ambulatory surgical center	RESDAC CMS Type of Service Table, RESDAC CMS Provider Specialty Code Table

Term	Definition	Source: of descriptors used in "Definition" column → i.e. that Type Service Code "F" means "ambulatory surgical center"
Eligible Specialty	The claim is of type PB and the Line CMS Provider Specialty Code (hcfaspcl) is indicated as eligible under MIPS	HCFA codes flagged with "ep_mips_ext = true"
ER Service	1. Service Type is Outpatient, and Revenue Center Code values indicate "Emergency Room" (0450-0459) or "Professional fees-Emergency Room" (0981) or 2. Service Type is Part B, and the Place of Service Code indicates "Emergency Room - Hospital" (23)	RESDAC Article: How to Identify Hospital Claims for Emergency Room Visits in the Medicare Claims Data, Place of Service Code Table
OP Physician	HCPCS code modifiers indicate services are delivered under an outpatient speech-language pathology (GN), occupational therapy (GO), or physical therapy (GP) plan of care; or RBCS subcategories indicate chiropractic treatments (RB) or physical, occupational, and speech therapy (RT); or RBCS code indicates cardiac rehabilitation (RX027N)	CMS Manual System Transmittal 4440, Restructured BETOS Final Report (PDF, 2.1 MB)
Overlapping IP Stay	The expense date of the Part B claim falls between the Admission Date and Discharge Date (inclusive) of any IP stay for that beneficiary or The expense date of the PB claim isn't finalized, while the Place of Service Code indicates an IP Hospital ("21") or IP Psych Facility ("51")	Place of Service Code Table

Patient-Level Reports

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 section provides additional information about these patient-level reports that can be downloaded in your 2024 performance feedback. Use the hyperlinks below to skip to a particular section.

Cost Performance Category

Quality Performance Category

General Questions

What are the case minimums and measure IDs for the 2024 MIPS cost and administrative claims-based quality measures for which patient-level reports are generated?

The case minimums are:

- 10 episodes for all procedural 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
- 20 episodes for the Emergency Medicine measure
- 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 Limb Ischemia	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
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

Measure Name	Case Minimum	Measure Type	Measure ID
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, 822 KB)	High Priority Quality Measure: Outcome	Quality ID: 479
Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS)	See measure methodology documents (ZIP, 568 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, 5 MB)	High Priority Quality Measure: Outcome	Quality ID: 484

Measure Name	Case Minimum	Measure Type	Measure ID
Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System	See measure methodology documents (ZIP, 1 MB)	High Priority Quality Measure: Outcome	Quality ID: 492
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
Depression	20	Chronic Condition EBCM	COST_DEP_1
Heart Failure	20	Chronic Condition EBCM	COST_HF_1
Low Back Pain	20	Chronic Condition EBCM	COST_LBP_1
Emergency Medicine	20	Care Setting EBCM	COST_EDV_1
Psychoses and Related Conditions	20	Acute inpatient medical condition EBCM	COST_PRC_1

Note: CMS has determined it will exclude the Acute Kidney Injury Requiring New Inpatient Dialysis measure for all MIPS eligible clinicians pursuant to § 414.1380(b)(2)(v)(B) and, therefore, this measure won't be included in CMS' calculation of MIPS eligible clinicians' scores under the cost performance category for the 2024 performance period/2026 MIPS payment year. Patient-level reports weren't generated for this measure. For more information, refer to the 2024 MIPS Cost Measure Exclusion Fact Sheet (PDF, 186 KB).

How should we interpret the Hierarchical Conditions Categories (HCC) Percentile Ranking figure in the patient-level reports for the following measures: TPCC, MSPB Clinician, Quality Measure ID #479 and Quality Measure ID #480?

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 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.

How should we interpret the HCC risk score 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 reports differentiated by costs of services provided by my TIN or TIN-NPI versus other TINs or other TIN-NPIs?

No, the MIPS patient-level cost data reports don't indicate which services included in the measure calculations were provided by your 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 only by the TIN/TIN-NPI to which the patient is attributed.

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

See previous BETOS codes explanation above.

What are place of service (POS) codes?

POS codes are used on professional claims to specify the entity where services were rendered.

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 Payment Standardization Overview.

Which costs, if any, are annualized in the supplemental cost reports and/or patient-level data reports?

To take into account the indefinite, long-term care which characterizes chronic conditions, chronic condition EBCMs can have a greater difference in episode length (e.g., more than one year) relative to acute condition and procedural EBCM types which have a defined beginning and end. Therefore, in the supplemental cost reports only, chronic condition EBCM costs are annualized prior to risk adjustment to make episodes comparable. The national and provider averages reflected in supplemental cost reports for chronic condition EBCMs have been calculated with the annualized costs.

Costs aren't annualized prior to risk adjustment in supplemental cost reports for acute condition and procedural type EBCMs. As a result, you'll be able to directly calculate the overall provider average in the supplemental cost report based on the costs reflected in the patient-level data reports for acute and procedural type EBCMs, but you won't be able to do so for chronic condition type EBCMs.

Additionally, for all EBCM types, no costs are annualized in the patient-level data reports.

TPCC Measure Patient-Level Report

Which individual MIPS eligible clinicians and/or groups received a 2024 MIPS TPCC patient-level data report?

Only clinicians and groups who met the case minimum of 20 received a 2024 MIPS TPCC patient-level data report.

How are Medicare patients attributed to a TIN or TIN-NPI for 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: TPCC Measure Information Form (PDF, 2.4 MB), and the measure codes list Excel file (ZIP, 10.2 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 visits, 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 Financing 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 2023 calendar year: diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and heart failure.

Please note: Diagnoses from the 2023 calendar year, not the 2024 MIPS performance period of 1/1/2024-12/31/2024, were used to identify whether attributed patients had diabetes, CAD, COPD and/or heart failure for these reports. These conditions were identified independently of measure construction.

What is the meaning of the patient-specific "Scaled Total 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 table below includes detailed descriptions of the figures presented in the 2024 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 yearlong 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 toward 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	Format	Calculation Details	Additional Information/Explanation
Entity Type	Description	N/A	Group, virtual group, or individual. Depends on participation and reporting level.
Entity ID	Alpha numeric	N/A	Applicable only to virtual groups
TIN	Numeric	See 2024 MIPS TPCC Measure Information Form linked above	TIN of the clinician or group to which the patient's costs were attributed
NPI	Numeric	See 2024 MIPS TPCC Measure Information Form linked above	NPI of the individual clinician to which the patient's costs were attributed, for clinicians participating in MIPS as individuals in 2024. Presence of this field will depend upon the 2024 MIPS participation level.
Measure ID	Alpha numeric	N/A	MIPS Measure ID
MBI	Numeric	N/A	Medicare Beneficiary Identifier
Gender	M=Male F=Female	N/A	Patient's gender
Date of Birth	Numeric Date	N/A	Patient's date of birth
Date of Death	Numeric Date	N/A	Patient's date of death. If the attributed patient died during the 2024 performance year, the patient's date of death will be reflected here.
HCC Risk Rank Percentile	Numeric	See Q&A above	This figure is an average of the patient's 2024 risk scores translated into a percentile

Column Header	Format	Calculation Details	Additional Information/Explanation
Had Diabetes Diagnosis	True or False Indicator	N/A	If true, a diagnosis of diabetes (based on ICD-10 diagnoses codes) was located on Medicare administrative claims submitted on behalf of the patient between 1/1/2023-12/31/2023. **Please note:** data from the prior calendar year, not the 2024 performance period, are used to determine this T/F value.
Had COPD Diagnosis	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 1/1/2023-12/31/2023. **Please note:** data from the prior calendar year, not the 2024 performance period, are used to determine this T/F value.
Had CAD Diagnosis	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 1/1/2023-12/31/2023. **Please note:** data from the prior calendar year, not the 2024 performance period, are used to determine this T/F value.
Had Heart Failure Diagnosis	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 1/1/2023-12/31/2023. **Please note:** data from the prior calendar year, not the 2024 performance period, are used to determine this T/F value.

Column Header	Format	Calculation Details	Additional Information/Explanation
Scaled Total Cost	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.
E&M Costs	Dollar Amount	hcpcsBetosCode4 in ('M1A', 'M1B', 'M2A', 'M2B', 'M2C', 'M4A', 'M4B', 'M5A', 'M5B', 'M5C', 'M5D') or substring(hcpcsBetosCode, 1, 2) in ('M3', 'M6')) and placeOfServiceCode5 not in ('23', '21', '51') and NOT AmbulatoryCenterCondition and NOT SpecialtyCondition and NOT TherapyCondition	Evaluation & Management Services Billed by Eligible Professionals. This figure includes costs for local carrier non-Durable 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. 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

Column Header	Format	Calculation Details	Additional Information/Explanation
			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) 49 = Ambulatory surgical center 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics) 52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics) 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 54 = Medical supply company not included in 51, 52, or 53. 55 = Individual certified orthotist 56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g. private ambulance companies, funeral homes 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

[1] https://resdac.org/sites/datadocumentation.resdac.org/files/CMS_PRVDR_SPCLTY_TB_rev01242018_0.txt

Column Header	Format	Calculation Details	Additional Information/Explanation
			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 (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, histocompatibility labs) (eff. 10/2/07) B5 = Ocularist C1 = Centralized Flu C2 = Indirect payment procedure
Major Procedure Costs	Dollar Amount	First 2 characters of hcpcsBetosCode in ('P1', 'P2', 'P3', 'P7') and NOT AmbulatoryCenterCondition and placeOfService NOT in ('23', '21',	Major Procedures Billed by Eligible Professionals. 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

Column Header	Format	Calculation Details	Additional Information/Explanation
		'51') and NOT TherapyCondition and NOT SpecialtyCondition[2]	assistants, clinical social workers, and nurse practitioners, for the following services: P1A = Major procedure - breast P1B = Major procedure - colectomy P1C = Major procedure - cholecystectomy P1D = Major procedure - turp P1E = Major procedure - hysterectomy P1F = Major procedure - explor/decompr/excisdisc P1G = Major procedure - Other P2A = Major procedure, cardiovascular-CABG P2B = Major procedure, cardiovascular-Aneurysm repair P2C = Major Procedure, cardiovascular-Thromboendarterectomy P2D = Major procedure, cardiovascular-Coronary angioplasty (PTCA) P2E = Major procedure, cardiovascular-Pacemaker insertion P2F = Major procedure, cardiovascular-Other P3A = Major procedure, orthopedic - Hip fracture repair P3B = Major procedure, orthopedic - Hip replacement P3C = Major procedure, orthopedic - Knee replacement P3D = Major procedure, orthopedic – other P7A = Oncology - radiation therapy P7B = Oncology - other This figure 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.

[2] https://resdac.org/sites/datadocumentation.resdac.org/files/CMS_PRVDR_SPCLTY_TB_rev01242018_0.txt

Column Header	Format	Calculation Details	Additional Information/Explanation
			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) 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 54 = Medical supply company not included in 51, 52, or 53. (Revised to mean medical supply company for DMERC) 55 = Individual certified orthotist 56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc. 60 = Public health or welfare agencies (federal, state, and local) 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities) 63 = Portable X-ray supplier 69 = Clinical laboratory (billing independently) 73 = Mass Immunization Roster Biller

Column Header	Format	Calculation Details	Additional Information/Explanation
			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 = Home Health Agency (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
Ambulatory Minor Procedure Costs	Dollar Amount	First 2 characters of HcpcsBetosCode in ('P4', 'P5', 'P6', 'P8') and placeOfService not in ('23', '21', '51') and NOT (primarySpecialty='49' or AmbulatoryCenterCondition) and NOT SpecialtyCondition and NOT TherapyCondition	Ambulatory/Minor Procedures Billed by Eligible Professionals. This figure includes costs for local carrier non-DMEPOS claim type claims, also referred to as "professional claims" submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services: P4B = Eye procedure - cataract removal/lens insertion

Column Header	Format	Calculation Details	Additional Information/Explanation
			P4C = Eye procedure - retinal detachment P4D = Eye procedure - treatment of retinal lesions P4E = Eye procedure - other P5A = Ambulatory procedures – skin P5B = Ambulatory procedures - musculoskeletal P5C = Ambulatory procedures - inguinal hernia repair P5D = Ambulatory procedures - lithotripsy P5E = Ambulatory procedures - other P6A = Minor procedures - skin P6B = Minor procedures - musculoskeletal P6C = Minor procedures - other (Medicare fee schedule) P6D = Minor procedures - other (non-Medicare fee schedule) 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 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.

Column Header	Format	Calculation Details	Additional Information/Explanation
			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 49 = Ambulatory surgical center 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics) 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 54 = Medical supply company not included in 51, 52, or 53. (Revised to mean medical supply company for DMERC) 55 = Individual certified orthotist 56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g., private ambulance companies, funeral homes 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

Column Header	Format	Calculation Details	Additional Information/Explanation
			87 = All other suppliers (e.g., drug and department stores) 88 = Unknown supplier/provider specialty 95 = Competitive Acquisition Program (CAP) 96 = Optician A0 = Hospital (DMERCs only) A1 = SNF (DMERCs only) A2 = Intermediate care nursing facility (DMERCs only) A3 = Nursing facility, other DMERCs only) A4 = HHA (DMERCs only) A5 = Pharmacy (DMERC) A6 = Medical supply company with respiratory therapist (DMERCs only) A7 = Department store (DMERC) A8 = Grocery store (DMERC)
Therapy Costs	Dollar Amount	Carrier Claim Type code (71,72) and TherapyCondition AND placeOfService not in ('23', '21', '51') and hcpcsBetosCode not in ('O1A', 'O1D', 'O1E', 'D1G') and substr(hcpcsBetosCode, 1, 2) not in ('P9', 'P0') OR (Outpatient Claims Type Code (40) and TherapyCondition and hcpcsBetosCode not in ('O1A', 'O1D', 'O1E', 'D1G') and substr(hcpcsBetosCode, 1, 2) not in ('P9', 'P0') and TypeOfBill not in ('22', '23', '33', '34', '72') and	This figure includes costs for local carrier non-DMEPOS claim type claims, also referred to as “professional claims” submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, AND costs for outpatient claim type claims[3] for the following services: services delivered under an outpatient speech language pathology plan of care, services delivered under an outpatient occupational therapy plan of care services delivered under an outpatient physical therapy plan of care. This figure doesn’t include services provided in the following places of service: Emergency room of a hospital, inpatient

[3] 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	Format	Calculation Details	Additional Information/Explanation
		revenueCenterCode NOT in ('0981', '0450', '0451', '0452', '0453', '0454', '0455', '0456', '0457', '0458', '0459')10	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)
Ancillary Services Costs	Dollar Amount	OutpatientClaims (claimTypeCode = 40) and first 2 characters of hcpcsBetosCode in ('T1', 'T2','I1', 'I2', 'I3', 'I4') and NOT TherapyCondition and TypeOfBill not in ('22', '23', '33', '34', '72') and revenueCenterCode NOT in ('0981', '0450', '0451', '0452', '0453', '0454', 0455', '0456', '0457', '0458', '0459') CarrierClaims(71,72) and first 2 characters of hcpcsBetosCode in ('T1', 'T2','I1', 'I2', 'I3', 'I4') and placeOfService not in (21,23,51) and NOT TherapyCondition DmeClaims(81,82) and hcpcsBetosCode NOT IN (O1D,O1E,O1G)	Ancillary Services. 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] 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

[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	Format	Calculation Details	Additional Information/Explanation
			I1D = Standard imaging - contrast gastrointestinal I1E = Standard imaging - nuclear medicine I1F = Standard imaging - other I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck I2B = Advanced imaging - CAT/CT/CTA: other I2C = Advanced imaging - MRI/MRA: brain/head/neck I2D = Advanced imaging - MRI/MRA: other I3A = Echography/ultrasonography - eye I3B = Echography/ultrasonography - abdomen/pelvis I3C = Echography/ultrasonography - heart I3D = Echography/ultrasonography - carotid arteries I3E = Echography/ultrasonography - prostate, transrectal I3F = Echography/ultrasonography - other I4A = Imaging/procedure - heart including cardiac catheterization I4B = Imaging/procedure – other. As noted above, this value does include durable medical equipment claims (excluding chemotherapy, other drugs, and immunizations/vaccinations). This value 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.
IP Facility Services Costs	Dollar Value	BillionProviderOscar (or CCN) ends in {0001- 0899},{1300-	This figure includes costs for inpatient claim type[5] services in short-term (general and specialty) hospitals.

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

Column Header	Format	Calculation Details	Additional Information/Explanation
		1399},{4000-4499} or its third character is M or S	Short-term (general and specialty) hospitals where type of bill (TOB) = 11X; ESRD clinic where TOB = 72X, hospitals participating in ORD demonstration projects where type of 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 claims submitted by inpatient hospital providers for reimbursement of facility costs. These claim records represent covered stays (Medicare paid FFS bills).
Eligible Professional Services Costs	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 Rehabilitation 45 = Mammography screening center

Column Header	Format	Calculation Details	Additional Information/Explanation
			47 = Independent Diagnostic Testing Facility 49 = Ambulatory surgical center 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics) 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 54 = Medical supply company not included in 51, 52, or 53. 55= Individual certified orthotist 56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g., private ambulance companies, funeral homes 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 96 = Optician A0 = Hospital (DMERCs only)

Column Header	Format	Calculation Details	Additional Information/Explanation
			A1 = SNF (DMERCs only) A2 = Intermediate care nursing facility (DMERCs only) A3 = Nursing facility, other DMERCs only) A4 = HHA (DMERCs only)
Emergency Services Not in Hospital Admission Costs	Dollar Amount	Carrier Claims and placeOfService = 23 and first 2 characters of hcpcsBetosCode in (M1-M6, P1-P8, T1,T2,I1-I4) and NOT SpecialtyCondition Outpatient Claims and first 2 characters of hcpcsBetosCode in (M1-M6, P1-P8, T1,T2,I1-I4) and revenueCenterCode in ('0981', '0450', '0451', '0452', '0453', '0454', '0455', '0456', '0457', '0458', '0459')	This figure includes costs for local carrier non-DMEPOS claim type claims, also referred to as "professional claims" submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, provided in the emergency room of a hospital, and including the following services: M1A = Office visits - new M1B = Office visits - established M2A = Hospital visit - initial M2B = Hospital visit - subsequent M2C = Hospital visit - critical care M4A = Home visit M4B = Nursing home visit M5A = Specialist - pathology M5B = Specialist - psychiatry M5C = Specialist - ophthalmology M5D = Specialist - other M6 = Consultations P1A = Major procedure – breast P1B = Major procedure - colectomy P1C = Major procedure - cholecystectomy P1D = Major procedure - turp P1E = Major procedure - hysterectomy P1F = Major procedure - explor/decompr/excisdisc P1G = Major procedure - Other P2A = Major procedure, cardiovascular-CABG P2B = Major procedure, cardiovascular-Aneurysm repair P2C = Major Procedure, cardiovascular-

Column Header	Format	Calculation Details	Additional Information/Explanation
			Thromboendarterectomy P2D = Major procedure, cardiovascular-Coronary angioplasty (PTCA) P2E = Major procedure, cardiovascular-Pacemaker insertion P2F = Major procedure, cardiovascular-Other P3A = Major procedure, orthopedic - Hip fracture repair P3B = Major procedure, orthopedic - Hip replacement P3C = Major procedure, orthopedic - Knee replacement P3D = Major procedure, orthopedic – other P4B = Eye procedure - cataract removal/lens insertion P4C = Eye procedure - retinal detachment P4D = Eye procedure - treatment of retinal lesions P4E = Eye procedure - other P5A = Ambulatory procedures - skin P5B = Ambulatory procedures - musculoskeletal P5C = Ambulatory procedures - inguinal hernia repair P5D = Ambulatory procedures - lithotripsy P5E = Ambulatory procedures - other P6A = Minor procedures - skin P6B = Minor procedures - musculoskeletal P6C = Minor procedures - other (Medicare fee schedule) P6D = Minor procedures - other (non-Medicare fee schedule) P8A = Endoscopy - arthroscopy P8B = Endoscopy - upper gastrointestinal P8C = Endoscopy - sigmoidoscopy P8D = Endoscopy - colonoscopy 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	Format	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 - CAT/CT/CTA: brain/head/neck I2B = Advanced imaging - CAT/CT/CTA: other I2C = Advanced imaging - MRI/MRA: brain/head/neck I2D = Advanced imaging - MRI/MRA: other I3A = Echography/ultrasonography - eye I3B = Echography/ultrasonography - abdomen/pelvis I3C = Echography/ultrasonography - heart I3D = Echography/ultrasonography - carotid arteries I3E = Echography/ultrasonography - prostate, transrectal I3F = Echography/ultrasonography - other I4A = Imaging/procedure - heart including cardiac catheterization I4B = Imaging/procedure - other Carrier/professional claims for services AREN'T included in this figure if provided by providers with the following CMS

Column Header	Format	Calculation Details	Additional Information/Explanation
			specialty codes: 31 = Intensive Cardiac Rehabilitation 45 = Mammography screening center 47 = Independent Diagnostic Testing Facility 49 = Ambulatory surgical center 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics) 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics) 54 = Medical supply company not included in 51, 52, or 53. 55= Individual certified orthotist 56 = Individual certified prosthetist 57 = Individual certified prosthetist-orthotist 58 = Medical supply company with registered pharmacist 59 = Ambulance service supplier, e.g., private ambulance companies, funeral homes 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

Column Header	Format	Calculation Details	Additional Information/Explanation
			95 = Competitive Acquisition Program 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[6] for the services listed above provided to the patient during the 2024 performance period if provided in locations with the following revenue center codes: 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
Post Acute Services Costs	Dollar Amount	Claim Type Code[7] 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).

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

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

Column Header	Format	Calculation Details	Additional Information/Explanation
			Outpatient SNF claims and outpatient home health claims aren't included in this figure.
Hospice Costs	Dollar Amount	All hospice claims (claim type code 50)	This figure reflects attributable costs for hospice claims.
Other Costs	Dollar Amount	Total Scaled Costs – sum (all other categories listed above)	This figure reflects the attributable costs of other services provided to patient that aren't captured in the categories above.

MSPB Clinician Measure Patient-Level Report

Which individual MIPS eligible clinicians and/or groups received a 2024 MSPB Clinician Patient-Level Report?

Only clinicians and groups who met the case minimum of 35 received a 2024 MSPB Clinician patient-level report.

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

For more information, view the 2024 MSPB Clinician MIF (PDF, 1,406 KB). 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 2024 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, Entity ID, NPI, TIN, Measure ID, MBI, Gender, Date of Birth, and Date of Death)

Column Header	Format	Calculation Details	Additional Information
Episode ID	Numeric	N/A	The ID for tracking a unique episode.
Episode Start Date	Numeric Date	N/A	The start date of the episode, which is 3 days before the date of the inpatient hospital admission that triggered the episode.
Inpatient Admission Date	Numeric Date	N/A	The date of the inpatient hospital admission that triggered the episode.
Inpatient Discharge Date	Numeric Date	N/A	The date of the discharge for the inpatient hospital admission that triggered the episode
Episode End Date	Numeric Date	N/A	The end date of the episode which is 30 days after the discharge for the inpatient hospital admission that triggered the episode.
HCC Risk Rank Percentile	Numeric	See Q&A above	This figure is an average of the beneficiary's 2024 risk scores translated into a percentile
Total Cost	Dollar Amount	N/A	This figure represents the unadjusted, price-standardized, observed cost of the episode. This figure is neither normalized nor Winsorized.

Column Header	Format	Calculation Details	Additional Information
Inpatient Index Admission Costs	Dollar Amount	claimType = 'INPATIENT' (Inpatient claims) and acute provider (3rd character of provider is '0' and not a repeat admission (no admission for the same beneficiary 30 days before the current admission)	This figure includes costs for inpatient claim type[8] services provided in short-term (general and specialty) hospitals,[9] 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 defined as any admission other than the index admission that occurs within 30 days of the index admission. Inpatient claims are fee-for-service claims submitted by inpatient hospital providers for reimbursement of facility costs. These claim records represent covered stays (Medicare paid FFS bills).
Inpatient Hospital Readmission Costs	Dollar Amount	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. A repeat admission is defined as any admission other than the index admission that occurs within 30 days of the index admission.

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

[9] See: https://resdac.org/sites/datadocumentation.resdac.org/files/Provider%20Number%20Table.txt

The first 2 digits of the "provider number variable" indicate the state where the provider is located, using the SSA state codes; the middle 2 characters indicate the type of provider; and the last 2 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)

Column Header	Format	Calculation Details	Additional Information
Inpatient Rehab LTCH Costs	Dollar Amount	claimtype = 'INPATIENT[10]' 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.
Physician Services Costs	Dollar Amount	claimtype = 'PROFESSIONAL' and placeOfService[11] in (21,51) and substring(hcpcsBetosGr oup,1,2) not in ('P0','P9') and hcpcsBetosCode[12] not in ('O1A','O1D','O1E','D1 G')[13]	This figure includes costs for local carrier non-durable medical equipment, prosthetics, orthotics and supplies claim type claims, also referred to as "professional claims" submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for services provided to the patient during the time period beginning 3 days prior to the index admission plus 30 days after discharge, in an inpatient hospital and/or inpatient Psychiatric Facility. This figure **doesn't** include the following services: anesthesia, dialysis, ambulance, chemotherapy, other DME, nor drugs administered through DME.

[10] Claims submitted by inpatient hospital providers for reimbursement of facility costs.
[11] https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
[12] https://www.resdac.org/cms-data/variables/line-berenson-eggers-type-service-betos-code
[13] https://resdac.org/sites/datadocumentation.resdac.org/files/BETOS%20Table.txt

Column Header	Format	Calculation Details	Additional Information
Home Health Costs	Dollar Amount	claimtype = 'HOME_HEALTH_SERVICES'	This figure includes costs for HHA 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.
SNF Costs	Dollar Amount	claimtype = 'SKILLED_NURSING_FACILITY'	This figure includes costs for swing-bed AND non-swing bed SNF 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.
Therapy Costs	Dollar Amount	claimtype = 'PROFESSIONAL' and (hcpcsModiferCode1 in ('GN[14]','GO','GP') or hcpcsModiferCode2in ('GN','GO','GP') or hcpcsModiferCode3 in('GN','GO','GP') or hcpcsModiferCode4 in ('GN','GO','GP') OR hcpcsModiferCode5 in ('GN','GO','GP'))	This figure includes costs for local carrier non-DMEPOS claim type claims, also referred to as "professional claims" submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the patient during the time period beginning 3 days prior to the index admission plus 30 days after discharge: Services delivered under an outpatient speech language pathology plan of care, services delivered under an outpatient occupational therapy plan of care, services delivered under an outpatient physical therapy plan of care.
ER E&M Costs	Dollar Amount	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

[14] 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"

Column Header	Format	Calculation Details	Additional Information
			providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following E&M 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: 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
ER Procedures Costs	Dollar Amount	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

Column Header	Format	Calculation Details	Additional Information
			P1D = Major procedure – turp P1E = Major procedure – hysterectomy P1F = Major procedure explor/decompr/excisdisc P1G = Major procedure – Other P2A = Major procedure, cardiovascular-CABG P2B = Major procedure, cardiovascular-Aneurysm repair P2C = Major Procedure, cardiovascular-Thromboendarterectomy P2D = Major procedure, cardiovascular-Coronary angioplasty (PTCA) P2E = Major procedure, cardiovascular-Pacemaker insertion P2F = Major procedure, cardiovascular-Other P3A = Major procedure, orthopedic – Hip fracture repair P3B = Major procedure, orthopedic – Hip replacement P3C = Major procedure, orthopedic – Knee replacement P3D = Major procedure, orthopedic – other P4A = Eye procedure – corneal transplant P4B = Eye procedure – cataract removal/lens insertion P4C = Eye procedure – retinal detachment P4D = Eye procedure – treatment of retinal lesions P4E = Eye procedure – other P5A = Ambulatory procedures – skin P5B = Ambulatory procedures – musculoskeletal P5C = Ambulatory procedures – inguinal hernia repair P5D = Ambulatory procedures – lithotripsy P5E = Ambulatory procedures – other

Column Header	Format	Calculation Details	Additional Information
			P6A = Minor procedures – skin P6B = Minor procedures – musculoskeletal P6C = Minor procedures – other (Medicare fee schedule) P6D = Minor procedures – other (non-Medicare fee schedule) P7A = Oncology – radiation therapy P7B = Oncology – other P8A = Endoscopy – arthroscopy P8B = Endoscopy – upper gastrointestinal P8C = Endoscopy – sigmoidoscopy P8D = Endoscopy – colonoscopy P8E = Endoscopy – cystoscopy P8F = Endoscopy – bronchoscopy P8G = Endoscopy – laparoscopic cholecystectomy P8H = Endoscopy – laryngoscopy P8I = Endoscopy – other
ER Labs Costs	Dollar Amount	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 1)='T' and placeOfServiceCode = '23'	This figure includes costs for local carrier non-DMEPOS claim type claims, also referred to as "professional claims" submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the patient in an emergency room of a hospital during the time period beginning 3 days prior to the index admission plus 30 days after discharge: T1A = Lab tests – routine venipuncture (non-Medicare fee schedule) T1B = Lab tests – automated general profiles T1C = Lab tests – urinalysis T1D = Lab tests – blood counts T1E = Lab tests – glucose

Column Header	Format	Calculation Details	Additional Information
			T1F = Lab tests – bacterial cultures T1G = Lab tests – other (Medicare fee schedule) T1H = Lab tests – other (non-Medicare fee schedule) T2A = Other tests – electrocardiograms T2B = Other tests – cardiovascular stress tests T2C = Other tests – EKG monitoring T2D = Other tests – other
ER Imaging Costs	Dollar Amount	claimtype = 'PROFESSIONAL' and substring (hcpcsBetosCode, 1, 1)='I' and placeOfServiceCode = '23'	This figure includes costs for local carrier non-DMEPOS claim type claims, also referred to as "professional claims" submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, for the following services provided to the patient in an emergency room of a hospital during the time period beginning 3 days prior to the index admission plus 30 days after discharge: I1A = Standard imaging – chest I1B = Standard imaging – musculoskeletal I1C = Standard imaging – breast I1D = Standard imaging – contrast gastrointestinal I1E = Standard imaging – nuclear medicine I1F = Standard imaging – other I2A = Advanced imaging – CAT/CT/CTA: brain/head/neck I2B = Advanced imaging – CAT/CT/CTA: other I2C = Advanced imaging – MRI/MRA: brain/head/neck I2D = Advanced imaging – MRI/MRA: other I3A = Echography/ultrasonography – eye I3B = Echography/ultrasonography – abdomen/pelvis I3C = Echography/ultrasonography – heart

Column Header	Format	Calculation Details	Additional Information
			I3D = Echography/ultrasonography – carotid arteries I3E = Echography/ultrasonography – prostate, transrectal I3F = Echography/ultrasonography – other I4A = Imaging/procedure – heart including cardiac catheterization I4B = Imaging/procedure – other
Dialysis Costs	Dollar Amount	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)
E&M Non-ER Costs	Dollar Amount	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

Column Header	Format	Calculation Details	Additional Information
			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
Mahor Procedures Anesthesia Costs	Dollar Amount	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-Coronary angioplasty (PTCA)

Column Header	Format	Calculation Details	Additional Information
			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
Minor Procedures Ambulatory Costs	Dollar Amount	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 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)

Column Header	Format	Calculation Details	Additional Information
			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
Ancillary Labs Costs	Dollar Amount	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

Column Header	Format	Calculation Details	Additional Information
Ancillary Imaging Costs	Dollar Amount	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 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

Column Header	Format	Calculation Details	Additional Information
			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
Hospice Costs	Dollar Amount	claimType = 'HOSPICE'	This figure includes costs for hospice 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
Ambulance Costs	Dollar Amount	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
Chemo Drugs DME Costs	Dollar Amount	claimtype in ('DURABLE_MEDICAL_EQUIPMENT','PROFESSIONAL') and hcpcsBetosCode in ('O1D','O1E','D1G')	This figure includes costs for local carrier non-DMEPOS claim type claims, also referred to as "professional claims" submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners, AND costs for local carrier DMEPOS claims, which are FFS claims submitted by DME suppliers to the DME Medicare Administrative Contractor, for the

Column Header	Format	Calculation Details	Additional Information
			following services provided to the 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 Costs	Dollar Amount	claimType = 'OUTPATIENT'	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 Costs	Dollar Amount	N/A	All services not otherwise classified.

Episode-Based Cost Measures Patient-Level Reports

The table below includes detailed descriptions of the figures presented in the 2024 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 ID, episode service category, episode service category description, service code(s), service code description, and standardized costs. Taken together, this information describes the service assignment rule(s) used to assign the cost of the service to the episode.

Column Header	Format	Additional Information
Entity Type	Description	Group, individual, etc. Depends on participation and reporting level.
Entity ID	Alpha numeric	Only applicable to virtual groups
TIN	Numeric	Refer to the 2024 MIPS Cost Measure Information Forms (ZIP, 47MB) and the 2024 MIPS Cost Measure Codes Lists (ZIP, 14MB) for more information.
NPI	Numeric	Presence of this field will depend upon the chosen 2024 MIPS participation level. Refer to the 2024 MIPS Cost Measure Information Forms (ZIP, 47MB) and the 2024 MIPS Cost Measure Codes Lists (ZIP, 14MB) for more information. information.
Measure ID	Alpha numeric	MIPS Measure ID
MBI	Numeric	N/A
Gender	M=Male F=Female	N/A
Date of Birth	Numeric Date	N/A
HCC Risk Score	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.
Date of Death	Numeric Date	If the attributed patient died during the 2024 performance year, the patient's date of death will be reflected here.
Episode ID		ID for Tracking Unique Episode

Column Header	Format	Additional Information
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.
Episode Service Category	Description	Refer to the measure codes list file for service categories and descriptions.
Episode Service Cat Description	Description	Refer to the measure codes list file for service categories and descriptions.
Service Code	Alpha numeric codes	Refer to the measure codes list file for service categories and descriptions.
Service Code Description	Description	Refer to the measure codes list file for service categories and descriptions.
Service Date	Numeric Date	Date of service provided associated with the unique line.
Service Provider	Numeric	Clinician that provided service associated with the unique line. Results will be either an NPI, CCN or empty depending on the service type.
Standardized Cost	Dollar Amount	This figure represents the unadjusted, 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, 1MB) for more detailed information.

How do I interpret the numeric codes contained in the "Service Code" column of the patient level reports for 2024 MIPS 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 particular service. Service category assignment rules for each episode-based measure are in the 2024 MIPS Cost Measure Codes Lists (ZIP, 14MB).

Consider the following 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 and 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’s 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 (Entity Type, Entity ID, TIN, NPI, Measure ID, MBI, Gender, Date of Death, Date of Birth) aren’t duplicated in the table below.
- There are no dollar values contained in this report.
- Refer to the MIPS 2024 Hospital-Wide All-Cause Unplanned Readmission Measure (ZIP, 703KB) containing 2 documents: MIPS Hospital-Wide Readmission MIF and the code tables.
- Eligible index admissions include acute care hospitalizations for Medicare FFS beneficiaries aged 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	Format	Additional Information
HCC Percentile Ranking	Numeric	This figure is an average of the patient’s 2024 risk scores translated into a percentile. This column may be blank when no HCC values (risk scores) are present in 20YY-1 table, i.e., for new beneficiaries.

Column Header	Format	Additional Information
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 the Agency for Healthcare Research and Quality (AHRW) clinical classification software (CCS)) are used to define the specialty cohorts.
Primary Index Diagnosis	Alpha-numeric code	ICD-10 Diagnosis code
Index Admission Date	Numeric Date	N/A
Index Discharge Date	Numeric Date	N/A
Primary Readmission Diagnosis	Alpha numeric code	ICD-10 Diagnosis code
Readmission Admission 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 (Entity Type, Entity ID, TIN, NPI, Measure ID, MBI, Gender, Date of Death, Date of Birth) aren't duplicated in the table below.
- Refer to the 2024 Hip Arthroplasty and Knee Arthroplasty Complication Measure (ZIP, 555 KB), containing 2 documents: the code tables and MIF.
- There are no dollar values in this report.

Column Header	Format	Additional Information
HCC Percentile Ranking	Numeric	This figure is an average of the patient's 2024 risk scores translated into a percentile.

Column Header	Format	Additional Information
Index Admission Date	Numeric Date	Date of index admission. Eligible index admissions include Medicare 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; • 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.
Patient Death Within 30 Days	TRUE or blank. A blank cell = false.	Patient death occurred within 30 days of the index stay admission date.
Index Complication	Alpha numeric code(s)	A list of all the complications found on the index stay. Possible values are AMI, Mechanical Complication, Pulmonary Embolism, Pneumonia, Sepsis, Infection, and Surgical Bleeding

Readmission Complication	Comma separated descriptions	A list of all the readmission complications found for the index stay, in the form of `<Complication Type> Within <Number of Days from Original Admission>`. Possible values are: Infection Within 90, Mechanical Complication Within 90, Pulmonary Embolism Within 30, Surgical Bleeding Within 30, AMI Within 7, Pneumonia Within 7, and Sepsis Within 7. This variable now includes the corresponding readmission date for each readmission complication.
Complication	TRUE or blank. A blank cell = false.	A boolean value stating the index stay had either patient death within 30 days, an index complication, or a readmission complication.

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 (Entity Type, Entity ID, TIN, NPI, Measure ID, MBI, Gender, Date of Death, Date of Birth) aren't duplicated in the table below.
- For more information, please refer to the 2024 MIPS All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions for ACOs (MCC) Measure Specifications (ZIP, 5 MB).

Data Element Label	Data Element Description
AMI	Indicator (value of TRUE or FALSE) for whether a patient meets requirements for inclusion in the AMI chronic condition category.
Alzheimer's	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.
Atrial Fibrillation	Indicator (value of TRUE or FALSE) for whether a patient meets requirements for inclusion in the atrial fibrillation chronic condition category

Data Element Label	Data Element Description
CKD	Indicator (value of TRUE or FALSE) for whether a patient meets requirements for inclusion in the CKD chronic condition category.
COPD	Indicator (value of TRUE or FALSE) for whether a patient meets requirements for inclusion in the COPD and asthma chronic condition category.
Depression	Indicator (value of TRUE or FALSE) for whether a patient meets requirements for inclusion in the depression condition category.
HF	Indicator (value of TRUE or FALSE) for whether a patient meets requirements for inclusion in the heart failure chronic condition category.
TIA	Indicator (value of TRUE or FALSE) for whether a patient meets requirements for inclusion in the stroke and TIA chronic condition category.
Diabetes	Indicator (value of TRUE or FALSE) for whether a patient meets requirements for inclusion in the diabetes chronic condition category.
Earliest Admission	Date of the first admission in the performance period
Latest Discharge	Date of the last discharge in the performance period
Unplanned Admission Count	The number of unplanned admissions for the performance period.
Earliest Unplanned Admission	The first unplanned admission for the beneficiary. If the beneficiary had only one unplanned admission, it will be both earliest and latest unplanned admissions.
Latest Unplanned Admission	The last unplanned admission for the beneficiary. If the beneficiary had only one unplanned admission, it will be both earliest and latest unplanned admissions.

Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System

The table below includes descriptions of the figures presented in the patient-level report for quality measure ID #492. Please note:

- The columns that are consistent across all patient-level cost measure reports (Entity Type, Entity ID, TIN, NPI, Measure ID, MBI, Gender, Date of Death, Date of Birth) aren't duplicated in the table below.
- For more information, please refer to the Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with HF Measure Specifications (ZIP, 1MB)

Data Element Label	Data Element Description
Earliest Admission	The first admission date for the beneficiary.
Latest Discharge	The latest discharge date for the beneficiary.
Unplanned Admission Count	The number of unplanned admissions that were found for the beneficiary.
Earliest Unplanned Admission	The first unplanned admission for the beneficiary. If the beneficiary had only one unplanned admission, it will be both earliest and latest unplanned admissions.
Latest Unplanned Admission	The last unplanned admission for the beneficiary. If the beneficiary had only one unplanned admission, it will be both earliest and latest unplanned admissions.

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 Telecommunications Relay Services Communications Assistant.

Version History

Date	Change Description
8/22/2025	Original Posting.