GPRO Web Interface Sampling Methodology for the Physician Quality Reporting System and the Medicare Shared Savings Program

Report

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SECTION 1
INTRODUCTION

The purpose of this document is to explain the sampling methodology for the 22 clinical quality measures that will be reported via the Group Practice Reporting Option (GPRO) Web Interface (WI). This guidance applies to all Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program with a 2012, 2013, or 2014 agreement period start date, all ACOs in the Pioneer ACO Model (referred to throughout as ACOs), and all group practices participating in Physician Quality Reporting System (PQRS) program using the WI for the 2014 performance year (referred to throughout as group practices), with ACOs and group practices collectively referred to as organizations. Each organization will be required to report on the same 22 nationally recognized measures, based on services rendered in 2014.

This document provides background information on the specific quality measures to be reported on using the WI, the number of beneficiaries each organization is expected to report on, and how those beneficiaries are selected.

SECTION 2
WEB INTERFACE QUALITY MEASURES

For the 2014 reporting period, ACOs and group practices that choose the WI reporting method will use the WI to collect and submit clinical data on the following 17 measures (15 individual measures, and 2 composite measures comprising 5 or 2 component measures, respectively). These measures span 15 modules (made up of 5 disease modules and 10 individual measure modules, each with its own specific population, or denominator, of interest):

- CARE-1 (NQF 0097): Medication Reconciliation
- CARE-2 (NQF 0101): Falls: Screening for Future Fall Risk
- PREV-5 (NQF N/A): Breast Cancer Screening
- PREV-6 (NQF 0034): Colorectal Cancer Screening
- PREV-7 (NQF 0041): Preventive Care and Screening: Influenza Immunization
- PREV-8 (NQF 0043): Pneumonia Vaccination Status for Older Adults
- PREV-9 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- PREV-10 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- PREV-11 (NQF N/A): Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
• PREV-12 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

• Diabetes Mellitus (DM) module (one individual measure plus five components of one component measure)
  – DM-2 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control
  – DM-13 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: High Blood Pressure Control
  – DM-14 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control
  – DM-15 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Hemoglobin A1c Control (<8%)
  – DM-16 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease
  – DM-17 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Tobacco Non-Use

• Hypertension (HTN) module (one measure)
  – HTN-2 (NQF 0018): Controlling High Blood Pressure

• Ischemic Vascular Disease (IVD) module (two measures)
  – IVD-1 (NQF 0075): Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
  – IVD-2 (0068): Ischemic Vascular Disease IVD): Use of Aspirin or Another Antithrombotic

• Heart Failure (HF) module (one measure)
  – HF-6 (NQF 0083): Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

• Coronary Artery Disease module (CAD): Composite (All or Nothing Scoring) (two components of one composite measure)
  – CAD-2 (NQF 0074): Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Lipid Control
Appendix A provides a summary table of the measure information presented here.

For further information on any of these measures, please refer to the following documents, available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html:

- The 2014 GPRO WI Disease Modules, Care Coordination/Patient Safety Measures, and Preventive Care Measures List document, which consists of the (22) 2014 GPRO WI reporting method measures.

- The 2014 GPRO WI Narrative Measure Specifications, which provides a description of each of the 22 measures.

- The 2014 GPRO WI Narrative Specification Release Notes, which provides a list of changes to existing measures made since the release of the 2013 GPRO Narrative Measure Specifications, Version 4.1.

- The 2014 GPRO WI Supporting Documents have been posted in Microsoft Excel format by module for program year 2014. Each document contains the following: Patient Confirmation, Data Guidance, and Downloadable Resource Tables, which include coding for each measure. Additionally, the “2014 Group Practice Reporting Option Web Interface Supporting Documentation Release Notes” are posted, documenting changes between program year 2013 and program year 2014.

- The 2014 Measure Flows for GPRO WI Users, containing performance rate calculation algorithms for the 22 WI measures, can be found in the associated zip file.
SECTION 3
WEB INTERFACE QUALITY MEASURE REPORTING AND SAMPLE SIZE REQUIREMENTS

Each ACO and group practice will report the 22 clinical quality measures via the WI, categorized into 15 modules (i.e., samples for 5 disease modules and 10 individual measure modules, each with its own specific population/disease, or denominator, requirement). The required reporting sample for each module is 411 for all ACOs (regardless of size) and group practices with 100 or more eligible professionals (EPs), and 218 for group practices with 25–99 EPs that choose the GPRO WI reporting method. The WI will use a sample of beneficiaries specifically assigned to each organization, and will include demographic and utilization information for those beneficiaries. Each beneficiary may be sampled into at least one module and assigned a rank based on the order in which they were sampled into a module. Each module will be partially prepopulated with beneficiary and clinical information, as applicable.

Whenever possible, each module of the WI will include a 50% oversample of the required reporting sample. For all ACOs (regardless of size) and group practices with 100 or more eligible professionals, each module of the WI will be prepopulated with 616 beneficiaries to obtain this 50% oversample. Likewise, for group practices with 25–99 eligible professionals, each module of the WI will be prepopulated with 327 beneficiaries. If the number of beneficiaries eligible for a given module is fewer than the required minimum reporting sample of 411 or 218, then all eligible beneficiaries will be populated into the WI for that module, and the ACO or group practice would need to report on 100% of the beneficiaries provided.

The organization will then be required to complete data fields in the WI that capture quality measure information with respect to rendered services applicable to the 2014 reporting period (January 1, 2014, through December 31, 2014). These data must be completed accurately for the required number of consecutively ranked and confirmed assigned Medicare beneficiaries. Group practices with 100 or more EPs and ACOs are required to completely report on 411 consecutively ranked beneficiaries. Group practices with 25–99 EPs are required to completely report on 218 consecutively ranked beneficiaries. Denominator inclusion and exclusion criteria for some modules may mean that reaching the target sample size is not possible for an organization. If fewer than the target numbers of eligible beneficiaries are available for a given module, the organization must report on 100 percent of the eligible beneficiaries provided for that disease module or individual measure module.
SECTION 4
WEB INTERFACE QUALITY MEASURE SAMPLING METHODOLOGY

ACOs and group practices will use the WI to submit data on samples of the organization’s fee-for-service (FFS) Medicare beneficiaries. Each organization’s samples will be determined using the following process:

4.1 Step 1: Identify Beneficiaries Eligible for Quality Measurement

The Centers for Medicare & Medicaid Services (CMS) will assign a Medicare beneficiary to an ACO or group practice based on current program rules. For ACOs, CMS will use beneficiaries assigned using the ACO assignment algorithm\(^1\) for the third quarter of 2014. For group practices, CMS will use beneficiaries assigned using the PQRS assignment algorithm\(^2\) for the third quarter of 2014.

Using Medicare administrative claims from January 1, 2014, through October 31, 2014, CMS will exclude from the above:

- beneficiaries with fewer than two primary care services\(^3\) during the reporting period,
- beneficiaries with part-year eligibility in Medicare FFS Part A and Part B, and
- beneficiaries who entered hospice during the measurement period.

The remaining beneficiaries will be considered eligible for quality measurement.

4.2 Step 2: Identify Beneficiaries Eligible for Sampling Into Each Module

The beneficiaries identified as eligible for quality measurement will then be assessed for eligibility for each of the modules. Eligibility based on denominator criteria is outlined below:

1. To be included in the any of the following denominators:
   - Colorectal Cancer Screening (PREV-6),
   - Pneumonia Vaccination Status for Older Adults (PREV-8),
   - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (PREV-9),

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1 The Shared Savings Program beneficiary assignment methodology can be found here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-v2.pdf
2 The PQRS assignment methodology document and training presentation can be found on this page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html
3 As defined by the Healthcare Common Procedure Coding System (HCPCS) codes in Appendices B and C for ACOs and Appendix B for PQRS group practices.
• Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (PREV-10),

• Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (PREV-11),

• Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (PREV-12), or

• Falls: Screening for Future Fall Risk (CARE-2)

A beneficiary must:

a. Meet age criteria; AND

b. Have at least one face-to-face encounter occurring during the measurement period.

2. To be included in the Medication Reconciliation (CARE-1) denominator, a beneficiary must:

a. Meet age criteria; AND

b. Have a discharge from an inpatient facility and a subsequent face-to-face encounter with a primary care physician in the organization within 30 days of the discharge date. Both the discharge and the follow-up visit must occur within the measurement year.

3. To be included in the Breast Cancer Screening (PREV-5) denominator, a beneficiary must:

a. Meet gender criteria; AND

b. Meet age criteria; AND

c. Have at least one face-to-face encounter occurring during the measurement period.

4. To be included in the Preventive Care and Screening: Influenza Immunization (PREV-7) denominator; a beneficiary must:

a. Meet age criteria; AND

b. Have at least one face-to-face encounter during the influenza season. The influenza season is defined at October 1, 2013, through March 31, 2014, for the 2014 measurement period.

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6 As defined by the specialty codes in Appendix D.
5. To be included in a DM denominator, a beneficiary must:
   a. Meet age criteria; AND
   b. Have at least two face-to-face encounters with a documented diagnosis of DM (type 1 or type 2) in an office or outpatient setting. The visits must be on different dates of service, and may occur either during the measurement period or the year prior to the measurement period.

6. To be included in the ischemic vascular disease (IVD) denominator, a beneficiary must:
   a. Meet age criteria; AND
   b. Have at least:
      c. Two face-to-face encounters during the measurement period with a documented diagnosis of IVD in an office or outpatient setting; OR
         i. One inpatient procedure for IVD during the year prior to the measurement year. Procedures include coronary artery bypass graft and percutaneous coronary intervention; OR
         ii. One inpatient discharge for an acute myocardial infarction during the year prior to the measurement year.

7. To be included in the coronary artery disease (CAD) denominator, a beneficiary must:
   a. Meet age criteria; AND
   b. Have at least two face-to-face encounters occurring during the measurement period with a documented diagnosis of or procedure related to CAD.

8. To be included in the hypertension (HTN) denominator, a beneficiary must:
   a. Meet age criteria; AND
   b. Have two face-to-face encounters with a documented diagnosis of hypertension, occurring during the first 6 months of the measurement period or the year prior to the measurement period.

9. To be included in the heart failure (HF) denominator, a beneficiary must:
   a. Meet age criteria; AND
   b. Have two face-to-face encounters occurring during the measurement period with a documented diagnosis of HF.

4.3 Step 3: Randomly Sample Beneficiaries Into Each Module

To reduce the burden on practices, CMS will use a methodology to generate samples that would enable one beneficiary to qualify for multiple modules, as applicable.

CMS will select an initial random sample of quality eligible beneficiaries (as defined in section 4.1) and populate them into the five disease modules and 10 individually sampled patient care measures for which they are eligible until the required number of beneficiaries plus a 50% oversample for the modules/ measures are reached. This is equivalent to 616 beneficiaries for ACOs and groups practices with 100 or more EPs, and 327 beneficiaries for group practices with
25-99 EPs (illustrated in Figure 1). CMS will use an initial sample of 900 beneficiaries for ACOs and group practices with 100 or more EPs. For group practices with 25–99 EPs an initial sample of 500 beneficiaries will be used.

If, after this step, a disease module/patient care measure has fewer than 616 beneficiaries (for ACOs and group practices with 100 or more EPs) or 327 beneficiaries (for group practices with 25–99 EPs), CMS will randomly sample additional eligible beneficiaries until the module has the required 616 or 327 beneficiaries, or until there are no additional eligible beneficiaries available. Using the same beneficiary across modules where possible reduces the administrative or abstraction burden for ACOs and group practices by minimizing the total number of beneficiaries on which data need to be collected.

Beneficiaries will be assigned a rank between 1 and 616 (for ACOs and group practices with 100 or more EPs) or 1 and 327 (for group practices with 25–99 EPs) based on the order in which they are populated into each denominator sample. ACOs and group practices with 100 or more eligible professionals will be required to consecutively complete a minimum of 411 beneficiaries (or all beneficiaries in the sample if there are fewer than 411). Group practices with 25–99 EPs will be required to consecutively complete a minimum of 218 beneficiaries (or all beneficiaries in the sample if there are fewer than 218). If the organization is unable to provide data on a particular beneficiary, the organization must indicate a reason the data cannot be provided. The organization cannot skip a beneficiary without providing a valid reason. The valid reasons will be available as options in the WI. For each beneficiary that is skipped the organization must completely report on the next consecutively ranked beneficiary until the target sample of 411 or 218 is reached or until the sample has been exhausted.

Although this sampling methodology does not guarantee that beneficiaries will have the same rank across modules, it does increase the likelihood that a beneficiary will have a similar rank across modules. Therefore, a low-ranked beneficiary in one module will likely have a low rank in the other modules for which he or she qualifies.
Figure 1
Sampling Process

Universe of ACO or PQRS assigned benees eligible for Quality Reporting (see Section 4.1)

Initial random sample of beneficiaries

Additional random samples as needed

PREV-5 → CARE-1
PREV-6 → CARE-2
PREV-7 → DM
PREV-8 → HTN
PREV-9 → IVD
PREV-10 → HF
PREV-11 → CAD
PREV-12
### APPENDIX A:
2014 WEB INTERFACE QUALITY MEASURES

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Measure Title</th>
<th>NQF #</th>
<th>ACO Domain</th>
<th>Disease Module/Individual Measure Module</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE-1</td>
<td>Medication Reconciliation</td>
<td>0097</td>
<td>Care coordination &amp; patient safety</td>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>CARE-2</td>
<td>Falls: Screening For Future Fall Risk</td>
<td>0101</td>
<td>Care coordination &amp; patient safety</td>
<td>Falls</td>
</tr>
<tr>
<td>PREV-5</td>
<td>Breast Cancer Screening</td>
<td>NA</td>
<td>Preventive health</td>
<td>Breast cancer screening</td>
</tr>
<tr>
<td>PREV-6</td>
<td>Colorectal Cancer Screening</td>
<td>0034</td>
<td>Preventive health</td>
<td>Colorectal cancer screening</td>
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<tr>
<td>PREV-7</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>0041</td>
<td>Preventive health</td>
<td>Influenza immunization</td>
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<tr>
<td>PREV-8</td>
<td>Pneumonia Vaccination Status For Older Adults</td>
<td>0043</td>
<td>Preventive health</td>
<td>Pneumonia vaccination</td>
</tr>
<tr>
<td>PREV-9</td>
<td>Preventive Care and Screening: Body Mass Index</td>
<td>0421</td>
<td>Preventive health</td>
<td>BMI screening</td>
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<td>PREV-10</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
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<td>Tobacco screening</td>
</tr>
<tr>
<td>PREV-11</td>
<td>Preventive Care and Screening: Screening For High Blood Pressure and Follow-Up Documented</td>
<td>NA</td>
<td>Preventive health</td>
<td>Blood pressure screening</td>
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<tr>
<td>PREV-12</td>
<td>Preventive Care and Screening: Screening For Clinical Depression and Follow-Up Plan</td>
<td>0418</td>
<td>Preventive health</td>
<td>Depression screening</td>
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<td>DM-2</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>0059</td>
<td>At-risk population</td>
<td>DM</td>
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<tr>
<td>DM-13 through 17</td>
<td>Diabetes Composite (All or Nothing Scoring):</td>
<td>0729</td>
<td>At-risk population</td>
<td>DM</td>
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<td></td>
<td>• Diabetes Mellitus: High Blood Pressure Control</td>
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<tr>
<td></td>
<td>• Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Diabetes Mellitus: Hemoglobin A1c Control (&lt;8%)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use For Patients With Diabetes and Ischemic Vascular Disease</td>
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</table>
## APPENDIX A:
### 2014 WEB INTERFACE QUALITY MEASURES

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Measure Title</th>
<th>NQF #</th>
<th>ACO Domain</th>
<th>Disease Module/Individual Measure Module</th>
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<tr>
<td>HTN-2</td>
<td>Controlling High Blood Pressure</td>
<td>0018</td>
<td>At-risk population</td>
<td>HTN</td>
</tr>
<tr>
<td>IVD-1</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control</td>
<td>0075</td>
<td>At-risk population</td>
<td>IVD</td>
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<tr>
<td>IVD-2</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin of Another Antithrombotic</td>
<td>0068</td>
<td>At-risk population</td>
<td>IVD</td>
</tr>
<tr>
<td>HF-6</td>
<td>Heart Failure (HF): Beta-Blocker Therapy For Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>0083</td>
<td>At-risk population</td>
<td>HF</td>
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<tr>
<td>CAD-2</td>
<td>Coronary Artery Disease Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Lipid Control</td>
<td>0074</td>
<td>At-risk population</td>
<td>CAD</td>
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<tr>
<td>CAD-7</td>
<td>Coronary Artery Disease Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy—Diabetes or Left Ventricular Systolic Dysfunction (LVEF &lt;40%)</td>
<td>0066</td>
<td>At-risk population</td>
<td>CAD</td>
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APPENDIX B:
PRIMARY CARE CODES USED TO IDENTIFY QUALITY ELIGIBILITY BENEFICIARIES FOR ACOS AND GROUP PRACTICES REPORTING VIA WI

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

Domiciliary, rest home, or custodial care services
99324  New Patient, brief
99325  New Patient, limited

(continued)
### APPENDIX B:
**PRIMARY CARE CODES USED TO IDENTIFY QUALITY ELIGIBILITY BENEFICIARIES FOR ACOS AND GROUP PRACTICES REPORTING VIA WI**

<table>
<thead>
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<th>Code</th>
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<tr>
<td>99326</td>
<td>New Patient, moderate</td>
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<tr>
<td>99327</td>
<td>New Patient, comprehensive</td>
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<tr>
<td>99328</td>
<td>New Patient, extensive</td>
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<tr>
<td>99334</td>
<td>Established Patient, brief</td>
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<tr>
<td>99335</td>
<td>Established Patient, moderate</td>
</tr>
<tr>
<td>99336</td>
<td>Established Patient, comprehensive</td>
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<td>99337</td>
<td>Established Patient, extensive</td>
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<td>99339,</td>
<td>Domiciliary, rest home, or home care plan oversight services</td>
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<td>99341</td>
<td>Home services</td>
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<td>99342</td>
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<td>99343</td>
<td>New Patient, limited</td>
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<td>New Patient, comprehensive</td>
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<td>99347</td>
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<td>99348</td>
<td>Established Patient, moderate</td>
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<td>99350</td>
<td>Established Patient, extensive</td>
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<td>G0402</td>
<td>Wellness visits</td>
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<td>G0438</td>
<td>Welcome to Medicare visit</td>
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<td>G0439</td>
<td>Annual wellness visit</td>
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APPENDIX C
ADDITIONAL PRIMARY CARE CODES USED IN BENEFICIARY ASSIGNMENT CRITERIA AND IN QUALITY ELIGIBILITY FOR ACOS\textsuperscript{7,8}

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0521</td>
<td>Clinic visit by member to RHC/FQHC</td>
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<tr>
<td>0522</td>
<td>Home visit by RHC/FQHC practitioner</td>
</tr>
<tr>
<td>0524</td>
<td>Visit by RHC/FQHC practitioner to a member, in a covered Part A stay at the skilled nursing facility (SNF)</td>
</tr>
<tr>
<td>0525</td>
<td>Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or nursing facility or intermediate care facility for individuals with mental retardation or other residential facility</td>
</tr>
</tbody>
</table>

\textsuperscript{8} Note: not applicable to PQRS GPROs
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<table>
<thead>
<tr>
<th>Primary Care Physician Specialty Codes</th>
<th></th>
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<tbody>
<tr>
<td>1 General Practice</td>
<td>8 Family Practice</td>
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<tr>
<td>11 Internal Medicine</td>
<td>38 Geriatric Medicine</td>
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