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Physician Quality Reporting System Group Practice Reporting Option: CAHPS for PQRS and Web Interface

2016 Assignment Methodology Specifications

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ACRONYMS

ACO	Accountable care organization
CAH	Critical access hospital
CCN	CMS certification number
CEHRT	Certified electronic health record technology
CMS	Centers for Medicare & Medicaid Services
EHR	Electronic health record
EP	Eligible professional
ETA	Electing teaching amendment
FFS	Fee-for-service
FQHC	Federally qualified health center
GPRO	Group practice reporting option
HCPCS	Healthcare Common Procedure Coding System
IDR	Integrated Data Repository
MPFS	Medicare Physician Fee Schedule
NPI	National provider identifier
OPPS	Outpatient prospective payment system
PECOS	Provider Enrollment, Chain and Ownership System
PQRI	Physician Quality Reporting Initiative
PQRS	Physician Quality Reporting System
RHC	Rural health clinic
SNF	Skilled nursing facility
TIN	Taxpayer identification number

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CONTENTS

ACRONYMS	i
EXECUTIVE SUMMARY	1
SECTION 1 INTRODUCTION	3
SECTION 2 MEDICARE DATA USED TO ASSIGN BENEFICIARIES	5
2.1 Data Used in Program	5
2.1.1 Medicare Enrollment Information	5
2.1.2 Claims Data	5
SECTION 3 GROUP PRACTICE BENEFICIARY ASSIGNMENT FOR CAHPS FOR PQRS AND WEB INTERFACE	7
3.1 Assignment Criteria	7
3.2 Programming Steps in Assigning Beneficiaries to Group Practices	9
3.3 Defining Primary Care Services	10
3.4 Special Processing for Part A Outpatient Claims	15
3.4.1 Processing CAH Claims	15
3.4.2 Processing FQHC and RHC Claims	16
3.4.3 Processing ETA Hospital Outpatient Claims	16
List of Tables	
1. Primary Care Service Codes	11
2. Primary Care Provider Specialty Codes	13
3. Physician Specialty Codes	13
4. Part A Outpatient Bill Type Codes	15

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EXECUTIVE SUMMARY

This report describes the process for assigning beneficiaries to a group practice participating in the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) via the Web Interface or the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS.¹ Group practices that satisfactorily report data on PQRS measures for 2016 will avoid the negative PQRS payment adjustment in 2018 (–2%). For PQRS purposes, a group practice is defined as a single tax identification number (TIN) with two or more national provider identifiers (NPI) that have reassigned their billing rights to the TIN.

Beneficiary Assignment: We use retrospective beneficiary assignment to (1) identify beneficiaries eligible to receive the CAHPS for PQRS survey and (2) identify beneficiaries eligible for sampling into the Web Interface. For CAHPS for PQRS, beneficiary assignment is determined retrospectively at the end of the registration period, which is June 30 for 2016. For the Web Interface, beneficiary assignment for group practices is determined retrospectively after October 31, 2016.² Note that a beneficiary assigned in one year may not be assigned in the following or preceding years. Further, a beneficiary assigned to a group practice for CAHPS for PQRS purposes may not be assigned to the same group practice for Web Interface purposes because of their differing assignment periods. However, the PQRS assignment process is the same for both CAHPS for PQRS and Web Interface purposes. If a beneficiary receives at least one primary care service from a primary care provider 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 the group practice if the beneficiary receives the plurality of his or her primary care services from primary care providers within the group practice. Primary care providers are defined as those with one of seven specialty designations: internal medicine, general practice, family practice, geriatric medicine, nurse practitioner, clinical nurse specialist, and physician assistant.
- The second step only considers beneficiaries who have not had any primary care service furnished by a primary care provider, including primary care providers external to the group practice. Under this second step, we assign a beneficiary to the group practice if the beneficiary receives the plurality of his or her primary care services from physicians within the group practice.³

¹ Note that Pioneer Model, Next Generation Model, and Shared Savings Program Accountable Care Organizations (ACOs) also report quality measures using the Web Interface and use the CAHPS for ACO survey. This document refers to the assignment process for PQRS only.

² October 31st falls on a Monday in 2016. Claims data loaded into the IDR the first week of November will only include those claims submitted through the previous Friday (October 28). Therefore, claims data through October 28 will be available for Web Interface assignment data.

³ Physician specialties used for assignment purposes are defined by the Value-Based Payment Modifier Program and differ slightly from the definition of eligible professionals under PQRS. The definition of eligible professional for PQRS is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_List_of_EPs.pdf.

A plurality means a greater proportion of primary care services was provided from within the group practice than from other entities, measured in terms of allowed charges. A plurality may be less than the majority of services.

SECTION 1 INTRODUCTION

This document outlines the process for assigning beneficiaries to a group practice participating in the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) via the Web Interface or the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS.⁴ Note that the quality reporting timeline is earlier than the timeline for calculating PQRS payment adjustments. Therefore, beneficiary assignment for the purpose of calculating PQRS payment adjustments is done separately after the close of the measurement year and may differ from the assignment process described below.

Statutory Background and Program Context: The 2006 Tax Relief and Health Care Act 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]) 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 State Children's Health Insurance Program Extension Act of 2007; the Medicare Improvements for Patients and Providers Act of 2008; the Affordable Care Act of 2010; and the American Taxpayer Relief Act of 2012.

In 2011, the program name was changed to Physician Quality Reporting System (PQRS). PQRS has become a quality reporting program that uses negative payment adjustments to promote reporting of quality information by individual eligible professionals (EPs) and group practices participating in the GPRO. Those who do not satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (MPFS) services furnished to Medicare Part B beneficiaries will be subject to a negative payment adjustment under PQRS. PQRS participants may opt to report as individual EPs, or as a group practice.⁵ They can choose from the following reporting mechanisms to submit their quality data, as applicable:⁶

Individual EP reporting option mechanisms

- Direct electronic health record (EHR) using certified EHR technology (CEHRT)
- CEHRT via data submission vendor
- Qualified PQRS registry
- Qualified clinical data registry
- Medicare Part B claims

⁴ In other documentation, the terms "assignment" and "attribution" are used interchangeably. For consistency, we use the term "assignment" throughout this document.

⁵ Note that some participants may be participating through other programs, such as the Shared Savings Program.

⁶ Please refer to the PQRS website for additional information on specific reporting mechanisms.
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/>

GPRO mechanisms

- Direct EHR using CEHRT
- CEHRT via data submission vendor
- Qualified PQRS registry
- Web Interface
- CAHPS for PQRS via CMS-Certified Survey Vendor⁷

Overview of the PQRS's payment adjustment: PQRS EPs and group practices that did not satisfactorily report data on PQRS quality measures for covered professional services during the 2013 program year were subjected to a negative payment adjustment beginning in 2015. EPs and group practices participating in PQRS receiving a PQRS negative payment adjustment in 2015 will be paid 1.5% less than the MPFS amount for services rendered from January 1 to December 31, 2015. Beginning in 2016, the payment adjustment rate increased to 2%, but this payment adjustment can be avoided as long as the EP or group practice met reporting criteria in 2014. The 2017 PQRS payment adjustment will be based on data collected for the 2015 PQRS program year, and the 2018 PQRS payment adjustment will be based on data collected for the 2016 program year.

Measurement period and registration timeline: The deadline for groups to register to participate in 2016 PQRS GPRO is June 30, 2016. For group practices that elect to report PQRS via GPRO using the Web Interface to avoid the 2018 payment adjustment, the measurement period is calendar year 2016.

This document focuses only on the CAHPS for PQRS and Web Interface reporting mechanisms. In particular, the subsequent sections of this report describe the procedures, as well as the underlying programming methods, for group practice beneficiary assignment for CAHPS for PQRS and Web Interface. The Medicare files that provide the data used to assign beneficiaries are described in Section 2. Finally, the method for assigning beneficiaries to a group practice is presented in Section 3.

⁷ CAHPS for PQRS is supplemental to PQRS group practice reporting. This mechanism alone is not sufficient to meet reporting requirements. CAHPS is optional for group practices with 25–99 EPs, but is required for group practices of 100+ EPs.

SECTION 2 MEDICARE DATA USED TO ASSIGN BENEFICIARIES

This section describes the Medicare data used to assign beneficiaries to each group practice participating in CAHPS for PQRS, PQRS GPRO using the Web Interface, or both. 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: (1) Medicare enrollment information and (2) claims data. 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

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

2.1.2 Claims Data

We use Medicare fee-for-service (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 (SNF), (5) home health agency, (6) durable medical equipment, and (7) hospice claims. On the basis of historical trends, we expect claims data generally to be 98–99% complete 3 months after the end of the calendar year. Waiting to perform assignment until 3 months after the end of the calendar year would unreasonably delay the Web Interface submission period for PQRS group practices; therefore, CMS uses partial-year data to assign beneficiaries for quality reporting purposes. Beneficiaries will be assigned on the basis of the first 6 calendar months of available claims data for CAHPS for PQRS, and the first 10 calendar months of available claims data for the Web Interface group practices.

Claims data is obtained from the Integrated Data Repository (IDR), which is updated each Monday to include claims data as of the previous Friday. For beneficiary assignment for CAHPS for PQRS, the effective date for claims will be set as January 1 through June 30. For beneficiary assignment for Web Interface purposes, the effective date for claims will be set as January 1 through the last Friday of October (October 28 in 2016). In each case, the IDR load date will be set as the first load date after the end effective date. For assignment purposes, we use the Outpatient and Carrier claims files in the IDR, which will be referred to as Part A Outpatient claims and Part B Physician claims throughout this report.

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SECTION 3
GROUP PRACTICE BENEFICIARY ASSIGNMENT FOR CAHPS FOR PQRS AND
WEB INTERFACE

The first step in identifying beneficiaries for CAHPS for PQRS and Web Interface purposes is to determine which beneficiaries are assigned to the group practice. For each participation year, beneficiary assignment is determined retrospectively after the PQRS GPRO registration period closes. Thus, a beneficiary assigned in one year may not be assigned in the following or preceding years. Further, a beneficiary assigned for CAHPS for PQRS purposes may not be assigned for Web Interface purposes because of the differing assignment periods (6 months and 10 months, respectively). However, the assignment process is the same for both CAHPS for PQRS and Web Interface purposes.

This section describes the stepwise methodology used for assigning beneficiaries for the above-stated purposes.

3.1 Assignment Criteria

Using Medicare claims, we will assign beneficiaries to a group practice in a two-step process. A beneficiary will be assigned to a participating group practice for a given year if the following beneficiary assignment criteria are satisfied within the assignment period:

A. Beneficiary must have a record of enrollment.

Medicare must have information about the beneficiary's Medicare enrollment status, as well as additional information needed to determine whether the beneficiary meets other eligibility criteria.

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. Those enrolled in a group health plan, including beneficiaries enrolled in Medicare Advantage 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 or possessions. This excludes beneficiaries who may have received care outside of the United States and for whom claims are not available. U.S. residence is defined as residence in

the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, or the Northern Marianas.

E. 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 D, 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 service⁸ furnished by a primary care provider⁹ at the participating group practice, and if more primary care services (measured by Medicare allowed charges) are furnished by primary care providers at the participating group practice than at any other entity.

Assignment Policy Step 2: This step applies only for those beneficiaries who have not received any primary care services from any primary care provider. 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 at the participating group practice, and more primary care services (measured by Medicare allowed charges) are furnished by physicians¹⁰ at the participating group practice than at any other entity.

Other entities used for beneficiary competition purposes include group and individual practices (uniquely identified by TIN), as well as federally qualified health centers (FQHCs), rural health clinics (RHCs), Method II critical access hospitals (CAHs), and electing teaching amendment (ETA) hospitals¹¹ (identified generally by their bill type code¹² and uniquely by their CMS Certification Number [CCN]¹³). Any of these types of entities could be the plurality provider of primary care services to a beneficiary, which would preclude assignment of that beneficiary to a given group practice. These entities are included in Assignment Policy Steps 1 and 2. Part B Physician claims will be used to identify services associated with a TIN, and Part A Outpatient claims will be used to identify services associated with an FQHC, RHC, CAH, or ETA hospital. In summary, we perform the assignment process simultaneously for all eligible organizations using both Part B and Part A Outpatient claims in each assignment policy step.

⁸ Primary care services are defined in Table 1.

⁹ Primary care provider is defined in Table 2.

¹⁰ Physician is defined in Table 3.

¹¹ 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 MPFS payments that might otherwise be made for these services.

¹² Refer to Table 4 for a list of bill type codes used.

¹³ ETA hospitals use the same bill type code as other outpatient hospital departments, so these entities are identified by a combination of bill type code and CCN.

3.2 Programming Steps in Assigning Beneficiaries to Group Practices

There are four programming steps involved in assigning beneficiaries to a group practice, in accordance with the process described in Section 3.1.

Programming Step 1: Create finder file for beneficiaries who received primary care services with a group practice.

We will use the Part B claims, and the TIN of the group practice that elected CAHPS for PQRS or the Web Interface reporting mechanism,¹⁴ to determine which beneficiaries received primary care services from those practices. This finder file will include a beneficiary identifier for each beneficiary who was furnished at least one primary care service by a provider (primary care or otherwise) in the group practice within the assignment period.

Programming Step 2: Revise finder file based on selected claims, enrollment, and demographic information for beneficiaries.

We will obtain eligibility information for each beneficiary identified in the finder file from Step 1. 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 will revise the finder file by removing beneficiaries who do not meet the general eligibility requirements described in A–D of Section 3.1.

Programming Step 3: Assign beneficiaries to participating group practices using Assignment Policy Step 1.

Using the beneficiaries identified in the revised finder file from Programming Step 2, we will identify beneficiaries who (1) received at least one primary care service (2) from a primary care provider (3) in the participating group practice (4) during the most recent assignment period. 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 providers in the group practice are greater than those furnished by primary care providers in other entities.

For each beneficiary identifier, we will sum allowed charges for primary care services. This includes allowed charges for primary care services for each beneficiary at each entity where primary care services were received.¹⁵ Primary care services are identified by looking for the applicable HCPCS or revenue center code in the “Line Item HCPCS” field of the claim. For Part B physician claims, we use the allowed charges for primary care services as stated on the claim. Part A Outpatient claims do not have an equivalent “allowed charges” field and thus require special handling to determine allowed charges. Additional information on the special handling on Part A Outpatient claims is provided in section 3.4. Specific primary care HCPCS codes and revenue codes are provided in Table 1.¹⁶ To determine where a beneficiary received the

¹⁴ These practices must have registered for PQRS GPRO reporting via the Web Interface during the registration period. They will be identified with the registered group practice TIN for assignment purposes.

¹⁵ The allowed charges must be greater than zero.

¹⁶ The specific codes that are considered primary care services may vary depending on the type of entity.

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 those provided by other entities.

We use allowed charges for assignment because, unlike expenditures, allowed charges include any Medicare deductible the beneficiary may have been responsible for during the assignment period. By using allowed charges rather than a simple service count, we also reduce the likelihood that there will be ties.

It is unlikely that allowed charges by two different entities would be equal, but it is possible. Therefore, we have established the following policy. If there is a tie, the beneficiary will be assigned to the entity that provided the most recent primary care service by a primary care provider. If there is still a tie, the beneficiary will be assigned to entity that provided the most recent primary care service by a physician. If there is still a tie, the beneficiary is randomly assigned to one of the tied entities.

Programming Step 4: 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 provider (within or outside of the group practice). That is, this step applies only for beneficiaries in the finder file from Programming Step 2 who remain unassigned to any group practice or other entity after Step 3. We will assign each of these beneficiaries to the group practice if the allowed charges for primary care services furnished to the beneficiary by physicians in the group practice are greater than those furnished by physicians in any other entity. If there is a tie, the beneficiary is assigned to the entity whose physician provided the most recent primary care service. If there is still a tie, the beneficiary is randomly assigned to one of the tied entities.

3.3 Defining Primary Care Services

For individual EPs, group practices, FQHCs, CAHs, and ETAs, primary care services are identified by the following HCPCS¹⁷ codes for CAHPS for PQRS and Web Interface beneficiary assignment purposes (Table 1).¹⁸

¹⁷ Includes Current Procedural Terminology codes, copyright 2011 American Medical Association, all rights reserved.

¹⁸ 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; G0439; and revenue center codes 0521, 0522, 0524, and 0525. Table 1 contains all codes in that range that are currently in use.

Table 1
Primary Care Service Codes

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

- 99304—New or established patient, brief
- 99305—New or established patient, limited
- 99306—New or established patient, comprehensive
- 99307—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
- 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
-

(continued)

Table 1(continued)
Primary Care Service Codes

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
Hospital outpatient clinic visit
G0463 ¹⁹ —Hospital outpatient clinic visit for assessment and management of a patient

For RHCs, primary care services include services identified by HCPCS code G0402, G0438, or G0439 or one of the following revenue center codes:

- 0521 Clinic visit by member to RHC
- 0522 Home visit by RHC practitioner
- 0524 Visit by RHC practitioner to a member in a covered Part A stay at a SNF
- 0525 Visit by RHC practitioner to a member in a SNF (in a non-covered Part A stay), nursing facility, intermediate care facility, or other residential facility

Table 2 lists the specialty codes that define a primary care provider for CAHPs for PQRS and Web Interface beneficiary assignment purposes.

¹⁹ Code G0463 is used by hospital outpatient departments covered by the outpatient prospective payment system (OPPS). Our algorithms only include ETA hospitals that use this code, excluding other types of OPPS-covered outpatient departments. That is, only CCNs belonging to ETA hospitals are allowed to use the G0463 for assignment purposes.

Table 2
Primary Care Provider Specialty Codes

1	General practice
8	Family practice
11	Internal medicine
38	Geriatric medicine
50	Nurse practitioner
89	Clinical nurse specialist
97	Physician assistant

The specialty codes shown in Table 3 are included in the definition of a physician used for CAHPS for PQRS and Web Interface beneficiary assignment purposes.

Table 3
Physician Specialty Codes

01	General practice
02	General surgery
03	Allergy/immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family practice
09	Interventional pain management
10	Gastroenterology
11	Internal medicine
12	Osteopathic manipulative therapy
13	Neurology
14	Neurosurgery
16	Obstetrics/gynecology
17	Hospice and palliative care
18	Ophthalmology
19	Oral Surgery
20	Orthopedic surgery
21	Cardiac electrophysiology

(continued)

Table 3 (continued)
Physician Specialty Codes

20	Pathology
21	Sports medicine
22	Plastic and reconstructive surgery
23	Physical medicine and rehabilitation
24	Psychiatry
25	Geriatric psychiatry
26	Colorectal surgery (formerly proctology)
27	Pulmonary disease
28	Diagnostic radiology
33	Thoracic surgery
34	Urology
35	Chiropractic
36	Nuclear medicine
37	Pediatric medicine
38	Geriatric medicine
40	Nephrology
41	Hand surgery
41	Optometry
44	Infectious disease
46	Endocrinology
48	Podiatry
66	Rheumatology
70	Multispecialty clinic or group practice
72	Pain management
76	Peripheral vascular disease
77	Vascular surgery
78	Cardiac surgery
79	Addiction medicine
81	Critical care (intensivists)
82	Hematology
83	Hematology/oncology
84	Preventive medicine
85	Maxillofacial surgery
86	Neuropsychiatry
90	Medical oncology
91	Surgical oncology

(continued)

**Table 3 (continued)
Physician Specialty Codes**

92	Radiation oncology
93	Emergency medicine
94	Interventional radiology
95	Gynecologist/oncologist
96	Unknown physician specialty
C0	Sleep medicine
C3	Interventional cardiology

The bill type codes in Table 4 (and any additional required information specified), identify CAH, RHC, FQHC, and ETA hospitals for CAHPS for PQRS and Web Interface beneficiary assignment purposes.

**Table 4
Part A Outpatient Bill Type Codes**

CAH Method II claims	85x with the presence of one or more of the following revenue center codes: 096x, 097x, or 098x
RHC claims	71x
FQHC claims	77x
ETA claims	13x with the presence of an ETA CCN

3.4 Special Processing for Part A Outpatient Claims

Part A Outpatient claims submitted to Medicare by CAHs, FQHC, RHCs, and ETA hospitals require additional handling when used for assignment purposes. Part A Outpatient claims do not provide an allowed charges field as Part B Physician claims do, so allowed charges must be calculated. Part A Outpatient claims also do not provide physician specialty codes. The following describes how Part A Outpatient claims are handled with respect to these issues.

3.4.1 Processing CAH Claims

Professional services rendered by CAHs (including primary care services) are identified on Part A Outpatient claims by bill type 85x in conjunction with one or more of the following revenue center codes: 096x, 097x, and 098x.²⁰

²⁰ These revenue codes are used to separate the professional fees from the facility fees on CAH claims.

- A CAH service reported on an outpatient claim is considered a primary care service if the claim includes a HCPCS code that meets the definition of a primary care service.
- To identify the rendering provider on CAH claims, we use the Rendering Provider NPI field.²¹ In the event that the Rendering Provider NPI field is blank, we use the Other Provider NPI field. If the Other Provider NPI field is also blank, we use the Attending Provider NPI field.
- To identify the CMS specialty of the identified physician or practitioner on a CAH claim, we use the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).
- Allowed charges are calculated using the Revenue Center Rate Amount.

3.4.2 Processing FQHC and RHC Claims

FQHC and RHC services are also billed on Part A Outpatient claims. FQHCs are identified using bill type code 77x, and RHCs are identified using bill type code 71x.

- An FQHC or RHC service reported on an outpatient claim is considered a primary care service if the claim includes a HCPCS or revenue center code, as applicable, that meets the definition of a primary care service.²²
- All primary care services billed by FQHCs and RHCs are assumed to have been performed by a primary care provider. This helps ensure that we do not disrupt established relationships between beneficiaries and FQHCs or RHCs.
- Allowed charges are calculated using the Revenue Center Payment Amount.

3.4.3 Processing ETA Hospital Outpatient Claims

ETA professional services (including primary care services) are identified on outpatient claims by bill type 13x in conjunction with a CCN²³ that meets the conditions for ETA hospitals.

- An ETA hospital service reported on an outpatient claim is considered a primary care service if the claim includes a HCPCS that meets the definition of a primary care service (Table 1).
- To identify the rendering physician/practitioner on ETA claims, we use the Rendering Provider NPI field.²⁴ In the event that the Rendering Provider NPI field is blank, we

²¹ The rendering provider field is not consistently populated in outpatient claims.

²² Note that the definition of “primary care service” varies for RHCs. See page 12.

²³ ETA hospitals use the same bill type code as other outpatient hospital departments. Requiring a specific CCN ensures that we are looking for services only at ETA hospitals.

²⁴ The rendering provider field is not consistently populated in outpatient claims.

use the Other Provider NPI field. If the Other Provider NPI field is also blank, we use the Attending Provider NPI field.

- To identify the CMS specialty of the identified physician/practitioner on a CAH claim, we use the Medicare PECOS.
- Primary care services can be identified as line items in an ETA Part A Outpatient claim; however, no charges are allowed on the claim for these services, nor do these services otherwise appear on Part A Outpatient or Part B Physician claims.²⁵ Therefore, the line item HCPCS code primary care service will indicate that a primary care service was rendered to a beneficiary, but the allowed charges associated with that service will be computed on the basis of the MPFS in effect for the geographic area during the assignment period.

²⁵ The ETA hospital bills CMS to recover facility costs incurred when ETA hospital physicians provide services. The physician services are reimbursed during settlement of the annual Medicare Cost Report for ETA hospitals.