# Medicare Fees for Service & Supplier Costs Include Order & Referring: Including PART\_B, HHA, DME, PMD & Average Wait Times Between Providers

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Introduction

The 2018 Referring Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) file presents information on DMEPOS products and services provided to Medicare beneficiaries ordered by physicians and other healthcare professionals. The Referring Provider DMEPOS contains data on utilization, payment, and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code and BETOS Classification, which is items, drugs, products, and wheelchairs offered. Number Of Suppliers (how many suppliers each healthcare professional or clinic has), Number Of Supplier Beneficiaries (number of beneficiaries associated with the supplier DMEPOS products/services ordered by the referring provider), Number Of Supplier Claims (number of DMEPOS claims submitted by the supplier, reflecting products/services ordered by the referring provider), and Number Of Supplier Services (number of DMEPOS products/services rendered by the supplier). Lastly, you have Average Supplier Submitted Charge (average of the charges that suppliers submit for DMEPOS products/services), Average Supplier Medicare Allowed Amounts (average Medicare allowed amounts for the DMEPOS product/service rendered by suppliers), and Average Supplier Medicare Payment Amount (average amount that Medicare paid suppliers after deductible and coinsurance amounts have been deducted for the line item DMEPOS product/service).

NOTE: Of particular importance is the fact that the data may not be representative of a physician’s entire practice as it only includes information on Medicare fee-for-service beneficiaries. (Data.cms.gov, 2018).

Datasets of Doc Graph Hop Teaming Documentation and Ordering and Referring References have been combined by “INNER JOIN” function to create one dataset. The Doc Graph Hop Teaming data structure uses the average amount of days a patient waits till they are seen from one NPI (medical provider) to another in sequence. It also provides the number of patients between the providers and number of transactions from one provider to another. (CareSet Dataset.com, 2019). The Ordering and Referring Reference provides CMS regulations that require physicians or other eligible professionals to be enrolled or validly opted-out of the Medicare Program to order and refer items or services for Medicare beneficiaries. It uses the NPI number to verify whether a provider offers PART B, DME, HHA, and PMD coverage to Medicare clients.

PART B: Is medical insurance and covers expenses like doctor appointments, laboratory tests and X-rays for patients.

DME or (Durable Medical Equipment): Refers to equipment needed for use in the home, such as, blood sugar meters, canes, commode chairs, walkers, wheelchairs/scooters, hospital beds, crutches, patient lifts etc.…

HHA or (Home Health Aides): Provide personal care to elderly adults with daily tasks such as bathing, getting dressed, preparing meals, eating, and hygiene needs. HHAs require certification by the state.

PMD or (Power Mobility Devices): Are covered under DME and are power operated vehicles which are power wheelchairs and scooters.

## Insight:

The physician self-referral low and commonly referred to as the “Stark Law” prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she has a financial relationship unless an exception applies. Prohibits the entity from presenting or causing to be presented claims to Medicare for those referred services (cms.gov, 2021).

Users of Medicaid data may note apparent inconsistencies which are primarily due to the difference in the information captured in MSIS, or the former HCFA-2082, versus CMS-64 reports. The most substantive difference is due to payments made to "disproportionate share hospitals." Disproportionate share hospitals receive higher Medicaid reimbursement than other hospitals because they treat a disproportionate share of Medicaid patients. States determine if hospitals meet the criteria to be considered a "disproportionate share hospital" and establish a formula used to calculate the amount of the payment, subject to certain minimum standards under the law. States claim the Federal match for payments to disproportionate share hospitals on the CMS-64. States combine this claim either with other inpatient hospital services claims or with mental health facility claims. However, payments to disproportionate share hospitals do not appear in MSIS since states directly reimburse these hospitals and there is no fee-for-service billing (cms.gov, 2021).

Individuals who must pay a premium for Part A must meet the following requirements to enroll in Part B:

Be age 65 or older;

Be a U.S. resident; AND

Be either a U.S. citizen, OR

Be an alien who has been lawfully admitted for permanent residence and has been residing in the United States for 5 continuous years prior to the month of filing an application for Medicare.

Data

I used three different datasets used in referring Medicare. Medicare Referring Provider DMEPOS PUF CY2018 presents information on DMEPOS products and services provided to Medicare beneficiaries ordered by physicians and other healthcare professionals. The Referring Provider DMEPOS PUF contains data on utilization, payment (allowed amount and Medicare payment), and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code and supplier rental indicator. This PUF is based on information from CMS administrative claims data for Medicare beneficiaries enrolled in the fee-for-service program available from the CMS Chronic Condition Data Warehouse ([www.ccwdata.org](http://www.ccwdata.org/)). The data in the Referring Provider DMEPOS PUF covers calendar year 2018 and contains final-action (i.e., all claim adjustments have been resolved) Part B non-institutional DMEPOS line items for the Medicare fee-for-service (FFS) population.

The source is the Medicare Provider Data Team ([medicareproviderdata@cms.hhs.gov](mailto:medicareproviderdata@cms.hhs.gov)), it contains 28 columns and 1.66M rows of data. This data was collected to monitor Medicare costs of provider and supplier, as well as claims and payments.

The Order and Referring data file have National Provider Identifier (NPI) and legal name (last name, first name) of all physicians and non-physician practitioners who are of a type/specialty that is legally eligible to order and refer in the Medicare program and who have current enrollment records in Medicare (i.e., they have enrollment records in PECOS).

The source is CMS ([cardinal.williams@cms.hhs.gov](mailto:cardinal.williams@cms.hhs.gov)), it contains 7 columns and 1.62M rows of data. This data was collected because of the requirements for physicians and other professionals to be enrolled or validly opted-out of the Medicare Program to order or refer items or services for Medicare beneficiaries.

The Doc Graph Hop Dataset looks at the from and to NPI to interpret the average number of days a patient waits till they see their other provider, and it goes back and forth. It contains 6 columns and over 100M rows of data, but this was combined with Order and Referring limited it to 78M rows. The purpose of this dataset is to monitor how long patients wait before seeing each provider on average. CareSet is a biomedical company so it was created by their analytical team for data analysis ([CareSet Dataset: DocGraph Hop Teaming Documentation - CareSet Systems](https://careset.com/datasets-3/hop-teaming/)).

Limitations:

While the Referring Provider DMEPOS PUF has a wealth of information on payment and utilization for Medicare DMEPOS services, the dataset has a few limitations. Of particular importance is the fact that the data may not be representative of a physician’s entire practice as it only includes information on Medicare fee-for-service beneficiaries. In addition, the data are not intended to indicate the quality of care provided and are not risk-adjusted to account for differences in underlying severity of disease of patient populations. the file does not include data for products or services that were performed on 10 or fewer claims, so users should be aware that summing the data in the file may underestimate the true Part B FFS DMEPOS totals that are ordered by the referring provider. Finally, if users try to link provider data (note: it is not possible to link by beneficiary) from this file to other public datasets, please be aware of the Medicare populations included and timeframes used in each file that will be merged. For example, efforts to link the Referring Provider DMEPOS PUF data to the Physician and Other Supplier PUF data would need to account for the fact that some providers (e.g., nurse practitioners/physician assistants) may refer DMEPOS products and services but may not necessarily render services as the performing NPI in the Physician and Other Supplier PUF. Also, efforts to link the Referring Provider DMEPOS PUF data to Part D prescription drug data would need to account for the fact that some beneficiaries who have FFS Part B coverage (and are thus included in the Referring Provider DMEPOS PUF) do not have Part D drug coverage (and thus not represented in Part D data files). At the same time, some beneficiaries that have Part D coverage (and are thus included in the Part D data) do not have FFS Part B coverage (and thus not included in the Referring Provider DMEPOS PUF). Another example would be linking to data constructed from different or non-aligning time periods, such as publicly available data on physician referral patterns, which is based on an 18-month period.

Ordering and Referring limitations include those who may have legally opted out of Medicare.

For Doc Graph Hop dataset, the transaction data is impossible to interpret, especially when multiple providers are working with the same patient and approximately the same time. (like during hospital or SNF stays, or during long term therapy). The performance of the algorithm is poor and becomes exponentially worse as the number of NPIs and event dates increase. The sequencing of the sliding window data set requires multiple different versions of the dataset. Working with exceptionally large datasets did make it difficult to pinpoint key information small enough for a graph.

*Range of values for major variables:*

Number\_of\_suppliers – Can range from 1 to tens of thousands.

Number\_of\_suppliers\_beneficiaries – Can range from 0 to tens of thousands.

Number\_of\_supplier\_claims – Can range from 0 to hundreds of thousands.

Number\_of\_supplier\_services – Can range from 0 to hundreds of thousands.

DME, PART B, HHA, PMD – Are True or False Booleans “1 or 0”.

Avg\_supplier\_submitted\_charge and Avg\_supplier\_allow\_amount – Can range from 0 to the millions in dollar amount.

Patient\_Count – From 0 to the 100s, it varies.

Average\_Day\_Wait – From 0 to hundreds of days before seeing the other provider.

### APPENDIX 1:

Refer for complete data dictionary.

### APPENDIX 2:

Refer for documentation of the data cleaning process.

Analysis and Results

First slide: The first question I asked after looking at the data was to look at when there are no beneficiaries that the supplier is providing product to, who is receiving the most supplies? I understand that providers will receive some supplies without the need of clients, but the numbers were large for two of the providers. I looked at the HCPCS CODE and HCPCS\_DESCRIPTION vs the NUMBER\_OF\_SUPPLIER\_CLAIMS to identify the items being claimed the most without beneficiaries.

Second slide: A few questions I asked here were is there an opportunity for another company to come in and take some of that business from the doctors with few suppliers? The AVG\_SUPPLIER\_SUBMITTED\_CHARGE is much higher than the payment amount from Medicare. Who pays the rest?

I looked at NUMBER\_OF\_SUPPLIERS that were at a minimum for providers that have a lot of business. Also, looked at the AVG\_SUPPLIER\_SUBMITTED\_CHARGE and AVG\_SUPPLIER\_MEDICARE\_PMT\_AMT to see if there were any outliers.

Third slide: Here are some doctors missing some referring credentials but are requesting a large NUMBER\_OF\_SUPPLIER\_SERVICES. They could have permission to do so, but it would be worth examining further to see why they are using many supplier services. Are they truly M.D. or D.O. or whatever is needed for all these services from their suppliers?

Fourth slide: Looked at providers who do offer HHA and Part B vs those providers who do not offer those. I assumed that those who accepted HHA and Part B would offer better and faster service to their clients. I analyzed the AVG\_DAY\_WAIT based on whether they offered HHA, PART B, DME, PMD or did not offer HHA and PART B.

Discussion

First slide: Albuterol Inhalation Solution has 437.7K supplier claims, it is used to prevent and treat difficulty breathing. Most inhalers are safe to use up to one year after expiration date accorder to (healthline.com) but these are a lot of them. Someone could follow up by checking what the provider is doing with all the inhalers and if they are allowing them to expire, and where are they being sold.

Second slide: The results show with so few suppliers for Dr. Patel and Dr. Johnson, there could be opportunity for another supplier to offer a lower price and win some of their business. There is only a small number of suppliers who are charging a large amount to the providers. The follow up here could be further research to see if there is an opportunity for another supplier or is it just more expensive.

Third slide: The data does not provide if these doctors are exempted from having proper credentials, but it is a possibility that they are getting supplies they are not authorized to have based on REFERRING\_CREDENTIALS. The NPI would need to be verified one-by-one to see if these doctors could legit order all these supplies based on the item they are ordering.

Fourth slide: The average amount of days clients wait between providers is not that much different which surprised me. The average for non-HHA and PART B clients is 54.19 days, while providers that offer HHA, PART B, DME, and PMD has an average of 53.26 days just looking at the top 10. There needs to be improvement here, so someone could follow up on how to reduce the average client wait times.

Conclusion

The 2018 Referring Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) file presents information on DMEPOS products and services provided to Medicare beneficiaries ordered by physicians and other healthcare professionals. The Referring Provider DMEPOS contains data on utilization, payment, and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code and BETOS Classification, which is items, drugs, products, and wheelchairs offered. Number Of Suppliers (how many suppliers each healthcare professional or clinic has), Number Of Supplier Beneficiaries (number of beneficiaries associated with the supplier DMEPOS products/services ordered by the referring provider), Number Of Supplier Claims (number of DMEPOS claims submitted by the supplier, reflecting products/services ordered by the referring provider), and Number Of Supplier Services (number of DMEPOS products/services rendered by the supplier). The data source is (Data.CMS.gov) created by ([medicareproviderdata@cms.hhs.gov](mailto:medicareproviderdata@cms.hhs.gov)). This dataset provided insight into the number of supplier claims, services, beneficiaries, and number of suppliers. It provided the HCPCS codes and descriptions to see what the providers are purchasing in each location. The dataset gave insight into average supplier submitted charges, amount Medicare pays and the average amount the supplier can charge.

Datasets of Doc Graph Hop Teaming Documentation and Ordering and Referring References have been combined by “INNER JOIN” function to create one dataset. The Doc Graph Hop Teaming data structure uses the average amount of days a patient waits till they are seen from one NPI (medical provider) to another in sequence. It also provides the number of patients between the providers and number of transactions from one provider to another. (CareSet Dataset.com, 2019). The high number of average days clients wait is much longer than I imagined and should be monitored more closely for the well-being of the older generation.

The Ordering and Referring Reference provides CMS regulations that require physicians or other eligible professionals to be enrolled or validly opted-out of the Medicare Program to order and refer items or services for Medicare beneficiaries. It uses the NPI number to verify whether a provider offers PART B, DME, HHA, and PMD coverage to Medicare clients. The fact that some providers do not offer PART B is something that needs to be corrected as a lot of senior citizens depend on Medicare for their health. Healthcare costs continue to rise, and you start to wonder if free healthcare-for-all is something the US should consider.

PART B: Is medical insurance and covers expenses like doctor appointments, laboratory tests and X-rays for patients.

DME or (Durable Medical Equipment): Refers to equipment needed for use in the home, such as, blood sugar meters, canes, commode chairs, walkers, wheelchairs/scooters, hospital beds, crutches, patient lifts etc.…

HHA or (Home Health Aides): Provide personal care to elderly adults with daily tasks such as bathing, getting dressed, preparing meals, eating, and hygiene needs. HHAs require certification by the state.

PMD or (Power Mobility Devices): Are covered under DME and are power operated vehicles which are power wheelchairs and scooters.

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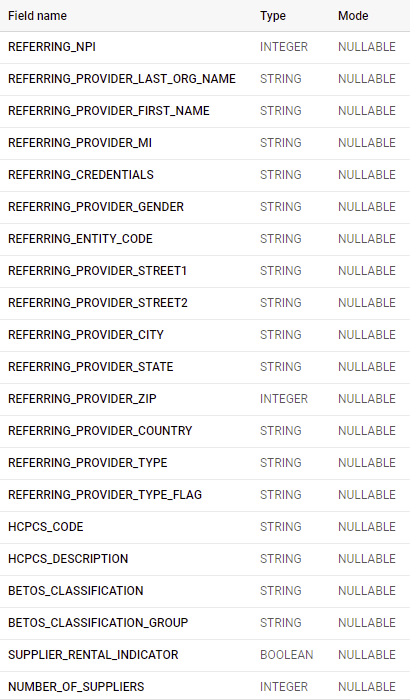
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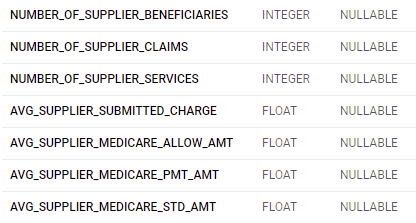
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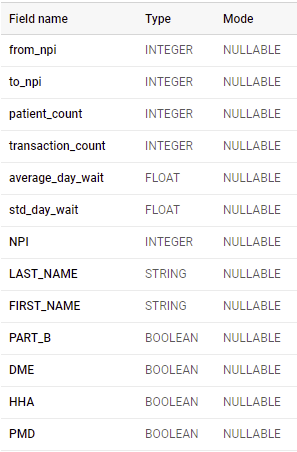
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### APPENDIX 1:

Medicare Referring Provider & Union Medical (DocGraph Hop Teaming & Order and Referring)







### APPENDIX 2:

SELECT REFERRING\_NPI, REFERRING\_PROVIDER\_LAST\_ORG\_NAME, REFERRING\_PROVIDER\_FIRST\_NAME, REFERRING\_CREDENTIALS, REFERRING\_PROVIDER\_GENDER, REFERRING\_PROVIDER\_CITY,

REFERRING\_PROVIDER\_STATE, REFERRING\_PROVIDER\_COUNTRY, REFERRING\_PROVIDER\_TYPE, HCPCS\_CODE,

 HCPCS\_DESCRIPTION, BETOS\_CLASSIFICATION\_GROUP, SUPPLIER\_RENTAL\_INDICATOR,

NUMBER\_OF\_SUPPLIERS, NUMBER\_OF\_SUPPLIER\_BENEFICIARIES, NUMBER\_OF\_SUPPLIER\_CLAIMS, NUMBER\_OF\_SUPPLIER\_SERVICES,

ROUND(AVG\_SUPPLIER\_SUBMITTED\_CHARGE,2) AS AVG\_SUPPLIER\_SUBMITTED\_CHARGE,

ROUND(AVG\_SUPPLIER\_MEDICARE\_ALLOW\_AMT,2) AS AVG\_SUPPLIER\_MEDICARE\_ALLOW\_AMT,

ROUND(AVG\_SUPPLIER\_MEDICARE\_PMT\_AMT,2) AS AVG\_SUPPLIER\_MEDICARE\_PMT\_AMT,

 ROUND(AVG\_SUPPLIER\_MEDICARE\_STD\_AMT,2) AS AVG\_SUPPLIER\_MEDICARE\_STD\_AMT

FROM `pioneering-axe-307101.Medicare\_Referring\_Provider.Medicare`

1ST SLIDE

SELECT DISTINCT HCPCS\_CODE, NUMBER\_OF\_SUPPLIER\_BENEFICIARIES, NUMBER\_OF\_SUPPLIER\_CLAIMS, NUMBER\_OF\_SUPPLIER\_SERVICES

FROM `pioneering-axe-307101.Medicare\_Referring\_Provider.Medicare`

WHERE NUMBER\_OF\_SUPPLIER\_BENEFICIARIES=0

ORDER BY NUMBER\_OF\_SUPPLIER\_SERVICES DESC, NUMBER\_OF\_SUPPLIER\_BENEFICIARIES DESC

2nd SLIDE

SELECT REFERRING\_PROVIDER\_LAST\_ORG\_NAME, REFERRING\_CREDENTIALS, REFERRING\_PROVIDER\_TYPE, BETOS\_CLASSIFICATION\_GROUP, NUMBER\_OF\_SUPPLIERS, REFERRING\_PROVIDER\_CITY, NUMBER\_OF\_SUPPLIER\_BENEFICIARIES,

ROUND(AVG\_SUPPLIER\_SUBMITTED\_CHARGE,2) AS AVG\_SUPPLIER\_SUBMITTED\_CHARGE,

ROUND(AVG\_SUPPLIER\_MEDICARE\_ALLOW\_AMT,2) AS AVG\_SUPPLIER\_MEDICARE\_ALLOW\_AMT,

ROUND(AVG\_SUPPLIER\_MEDICARE\_PMT\_AMT,2) AS AVG\_SUPPLIER\_MEDICARE\_PMT\_AMT,

FROM `pioneering-axe-307101.Medicare\_Referring\_Provider.Medicare`

3RD SLIDE

SELECT From\_npi, to\_npi, patient\_count, transaction\_count, average\_day\_wait, std\_day\_wait, NPI, LAST\_NAME, FIRST\_NAME, PART\_B, DME,

HHA, PMD

FROM `pioneering-axe-307101.Union\_Referring\_Provider.Union\_Medical`

WHERE PART\_B=FALSE AND HHA=FALSE

ORDER BY average\_day\_wait DESC

3RD SLIDE

SELECT From\_npi, to\_npi, patient\_count, transaction\_count, average\_day\_wait, std\_day\_wait, NPI, LAST\_NAME, FIRST\_NAME, PART\_B, DME,

HHA, PMD

FROM `pioneering-axe-307101.Union\_Referring\_Provider.Union\_Medical`

WHERE PART\_B=TRUE AND HHA=TRUE AND DME=TRUE AND PMD=TRUE

ORDER BY average\_day\_wait ASC

4th SLIDE

SELECT DISTINCT NPI, patient\_count, average\_day\_wait, PART\_B, DME, HHA, PMD,

  REFERRING\_NPI,

  REFERRING\_PROVIDER\_LAST\_ORG\_NAME,

  REFERRING\_CREDENTIALS,

  REFERRING\_PROVIDER\_COUNTRY,

  REFERRING\_PROVIDER\_CITY,

  REFERRING\_PROVIDER\_TYPE,

  HCPCS\_CODE,

  BETOS\_CLASSIFICATION\_GROUP,

  NUMBER\_OF\_SUPPLIERS,

  NUMBER\_OF\_SUPPLIER\_BENEFICIARIES,

  NUMBER\_OF\_SUPPLIER\_CLAIMS,

  NUMBER\_OF\_SUPPLIER\_SERVICES,

  ROUND(AVG\_SUPPLIER\_SUBMITTED\_CHARGE,2) AS AVG\_SUPPLIER\_SUBMITTED\_CHARGE,

  ROUND(AVG\_SUPPLIER\_MEDICARE\_ALLOW\_AMT,2) AS AVG\_SUPPLIER\_MEDICARE\_ALLOW\_AMT,

  ROUND(AVG\_SUPPLIER\_MEDICARE\_PMT\_AMT,2) AS AVG\_SUPPLIER\_MEDICARE\_PMT\_AMT

FROM `pioneering-axe-307101.Union\_Referring\_Provider.Union\_Medical` INNER JOIN `pioneering-axe-307101.Medicare\_Referring\_Provider.Medicare`

ON NPI = REFERRING\_NPI

WHERE PART\_B=TRUE AND HHA=FALSE AND PMD=FALSE

ORDER BY NPI

SELECT

  HCPCS\_DESCRIPTION, BETOS\_CLASSIFICATION\_GROUP, REFERRING\_PROVIDER\_CITY,

  REFERRING\_PROVIDER\_LAST\_ORG\_NAME, REFERRING\_CREDENTIALS, HCPCS\_CODE,

  NUMBER\_OF\_SUPPLIERS,

  NUMBER\_OF\_SUPPLIER\_BENEFICIARIES,

  NUMBER\_OF\_SUPPLIER\_CLAIMS,

  NUMBER\_OF\_SUPPLIER\_SERVICES,

  ROUND(AVG\_SUPPLIER\_SUBMITTED\_CHARGE,2) AS AVG\_SUPPLIER\_SUBMITTED\_CHARGE,

  ROUND(AVG\_SUPPLIER\_MEDICARE\_ALLOW\_AMT,2) AS AVG\_SUPPLIER\_MEDICARE\_ALLOW\_AMT,

  ROUND(AVG\_SUPPLIER\_MEDICARE\_PMT\_AMT,2) AS AVG\_SUPPLIER\_MEDICARE\_PMT\_AMT,

FROM

  `pioneering-axe-307101.Medicare\_Referring\_Provider.Medicare`

WHERE

  REFERRING\_PROVIDER\_COUNTRY='US'

## Trifacta

