October 2014

# Physician Quality Reporting System Group Practice Reporting Option Web Interface Assignment Methodology Specifications

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## CONTENTS



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## ACRONYMS

| | |
|---|---|
| ACO | Accountable Care Organization |
| CAH | Critical Access Hospital |
| CCN | CMS Certification Number |
| CMS | Centers for Medicare & Medicaid Services |
| CPT | Current Procedural Terminology |
| CY | Calendar Year |
| ETA | Electing Teaching Amendment Hospital |
| FFS | Fee-for-Service |
| FQHC | Federally Qualified Health Center |
| GPRO | Group Practice Reporting Option |
| HCPCS | Healthcare Common Procedure Coding System |
| IDR | Integrated Data Repository |
| NCH | National Claims History |
| NPI | National Provider Identifier |
| PECOS | Provider Enrollment, Chain and Ownership System |
| PQRI | Physician Quality Reporting Initiative |
| PQRS | Physician Quality Reporting System |
| RHC | Rural Health Clinic |
| TIN | Taxpayer Identification Number |

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## EXECUTIVE SUMMARY

This report describes the specifications for beneficiary assignment for the purposes of sampling beneficiaries for quality reporting via the Physician Quality Reporting System Group Practice Reporting Option (PQRS GPRO) Web Interface. Group practices that satisfactorily report data on PQRS measures for 2014 are eligible to earn a PQRS incentive payment equal to 0.5% of the group practice's total estimated Medicare Part B Physician Fee Schedule allowed charges for covered professional services furnished during the reporting period and may also avoid the negative (-2%) PQRS payment adjustment in 2016. For PQRS purposes, a group practice is defined as a practice with a single tax identification number.

*Beneficiary Assignment:* Beneficiary assignment is determined retrospectively at the end of the registration period, which is September 30 for 2014. Thus, a beneficiary assigned in 1 year may or may not be assigned in the following or preceding years. We use retrospective assignment for the purpose of identifying beneficiaries eligible for sampling into the GPRO Web Interface. If a beneficiary receives at least one primary care service from a physician within the group practice, the beneficiary is eligible to be assigned to the group practice based on a two-step process:

- The first step assigns a beneficiary to a group practice if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the group practice. Primary care physicians are defined as those with one of four specialty designations: internal medicine, general practice, family practice, and geriatric medicine.

- The second step only considers beneficiaries who have not had a primary care service furnished by any primary care physician, including primary care physicians external to the group practice. Under this second step, we assign a beneficiary to a group practice if the beneficiary receives the plurality of his or her primary care services from other professionals within the group practice, including: non–primary care physicians, nurse practitioners, clinical nurse specialists, and physician assistants. Note that the physician specialties used for assignment purposes are determined by the list defined by the Medicare Shared Savings Program and differ slightly from the definition of eligible professionals used to calculate PQRS incentive payments.[1]

A plurality means a greater proportion of primary care services within the group practice than from other individual providers or provider organizations, measured in terms of allowed charges; a plurality can be less than the majority of services.

[1] The definition of eligible professional for PQRS incentive payment purposes is available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_List-of-EligibleProfessionals_022813.pdf.

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## SECTION 1
## INTRODUCTION

This document outlines the process for assigning[2] beneficiaries to a group practice participating in the Physician Quality Reporting System Group Practice Reporting Option (PQRS GPRO) via the GPRO Web Interface. The beneficiary assignment process described here is used as a first step in identifying beneficiaries eligible for quality reporting by a specific group practice. Note that the quality reporting timeline is earlier than the timeline for calculating PQRS incentive payments. Therefore, beneficiary assignment for the purpose of calculating incentive payments is done separately after the close of the measurement year and may differ from the assignment process described subsequently.

*Statutory Background and Program Context*: The 2006 Tax Relief and Health Care Act (TRHCA) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN])[3] who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). The Centers for Medicare & Medicaid Services (CMS) named this program the Physician Quality Reporting Initiative (PQRI). The PQRI was further modified as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and the Medicare Improvements for Patients and Providers Act of 2008.

In 2010, CMS created a new GPRO for PQRI. In 2011, the program name was changed to Physician Quality Reporting System (PQRS). Group practices that satisfactorily report data on PQRS measures for a particular reporting period are eligible to earn a PQRS incentive payment equal to a specified percentage of the group practice's total estimated Medicare Part B Physician Fee Schedule allowed charges for covered professional services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer) during the reporting period. To earn an incentive for the 2014 PQRS program year, group practices may register to participate in GPRO via Web Interface, registry reporting, or Electronic Health Record reporting. Alternatively, groups may be participating through other programs such as the Shared Savings Program.

*Overview of the Physician Quality Reporting System's incentive payment models and value modifier payment adjustment:* For 2014, the program provides a 0.5% incentive payment to practices that successfully report data on quality measures. Beginning in 2015, the program also applies a payment adjustment to eligible professionals and group practices who do not satisfactorily report data on quality measures for covered professional services. The 2015 PQRS payment adjustment will be based on data collected for the 2013 PQRS program year, and the 2016 PQRS payment adjustment will be based on data collected for the 2014 program year.

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[2] In other documentation the terms "assignment" and "attribution" are used interchangeably. For consistency we use the term "assignment" throughout this document.

[3] Note that for the purposes of beneficiary assignment, professionals is defined by the Medicare Shared Savings Program. The PQRS definition of eligible professional is used for incentive payment purposes.

Groups with 10 or more eligible professionals can avoid the automatic -2.0% Value Modifier payment adjustment in calendar year (CY) 2016 by participating in the PQRS GPRO in CY 2014 and meeting the satisfactory reporting criteria to avoid the CY 2016 PQRS payment adjustment. If these group practices do not participate in the PQRS GPRO in CY 2014, then they can also avoid the automatic -2.0% Value Modifier payment adjustment in CY 2016 if the eligible professionals in the group participate in the PQRS as individuals and at least 50% of the eligible professionals meet the requirements to avoid the CY 2016 PQRS payment adjustment.

*Measurement period and registration timeline*: The deadline for groups to register to participate in the 2014 PQRS GPRO is September 30, 2014. The measurement period for the 2014 PQRS GPRO Web Interface reporting option is the calendar year 2014.

The subsequent sections of this report describe these procedures and the underlying programming methods in more detail. The Medicare data files that provide the data used to calculate shared savings and shared losses are described in Section 2. Finally, the method for assigning beneficiaries to a group practice is presented in Section 3.

## SECTION 2
## MEDICARE DATA USED TO ASSIGN BENEFICIARIES

This section describes the Medicare data used to assign beneficiaries to each group practice participating in PQRS GPRO by reporting clinical quality measures through the GPRO Web Interface. Acquiring and processing program data for assignment is discussed in Section 2.2.

### 2.1 Data Used in Program

We primarily use data from two Medicare data sources to assign beneficiaries for the program. The Medicare enrollment information is described in Section 2.1.1, and the claims data are described in Section 2.1.2.

#### 2.1.1 Medicare Enrollment Information

We use Medicare enrollment information for beneficiaries entitled to Medicare, including demographic information, enrollment dates, third-party buy-in information, and Medicare managed care enrollment.

#### 2.1.2 Claims Data

We use Medicare FFS claims data in assigning beneficiaries to a group practice. There are seven components of claims: (1) Inpatient; (2) Outpatient; (3) Carrier (Physician/Supplier Part B); (4) Skilled Nursing Facility; (5) Home Health Agency; (6) Durable Medical Equipment; and (7) Hospice Claims. Based on historical trends, we expect claims data generally to be 98%–99% complete 3 months after the end of the calendar year. Due to the timing of the quality reporting cycle, CMS will use partial-year data to assign beneficiaries for quality reporting purposes. For this purpose we use three quarters of data with a 1-month run-out. Therefore, we assign beneficiaries based on 10 months of available claims data in the measurement period (calendar year). This coincides with the finalization of the participant list.

For beneficiary assignment for quality reporting purposes, the effective date for claims will be set as the first Friday in November, and the Integrated Data Repository (IDR) load date will be set as the first load date after that effective date.

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## SECTION 3
## BENEFICIARY ASSIGNMENT FOR PQRS GPRO WEB INTERFACE PARTICIPANTS

The first step in identifying beneficiaries for GPRO Web Interface quality reporting purposes is to determine which beneficiaries are assigned to the group practice. For each participation year, beneficiary assignment is determined retrospectively at the end of the registration period. Thus, a beneficiary assigned in one year may or may not be assigned in the following or preceding years.

During retrospective assignment for quality reporting purposes, three quarters of claims are used with a 1-month claims run-out period. The list of assigned beneficiaries for each group practice is then used for identifying beneficiaries eligible for sampling into the GPRO Web Interface.

This section describes the stepwise methodology used for assigning beneficiaries to a group practice participating in PQRS by reporting clinical quality measures through the GPRO Web Interface.

### 3.1 Assignment Criteria

Using Medicare claims, we will assign beneficiaries to a group practice, in a two-step process, if they receive at least one primary care service from a physician within the group practice. For each year, a beneficiary will be assigned to a participating group practice if the following beneficiary assignment criteria are satisfied:

**A. Beneficiary must have a record of enrollment.**

Medicare must have enrollment information about the beneficiary's Medicare enrollment status and other information that is needed to determine whether the beneficiary meets other eligibility criteria.[4]

**B. Beneficiary must have at least 1 month of both Part A and Part B enrollment, and cannot have any months of Part A only or Part B only enrollment.**

Because the purpose of this program is to align incentives between Part A and Part B, beneficiaries who only have coverage under one of these parts are not included.

**C. Beneficiary cannot have any months of Medicare group (private) health plan enrollment.**

Only beneficiaries enrolled in traditional Medicare FFS under Parts A and B are eligible to be assigned to a group practice participating via the GPRO Web Interface reporting option. Those enrolled in a group health plan, including beneficiaries enrolled in Medicare Advantage

[4] Please note that a beneficiary with Medicare secondary payer status is not excluded from assignment to a PQRS GPRO.

plans under Part C, eligible organizations under section 1876 of the Social Security Act, and Program of All Inclusive Care for the Elderly programs under section 1894 are not eligible.

**D. Beneficiary must reside in the United States or U.S. territories and possessions.**

We exclude beneficiaries whose permanent residence is outside the United States or U.S. territories and possessions, so that we exclude beneficiaries who may have received care outside of the United States and for whom claims are not available. U.S. residence includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Marianas.

**E. Beneficiary must have a primary care service with a physician at the group practice.**

In order for a beneficiary to be eligible for assignment to group practice, the beneficiary must have had at least one primary care service that was furnished by a physician at the participating group practice. Key terms for the assignment process, including "primary care service," are defined in Tables 1–4.

**F. Beneficiary must have the largest share of his/her primary care services provided by the participating group practice.**

If a beneficiary meets the screening criteria in A through E, then the beneficiary is assigned to a group practice in a two-step process:

*Assignment Policy Step (1):* We will assign the beneficiary to the participating group practice in this step if the beneficiary has at least one primary care service furnished by a primary care physician (Table 2) at the participating group practice, and more primary care services (measured by Medicare allowed charges) furnished by primary care physicians at the participating group practice than furnished by primary care physicians at any other entity (e.g., a Rural Health Clinic or an accountable care organization [ACO] participant). TINs are used to identify participation as a group practice; TINs and CMS Certification Numbers (CCNs) are used to identify other entities.[5]

*Assignment Policy Step (2):* This step applies only for those beneficiaries who have not received any primary care services from a primary care physician. We will assign the beneficiary to the participating group practice in this step if the beneficiary has at least one primary care service furnished by a physician (as defined in Tables 2 and 3) at the participating group practice, and more primary care services are furnished by professionals (physician regardless of specialty, nurse practitioner, physician assistant or clinical nurse specialist; measured by Medicare allowed charges) at the participating group practice than at any other entity.

We will include TINs from the physician/supplier carrier claims file, and other identifiers discussed below for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Method II Critical Access Hospitals (CAHs), and Electing Teaching Amendment (ETA)

[5] TIN is Taxpayer Identification Number, assigned by the U.S. Internal Revenue Service. There are two types of TINs: Social Security Numbers and Employer Identification Numbers.

hospitals in the assignment algorithm in both Assignment Policy Steps 1 and 2 using their claims from the outpatient (institutional) file loaded in the IDR. Sections 3.3, 3.4, and 3.5 contain details about how these other organization types will be identified in the outpatient claims. We will include other organizations in the assignment algorithm because another entity could be the plurality provider of primary care services to a beneficiary, which would preclude assignment of that beneficiary to a group practice. In summary, we perform the assignment process simultaneously for all eligible organizations using both carrier (physician/supplier Part B) and outpatient claims in each step.

## 3.2 Programming Steps in Assigning Beneficiaries to Group Practices

There are six programming steps involved in assigning beneficiaries to a group practice in accordance with the methodology in 3.1.

**Programming Step 1: Identify only those beneficiaries who satisfy pre-screening criteria 3.1 F.**

We identify all Part B claims that have at least one line item with a primary care code furnished by a group practice participating via Web Interface reporting (based on the group practice's TIN). We will use a participating group practice's TIN to identify beneficiaries who had a Part B claim that includes at least one primary care service furnished by a physician at the group practice within the year.

That is, in programming step 1, we will identify beneficiaries who received at least one primary care service within the year (identified by the Healthcare Common Procedure Coding System [HCPCS] and/or revenue center codes listed in Table 1) from any physician (regardless of specialty; all eligible physician specialty codes, including primary care, are listed in Table 3) participating in a group practice.

**Programming Step 2: Create finder file for beneficiaries identified in Programming Step 1.**

We will create a finder file for each group practice of the beneficiaries identified in Programming Step 1. The finder file includes the beneficiary identifier for each beneficiary who was furnished at least one primary care service by the group practice's physicians within the year.

**Programming Step 3: Obtain selected claims, enrollment and demographic information for beneficiaries.**

We will use the finder file from Programming Step 2 to obtain enrollment information for each beneficiary who had a primary care service provided by physicians at the group practice. Eligibility information includes enrollment in Medicare Parts A and B, enrollment in a group health plan, primary payer code, and other enrollment information for these beneficiaries. We drop beneficiaries from the finder file who do not meet general eligibility requirements described in Section 3.1.

**Programming Step 4: Assign beneficiaries to PQRS GPROs using Assignment Policy Step 1.**

We will use the revised finder file in Programming Step 3 to identify beneficiaries who received at least one primary care service from a primary care physician in a participating group practice during the most recent year. We will assign beneficiaries who meet this condition to a group practice if the allowed charges for primary care services furnished to the beneficiary by primary care physicians in the group practice are greater than the allowed charges for primary care services furnished by primary care physicians in other entities (as identified by individual or group TIN or CCN for FQHC, RHC, or method II CAH as indicated in Section 3.3 and Section 3.4).

For each group practice, we will sum allowed charges for primary care services by beneficiary identifier. We include the primary care allowed charges for each beneficiary at each entity where provided primary care services were received. We will sum primary care allowed charges by the "Line HCPCS Code" on Part B and method II CAH claims, and by revenue codes on claims from FQHCs and RHCs. For a list of the primary care HCPCS codes and revenue codes we include in beneficiary assignment, see Table 1. We will use allowed charges for assignment because, unlike expenditures, they include the Medicare deductible, the first dollars of Medicare Part B payments by a beneficiary within the year (e.g., $140 in 2012). By using allowed charges rather than a simple service count, we also reduce the likelihood that there would be ties. To determine where a beneficiary received the plurality of his or her primary care services, we compare the allowed charges for each beneficiary for primary care services provided by the group practice to the allowed charges for primary care services provided by other entities.

It is unlikely that allowed charges by two different entities would be equal, but it is possible. Therefore, we have established the following policy in the event of such an occurrence. If there is a tie, then the tie breaker will be the group practice or entity that provided the most recent primary care service by a primary care physician. If there is still a tie, then the tie breaker will be the group practice or other entity that provided the most recent primary care service by a physician. If there is still a tie, the beneficiary is randomly assigned.

**Programming Step 5: Apply Assignment Policy Step 2 to beneficiaries who were not assigned in Assignment Policy Step 1.**

This step applies only for those beneficiaries who have not received any primary care services from a primary care physician (within or outside of the group practice). That is, this step applies only for beneficiaries in the finder file from step 2 who remain unassigned to any group practice or other entity after step 4. We will assign each of these beneficiaries to a group practice if the allowed charges for primary care services furnished to the beneficiary by all other professionals (including non–primary care physicians, nurse practitioners, clinical nurse specialists, and physician assistants) in the group practice are greater than the allowed charges for primary care services furnished by all professionals in each other entity (Table 3 lists all specialty codes included in the definition of a physician). It is important to note that the definition of a physician for purposes of the PQRS GPRO Web Interface beneficiary assignment

includes only MD/DO physicians. Table 4 lists specialty codes included in the definition of a professional used for assignment purposes.

If there is a tie, then the tie breaker is the group practice that provided the most recent primary care service by a professional. If there is still a tie, the beneficiary is randomly assigned.

### 3.3 Special Policy for Processing Method II CAH Claims for Professional Services

Method II CAH professional services are billed on institutional claim form 1450, bill type 85X (with the presence of one or more of the following revenue center codes: 096x, 097x, and/or 098x) and require special processing for purposes sampling beneficiaries for quality reporting via the PQRS GPRO Web Interface.

- We use the CCN as the unique identifier for an individual method II CAH.

- To obtain the rendering physician/practitioner for method II CAH claims, we use the "rendering NPI" field. In the event that the rendering NPI field is blank, we use the "other provider" NPI field. If the other provider NPI field is also blank on a claim, we use the attending NPI field.

- To obtain the CMS specialty for method II CAH claims, we use PECOS.

### 3.4 Special Rules for Processing FQHC and RHC Claims

FQHC and RHC services are billed on an institutional claim form (see Table 5 for bill types) and require special handling in order to incorporate them into the beneficiary assignment process. It is important to note in Tables 1–4 that the definition of a primary care service or a primary care physician depends on the bill type and date of service.

- We will treat a FQHC or RHC service reported on an institutional claim as a primary care service if the claim includes a HCPCS or revenue center code that meets the definition of a primary care service. That is, for FQHCs and RHCs, we will assume that all their primary care services are performed by a primary care physician. This will help assure that we do not disrupt established relationships between beneficiaries and FQHCs/RHCs.

- We will use the CCN as the unique identifier for an individual FQHC/RHC.

### 3.5 Special Rules for Processing ETA Institutional Claims

ETA hospitals are hospitals that have voluntarily elected to receive payment on a reasonable cost basis for the direct medical and surgical services of their physicians in lieu of Medicare fee schedule payments that might otherwise be made for these services.

ETA institutional claims are identified with claim type code equal to 40, bill type equal to 13 and require that the CCN on the claim meet the conditions for ETA hospitals. The line item HCPCS codes on the ETA institutional claims are used to identify whether a primary care service was provided. The reason for this is that physician services provided at ETA hospitals do

not otherwise appear in either outpatient or physician claims.[6] ETA hospitals, however, do bill CMS to recover facility costs incurred when ETA hospital physicians provide services. The HCPCS code, thus, will provide identification that a primary care service was rendered to a beneficiary. (We will not scan revenue center codes.) The list of HCPCS codes that will be used to identify primary care services for ETA institutional claims are listed in Table 1.

- To obtain the rendering physician/practitioner for ETA institutional claims, we will use the "other provider" NPI field. If this field is blank on a claim, we will use the attending NPI field.

- To obtain the CMS specialty for ETA institutional claims, we will use PECOS.

### 3.6 Tables for Section 3

- Table 1 lists the primary care codes (HCPCS and Revenue Center Codes) included in beneficiary assignment criteria.

- Table 2 lists specialty codes and other criteria that define a primary care physician. Specialty is identified by the specialty code associated with each line item on a claim.

- Table 3 lists all specialty codes included in the definition of a physician. It is important to note that the definition of a physician for purposes of PQRS GPRO Web Interface beneficiary assignment includes only MD/DO physicians.

- Table 4 lists specialty codes included in the definition of a professional for PQRS GPRO Web Interface beneficiary assignment purposes.

[6] The physician services, per se, are reimbursed during settlement of the annual Medicare Cost Report for ETA hospitals.

**Table 1**
**Primary care codes included in beneficiary assignment criteria**

For services billed under the physician fee schedule (note: includes method II CAHs), and for FQHC services furnished after 1/1/2011, primary care services include services identified by the following HCPCS/CPT codes (CPT only: copyright 2011 American Medical Association, all rights reserved):

**Office or Other Outpatient Services**

99201 New Patient, brief
99202 New Patient, limited
99203 New Patient, moderate
99204 New Patient, comprehensive
99205 New Patient, extensive
99211 Established Patient, brief
99212 Established Patient, limited
99213 Established Patient, moderate
99214 Established Patient, comprehensive
99215 Established Patient, extensive

**Initial Nursing Facility Care**

99304 New or Established Patient, brief
99305 New or Established Patient, moderate
99306 New or Established Patient, comprehensive

**Subsequent Nursing Facility Care**

99307 New or Established Patient, brief
99308 New or Established Patient, limited
99309 New or Established Patient, comprehensive
99310 New or Established Patient, extensive

**Nursing Facility Discharge Services**

99315 New or Established Patient, brief
99316 New or Established Patient, comprehensive

**Other Nursing Facility Services**

99318 New or Established Patient

(continued)

**Table 1 (continued)**
**Primary care codes included in beneficiary assignment criteria**

| |
|---|
| **Domiciliary, Rest Home, or Custodial Care Services** |
| 99324 New Patient, brief |
| 99325 New Patient, limited |
| 99326 New Patient, moderate |
| 99327 New Patient, comprehensive |
| 99328 New Patient, extensive |
| 99334 Established Patient, brief |
| 99335 Established Patient, moderate |
| 99336 Established Patient, comprehensive |
| 99337 Established Patient, extensive |
| **Domiciliary, Rest Home, or Home Care Plan Oversight Services** |
| 99339, brief |
| 99340, comprehensive |
| **Home Services** |
| 99341 New Patient, brief |
| 99342 New Patient, limited |
| 99343 New Patient, moderate |
| 99344 New Patient, comprehensive |
| 99345 New Patient, extensive |
| 99347 Established Patient, brief |
| 99348 Established Patient, moderate |
| 99349 Established Patient, comprehensive |
| 99350 Established Patient, extensive |
| **Wellness Visits** |
| G0402 Welcome to Medicare visit |
| G0438 Annual wellness visit |
| G0439 Annual wellness visit |

CAH = Critical Access Hospital; CPT = Current Procedural Terminology; FQHC = Federally Qualified Health Center; HCPCS = Healthcare Common Procedure Coding System.

NOTE: 42 CFR Part 425 defines primary care services as the set of services identified by the following HCPCS codes: 99201 through 99215; 99304 through 99340; 99341 through 99350; G0402; G0438; and G0439; Revenue center codes 0521, 0522, 0524, and 0525. Table 1 contains all codes in that range that are currently in use.

**Table 2**
**CMS specialty codes for primary care physicians**

| For physician fee schedule based claims: |
|---|
| 1 General Practice |
| 8 Family Practice |
| 11 Internal Medicine |
| 38 Geriatric Medicine |

CMS = Centers for Medicare & Medicaid Services.

**Table 3**
**CMS specialty codes included in the definition of a physician (MD/DO only) for PQRS GPRO Web Interface beneficiary assignment purposes.**

| | |
|---|---|
| 01 | General practice |
| 02 | General surgery |
| 03 | Allergy/immunology |
| 04 | Otolaryngology |
| 05 | Anesthesiology |
| 06 | Cardiology |
| 07 | Dermatology |
| 08 | Family practice |
| 09 | Interventional Pain Management (IPM) (eff. 4/1/2003) |
| 10 | Gastroenterology |
| 11 | Internal medicine |
| 12 | Osteopathic manipulative therapy |
| 13 | Neurology |
| 14 | Neurosurgery |
| 16 | Obstetrics/gynecology |
| 17 | Hospice and Palliative Care |
| 18 | Ophthalmology |
| 20 | Orthopedic surgery |
| 21 | Cardiac Electrophysiology |
| 22 | Pathology |
| 23 | Sports medicine |
| 24 | Plastic and reconstructive surgery |
| 25 | Physical medicine and rehabilitation |
| 26 | Psychiatry |
| 27 | Geriatric psychiatry |
| 28 | Colorectal surgery (formerly proctology) |
| 29 | Pulmonary disease |
| 30 | Diagnostic radiology |
| 33 | Thoracic surgery |
| 34 | Urology |
| 36 | Nuclear medicine |
| 37 | Pediatric medicine |
| 38 | Geriatric medicine |
| 39 | Nephrology |
| 40 | Hand surgery |
| 44 | Infectious disease |
| 46 | Endocrinology (eff. 5/1992) |
| 66 | Rheumatology (eff. 5/1992 |
| 70 | Multispecialty clinic or group practice |
| 72 | Pain management (eff. 1/1/2002) |
| 76 | Peripheral vascular disease (eff. 5/1992) |

(continued)

**Table 3 (continued)**
**CMS specialty codes included in the definition of a physician (MD/DO only) for PQRS GPRO Web Interface beneficiary assignment purposes.**

| | |
|---|---|
| 77 | Vascular surgery (eff. 5/1992) |
| 78 | Cardiac surgery (eff. 5/1992) |
| 79 | Addiction medicine (eff. 5/1992) |
| 81 | Critical care (intensivists) (eff. 5/1992) |
| 82 | Hematology (eff. 5/1992) |
| 83 | Hematology/oncology (eff. 5/1992) |
| 84 | Preventive medicine (eff. 5/1992) |
| 85 | Maxillofacial surgery |
| 86 | Neuropsychiatry (eff. 5/1992) |
| 90 | Medical oncology (eff. 5/1992) |
| 91 | Surgical oncology (eff. 5/1992) |
| 92 | Radiation oncology (eff. 5/1992) |
| 93 | Emergency medicine (eff. 5/1992) |
| 94 | Interventional radiology (eff. 5/1992) |
| 98 | Gynecologist/oncologist (eff. 10/1994) |
| 99 | Unknown physician specialty |
| C0 | Sleep medicine |

CMS = Centers for Medicare & Medicaid Services; GPRO = Group Practice Reporting Option; PQRS = Physician Quality Reporting System.

**Table 4**
**Specialty codes included in the definition of a Professional for PQRS GPRO Web Interface beneficiary assignment purposes.**

All specialty codes in Table 3 plus the following:

| | |
|---|---|
| 50 | Nurse Practitioners |
| 89 | Clinical Nurse Specialist |
| 97 | Physician Assistant |

ACO = Accountable Care Organization; GPRO = Group Practice Reporting Option; PQRS = Physician Quality Reporting System.

NOTE: This is the list of ACO professionals identified by the Medicare Shared Savings Program and differs from the definition of an eligible professional used by the Physician Quality Reporting System.