Quality Payment
PROGRAM

Items and Services Quarterly Reports

Frequently Asked Questions

What Is the Purpose of the Items and Services Report?

The Items and Services report provides clinicians with quarterly updates on information about the healthcare and emergency department (ED) services received by their patients throughout each calendar year (CY). **Items and Services data is provided for informational purposes only and won't affect your MIPS performance scores.**

How Are You Defining the Types of Items and Services Used by Patients?

We define the types of items and services using Healthcare Common Procedure Coding System (HCPCS) codes. HCPCS codes represent a standard coding system for procedures, supplies, products, and services billed by healthcare providers. The data in the Items and Services report is aggregated by ranges of HCPCS codes.

What Is a HCPCS Code and How Are They Classified by Level?

The HCPCS is a collection of codes that represent procedures, supplies, products, and services that may be provided to Medicare patients and to individuals enrolled in other health insurance programs. The codes are divided into 2 levels:

- **Level I HCPCS Codes**: Codes and descriptors copyrighted by the American Medical Association's (AMA) Current Procedural Terminology (CPT®), fourth edition (CPT-4). These are 5 position numeric codes representing services of physicians, non-physician practitioners, and other suppliers.
- **Level II HCPCS Codes**: Alphanumeric codes consisting of a single alphabetical letter followed by 4 numeric digits. Level II HCPCS codes are used primarily to identify products, supplies and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes and descriptors are maintained and distributed by CMS.[1]

[1] Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures

What Is a CPT Code?

CPT codes offer healthcare professionals a uniform language for coding medical services and procedures to streamline reporting and increase accuracy and efficiency. All CPT codes have 5 digits and can be either numeric or alphanumeric, depending on the category. As noted above, Level I of the HCPCS is composed of CPT-4 codes, a numeric coding system maintained by the AMA.

How Are HCPCS Codes Categorized in Items and Services?

In the Items and Services report, the HCPCS codes are categorized as follows:

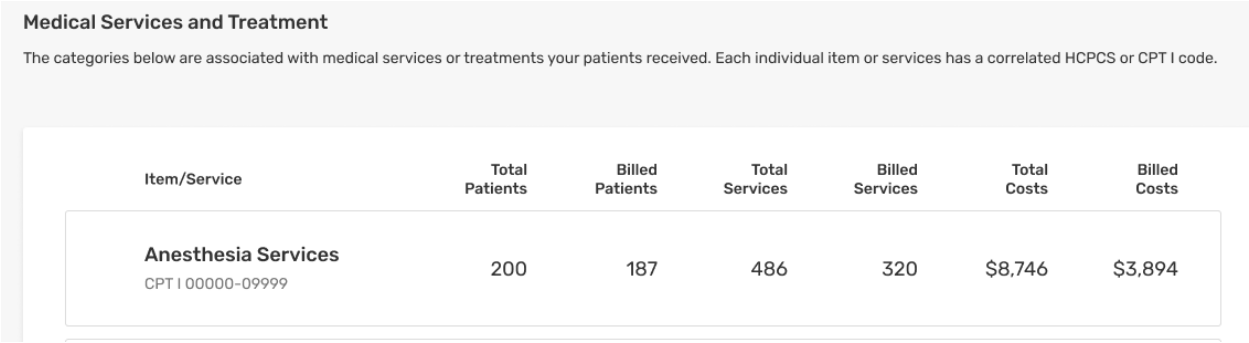
HCPCS Code	Definition of HCPCS Code Ranges
Level 1 HCPCS[2]	
00000-01999	Anesthesia services
10000-19999	Integumentary system
20000-29999	Musculoskeletal system
30000-39999	Respiratory, cardiovascular, hemic, and lymphatic system
40000-49999	Digestive system
50000-59999	Urinary, male genital, female genital, maternity care, and delivery system
60000-69999	Endocrine, nervous, eye and ocular adnexa, auditory system
70000-79999	Radiology services
80000-89999	Pathology and laboratory services
90000-99999	Medicine, valuation and management services
Level 2 HCPCS[3]	
HCPCS A	Transportation services including ambulance, medical & surgical supplies
HCPCS B	Enteral and parenteral therapy

[2] Medicare NCCI Policy Manual | CMS
[3] https://hcpcs.codes/section/

HCPCS Code	Definition of HCPCS Code Ranges
HCPCS C	Temporary codes for use with outpatient prospective payment system
HCPCS E	Durable medical equipment (DME)
HCPCS G	Procedures or professional services (temporary codes)
HCPCS H	Alcohol and drug abuse treatment services / rehabilitative services
HCPCS J	Drugs administered other than oral method, chemotherapy drugs
HCPCS K	DME for Medicare administrative contractors (DME MACs)
HCPCS L	Orthotic and prosthetic procedures, devices
HCPCS M	Medical services
HCPCS P	Pathology and laboratory services
HCPCS Q	Miscellaneous services (temporary codes)
HCPCS R	Diagnostic radiology services
HCPCS S	Commercial payers (temporary codes)
HCPCS T	Established for state medical agencies
HCPCS U	Codes for Coronavirus lab tests
HCPCS V	Vision, hearing and speech-language pathology services

What Data Is Being Used in the Items and Services Section of Performance Feedback?

Beginning in 2025, the Items and Services report will be provided quarterly. The report uses Medicare Part B professional claims (Claim Types 71 and 72) billed with dates of services between January 1 of the calendar year and the end of the latest available quarter and received by CMS within 60 days of the end of that quarter. For example, for quarter 1 of 2026, the reports would include claims with dates of services between January 1, 2026 and March 31, 2026 and received by CMS within 60 days of March 31, 2026 (a “60-day runout”). For quarter 2 of 2026, the reports would include claims with dates of services between January 1, 2026 and June 30, 2026 and received by CMS within 60 days of June 30, 2026 (a “60-day runout”).



Medical Services and Treatment

The categories below are associated with medical services or treatments your patients received. Each individual item or services has a correlated HCPCS or CPT I code.

Item/Service	Total Patients	Billed Patients	Total Services	Billed Services	Total Costs	Billed Costs
Anesthesia Services CPT I 00000-09999	200	187	486	320	$8,746	$3,894

How Is the Number of "Total Patients" Displayed in the Items and Service Report Derived?

For individual clinicians, this number includes all unique Part B-enrolled patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during the calendar year up until the end of the latest calendar quarter AND at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during the calendar year up until the end of the latest calendar quarter.

For groups, this number includes all unique Part B-enrolled patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during the calendar year up until the end of the latest calendar quarter AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during the calendar year up until the end of the latest calendar quarter.

While the "Total Patients" number is not specific to patients who received a qualifying service provided by you but rather includes patients who received a qualifying service from any clinician during the calendar year up until the end of the latest calendar quarter, the "Billed Patients" figure only includes patients you provided a qualifying service to.

How Is the "Total Cost" per CPT Code Range in the Items and Service Section of Performance Feedback Derived? Is the Cost Adjusted and/or Price Standardized?

The cost reflected in the Items and Services section of performance feedback is the sum of all positive allowed charge amounts for the related HCPCS/CPT codes on Part B professional claim lines with dates of service during the calendar year up until the end of the latest calendar quarter. These numbers are raw allowed charge amounts and aren't payment-standardized, risk-adjusted, or specialty adjusted.

For individual clinicians, the number is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines for patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during the calendar year up until the end of the latest calendar quarter AND at least one qualifying service (identified by the relevant CPT code within the designated range) from any provider during the calendar year up until the end of the latest calendar quarter.

For groups, this number is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines with allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during the calendar year up until the end of the latest calendar quarter AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during the calendar year up until the end of the latest calendar quarter.

While the "Total Costs" figure is not specific to services provided by you but rather includes any services your patient may have sought out during the calendar year up until the end of the latest calendar quarter, the "Billed Costs" figure only includes costs for services you provided.

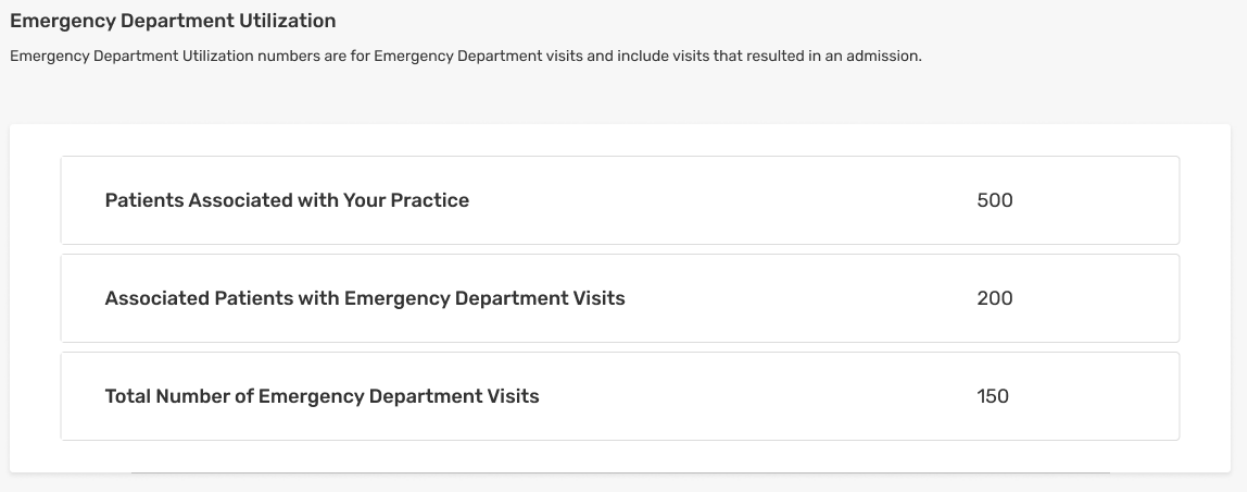
How Is the Number of "Total Services" in the Items and Services Section of Performance Feedback Derived?

For individual clinicians, the number of services reflected is the sum of all Part B-enrolled patients' service unit quantity counts on professional claim lines with positive allowed charges for patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during the calendar year up until the end of the latest calendar quarter AND received at least one qualifying service (identified by the relevant CPT code within the designated range) from any clinician during the calendar year up until the end of the latest calendar quarter.

For groups, this number is the sum of all Part B-enrolled patients' service unit quantity counts on professional claim lines with positive allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during the calendar year up until the end of the latest calendar quarter AND at least one qualifying service (identified by the relevant CPT code within the designated range) from any clinician during the calendar year up until the end of the latest calendar quarter.

While the "Total Services" figure is not specific to services provided by you but rather includes any services your patient may have sought out during the calendar year up until the end of the latest calendar quarter, the "Billed Services" figure only includes services you provided.

Emergency Department Utilization



Which Patients Are Counted in the "Patients Associated with Your Practice" Entry Under the "Emergency Department Utilization" Heading?

In this report, "patients associated with your practice" are the patients attributed to an individual clinician's TIN/NPI or to a group's TIN (depending on the chosen level of reporting) through a 2-step attribution process.

- Patients are attributed to a single TIN/NPI based on the amount of primary care services received, and the clinician specialties that performed those services, during the performance period.
- Only patients who received a primary care service during the performance period can be attributed to a TIN/NPI. A patient is attributed to a single TIN/NPI or a single entity's CMS Certification Number (CCN) assigned to either a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) in 1 of 2 steps, described below.
- Note: If a patient is attributed to an FQHC's or RHC's CCN, then that patient and their services aren't included in the provision of Items and Services data for an individual MIPS eligible clinician or group.

  Step 1: If a patient received more primary care services from an individual TIN/NPI that's classified as a primary care physician (PCP), nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) than from any other TIN/NPI during the performance period, then the patient is attributed to that TIN/NPI. If, during the performance period, a patient received more primary care services from an entity's CCN than from any other TIN/NPI, then the patient is attributed to the CCN.

  Step 2: If a patient didn't receive a primary care service from a TIN/NPI classified as a PCP, NP, PA, or CNS during the performance period, then the patient may be assigned to a TIN/NPI in "Step 2." If a patient received more primary care services from a specialist physician's TIN/NPI than from any another clinician's TIN/NPI during the performance period, then the patient is assigned to the specialist physician's TIN/NPI.

For a list of CMS specialty codes for PCPs and non-physician practitioners included in the first step of attribution, see Appendix A. See Appendix B for a list of medical specialists, surgeons, and other physicians included in the second step of attribution.

A patient is excluded from the population measured for the purposes of providing Items and Services data if:

- The patient wasn't enrolled in both Medicare Parts A & B for every month of the performance period up until the end of the latest calendar quarter.
- The patient was enrolled in a private Medicare health plan during any month of the performance period up until the end of the latest calendar quarter.
- The patient resided outside the United States (including territories) during any month of the performance period up until the end of the latest calendar quarter.
- The patient was enrolled in Medicare Parts A & B for a partial year because they were newly enrolled in Medicare, or they died during the performance period.

The case minimum for provision of Items and Services data is 20. For a MIPS eligible clinician participating in MIPS as an individual, 20 patients must be assigned to the individual MIPS eligible clinician's TIN/NPI for Items and Services data to be provided. For groups of clinicians participating in MIPS as a group, a total of 20 patients must be assigned to TIN/NPIs across the TIN/NPIs under the group's TIN for Items and Services data to be provided.

Which Patients Are Counted in the "Associated Patients with Emergency Department Visits" Entry Under the "Emergency Department Utilization" Heading?

This metric reflects the number of attributed patients who also had an ED visit in the calendar year up until the end of the latest calendar quarter. An ED visit is defined as any claim with a claim line containing any of the following ED revenue center codes: 0450 – 0459 and/or 0981.

How Is the "Total Number of Emergency Department Visits" Entry Under the "Emergency Department Utilization" Heading Defined?

The figure reflects the actual number of ED visits across all attributed patients in the calendar year up until the end of the latest calendar quarter.

Appendix A: Specialty Codes for PCPs and Non-Physician Practitioners Included in the First Step Attribution

Specialty Description (CMS Specialty Code)
Primary Care Physicians
General Practice (01)
Family Practice (08)
Internal Medicine (11)
Geriatric Medicine (38)
Non-physician Practitioners
Clinical Nurse Specialist (89)
Nurse Practitioner (50)
Physician Assistant (97)

Note: For claims for either FQHC or RHC services: All primary care services are considered in the first step of attribution unless the FQHC or RHC participates in an ACO but the attending physician does not. If the FQHC or RHC participates in an ACO but the attending physician does not, then the services are considered in the first step only if the attending physician is a PCP as defined in the table.

Appendix B: Specialty Codes for Medical Specialists, Surgeons, and Other Physicians Included in the Second Step Attribution

Specialty Description (CMS Specialty Code)	
Medical Specialists	**Other Physicians**
Addiction Medicine (79)	Anesthesiology (05)
Allergy/Immunology (03)	Chiropractic (35)
Clinical Cardiac Electrophysiology (21)	Diagnostic Radiology (30)
Cardiology (06)	Emergency Medicine (93)
Critical Care (Intensivists) (81)	Interventional Radiology (94)
Dermatology (07)	Nuclear Medicine (36)
Dentist (C5)	Optometry (41)
Endocrinology (46)	Pain Management (72)
Gastroenterology (10)	Pathology (22)
Geriatric Psychiatry (27)	Pediatric Medicine (37)
Hematology (82)	Podiatry (48)
Hematology-Oncology (83)	Radiation Oncology (92)
Hospice and Palliative Care (17)	Clinic or Group Practice (70)
Infectious Disease (44)	Sports Medicine (23)
Interventional Cardiology (C3)	Undefined Physician Type (99)
Interventional Pain Management (09)	**Surgeons**
Medical Oncology (90)	Cardiac Surgery (78)
Nephrology (39)	Colorectal Surgery (Proctology) (28)
Neurology (13)	General Surgery (02)
Neuropsychiatry (86)	Gynecological Oncology (98)
Osteopathic Manipulative Medicine (12)	Hand Surgery (40)
Physical Medicine and Rehabilitation (25)	Maxillofacial Surgery (85)
Preventative Medicine (84)	Neurosurgery (14)
Psychiatry (26)	Obstetrics & Gynecology (16)
Pulmonary Disease (29)	Ophthalmology (18)
Rheumatology (66)	Oral Surgery (Dentists Only) (19)
Sleep Medicine (C0)	Orthopedic Surgery (20)
	Otolaryngology (04)
	Peripheral Vascular Disease (76)
	Plastic and Reconstructive Surgery (24)
	Surgical Oncology (91)
	Thoracic Surgery (33)
	Urology (34)
	Vascular Surgery (77)

Where Can I Go for Help?

Contact the QPP 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). People who are deaf or hard of hearing can dial 711 to be connected to a Telecommunications Relay Services (TRS) Communications Assistant.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Version History

Date	Change Description
09/12/2025	Original version