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

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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
DME	Durable Medical Equipment
EIN	Employer Identification Number
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
HHA	Home Health Agency
IDR	Integrated Data Repository
MA	Medicare Advantage
NCH	National Claims History
NPI	National Provider Identifier
PACE	Program of All Inclusive Care for the Elderly
PECOS	Provider Enrollment, Chain and Ownership System
PQRS	Physician Quality Reporting System
PY	Performance Year
RHC	Rural Health Clinic
SNF	Skilled Nursing Facility
SSN	Social Security Number
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 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 (PFS) allowed charges for covered professional services furnished during the reporting period. To earn an incentive for the 2013 PQRS program year, group practices may self-nominate or register to participate in GPRO via Web Interface or registry reporting.

Beneficiary Assignment: 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. 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 PQRS GPRO, the beneficiary is eligible to be assigned to the PQRS GPRO based on a two-step process:

- The first step assigns a beneficiary to a PQRS GPRO 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 PQRS GPRO 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 is the list defined by the Medicare Shared Savings Program and differs slightly from the definition of Eligible Professionals used for calculating the 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, but 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 assigning² 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 below 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 below.

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). 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 (MMSEA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

In 2010, CMS created a new GPRO for PQRI. In 2011, the program name was changed to Physician Quality Reporting System (Physician Quality Reporting). 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 (PFS) 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 2013 PQRS program year, group practices may self-nominate or register to participate in GPRO via Web Interface or registry reporting or through other programs such as the Shared Savings Program.

Overview of the Physician Quality Reporting System's incentive payment models: For 2013, 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. During the registration timeframe referenced below, groups may elect the CMS-calculated administrative claims-based reporting option to

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 the definition of professionals is defined by the Medicare Shared Savings Program. The PQRS definition of Eligible Professional is used for incentive payment purposes.

avoid the 2015 PQRS payment adjustment. Groups that solely elect administrative claims will not be eligible for the PQRS incentive as a GPRO but may avoid the 2015 PQRS payment adjustment.

Measurement period and registration timeline: Group practices must self-nominate/register to participate in PQRS GPRO. The timeline for those organizations participating as a 2013 PQRS GPRO is as follows:

- The deadline for group practices to self-nominate for 2013 PQRS GPRO and/or eRx GPRO via the Quality Reporting Communication Support Page: January 31, 2013
- The deadline for group practices to register for PQRS GPRO only: July 15, 2013-October 15, 2013
 - Group practices who previously self-nominated may change their selected reporting option during this timeframe.
 - Groups who did not previously self-nominate for 2013 PQRS GPRO participation may register during this timeframe.
- All registrants as of October 15, 2013 will be considered a 2013 PQRS GPRO participant and will be analyzed at the TIN level.

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 PQRS GPRO 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 PQRS GPRO. There are seven components of claims: (1) Inpatient; (2) Outpatient; (3) Carrier (Physician/Supplier Part B); (4) Skilled Nursing Facility (SNF); (5) Home Health Agency (HHA); (6) Durable Medical Equipment (DME); and (7) Hospice Claims. Based on historical trends, we expect claims data to generally be between ninety-eight and ninety-nine percent complete three 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 one-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 PQRS GPRO. 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 one-month claims run-out period. The list of assigned beneficiaries for each PQRS GPRO is then used for identifying beneficiaries eligible for sampling into the GPRO Web Interface.

This Section describes the step-wise assignment methodology utilized 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 PQRS GPRO, 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 PQRS GPRO 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 which is needed to determine if the beneficiary meets other criteria below.⁴

B) Beneficiary must have at least one month of 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 PQRS GPRO 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 (MSP) status is not excluded from assignment to a PQRS GPRO.

(MA) plans under Part C, eligible organizations under section 1876 of the Social Security Act, and Program of All Inclusive Care for the Elderly (PACE) 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, 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. United States 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 PQRS GPRO, 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 the tables below.

F) Beneficiary must have the largest share of his/her primary care services provided by the participating PQRS GPRO

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

Assignment Policy Step (1): We will assign the beneficiary to the participating PQRS GPRO 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 ACO participant). Taxpayer identification numbers (TINs) are used to identify participation as a PQRS GPRO and TINs as well as 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 PQRS GPRO in this step if the beneficiary has at least one primary care service furnished by a physician (as defined in Tables 2 and 3 below) at the participating PQRS GPRO, 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 PQRS GPRO 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),

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

Method II Critical Access Hospitals (CAHs), and Electing Teaching Amendment (ETA) hospitals in the assignment algorithm in both Assignment Policy Steps 1 and 2 using their claims from the outpatient (institutional) file loaded in the Integrated Data Repository (IDR). Sections 3.3, 3.4, and 3.5 contain details on 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 PQRS GPRO. In summary, we perform the assignment process simultaneously including all eligible organizations using both carrier (physician/supplier Part B) and outpatient claims together in each step.

3.2 Programming Steps in Assigning Beneficiaries to PQRS GPROs

There are six programming steps involved in assigning beneficiaries to a PQRS GPRO 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 PQRS GPRO participating via Web Interface reporting (based on the GPRO's TIN). We will use a participating GPRO'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 PQRS GPRO.

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

We will create a "finder file" for each PQRS GPRO 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 GPRO's physicians within the year.

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

We will use the finder file from step 2 to obtain enrollment information for each beneficiary who had a primary care service provided by physicians at the GPRO. Eligibility information includes Medicare Parts A and B enrollment, 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 Step 3 to identify beneficiaries who received at least one primary care service from a primary care physician participating as a PQRS GPRO during the most recent year. We will assign beneficiaries who meet this condition to a GPRO if the allowed charges for primary care services furnished to the beneficiary by primary care physicians in the GPRO 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 GPRO, 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 GPRO 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 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 GPRO 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 GPRO 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 GPRO). That is, this step applies only for beneficiaries in the finder file from step 2 who remain unassigned to any GPRO or other entity after step 4. We will assign each of these beneficiaries to a GPRO 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 GPRO 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 will be the GPRO 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 Physician Quality Reporting System Group Practice Reporting Option (PQRS GPRO) Web Interface.

- We will 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 will use the “rendering NPI” field. In the event the rendering NPI field is blank, we will use the “other provider” NPI field. If the other provider NPI field is also blank on a claim, we will use the attending NPI field (see Change Request XXXXX for details).
- To obtain the CMS specialty for method II CAH claims, we will use the Provider Enrollment, Chain and Ownership System (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 the tables below 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
-

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

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

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
-

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.