Quality Payment
PROGRAM

2024 Merit-Based Incentive Payment System (MIPS) Assignment Methodology Specifications for CAHPS for MIPS Survey

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Acronyms

APM	Alternative Payment Model
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCN	CMS Certification Number
CMS	Centers for Medicare & Medicaid Services
CPT©	Current Procedural Terminology
EHR	Electronic Health Record
ETA	Electing Teaching Amendment
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
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
MVP	MIPS Value Pathway
PECOS	Provider Enrollment, Chain and Ownership System
POS	Place of Service
QPP	Quality Payment Program
RHC	Rural Health Clinic
SNF	Skilled Nursing Facility
TIN	Taxpayer Identification Number

Executive Summary

This document outlines the Merit-based Incentive Payment System (MIPS) assignment methodology process for groups, virtual groups, subgroups, and Alternative Payment Model (APM) Entities administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey.

For purposes of MIPS, there are various ways to participate in MIPS, including the following options: as an individual MIPS eligible clinician, group, virtual group, subgroup, or APM Entity. Under MIPS, a group is defined as a single taxpayer identification number (TIN) with 2 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 2 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. Under MIPS, a subgroup is defined as a subset of a group which contains at least one MIPS eligible clinician and is identified by a combination of the group TIN, a subgroup identifier, and each eligible clinician's NPI.[1]

For patient assignment, the Centers for Medicare & Medicaid Services (CMS) uses retrospective patient assignment to identify patients eligible to receive the CAHPS for MIPS survey.

For the CAHPS for MIPS survey, patient assignment for groups, virtual groups, subgroups, and APM Entities is determined retrospectively at the end of the registration period, which closed on June 30, 2024.

Note that a patient assigned in one year may not necessarily be assigned in the following or preceding years. Similarly, a patient assigned to a group, virtual group, subgroup, or APM Entity for CAHPS for MIPS survey may not be assigned to the same group, virtual group, subgroup, or APM Entity for cost calculations.

If a patient receives at least one primary care service by a clinician who is part of the group, virtual group, or APM Entity, the patient is eligible to be assigned to the group, virtual group, or APM Entity based on a 2-step process:

1. The first step assigns a patient to the group, virtual group, or APM Entity if the patient receives at least one primary care service furnished by a primary care clinician in the participating group, virtual group, or APM Entity and if the plurality of their primary care services is from primary care clinicians who are part of the group, virtual group, or APM Entity. Primary care clinicians are defined as those with one of seven specialty designations: general practice, family practice, internal medicine, geriatric medicine, nurse practitioner, clinical nurse specialist, or physician assistant.

[1] To participate in MIPS as a subgroup, registration for a MIPS Value Pathway (MVP) is required.

2. The second step only considers patients who have not had any primary care services furnished by a primary care clinician, including primary care clinicians external to the group or the virtual group. Under the second step, CMS assigns a patient to the group or the virtual group if the patient receives the plurality of his or her primary care services from clinicians who are not primary care clinicians within the group, virtual group, or APM Entity.

A plurality means a greater proportion of primary care services was provided from clinicians who are part of the group, virtual group, or APM Entity than any other entity, which is measured in terms of Medicare allowed charges (henceforth referred to as allowed charges). A plurality may be less than the majority of services.

Subgroup assignment is determined using a similar 2-step process as described above, but for subgroup assignment determination, only claims furnished within the parent group (TIN/group that the subgroup is a part of) are used to determine plurality of care for assignment to the subgroup. For patients assigned to a group, these patients are then assessed for subgroup assignment. It should be noted that only patients assigned to groups are eligible to receive a subgroup assignment, but not all patients assigned to a group will receive a subgroup assignment. Patients assigned to a virtual group or APM Entity are not eligible to receive a subgroup assignment. Patients who receive a subgroup assignment will have both a group and subgroup assignment.

Section 1: Introduction

The information in this document outlines the MIPS assignment methodology for assigning patients to groups, virtual groups, subgroups, and APM Entities that elected and registered to administer the CAHPS for MIPS survey.

For groups, virtual groups, subgroups, and APM Entities electing to administer the CAHPS for MIPS survey for the 2024 performance period, they are required to register through the MIPS Registration System between April 1, 2024, and July 1, 2024.

Section 2: Medicare Data Used to Assign Patients

This section describes the Medicare data used to assign patients to each group, virtual group, subgroup, and APM Entity participating in MIPS that elects to administer the CAHPS for MIPS survey.

2.1 Data Sources

CMS primarily uses data from two Medicare data sources to assign patients 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 is described in Section 2.1.2.

2.1.1 Medicare Enrollment Information

For patients entitled to Medicare, we use Medicare enrollment information, including demographic information, enrollment dates, and Medicare managed care enrollment information.

2.1.2 Claims Data

CMS uses Medicare fee-for-service (FFS) claims data in assigning patients to a group, virtual group, subgroup, or APM Entity. For MIPS assignment, CMS uses Medicare enrollment data and 2 types of claims: (1) Carrier (physician/supplier) and (2) Institutional Outpatient claims. Based on historical trends pertaining to claims data, 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 CAHPS for MIPS survey submission period; therefore, CMS uses partial-year data to assign patients for purposes of the quality performance category under MIPS. Patients are assigned on the basis of the first 6 calendar months of available claims data for the CAHPS for MIPS survey.

The effective date range for claims is set as January 1, 2024, through June 30, 2024.

CMS obtains claims data using the Institutional Outpatient and Carrier claims files in the Integrated Data Repository (IDR). The IDR is updated each Monday to include claims data as of the previous Friday. For the CAHPS for MIPS survey, the claims are available the Monday (July 1, 2024) following the final date of the assignment period.

Section 3: Group, Virtual Group, Subgroup, and APM Entity Patient Assignment for CAHPS for MIPS Survey

The first step in identifying patients for purposes of the CAHPS for MIPS survey is to determine which patients are assigned to the group, virtual group, subgroup (based on patients assigned to the applicable group), or APM Entity. For each performance period, patient assignment is determined retrospectively. Thus, a patient assigned in one calendar year may not necessarily be assigned in the following or preceding calendar years.

Section 3.1 describes each step of the methodology used for assigning patients to a group, virtual group, or APM Entity. Section 3.2 describes the programming steps in assigning patients to groups, virtual groups, and APM Entities. Section 3.3 describes the steps for determining subgroup assignment for patients assigned to groups. Section 3.4 describes the programming steps in subgroup assignment. Section 3.5 provides definitions for primary care services, and Section 3.6 details the special processing for outpatient claims.

3.1 Assignment Criteria for Groups, Virtual Groups, and APM Entities

Using Medicare claims, CMS assigns patients to a group, virtual group, or APM Entity in a 2-step process. A patient will be assigned to a participating group, virtual group, or APM Entity for a given year if the following patient assignment criteria are satisfied within the assignment period (January 1, 2024, to June 30, 2024).

A. Patient must have a record of enrollment in Medicare.
    - Medicare must have information about the patient's Medicare enrollment status, as well as additional information needed to determine whether the patient meets other eligibility criteria.

B. Patient 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.
    - Patients who only have coverage under one of these parts are not included.

C. Patient cannot have any months of Medicare group (private) health plan enrollment.
    - Only patients 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 patients 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. Patient must reside in the United States (U.S.) or U.S. territories and possessions.
    - CMS excludes patients whose permanent residence is outside the U.S. or U.S. territories or possessions. This excludes patients who may have received care outside of the U.S. and for whom claims are not available. A U.S. residence is defined as a residence in one of the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, or the Northern Marianas.

E. Patient must have the largest share of their primary care services provided by the participating group or within a virtual group or APM Entity.

- If a patient meets the screening criteria in A through D, the patient is assigned to a group, virtual group, or APM Entity in a 2-step process:
    - Assignment Step 1: CMS will assign the patient to the participating group, virtual group, or APM Entity in this step if the patient has at least one primary care service[2] furnished by a primary care clinician[3] in the participating group, virtual group, or APM Entity, and if more primary care services (measured by allowed charges) are furnished by primary care clinicians who are part of the participating group, virtual group, or APM Entity compared to any other group (TIN), virtual group, or APM Entity, or CMS Certification Number (CCN).
    - Assignment Step 2: This step applies only for those patients who have not received any primary care services from any primary care clinician. CMS will assign the patient to the participating group, virtual group, or APM Entity in this step if the patient has at least one primary care service furnished by a clinician who is part of the participating group, virtual group, or APM Entity, and more primary care services (measured by allowed charges) are furnished by the participating group, virtual group, or APM Entity than any other group, virtual group, or APM Entity.

      Organizations used to determine patient assignment include group and individual practices (uniquely identified by a 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[4] (identified generally by their bill type code[5] and uniquely by their CCN[6]). Any of these types of organizations could provide the plurality of primary care services to a patient, which would preclude assignment of that patient to a given group. These organizations are included in Assignment Steps 1 and 2. Carrier claims will be used to identify services associated with a TIN, and Institutional Outpatient claims will be used to identify services associated with an FQHC, RHC, CAH, or ETA hospital. In summary, CMS performs the

[2] 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.

[3] Primary care clinician is defined in Table 2.

[4] 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)).

[5] Refer to Table 4 for a list of bill type codes used.

[6] 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.

assignment process simultaneously for all eligible entities using both Carrier and Institutional Outpatient claims in each assignment step.

3.2 Programming Steps in Assigning Patients to Groups, Virtual Groups, and APM Entities

There are 4 programming steps involved in assigning patients to a group, virtual group, or APM Entity in accordance with the process described in Section 3.1.

- Programming Step 1: Create finder file for patients who received primary care services with a group, TINs comprising a virtual group, or TINs comprising an APM Entity.
    - CMS will use the Carrier claims, the TIN of the group, the TINs comprising a virtual group, or the TINs comprising an APM Entity[7] to determine which patients received primary care services from those groups, virtual groups, or APM Entities. This finder file will include a patient identifier for each patient who was furnished at least one primary care service by a clinician (primary care or otherwise) who is part of the group, virtual group, or APM Entity within the assignment period.
- Programming Step 2: Revise finder file based on selected claims, enrollment, and demographic information for patients.
    - CMS will obtain eligibility information for each patient identified in the finder file from Programming 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 patients. CMS will revise the finder file by removing patients who do not meet the general eligibility requirements described in A through D of Section 3.1.
- Programming Step 3: Assign patients to participating groups, virtual groups, and APM Entities using Assignment Step 1.
    - Using the patients identified in the revised finder file from Programming Step 2, CMS will identify patients who (1) received at least one primary care service (2) from a primary care clinician (3) who is part of the participating group, virtual group, or APM Entity (4) during the most recent assignment period. CMS will assign patients who meet this condition to a group or a virtual group if the allowed charges for primary care services furnished to the patient by primary care clinicians who are part of the group, virtual group, or APM Entity are greater than those furnished by primary care clinicians in other entities.

      For each patient identifier, CMS will sum allowed charges for primary care services. This includes allowed charges for primary care services for each patient at each

[7] Groups, virtual groups, and APM Entities must register for the CAHPS for MIPS survey during the registration period (April 1, 2024, through July 1, 2024). They will be identified by the registered group TIN, virtual group identifier, or TINs associated with the APM Entity for assignment purposes. An APM Entity may be comprised of one or more TINs. For APM Entities with multiple TINs, allowed charges for all the TINs within the APM Entity are summed together to determine plurality for patient assignment.

organization where primary care services were received.[8] Primary care services are identified by looking for the applicable Healthcare Common Procedure Coding System (HCPCS) or revenue center code in the "Line Item HCPCS" field of the claim. For Carrier claims, CMS uses the allowed charges for primary care services as stated on the claim. Institutional 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 of Institutional Outpatient claims is provided in section 3.4. Specific primary care HCPCS codes and revenue codes are provided in Table 1.[9] To determine where a patient received the plurality of their primary care services, CMS compares the allowed charges for each patient for primary care services provided by clinicians who are part of the group, virtual group, or APM Entity to those provided by other groups (TINs), virtual groups, or APM Entities.

CMS uses allowed charges for assignment because, unlike expenditures, allowed charges include any Medicare deductible the patient 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 2 different groups (TINs), virtual groups, APM Entities, or CCNs would be equal, but it is possible. To account for this scenario, the following has been established. If there are allowed charges that are equal for 2 different groups (TINs), virtual groups, APM Entities, and CCNs then the patient 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, then the patient will be assigned to the group (TIN), virtual group, APM Entity, or CCN that provided the most recent primary care service by a clinician. If there is still a tie, the patient is randomly assigned to one of the tied groups (TINs), virtual groups, APM Entities, or CCNs.

- Programming Step 4: Apply assignment Step 2 to patients who were not assigned in assignment Step 1.
    - This step applies only for those patients who have not received any primary care services from any primary care clinician. Thus, this step applies only for patients in the finder file from Programming Step 2 who remain unassigned to any group, virtual group, APM Entity, or other organization after Programming Step 3. CMS will assign each of these patients to the group or virtual group if the allowed charges for primary care services furnished to the patient by clinicians who are part of the group, virtual group, or APM Entity are greater than those furnished by clinicians in any other entity. If there is a tie, then the patient is assigned to the entity whose clinician provided the most recent primary care service. If there is still a tie, then the patient is randomly assigned to one of the tied entities.

[8] The allowed charges must be greater than zero.

[9] The specific codes that are considered primary care services may vary depending on the type of organization.

3.3 Assignment Criteria for Subgroups

Patients assigned to groups are the only patients eligible to receive a subgroup assignment. Not all patients assigned to a group will receive a subgroup assignment. Patient are assigned to a subgroup in a 2-step process. CMS uses only claims furnished by clinicians within the parent group in the plurality determination for subgroup assignment.[10] Claims furnished by clinicians outside the parent group of the subgroup are not used in the subgroup plurality determination.

- Assignment Step 1: CMS will assign the patient to a subgroup in this step if the patient had at least one primary care service[11] furnished by a primary care clinician[12] in the subgroup, and if more primary care services (measured by allowed charges) are furnished by primary care clinicians who are part of the subgroup, compared to (1) the sum of allowed charges furnished by primary care clinicians in any other subgroup that is part of the parent group, and (2) the sum of allowed charges furnished by primary care providers in the parent group, but who are not a part of any subgroup.
- Assignment Step 2: This step applies only for those patients who have not received any primary care services from any primary care clinician. CMS will assign the patient to the subgroup in this step if the patient has at least one primary care service furnished by a clinician who is part of a subgroup, and more primary care services (measured by allowed charges) are furnished by clinicians who are part of the subgroup, compared to (1) the sum of allowed charges for any other subgroup that is a part of the parent group, and (2) the sum of allowed charges furnished by primary care providers in the parent group, but who are not a part of any subgroup.
- Organizations used to determine patient assignment include only the parent group (uniquely identified by a TIN).

3.4 Programming Steps in Assigning Patients to Subgroups

There are 3 programming steps involved in assigning patients to a subgroup in accordance with the process described in Section 3.3.

- Programming Step 1: Create finder file of patients who received a group assignment.
    - CMS will use the Carrier claims and the TIN of the group to determine which patients received a group assignment. This finder file will include a patient identifier for each assigned patient.
- Programming Step 2: Assign patients to subgroups.
    - Using the patients identified in the revised finder file from Programming Step 1, CMS will identify patients who (1) received at least one primary care service (2) from a

[10] Subgroups must register for the CAHPS for MIPS survey during the registration period (April 1, 2024, through July 1, 2024). They will be identified by the registered subgroup identifier for assignment purposes.

[11] 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.

[12] Primary care clinician is defined in Table 2.

primary care clinician (3) who is part of a subgroup. CMS will assign patients who meet this condition to a subgroup if the allowed charges for primary care services furnished to the patient by primary care clinicians who are part of the subgroup are greater than those furnished by primary care clinicians in other subgroups within the parent group or across all primary care clinicians within the parent group, but who are not part of a subgroup.

- For each patient identifier, CMS will sum allowed charges for primary care services. This includes summing allowed charges for primary care services for each patient for each subgroup within the parent group and among primary care clinicians within the parent group, but who are not a part of a subgroup.[13] Primary care services are identified by looking for the applicable Healthcare Common Procedure Coding System (HCPCS) or revenue center code in the "Line Item HCPCS" field of the claim. For Carrier claims, CMS uses the allowed charges for primary care services as stated on the claim. Institutional 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 of Institutional Outpatient claims is provided in section 3.4. Specific primary care HCPCS codes and revenue codes are provided in Table 1.[14] To determine if a patient received a plurality of their primary care services within a subgroup, CMS compares the allowed charges for each patient for primary care services provided by clinicians who are part of a subgroup to those provided by other subgroups or the group of clinicians within the parent group who are not a part of a subgroup.

  CMS uses allowed charges for assignment because, unlike expenditures, allowed charges include any Medicare deductible the patient 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 subgroups or a subgroup compared to the clinicians who are not a part of a subgroup would be equal, but it is possible. In order to account for this scenario, the following has been established. If there are allowed charges that are equal for two different subgroups or a subgroup and the clinicians who are not a part of a subgroup, then the patient will be assigned to the subgroup that provided the most recent primary care service by a primary care clinician. If there is still a tie, then the patient will be assigned to the subgroup that provided the most recent primary care service by a clinician. If there is still a tie, the patient is randomly assigned to one of the subgroups groups. If the winner for any of these ties is the group of clinicians who are not a part of a subgroup, then the patient will not receive a subgroup assignment.

[13] The allowed charges must be greater than zero.

[14] The specific codes that are considered primary care services may vary depending on the type of organization.

- Programming Step 3: Apply Assignment Step 2 to patients who were not assigned in Assignment Step 1.

  This step applies only for those patients who have not received any primary care services from any primary care clinician. CMS will assign each of these patients to the subgroup if the allowed charges for primary care services furnished by clinicians who are part of the subgroup are greater than those furnished by clinicians in other subgroups within the parent group or across all clinicians within the parent group but not a part of a subgroup. If there is a tie, then the patient is assigned to the subgroup whose clinician provided the most recent primary care service. If there is still a tie, then the patient is randomly assigned to one of the tied entities. If the winner for any of these ties is the group of clinicians not a part of a subgroup, then the patient will not receive a subgroup assignment.

3.5 Defining Primary Care Services

For individual MIPS eligible clinicians, groups, virtual groups, subgroups, APM Entities, FQHCs, CAHs, and ETAs, primary care services are identified by the following HCPCS codes for MIPS patient assignment purposes (Table 1).

Table 1: Primary Care Service Codes[15]

Office or Other Outpatient Services
96160—Administration of patient-focused health risk assessment instrument
96161—Administration of caregiver-focused health risk assessment instrument
99201—New patient, brief
99202—New patient, limited
99203—New patient, moderate
99204—New patient, comprehensive
99205—New patient, extensive
99211—Established patient, brief

(continued)

[15] No exclusions for Modifier 95 and POS 11 or POS 2.

Table 1: Primary Care Service Codes (Continued)[16,17]

99212—Established patient, limited

99213—Established patient, moderate

99214—Established patient, comprehensive

99215—Established patient, extensive

99487—Complex chronic care management

99489—Complex chronic care management

99490—Chronic care management service

99495—Transitional care management within 14 days if discharge

99496—Transitional care management within 7 days of discharge

Initial 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, moderate

99306—New or established patient, comprehensive

Subsequent nursing facility care (services that take place in a skilled nursing facility (i.e., on claims with a POS 31 indicator) are excluded)

99307—New or established patient, brief

99308—New or established patient, limited

99309—New or established patient, comprehensive

99310—New or established patient, extensive

Nursing Facility Discharge Services (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

(continued)

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17 No exclusions for Modifier 95 and POS 11 or POS 2.

Table 1: Primary Care Service Codes (Continued)[18,19]

Domiciliary, Rest Home, or Custodial Care Services

99324—New patient, brief
99325—New patient, limited
99326—New patient, moderate
99327—New patient, comprehensive
99328—New patient, extensive
99334—Established patient, brief
99335—Established patient, moderate
99336—Established patient, comprehensive
99337—Established patient, extensive

Domiciliary, Rest Home, or Home Care Plan Oversight Services

99339—Brief
99340—Comprehensive

Home Services

99341—New patient, brief
99342—New patient, limited
99343—New patient, moderate
99344—New patient, comprehensive
99345—New patient, extensive
99347—Established patient, brief
99348—Established patient, moderate
99349—Established patient, comprehensive
99350—Established patient, extensive

Wellness Visits

G0402—Welcome to Medicare visit
G0438—Annual wellness visit
G0439—Annual wellness visit

(continued)

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[19] No exclusions for Modifier 95 and POS 11 or POS 2.

Table 1: Primary Care Service Codes (Continued)[20,21]

Telehealth Visits

G2010 – Remote Evaluation of Patient Video/Images

G2012 – Virtual Check-In

99421 – E-visit; 5-10 minutes

99422 – E-visit; 11-20 minutes

99423 – E-visit; 21 or more minutes

99441 – Telephone Evaluation and Management; 5-10 minutes

99442 – Telephone Evaluation and Management; 11-20 minutes

99443 – Telephone Evaluation and Management; 21 or more minutes

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 patient assignment purposes.

Table 2: Primary Care Clinician Specialty Codes

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

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[21] No exclusions for Modifier 95 and POS 11 or POS 2.

The specialty codes shown in Table 3 are included in the definition of a physician used for MIPS patient 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
22	Pathology
23	Sports medicine
24	Plastic and reconstructive surgery
25	Physical medicine and rehabilitation
26	Psychiatry
27	Geriatric psychiatry
28	Colorectal surgery (formerly proctology)
29	Pulmonary disease
30	Diagnostic radiology
33	Thoracic surgery

(continued)

Table 3 (Continued): Physician Specialty Codes

34	Urology
35	Chiropractic
36	Nuclear medicine
37	Pediatric medicine
38	Geriatric medicine
39	Nephrology
40	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
98	Gynecologist/oncologist
99	Unknown physician specialty
C0	Sleep medicine
C3	Interventional cardiology
C5	Dentist
C6	Hospitalist

(continued)

Table 3 (Continued): Physician Specialty Codes

C7	Advanced Heart Failure and Transplant Cardiology
C8	Medical Toxicology
C9	Hematopoietic Cell Transplantation and Cellular Therapy
D3	Medical Genetics and Genomics
D7	Micrographic Dermatologic Surgery
D8	Adult Congenital Heart Disease
E4	Dental public health
E5	Endodontics
E6	Oral and maxillofacial pathology
E7	Oral and maxillofacial radiology
E9	Oral medicine
F3	Pediatric dentistry
F4	Periodontics
F5	Prosthodontics

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

Table 4: Institutional 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

3.6 Special Processing for Institutional Outpatient Claims

Institutional Outpatient claims submitted to Medicare by CAHs, FQHCs, RHCs, and ETA hospitals require additional handling when used for assignment purposes. Institutional Outpatient claims do not provide an allowed charges field as Carrier 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.

3.6.1 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.[22]

- 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.[23] 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.

3.6.2 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.[24]
- 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 patients and FQHCs or RHCs.
- Allowed charges are calculated using the Revenue Center Payment Amount.

3.6.3 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[25] 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).

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

[23] The rendering provider field is not consistently populated in outpatient claims.

[24] Note that the definition of “primary care service” varies for RHCs (see page 14).

[25] 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.

- To identify the rendering clinician on ETA claims, CMS uses the Rendering Provider NPI field.[26] 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/clinician on an ETA claim, CMS uses the Medicare PECOS.
- Primary care services can be identified as line items in an ETA Institutional Outpatient claim; however, no charges are allowed on the claim for these services, nor do these services otherwise appear on Institutional Outpatient or Carrier claims.[27] Therefore, the line item HCPCS code primary care service will indicate that a primary care service was rendered to a patient, but the allowed charges associated with that service will be computed on the basis of the Medicare Physician Fee Schedule (MPFS) in effect for the geographic area during the assignment period.

[26] The rendering provider field is not consistently populated in outpatient claims.

[27] 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.