Quality Payment
PROGRAM

2017 Assignment Methodology Specifications for the CMS Web Interface and CAHPS for MIPS Survey

October 31, 2017

ACRONYMS

ACO	Accountable care organization
CAH	Critical access hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCN	CMS certification number
CCM	Chronic care management
CEHRT	Certified electronic health record technology
CMS	Centers for Medicare & Medicaid Services
EHR	Electronic health record
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
MIPS	Merit-based Incentive Payment System
OPPS	Outpatient prospective payment system
PECOS	Provider Enrollment, Chain and Ownership System
POS	Place of service
PQRS	Physician Quality Reporting System
QPP	Quality Payment Program
RHC	Rural health clinic
SNF	Skilled nursing facility
TCM	Transitional care management
TIN	Taxpayer identification number

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CONTENTS

ACRONYMS 2
EXECUTIVE SUMMARY 6
SECTION 1 INTRODUCTION 8
SECTION 2 MEDICARE DATA USED TO ASSIGN BENEFICIARIES 10
2.1 Data Used in Program 10
2.1.1 Medicare Enrollment Information 10
2.1.2 Claims Data 10
SECTION 3 GROUP BENEFICIARY ASSIGNMENT FOR CAHPS FOR MIPS SURVEY AND CMS WEB INTERFACE 12
3.1 Assignment Criteria 12
3.2 Programming Steps in Assigning Beneficiaries to Group Practices 14
3.3 Defining Primary Care Services 15
3.4 Special Processing for Part A Outpatient Claims 23
3.4.1 Processing CAH Claims 23
3.4.2 Processing FQHC and RHC Claims 23
3.4.3 Processing ETA Hospital Outpatient Claims 24

List of Tables

1. Primary Care Service Codes 16
2. Primary Care Provider Specialty Codes 19
3. Physician Specialty Codes 19
4. Part A Outpatient Bill Type Codes 22

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EXECUTIVE SUMMARY

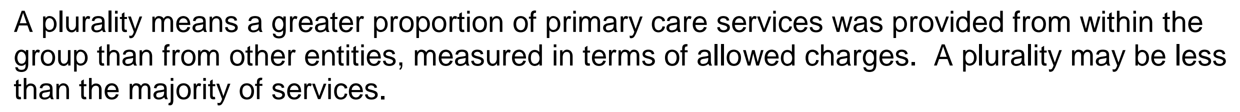
This report describes the process for assigning beneficiaries to a group participating in the Merit-based Incentive Payment System (MIPS). Assigned beneficiaries are used in the Centers for Medicare & Medicaid Services (CMS) Web Interface reporting, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey, and in cost measure calculations.[1] For MIPS purposes, a group is defined as a single tax identification number (TIN) with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their individual National Provider Identifier (NPI), who have reassigned their billing rights to the TIN.

Beneficiary Assignment: CMS uses retrospective beneficiary assignment to (1) identify beneficiaries eligible to receive the CAHPS for MIPS survey; (2) identify beneficiaries eligible for sampling into the CMS Web Interface; and (3) identify the beneficiary claims that will be used for cost calculations. For the CAHPS for MIPS survey, beneficiary assignment is determined retrospectively at the end of the registration period, which is June 30 for 2017. For the CMS Web Interface, beneficiary assignment for groups is determined retrospectively after October 31, 2017. Note that a beneficiary assigned in one year might not be assigned in the following or preceding years. Further, a beneficiary assigned to a group for CAHPS for MIPS survey purposes may not be assigned to the same group for CMS Web Interface purposes because of their differing assignment periods. Similarly, a beneficiary assigned to a group for CAHPS for MIPS survey or CMS Web Interface purposes, may not be assigned to the same group for cost calculations. However, the MIPS assignment process is the same for both CAHPS for MIPS and the CMS Web Interface (except for the differing assignment periods). This document will describe the assignment process for the CAHPS for MIPS and the CMS Web Interface.

If a beneficiary receives at least one primary care service within the group, the beneficiary is eligible to be assigned to the group based on a two-step process:

- The first step assigns a beneficiary to the group if the beneficiary receives the plurality of his or her primary care services from primary care clinicians within the group. Primary care clinicians 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 clinician, including primary care clinicians external to the group. Under this second step, we assign a beneficiary to the group if the beneficiary receives the plurality of his or her primary care services from clinicians who are not primary care within the group.

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



A plurality means a greater proportion of primary care services was provided from within the group 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 participating in MIPS if the group is reporting using the CMS Web Interface or the CAHPS for MIPS survey. Assigned beneficiaries are used in CMS Web Interface reporting, and the CAHPS for MIPS survey.

Statutory Background and Program Context: The Physician Quality Reporting System (PQRS) is 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 group practice reporting option (GPRO), and applies negative payment adjustments for not meeting the reporting requirements of this program.

Beginning with performance periods occurring in 2017 and 2019 payments, the PQRS program is being sunset in favor of the Quality Payment Program, authorized as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the payment adjustments under PQRS end in 2018 (based on reporting in 2016), and the provisions of the Quality Payment Program (QPP) begin in 2019 (based on reporting in 2017). QPP incorporates components of PQRS as well as the Value-based Payment Modifier program and the Medicare Electronic Health Record Incentive Program. Under the Quality Payment Program, eligible clinicians have two participation tracks available to them: MIPS or the Advanced Alternative Payment Models (Advanced APMs). Note that this document applies only to MIPS.[2]

Under MIPS, groups have the option to report at the individual or group level.[3] The following are the submission mechanisms available to groups:[4]

- Electronic Health Record (EHR)
- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- Attestation
- CMS Web Interface (groups with 25 or more eligible clinicians)
- CAHPS for MIPS Survey[5] [6]

Registration period and performance period: By June 30, 2017, groups were required to register if they elect to use the CMS Web Interface and/or administer the CAHPS for MIPS survey. For groups that elect to submit data using the CMS Web Interface, they agree to submit data on all

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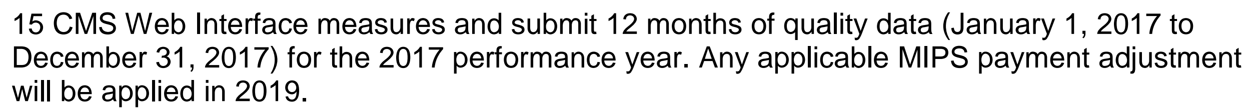
2 For those participating in the QPP through an APM, you should refer to the document released by your specific APM.

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

4 Please refer to the QPP website for additional information on regarding the submission mechanisms available to groups. https://qpp.cms.gov/.

5 Available to groups with 2 or more eligible clinicians (not an available option for individual MIPS eligible clinicians).

6 The CAHPS for MIPS survey is available to groups to supplement their quality reporting. The administration of the CAHPS for MIPS survey alone is not sufficient to meet reporting requirements under MIPS.



15 CMS Web Interface measures and submit 12 months of quality data (January 1, 2017 to December 31, 2017) for the 2017 performance year. Any applicable MIPS payment adjustment will be applied in 2019.

The subsequent sections of this report describe the procedures, as well as the underlying programming methods, for group beneficiary assignment for the CAHPS for MIPS survey and CMS 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 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 participating in MIPS using the CMS Web Interface and administering the CAHPS for MIPS survey. 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, 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. 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 CMS Web Interface submission period; therefore, CMS uses partial-year data to assign beneficiaries for purposes of the quality performance category under MIPS. Beneficiaries will be assigned on the basis of the first 6 calendar months of available claims data for the CAHPS for MIPS survey, and the first 10 calendar months of available claims data for the CMS Web Interface.

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 the CAHPS for MIPS survey, the effective date for claims will be set as January 1 through June 30. For beneficiary assignment for purposes of the CMS Web Interface, the effective date for claims will be set as January 1 through the last Friday of October (October 27 in 2017). For the CMS Web Interface and the CAHPS for MIPS survey, the claims will become available the Monday following the final date of the assignment period. For assignment purposes, we use the Outpatient and Carrier claims files in the integrated data repository (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
MIPS BENEFICARY ASSIGNMENT

The first step in identifying beneficiaries for purposes of the CMS Web Interface and the CAHPS for MIPS survey is to determine which beneficiaries are assigned to the group. For each participation year, beneficiary assignment is determined retrospectively. Thus, as previously noted, a beneficiary assigned in one year might not be assigned in the following or preceding years. However, the assignment process is the same for the CMS Web Interface and the CAHPS for MIPS survey.

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 in a two-step process. A beneficiary will be assigned to a participating group 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.

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.

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

Assignment Step 1: We will assign the beneficiary to the participating group in this step if the beneficiary has at least one primary care service[7] furnished by a primary care clinician[8] at the participating group, and if more primary care services (measured by Medicare allowed charges) are furnished by a primary care clinician at the participating group than by any other primary care clinician.

***Assignment Step 2*:** This step applies only for those beneficiaries who have not received any primary care services from any primary care clinician. We will assign the beneficiary to the participating group in this step if the beneficiary has at least one primary care service furnished by a clinician at the participating group, and more primary care services (measured by Medicare allowed charges) are furnished by the clinician[9] at the participating group than at any other entity.

Entities used to determine beneficiary assignment 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) hospitals[10] (identified generally by their bill type code[11] and uniquely by their CMS Certification Number (CCN)[12]). Any of these types of entities could provide the plurality of primary care services to a beneficiary, which would preclude assignment of that beneficiary to a given group. These entities are included in Assignment 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 step.

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7 Primary care services are defined in Table 1. Services that take place in a skilled nursing facility (i.e., on claims with a place of service (POS) 31 indicator) are excluded.

8 Primary care clinician is defined in Table 2.

9 Physician is defined in Table 3.

10 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 (42 C.F.R. § 415.160(a)).

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

12 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 Groups

There are four programming steps involved in assigning beneficiaries to a group, 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.

We will use the Part B claims, and the TIN of the group,[13] to determine which beneficiaries received primary care services from those groups. This finder file will include a beneficiary identifier for each beneficiary who was furnished at least one primary care service by a clinician (primary care or otherwise) in the group 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 groups using Assignment 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 clinician (3) in the participating group (4) during the most recent assignment period. We will assign beneficiaries who meet this condition to a group if the allowed charges for primary care services furnished to the beneficiary by primary care clinicians in the group are greater than those furnished by primary care clinicians 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.[14] 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.[15] To determine where a beneficiary received

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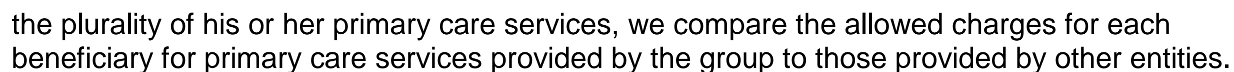
13 Groups must have registered for the CMS Web Interface and the CAHPS for MIPS survey during the registration period. They will be identified with the registered group TIN for assignment purposes.

14 The allowed charges must be greater than zero.

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



the plurality of his or her primary care services, we compare the allowed charges for each beneficiary for primary care services provided by the group 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 clinician. If there is still a tie, the beneficiary will be assigned to the entity that provided the most recent primary care service by a clinician. If there is still a tie, the beneficiary is randomly assigned to one of the tied entities.

Programming Step 4: Apply Assignment Step 2 to beneficiaries who were not assigned in Assignment Step 1.

This step applies only for those beneficiaries who have not received any primary care services from a primary care clinician (within or outside of the group). That is, this step applies only for beneficiaries in the finder file from Programming Step 2 who remain unassigned to any group or other entity after Step 3. We will assign each of these beneficiaries to the group if the allowed charges for primary care services furnished to the beneficiary by clinicians in the group are greater than those furnished by clinicians in any other entity. If there is a tie, the beneficiary is assigned to the entity whose clinician 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 Primary Care Services

For individual MIPS eligible clinicians, groups, FQHCs, CAHs, and ETAs, primary care services are identified by the following HCPCS[16] codes for MIPS beneficiary assignment purposes (Table 1).

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

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
99490	Chronic care management service
99495	Transitional care management within 14 days if discharge
99496	Transitional care management within 7 days of discharge
Subsequent nursing facility care (services that take place in a skilled nursing facility (i.e., on claims with a POS 31 indicator) are excluded)	
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 (services that take place in a skilled nursing facility (i.e., on claims with a POS 31 indicator) are excluded)	
99315	New or established patient, brief
99316	New or established patient, comprehensive
Other nursing facility services (services that take place in a skilled nursing facility (i.e., on claims with a POS 31 indicator) are excluded)	
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, moderate99336—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
Hospital outpatient clinic visit	
G0463[17]	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 clinician for beneficiary assignment purposes.

17 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 Clinician Specialty Codes

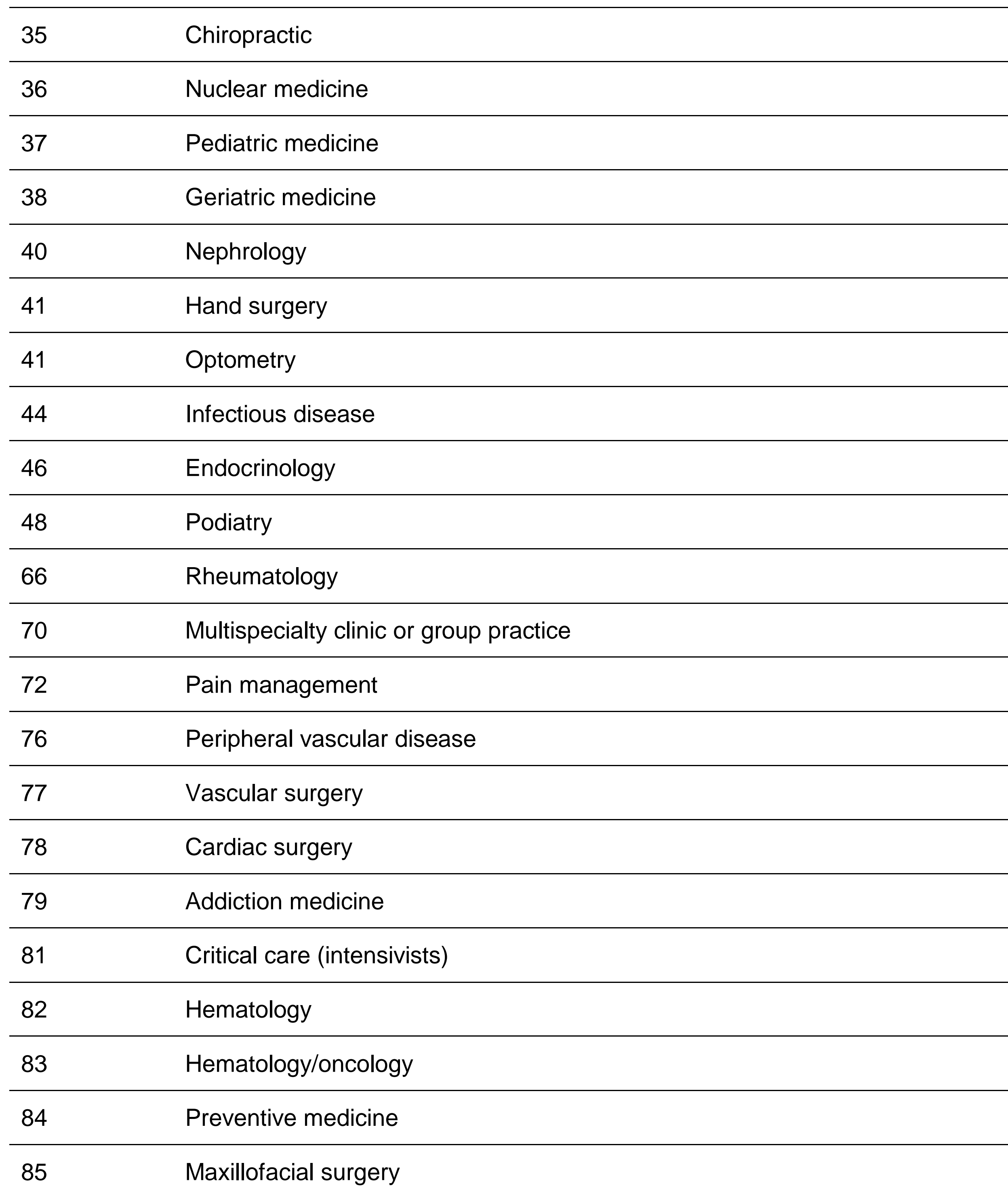
1	General practice
8	Family practice
11	Internal medicine
38	Geriatric medicine
50	Nurse practitioner
89	Clinical nurse specialist
97	Physician assistant

The specialty codes shown in Table 3 are included in the definition of a physician used for MIPS 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
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
92	Radiation oncology
93	Emergency medicine
94	Interventional radiology
95	Gynecologist/oncologist
96	Unknown physician specialty
C0	Sleep medicine
C3	Interventional cardiology
C6	Hospitalist

The bill type codes in Table 4 (and any additional required information specified), identify CAH, RHC, FQHC, and ETA hospitals for MIPS 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.[18]

- 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 clinician on CAH claims, we use the Rendering Provider NPI field. In the event that the Rendering Provider NPI field[19] 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 clinician 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.[20]
- All primary care services billed by FQHCs and RHCs are assumed to have been performed by a primary care clinician. 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.

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

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

20 Note that the definition of "primary care service" varies for RHCs. See page 12.

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 CCN[21] 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 code that meets the definition of a primary care service (Table 1).
- To identify the rendering clinician on ETA claims, we use the Rendering Provider NPI field.[22] 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/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.[23] 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.

21 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.

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

23 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.