Attribution Methodology
[Regence]

Effective January 1, 2024, and valid until updated

The attribution process retrospectively reviews members' primary care provider ("PCP") selection and claims data to identify member relationships with health care professionals. Management of members is assessed using the set of Evaluation and Management (E&M) procedure codes listed in Table 1b. Unless an applicable value-based care agreement between Regence and a provider specifies otherwise, members are retrospectively attributed to a provider using the following process:

1. Regence attributes members to health care professionals based primarily on the member's selected PCP, followed by number of visits a member makes to a particular health care professional within a particular period of time, as described in the sequential process below.
    a. The member is attributed based on the member's selection or designation, as properly communicated to Regence, of a health care professional as the member's PCP.
    b. If a member cannot be attributed because they have not selected a PCP, the member is attributed if the member has 1 visit in a consecutive 24-month period for which a health care professional practicing in a specialty listed in Table 1a submits a valid claim for an E&M service listed in Table 1b.
    c. If a member cannot be attributed by member PCP-selection or by visits with primary care health care professionals, the member remains unattributed.

2. In some cases, a member may be attributed to more than one health care system or entity or more than one health care professional. This section provides clarification regarding how any conflicts are resolved.
    a. The process described above applies first at the health care system or entity level before applying within a system or entity to the individual professional level.
    b. When there are conflicts at the system or entity level or at the individual health care professional level, members are attributed according to the hierarchy in the order listed below:
        i. Highest number of valid, qualifying E&M visits (i.e. visits listed in the applicable tables below for step 1b above)
        ii. Most recent date of valid, qualifying E&M visit
        iii. Highest total RVUs for valid, qualifying E&M visits

Table 1a: Provider Specialties considered as Primary Care

Specialty Code	Specialty Description
01	General practice
08	Family practice
11	Internal medicine
16*	Obstetrics/gynecology*
37	Pediatric medicine
38	Geriatric medicine
84	Preventive medicine

*Obstetrics/gynecology specialty is only applicable for attribution to Total Care, ACO/AHN and Medicare QIP

Table 1b: E&M Codes considered for attribution

Procedure Codes	Description
98966 - 98968	Hc pro phone call
98969	Online service by hc pro
99201 - 99205	Office/outpatient visit, new
99211 - 99215	Office/outpatient visit, est
99354 & 99355	Prolonged service, office
99358 & 99359	Prolonged service, w/o contact
99381, 99382 & 99387	Init pm e/m, new pat
99383-99386	Prev visit, new
99391 & 99397	Per pm reeval, est pat
99392-99396	Prev visit, est
99401 - 99404	Preventive counseling, indiv
99411 & 99412	Preventive counseling, group
99420	Health risk assessment test
99421 - 99423	Digital e/m (Telemedicine)
99429	Unlisted preventive service
99441 - 99443	Phone e/m by phys
99444	Online e/m by phys
99499	Unlisted e&m service
G0344 & G0402	Initial preventive exam
G0438 & G0439	Annual Wellness Visit
S0610, S0612 & S0613	Annual gynecological exam
S0280	Medical home, initial plan
S0281	Medical home, maintenance

* E&M codes will be excluded if procedure performed in Urgent Care setting (POS=20)