Comprehensive Care for Joint Replacement Model:
Data and Pricing Frequently Asked Questions

This document provides participants in the Comprehensive Care for Joint Replacement Model (CJR) with answers to frequently asked questions about target prices, baseline data, and the first set of reports that became available to participants in February 2016. Additional resources on the raw claims data and summary reports can be found in the specification documents and file layouts that were provided to participants along with their data and target prices. Please send other questions to CJRSupport@cms.hhs.gov

What is the time period of episodes included in the historical claims data provided to hospitals in February 2016?

The first set of files that were made available to CJR participants in February 2016 included information on episodes that were used to calculate the first target prices for Performance Year 1. These episodes, which are available in the EPI file, began between 1/1/2012 and 12/31/2014, inclusive, and ended before 3/31/2015. The EPIEXC file is provided to demonstrate which episodes during this time period were excluded from target price calculations and why. Please note that claims associated with episodes in the EPIEXC file are not provided in the individual claims files.

How often will CJR participants receive files with updated claims data? Will the quarterly files be in the same format as the baseline files?

CJR participants will receive updated claims data reports on a quarterly basis beginning in August 2016. The first quarterly report will include all potential CJR episodes that start between April 1 and June 30, 2016. All inpatient stays with DRG 469 or 470 will be included in this data report. These will be cumulative files that will contain up to a year's worth of potential episodes and claims. We say that these are "potential" episodes because they could be excluded later on based on the exclusions in the CJR Rule: https://federalregister.gov/a/2015-29438. In general, the quarterly files will be in a similar format as the baseline data files. If there are any changes to the format of the files, we will provide updated file layouts. Please note that the episode-level spending variables and standardized payments will not be available in the quarterly reports.

Which variables can I use to merge or connect the claims in my hospital's files?

EPI_ID can be used to tie all individual claims back to a given episode in the EPI file. Please note that claims associated with episodes in the EPIEXC file are not provided in the individual claims files.

EPI_ID, GEO_BENE_SK, CLM_DT_SGNTR_SK, CLM_TYPE_CD, and CLM_NUM_SK can be used to tie individual claims to one another.

BENE_SK can be used to tie information from the DENOM file (enrollment file) to episodes in the EPI file.

What is the difference between the header, detail, and value files for claims?

The term header refers to the top or main portion of a claim that typically provides general information such as the provider that is submitting the claim, general dates of service, and patient identifiers. A claim also contains individual line items that display more detailed information, such as the procedure and diagnosis codes. Detailed line level or revenue center information is provided in the detail file. Finally, the value file provides additional information related to add-on payments.

How many days after the anchor stay are included in an episode?

A CJR episode includes the length of stay of the anchor hospitalization plus the 90 day period following this anchor stay, called the post-discharge period. The first day of the post-discharge period is the discharge date of the anchor hospitalization and the last day of the period is 89 days after the anchor discharge date.

Why do my hospital's files contain claims that exceed the episode period?

The raw claims files contain all Part A and Part B header or line items that have dates of service from the admission date of the anchor stay through 120 days after the end of the anchor stay (even though the episode length is only 90 days post-discharge). For claims outside of the episode length, the COSTINC variable is set to 0 to indicate that the associated cost is not included in the cost of the episode. We provide participants with claims data past the episode period as supplemental information because the CJR post-episode monitoring activities will eventually review encounters 91-120 days after the anchor stay.

How can I find out why an episode was excluded from target price calculations?

Episodes listed in the EPIEXC file are excluded from your hospital's target price calculations. To find out why an episodes is listed in the EPIEXC file, look at the value listed under the DROPREASON column. The number listed under DROPREASON for each episode corresponds to text that can be found in the beneficiary file layout (available in the BENE subfolder). The DROPREASON Code List in the file layout explains the exclusion reason that corresponds to the numeric value in the EPIEXC file.

Why are some encounters excluded from episode spending?

The determination of whether encounters (claims) are related to the episode (and therefore included in episode spending) is primarily based on diagnosis and MS-DRG codes, with a few special exclusions using other information on the claims. You can find the list of exclusion codes on the CJR model website: https://innovation.cms.gov/Files/worksheets/ccjr-exclusions.xlsx
Starting with the August quarterly reports, hospitals will receive an additional variable on the claims file explaining why a claim was excluded (has COSTINC = 0) from episode spending.

We also encourage you to review the CJR Episode Definition Specifications and file layouts that participants received with their target prices and baseline data. These files provide more detailed information on how episodes are constructed.

Are readmissions included in the episode spending amount?

Some readmissions could be included in episode spending as long as they are not excluded for another reason based on the CJR Rule. To find out if there are any readmissions included in your hospital's episode spending, go to the IPHDR file. Find claims where COSTINC = 1 and the DRG is anything other than 469 or 470. The encounters that remain are readmissions that are included in episode spending.

How are BPCI cases included in target prices, claims files, and reconciliation?

CJR target prices include BPCI cases. In the historical claims files that CJR participants have received, historical BPCI cases (that were not excluded based on another reason from the CJR Rule) are included in the claims-level data and summary reports.

Quarterly claims files will contain BPCI cases because they cannot be positively identified until BPCI has completed reconciliation. In future claims files, CJR episodes that potentially overlap with BPCI lower extremity joint replacements (LEJR) episodes will be flagged.

Reconciliation will remove all BPCI LEJR episodes.

Was sequestration accounted for when calculating target prices?

Yes, claims with through dates (CLM_THRU_DT) on or before March 31, 2013 were decreased by 2% to account for sequestration. Please note that the dollar amounts and the STD_AMT_EPI field included in the raw claims files (i.e. IPHDR, IPDTL, PBDTL) **do not** account for sequestration. The values in the episode summary, target price, hospital summary, and regional summary files do account for sequestration.

What is the difference between allowed charges and standardized allowed charges?

Allowed charges are the actual payments that providers received when caring for Medicare beneficiaries. Allowed charges on claims are used by CJR in rare cases when the standardized payment is missing.

Standardized payments are used to calculate target prices and reconciliation amounts. Standardized payments remove the effects of incentive programs and differences in wages on spending amounts. Target prices and reconciliation amounts, however, are expressed as "real" dollars. We apply a wage factor to translate the standardized amounts (target prices and reconciliation amount) into "real" dollars for each hospital at the end of all prior calculations. Target prices and reconciliation amounts will be presented in real dollars, not standardized amounts, in the CJR data files and summary reports.

How do I know if a dollar amount is represented in "real" dollars or standardized amounts?

Unless otherwise specified, target prices, available in the PRICE folder, are in real dollars. The dollar amounts listed in the episode file, hospital summary file, and regional summary file are all displayed in standardized amounts. The baseline claims files contain both actual and standardized amounts. The file layouts available in the BENE folder provide descriptions for all variables in the claims files. These descriptions specify which amounts are in standardized dollars.

Why are the amounts listed for EPI_ACUTE in the EPI file not equal to the sum of included costs in the IPHDR file?

To understand how the IPHDR file relates to the different cost categories (Acute, IRF, etc.) please refer to the CJR Episode Definition Specifications, which is located in the SPECS folder. In general, only claims paid by the Inpatient Prospective Payment System are included in the acute cost category. Most likely, some of the claims from the IPHDR file that are included in episode spending can be found in the EPI_OTHER and EPI_IRF cost categories.

What costs are included in the EPI_OTHER category?

The costs that are included in the EPI_OTHER category are payments from sources other than those categorized into the EPI_ACUTE, EPI_SNF, EPI_IRF, EPI_HH, and EPI_PB categories according to the CJR Episode Definition Specifications, which is located in the SPECS folder. Examples of services categorized into EPI_OTHER include claims for hospital outpatient services, critical access hospitals and swing beds, hospice, and durable medical equipment.

What is the difference between Part B claims and outpatient claims?

Part B claim files (PBHDR and PBDTL) refer to carrier claims, such as physician visits, professional services, or anesthesia. Outpatient claims (OPHDR or OPDTL) are for hospital outpatient services, such as outpatient surgery or emergency care.