Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS) 2018 Assignment Methodology Specifications for the CMS Web Interface and CAHPS for MIPS Survey

September 2018

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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Executive Summary

This report describes the process for assigning beneficiaries to a group or a virtual group participating in the Merit-based Incentive Payment System (MIPS). Assigned beneficiaries are used for 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. Under MIPS, a virtual group is defined as a combination of two or more TINs assigned to one or more solo practitioners or to one or more groups consisting of 10 or fewer clinicians (including at least one MIPS eligible clinician), or both, that elect to form a virtual group for a performance period for a year.

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 July 2 for 2018. For the CMS Web Interface, beneficiary assignment for groups and virtual groups is determined retrospectively after the last Friday in October of 2018. 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 or a virtual group for CAHPS for MIPS survey purposes may not be assigned to the same group or virtual group for CMS Web Interface purposes due to the differing assignment periods. Similarly, a beneficiary assigned to a group or a virtual group for CAHPS for MIPS survey or CMS Web Interface purposes may not be assigned to the same group or virtual group for cost calculations. However, the MIPS assignment process is the same for both the CAHPS for MIPS survey and the CMS Web Interface (except for the differing assignment periods). This document will describe the assignment process for the CAHPS for MIPS survey and the CMS Web Interface.

If a beneficiary receives at least one primary care service by a primary care clinician who is part of the group or virtual group, the beneficiary is eligible to be assigned to the group or virtual group based on a two-step process:

- The first step assigns a beneficiary to the group or virtual group if the beneficiary receives the plurality of his or her primary care services from primary care clinicians who are part of the group or the virtual 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.

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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.

- 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 or the virtual group. Under this second step, we assign a beneficiary to the group or the virtual group if the beneficiary receives the plurality of his or her primary care services from clinicians who are not primary care clinicians within the group or virtual group.

A plurality means a greater proportion of primary care services was provided from clinicians who are part of the group or the virtual group than any other entity, 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 or a virtual group participating in MIPS that has elected to report data for the Quality performance category via the CMS Web Interface and/or administer the CAHPS for MIPS survey. Assigned beneficiaries are used for groups and virtual groups reporting via the CMS Web Interface and/or administering the CAHPS for MIPS survey.

Under MIPS, the following submission mechanisms are available to groups and virtual groups:[2]

- Electronic Health Record (EHR)
- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- Attestation
- CMS Web Interface (groups and virtual groups with 25 or more clinicians)
- CAHPS for MIPS Survey[3,4]

Registration period and performance period: By July 2, 2018, groups and virtual groups were required to register if they elect to use the CMS Web Interface and/or administer the CAHPS for MIPS survey. For groups and virtual groups that elect to submit data using the CMS Web Interface, they agree to submit data on all 15 CMS Web Interface measures (CARE-1, CARE-2, DM-2, DM-7, HTN-2, IVD-2, MH-1, PREV-5 through PREV-10, PREV-12, and PREV-13) and submit 12 months of quality data (January 1, 2018 to December 31, 2018) for the 2018 performance year. Any applicable MIPS payment adjustment will be applied in 2020.

The subsequent sections of this report describe the procedures, as well as the underlying programming methods, for group and virtual group beneficiary assignment for the CAHPS for MIPS survey and the CMS Web Interface. The Medicare files that provide the data used to

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

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

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

assign beneficiaries are described in Section 2. Finally, the method for assigning beneficiaries to a group or a virtual 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 and virtual group participating in MIPS that has elected to report data for the Quality performance category via the CMS Web Interface and/or administer 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 or virtual 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, CMS expects 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 start of 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 26 in 2018). 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, CMS uses 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.

Section 3: MIPS Beneficiary 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 or virtual group. For each performance period, beneficiary assignment is determined retrospectively. Thus, as previously noted, a beneficiary assigned in one calendar year may not be assigned in the following or preceding calendar years. However, the assignment process is the same for the CMS Web Interface and the CAHPS for MIPS survey.

This section describes each step of the methodology used for assigning beneficiaries.

3.1 Assignment Criteria

Using Medicare claims, CMS assigns beneficiaries to a group or virtual group in a two-step process. A beneficiary will be assigned to a participating group or virtual 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 private or 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.

CMS excludes 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 or virtual group in a two-step process:

- *Assignment Step 1:* We will assign the beneficiary to the participating group or virtual group in this step if the beneficiary has at least one primary care service[5] furnished by a primary care clinician[6] at the participating group or virtual group, and if more primary care services (measured by Medicare allowed charges) are furnished by a primary care clinician part of the participating group or virtual group than 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. CMS will assign the beneficiary to the participating group or virtual group in this step if the beneficiary has at least one primary care service furnished by a clinician part of the participating group or virtual group, and if more primary care services (measured by Medicare allowed charges) are furnished by the clinician[7] part of the participating group or virtual group than any other entity.

Entities used to determine beneficiary assignment include group and individual practices (uniquely identified by a TIN), virtual groups (uniquely identified by a virtual group identifier), as well as Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), Method II critical access hospitals (CAHs), and electing teaching amendment (ETA) hospitals[8] (identified generally by their bill type code[9] and uniquely by their CMS Certification Number (CCN)[10]). 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

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

6 Primary care clinician is defined in Table 2.

7 Physician is defined in Table 3.

8 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)).

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

10 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.

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, CMS performs the assignment process simultaneously for all eligible entities using both Part B and Part A Outpatient claims in each assignment step.

3.2 Programming Steps in Assigning Beneficiaries to Groups

There are four programming steps involved in assigning beneficiaries to a group or a virtual 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 or the TINs comprising a virtual group[11] to determine which beneficiaries received primary care services from those groups or virtual 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) who is part of the group or the virtual group within the assignment period.

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

CMS 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. CMS 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, CMS will identify beneficiaries who (1) received at least one primary care service (2) from a primary care clinician (3) who is part of the participating group or virtual group (4) during the most recent assignment period. CMS will assign beneficiaries who meet this condition to a group or a virtual group if the allowed charges for primary care services furnished to the beneficiary by primary care clinicians who are part of the group or virtual group are greater than those furnished by primary care clinicians in other entities.

For each beneficiary identifier, CMS 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.[12] Primary care services are identified by looking for the

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11 Groups and virtual groups must have registered for the CMS Web Interface and/or the CAHPS for MIPS survey during the registration period. They will be identified with the registered group TIN or virtual group identifier for assignment purposes.

12 The allowed charges must be greater than zero.

applicable HCPCS or revenue center code in the “Line Item HCPCS” field of the claim. For Part B physician claims, CMS uses 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.[13] To determine where a beneficiary received the plurality of his or her primary care services, CMS compares the allowed charges for each beneficiary for primary care services provided by clinicians who are part of the group or virtual group to those provided by other entities.

CMS uses 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, it also reduces 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 (part of or not part of the group or virtual group). That is, this step applies only for beneficiaries in the finder file from Programming Step 2 who remain unassigned to any group or virtual group, or other entity after Step 3. CMS will assign each of these beneficiaries to the group or virtual group if the allowed charges for primary care services furnished to the beneficiary by clinicians who are part of the group or virtual 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.

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

3.3 Primary Care Services

For individual MIPS eligible clinicians, groups, virtual groups, FQHCs, CAHs, and ETAs, primary care services are identified by the following HCPCS[14] codes for MIPS beneficiary assignment purposes (Table 1).

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

[14] Includes Current Procedural Terminology codes, copyright 2011 American Medical Association, all rights reserved.

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

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 —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.

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

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.

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

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

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.[15]

- 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, CMS uses the Rendering Provider NPI field.[16] In the event that the Rendering Provider NPI field is blank, CMS uses the Other Provider NPI field. If the Other Provider NPI field is also blank, CMS uses the Attending Provider NPI field.
- To identify the CMS specialty of the identified clinician on a CAH claim, CMS uses 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.

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

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

- 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.[17]
- All primary care services billed by FQHCs and RHCs are assumed to have been performed by a primary care clinician. This helps ensure that there is not a disruption to the 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 CCN[18] 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, CMS uses the Rendering Provider NPI field.[19] In the event that the Rendering Provider NPI field is blank, CMS uses the Other Provider NPI field. If the Other Provider NPI field is also blank, CMS uses the Attending Provider NPI field.
- To identify the CMS specialty of the identified physician/practitioner on an ETA claim, CMS uses 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.[20] 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.

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

18 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.

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

20 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.