CONFIDENTIAL
2010 QUALITY AND RESOURCE USE REPORT
MEDICARE FEE-FOR-SERVICE

Dr. [Physician Name]

National Provider Identifier (NPI) [#]

Specialty: [ ]

<table>
<tr><th colspan="2">ABOUT THIS REPORT FROM MEDICARE</th></tr>
<tr><td>WHAT</td><td>This report presents information about the quality of care provided to Medicare fee-for-service (FFS) patients you treated in 2010 and the amount that Medicare paid you and other Medicare providers to deliver this care. This report is for informational purposes only. It will not affect your Medicare payment or your participation in the Medicare Program.</td></tr>
<tr><td>WHY</td><td>• To enable you to compare the quality and cost of your Medicare patients' care with that of Medicare patients treated by physicians in your specialty and by all physicians in Iowa, Kansas, Missouri, and Nebraska.
• To highlight your degree of involvement with all patients you treated, based on claims you submitted to Medicare.
• To identify possible components of a payment modifier required by the Affordable Care Act of 2010. The payment modifier will provide for differential payment to physicians or to groups of physicians under the physician fee schedule based upon the quality of care furnished compared with cost. This report begins to provide you with quality-of-care and cost information that can be used in a future payment modifier.</td></tr>
<tr><td>WHEN</td><td>Medicare is required by federal legislation to phase in the payment modifier beginning in 2015. By 2017, Medicare is required to apply the payment modifier to all physicians and groups of physicians.</td></tr>
<tr><td>WHO</td><td>Medicare is providing this confidential feedback report to you and other physicians who practice in Iowa, Kansas, Missouri, and Nebraska. We chose physicians in these states because they share a common Medicare Administrative Contractor that could help disseminate the reports.</td></tr>
<tr><td>WHAT YOU CAN DO</td><td>• Consider the information in this report to help you identify clinical areas in which you are doing well and those areas that might need improvement.
• Share your thoughts about how to make these reports more meaningful and actionable. You can email CMS at CMS_Medicare_Physician_Feedback_Program@mathematica-mpr.com with your comments, or you can participate in one of the conference calls that CMS has scheduled with report recipients.
• More information is available at <u>http://www.cms.gov/physicianfeedbackprogram</u>.</td></tr>
</table>

PERFORMANCE HIGHLIGHTS
Dr. [Physician Name]

YOUR MEDICARE PATIENTS AND THE PHYSICIANS TREATING THEM

Based on Medicare claims filed in 2010:

- You submitted Medicare claims for [#] **Medicare fee-for-service patients.**
- On average, [#] **different physicians treated each of the Medicare patients** for whom you submitted any claim.

QUALITY OF YOUR MEDICARE PATIENTS' CARE

*Compared with **all physicians** practicing in Iowa, Kansas, Missouri, and Nebraska, claims-based quality indicators for all Medicare beneficiaries you treated in 2010 were:*

- **Better than or equal to average** for [#] out of [#] quality indicators
- **Worse than average** for [#] out of [#] quality indicators

MEDICARE HAS RISK ADJUSTED YOUR COSTS

- **All cost data in this report have been risk adjusted** to account for differences in patients' age, gender, Medicaid eligibility, and history of medical conditions.
- Based on your patients' characteristics (age, gender, Medicaid eligibility, and history of medical conditions), risk adjustment resulted in total per capita costs for your Medicare patients that were adjusted [downward/upward] by [#] percent.
- The degree and direction of the risk adjustment applied to other cost measures in this report may differ from the percentage shown above because the risk adjustment above included **all** of the Medicare patients for whom you submitted a claim in 2010. Other cost measures in this report are based on subpopulations of your Medicare patients that might have different characteristics than your total Medicare population.

MEDICARE'S COSTS FOR YOUR PATIENTS' CARE

- **After risk adjustment,** Medicare's average annual (per capita) costs for Medicare patients for whom you submitted any claim in 2010 were **[# percent higher than/ # percent lower than/ equal to]** the average risk-adjusted per capita costs of physicians in your specialty practicing in Iowa, Kansas, Missouri, and Nebraska.

PART I. QUALITY OF CARE

Quality Measures Derived from Medicare Claims

Exhibit 1 shows how many of the[#] Medicare patients for whom you filed at least one claim in 2010 received specific recommended clinical services, based on all Medicare claims from **all physicians treating them** (including you). If the number of patients is small (fewer than 30), please use caution in making comparisons.

Exhibit 1. Physician Performance on Medicare Claims–Based Quality Measures for All Patients for Whom the Physician Filed at Least One Medicare Claim in 2010

Clinical Condition and Measure	Physician Performance for All Medicare Patients			
	YOU		Physicians in Iowa, Kansas, Missouri, and Nebraska	
Specifications for these clinical measures are posted at http://www.cms.gov/PhysicianFeedbackProgram/Downloads/claims_based_measures_with_descriptions_num_denom_excl.pdf	Number of Medicare Patients for Whom This Service Was Indicated	Percentage of Medicare Patients Who Received the Service	Number of Physicians Included	Percentage of Medicare Patients Who Received the Service
Chronic Obstructive Pulmonary Disease (COPD)				
Pharmacotherapy Management of COPD Exacerbation				
1. Dispensed Systemic Corticosteroid Within 14 Days of Event				
2. Dispensed Bronchodilator Within 30 Days of Event				
Use of Spirometry Testing to Diagnose COPD				
Bone, Joint, and Muscle Disorders				
Osteoporosis Screening for Chronic Steroid Use				
Osteoporosis Management in Women ≥ 67 Who Had a Fracture				
Disease-Modifying Antirheumatic Drug Therapy for Rheumatoid Arthritis				
Cancer				
Breast Cancer Surveillance for Women with a History of Breast Cancer				
PSA Monitoring for Men with Prostate Cancer				
Diabetes				
Dilated Eye Exam for Beneficiaries ≤ 75 with Diabetes				
HbA1c Testing for Beneficiaries ≤ 75 with Diabetes				
Urine Protein Screening for Beneficiaries ≤ 75 with Diabetes				
Lipid Profile for Beneficiaries ≤ 75 with Diabetes				
Gynecology				
Endometrial Sampling or Hysteroscopy with Biopsy Before Endometrial Ablation Procedure				
Heart Conditions				
Statin Therapy for Beneficiaries with Coronary Artery Disease				
1. Percentage Prescribed Statin Therapy				
2. Average Medication Possession Ratio*				
3. Percentage with Medication Possession Ratio ≥ 0.80*				
Persistence of β-Blocker Treatment After Heart Attack				
Lipid Profile for Beneficiaries with Ischemic Vascular Disease				
Human Immunodeficiency Virus (HIV)				
Monitoring for Disease Activity for Beneficiaries with HIV				
Viral Load Testing for Beneficiaries with Antiviral Therapy for Hepatitis C				

Exhibit 1 (continued). Physician Performance on Medicare Claims–Based Quality Measures for All Patients for Whom the Physician Filed at Least One Medicare Claim in 2010

Clinical Condition and Measure	**Physician Performance for All Medicare Patients**			
	YOU		**Physicians in Iowa, Kansas, Missouri, and Nebraska**	
Specifications for these clinical measures are posted at http://www.cms.gov/PhysicianFeedbackProgram/Downloads/claims_based_measures_with_descriptions_num_denom_excl.pdf	Number of Medicare Patients for Whom This Service Was Indicated	Percentage of Medicare Patients Who Received the Service	Number of Physicians Included	Percentage of Medicare Patients Who Received the Service
Mental Health				
Antidepressant Treatment for Depression				
1. Acute Phase Treatment (at least 12 weeks)				
2. Continuation Phase Treatment (at least 6 months)				
Follow-Up After Hospitalization for Mental Illness				
1. Percentage of Patients Receiving Follow-Up Within 30 Days				
2. Percentage of Patients Receiving Follow-Up Within 7 Days				
Prevention				
Breast Cancer Screening for Women ≤ 69				
Medication Management				
Lipid Profile for Beneficiaries Who Started Lipid-Lowering Medications				
Annual Monitoring for Beneficiaries on Persistent Medications				
1. Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB)				
2. Digoxin				
3. Diuretics				
4. Anticonvulsants				
5. Total Rate (sum of 4 previous numerators divided by sum of 4 previous denominators)				
Anticoagulation Treatment ≥ 3 Months After Deep Vein Thrombosis				
Anticoagulation Treatment ≥ 3 Months After Pulmonary Embolism				
International Normalized Ratio (INR) Testing for Beneficiaries Taking Warfarin and Interacting Anti-Infective Medications				
NOTE: For the measures shown below, ***lower*** ***percentages reflect better performance***				
Drugs to Be Avoided for Beneficiaries ≥ 65				
1. Patients Who Receive at Least One Drug to Be Avoided				
2. Patients Who Receive at Least Two Different Drugs to Be Avoided				
Potentially Harmful Drug-Disease Interactions for Beneficiaries ≥ 65				
1. Prescription for Tricyclic Antidepressants, Antipsychotics, or Sleep Agents for Patients with a History of Falls				
2. Prescription for Tricyclic Antidepressants or Anticholinergic Agents for Patients with Dementia				
3. Prescription for Nonaspirin NSAIDs or Cox-2 Selective NSAIDs for Patients with Chronic Renal Failure				
4. Total Rate (sum of 3 previous numerators divided by sum of 3 previous denominators)				
Lack of Monthly INR Monitoring for Beneficiaries on Warfarin				

* Unlike the other measures in this exhibit, these values represent a ratio, not a percentage of patients receiving the service. See Terms/Definitions at end of report for an explanation of the ratios.

Quality Measures Used in the Physician Quality Reporting System

Exhibit 2 is based on information **you successfully reported** about the patients you cared for as part of the 2010 Physician Quality Reporting System (PQRS).

Note: Whenever the number of patients is small (fewer than 30), please use caution in making comparisons. If fewer than 30 physicians in Iowa, Kansas, Missouri, and Nebraska reported the measure, the comparison group performance rate is not displayed.

Exhibit 2. Physician Performance on PQRS Quality Measures for Patients Reported on in 2010

PQRS Measure Number	Clinical Condition and PQRS Measure Specifications for PQRS clinical measures are posted at http://www.cms.gov/PQRS/Downloads/2010_PQRI_MeasuresList_111309.pdf http://www.cms.gov/PQRI/downloads/2010PQRIMeasuresGroupsSpecsManualandReleaseNotes_121809_2.zip	Physician PQRS Performance: YOU		Physician PQRS Performance: Physicians in Iowa, Kansas, Missouri, and Nebraska Participating in PQRS	
		Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Medicare Patients Who Received the Service	Number of Participating Physicians Reporting Cases for the Measure	Percentage of Medicare Patients Who Received the Service
	Chronic Obstructive Pulmonary Disease (COPD)				
51	Spirometry Evaluation	#	%	#	%
52	Bronchodilator Therapy				
	Diabetes				
1	Hemoglobin A1c Poor Control				
2	Low-Density Lipoprotein Control				
3	High Blood Pressure Control				
117	Dilated Eye Exam in Diabetic Patient				
	Coronary Artery Disease (CAD)				
6	Oral Antiplatelet Therapy Prescribed for Patients with CAD				
118	ACE or ARB Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)				
	Heart Failure				
5	ACE Inhibitor or ARB Therapy for LVSD				
8	Beta-Blocker Therapy for LVSD				
198	Left Ventricular Function (LVF) Assessment				
199	Patient Education				
200	Warfarin Therapy for Patients with Atrial Fibrillation				
	Preventive Care and Screening				
110	Influenza Immunization for Patients ≥ 50 Years Old				
111	Pneumonia Vaccination for Patients ≥ 65 Years Old				
112	Screening Mammography for Women ≤ 69 Years Old				
113	Colorectal Cancer Screening for Patients 50 to 75 Years Old				
173	Unhealthy Alcohol Use Screening				

These data reflect totals reported for your NPI by every organization through which you successfully participated in PQRS. If you participated through more than one organization (that is, under more than one Tax Identification Number, or TIN), see the appendix for a breakdown of performance by organization.

PART II. COSTS OF CARE

The cost data in this report are based on Medicare claims submitted in calendar year 2010 **by all providers caring for your patients.** These include two types of Medicare fee-for-service (FFS) claims:

- **Institutional** claims (Medicare Part A), such as for hospital and skilled nursing care.
- **Professional** services claims (Medicare Part B), such as for physician and other medical professional services and medical equipment.

Medicare cost data are shown on an annual per capita basis, calculated by dividing 2010 Medicare costs by the number of Medicare patients. To make cost comparisons fair in this report, all cost data have been **risk adjusted** to account for differences in patient characteristics and **price standardized** to account for differences in Medicare payments across geographic areas (due to factors such as wages or rents).

Categorizing Your Patients

Exhibit 3 identifies your Medicare FFS patients according to the level of care you provided to them in 2010, as measured by outpatient evaluation and management (E&M) office visits or total professional costs.

1. **Patients whose care you *directed*** are those for whom you billed 35 percent or more of all of their outpatient E&M visits. For example, *primary care physicians* are likely to provide this level of care to many of their patients because they usually have face-to-face visits with patients more often than do the specialists to whom patients may be referred.
2. **Patients whose care you *influenced*** are those for whom you billed fewer than 35 percent of their outpatient E&M visits, but 20 percent or more of their professional costs. For example, *surgeons or other proceduralists* might provide this level of care to many patients because of the relatively higher costs of procedures and lower volume of face-to-face office visits.
3. **Patients to whose care you *contributed*** are those for whom you billed fewer than 35 percent of their outpatient E&M visits and less than 20 percent of their total medical professional costs. For all physicians, patients in this category are those seen episodically, whose care might be more dispersed.

Exhibit 3. Categories of Your Medicare Patients

	Your Medicare Patients			
	Number of Patients*	**Total Per Capita Costs, Institutional and Professional**	**Average Number of E&M Office Visits You Billed**	**Percentage of Total Physician Professional Costs You Billed**
Total for Whom You **Filed Any Claim**	#	$XX,XXX	#	%
Patients Whose Care You **Directed**				
Patients Whose Care You **Influenced**				
Patients to Whose Care You **Contributed**				

*The number patients is the total included in calculating per capita costs, after risk adjustment. Because some patients with missing data were dropped from the analysis during the risk-adjustment process, this number may be smaller than the total shown in the Highlights section and in Exhibit 1.

The following sections show more detailed per capita cost analyses for each patient category that included at least 10 percent of all patients for whom you submitted claims or 10 percent of costs you billed.

Per Capita Costs of Patients Whose Care You Directed

Exhibit 4 shows the total risk-adjusted and price-standardized per capita costs and per capita costs of specific services for the [#] Medicare patients whose care you **directed,** compared with patients whose care was directed by physicians in your specialty in Iowa, Kansas, Missouri, and Nebraska. Note: Whenever the number of patients or physicians is small (fewer than 30), please use caution in making comparisons.

Exhibit 4. 2010 Total Per Capita Costs for Specific Services for the [#] Patients Whose Care You Directed

Service Category	Medicare Patients Whose Care You Directed			Average for Medicare Patients Whose Care Was Directed by [#] Physicians in Your Specialty in Iowa, Kansas, Missouri, & Nebraska			Amount by Which Your Medicare Patients' Per Capita Costs Were Higher (or Lower) than Average
	Your Medicare Patients Using Any Service in This Category		Total Risk-Adjusted Per Capita Costs	Medicare Patients Using Any Service in This Category		Total Risk-Adjusted Per Capita Costs	
	Number	Percentage		Number	Percentage		
All Services	**#**	**100%**	**$XX,XXX**	**#**	**100%**	**$XX,XXX**	**($X,XXX)**
Evaluation and Management Services in All Settings							
Provided by YOU for Your Patients	**#**	**%**	**$XX,XXX**	**#**	**%**	**$XX,XXX**	**($X,XXX)**
Provided by OTHER Physicians Treating Your Patients							
Procedures in All Settings							
Provided by YOU for Your Patients							
Provided by OTHER Physicians Treating Your Patients							
Inpatient and Outpatient Facility Services							
Inpatient Hospital Facility Services							
Outpatient and Emergency Services							
Clinic or Emergency Visits							
Procedures							
Laboratory and Other Tests							
Imaging Services							
Services in Ambulatory Settings							
All Ancillary Services							
Laboratory and Other Tests							
Imaging Services							
Durable Medical Equipment							
Post-Acute Care Services							
All Post-Acute Services							
Skilled Nursing Facility							
Psychiatric, Rehab, or Other Long-Term Facility							
Home Health							
Other Services							
All Other Services*							

* All Other Services is defined in the Terms/Definitions section at the end of this report.

Exhibit 5 shows how many other physicians treated the patients whose care you directed, compared with other physicians in your specialty and across the four states who also directed care.

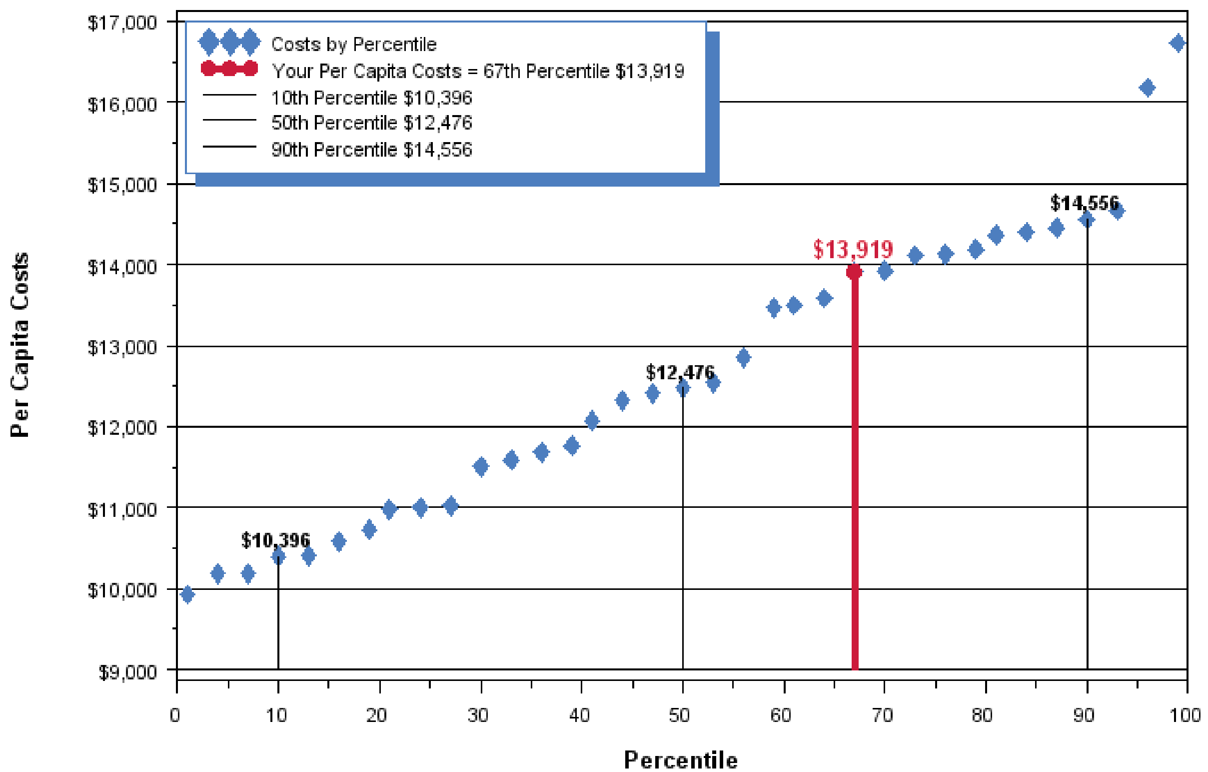
Exhibit 5. Other Physicians Treating the Medicare Patients Whose Care Was Directed

	For Your Medicare Patients	Average for Medicare Patients of [#] Physicians in Your Specialty in Iowa, Kansas, Missouri, & Nebraska	Average for Medicare Patients of All [#] Physicians in Iowa, Kansas, Missouri, & Nebraska
Number of Other Physicians Who Submitted Claims	#	#	#

Per Capita Costs of Patients Whose Care You Directed

Exhibit 6 shows the distribution of total risk-adjusted and price-standardized per capita costs, by percentile, among physicians in your specialty practicing in Iowa, Kansas, Missouri, and Nebraska, for patients whose care was **directed.**

Exhibit 6. Distribution of the 2010 Total Per Capita Costs of Patients Whose Care Was Directed by Physicians in Your Specialty in Iowa, Kansas, Missouri, and Nebraska



Per Capita Costs of Patients Whose Care You Influenced

Exhibit 7 shows the total risk-adjusted and price-standardized per capita costs and per capita costs of specific services for the [#] Medicare patients whose care you **influenced,** compared with patients whose care was influenced by physicians in your specialty in Iowa, Kansas, Missouri, and Nebraska. Note: Whenever the number of patients or physicians is small (fewer than 30), please use caution in making comparisons.

Exhibit 7. 2010 Total Per Capita Costs for Specific Services for the [#] Patients Whose Care You Influenced

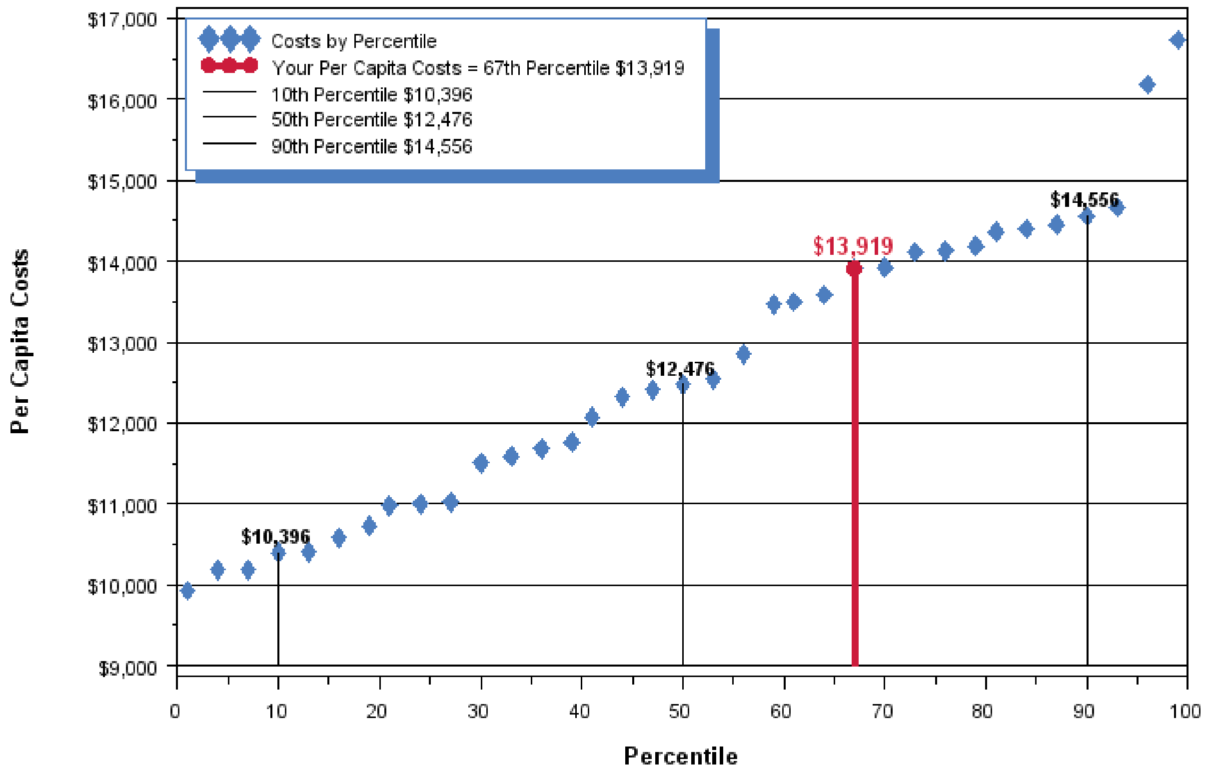
Service Category	Medicare Patients Whose Care You Influenced			Average for Medicare Patients Whose Care Was Influenced by [#] Physicians in Your Specialty in Iowa, Kansas, Missouri, & Nebraska			Amount by Which Your Medicare Patients' Per Capita Costs Were Higher (or Lower) than Average
	Your Medicare Patients Using Any Service in This Category		Total Risk-Adjusted Per Capita Costs	Medicare Patients Using Any Service in This Category		Total Risk-Adjusted Per Capita Costs	
	Number	Percentage		Number	Percentage		
All Services	**#**	**100%**	**$XX,XXX**	**#**	**100%**	**$XX,XXX**	**($X,XXX)**
Evaluation and Management Services in All Settings							
Provided by YOU for Your Patients	**#**	**%**	**$XX,XXX**	**#**	**%**	**$XX,XXX**	**($X,XXX)**
Provided by OTHER Physicians Treating Your Patients							
Procedures in All Settings							
Provided by YOU for Your Patients							
Provided by OTHER Physicians Treating Your Patients							
Inpatient and Outpatient Facility Services							
Inpatient Hospital Facility Services							
Outpatient and Emergency Services							
Clinic or Emergency Visits							
Procedures							
Laboratory and Other Tests							
Imaging Services							
Services in Ambulatory Settings							
All Ancillary Services							
Laboratory and Other Tests							
Imaging Services							
Durable Medical Equipment							
Post-Acute Care Services							
All Post-Acute Services							
Skilled Nursing Facility							
Psychiatric, Rehab, or Other Long-Term Facility							
Home Health							
Other Services							
All Other Services*							

* All Other Services is defined in the Terms/Definitions section at the end of this report.

Per Capita Costs of Patients Whose Care You Influenced

Exhibit 8 shows the distribution of total risk-adjusted and price-standardized per capita costs, by percentile, among physicians in your specialty practicing in Iowa, Kansas, Missouri, and Nebraska, for patients whose care was **influenced.**

Exhibit 8. Distribution of the 2010 Total Per Capita Costs of Patients Whose Care Was Influenced by Physicians in Your Specialty in Iowa, Kansas, Missouri, and Nebraska



Per Capita Costs of Patients to Whose Care You Contributed

Exhibit 9 shows the total risk-adjusted and price-standardized per capita costs and per capita costs of specific services for the [#] Medicare patients to whose care you **contributed,** compared with patients to whose care physicians in your specialty in Iowa, Kansas, Missouri, and Nebraska contributed. Note: Whenever the number of patients or physicians is small (fewer than 30), please use caution in making comparisons.

Exhibit 9. 2010 Total Per Capita Costs for Specific Services for the [#] Patients to Whose Care You Contributed

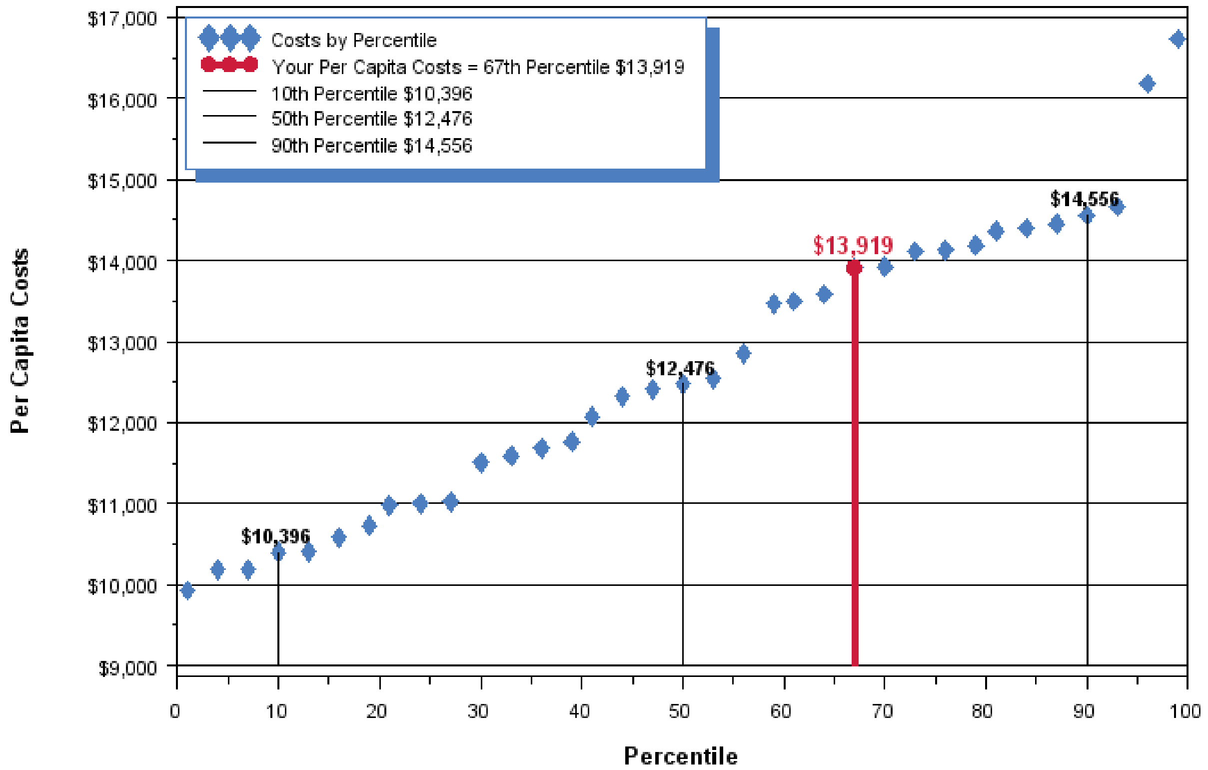
Service Category	Medicare Patients to Whose Care You Contributed			Average for Medicare Patients Whose Care Was Contributed to by [#] Physicians in Your Specialty in Iowa, Kansas, Missouri, & Nebraska			Amount by Which Your Medicare Patients' Per Capita Costs Were Higher (or Lower) Than Average
	Your Medicare Patients Using Any Service in This Category		Total Risk-Adjusted Per Capita Costs	Medicare Patients Using Any Service in This Category		Total Risk-Adjusted Per Capita Costs	
	Number	Percentage		Number	Percentage		
All Services	**#**	**100%**	**$XX,XXX**	**#**	**100%**	**$XX,XXX**	**($X,XXX)**
Evaluation and Management Services in All Settings							
Provided by YOU for Your Patients	**#**	**%**	**$XX,XXX**	**#**	**%**	**$XX,XXX**	**($X,XXX)**
Provided by OTHER Physicians Treating Your Patients							
Procedures in All Settings							
Provided by YOU for Your Patients							
Provided by OTHER Physicians Treating Your Patients							
Inpatient and Outpatient Facility Services							
Inpatient Hospital Facility Services							
Outpatient and Emergency Services							
Clinic or Emergency Visits							
Procedures							
Laboratory and Other Tests							
Imaging Services							
Services in Ambulatory Settings							
All Ancillary Services							
Laboratory and Other Tests							
Imaging Services							
Durable Medical Equipment							
Post-Acute Care Services							
All Post-Acute Services							
Skilled Nursing Facility							
Psychiatric, Rehab, or Other Long-Term Facility							
Home Health							
Other Services							
All Other Services*							

* All Other Services is defined in the Terms/Definitions section at the end of this report.

Per Capita Costs of Patients to Whose Care You Contributed

Exhibit 10 shows the distribution of total risk-adjusted and price-standardized per capita costs, by percentile, among physicians in your specialty practicing in Iowa, Kansas, Missouri, and Nebraska, for patients to whom care was **contributed.**

Exhibit 10. Distribution of the 2010 Total Per Capita Costs of Patients to Whose Care Physicians in Your Specialty Contributed in Iowa, Kansas, Missouri, and Nebraska



Per Capita Costs of All Patients You Treated Who Have Chronic Conditions

Exhibit 11 shows total per capita costs incurred by **patients identified as having one or more of four specific chronic health conditions, based on all** [#] **Medicare patients** for whom you filed a claim.

- Per capita costs for each condition subgroup **include all Medicare patients** diagnosed with the condition and **their total costs of care.** The conditions in Exhibit 11 are not mutually exclusive, because it is likely that Medicare beneficiaries have more than one of these chronic conditions.

Note: Whenever the number of patients or physicians is small (fewer than 30), please use caution in making comparisons.

Exhibit 11. 2010 Total Per Capita Costs for Medicare Patients with Specific Chronic Conditions, for All Patients for Whom You Filed at Least One Medicare Claim in 2010

	Medicare Patients for Whom You Filed a Claim		**Medicare Patients Treated by Physicians in Your Specialty in Iowa, Kansas, Missouri, and Nebraska**	
	Number of Your Patients*	Total Risk-Adjusted Per Capita Costs	Average Number of Patients Per Physician	Average Total Risk-Adjusted Per Capita Costs
Diabetes	#	$XX,XXX	#	$XX,XXX
Coronary Artery Disease				
Chronic Obstructive Pulmonary Disease				
Heart Failure				

*The number of Medicare patients shown in Exhibit 11 are the numbers included in calculating per capita costs, after risk adjustment. Because some patients with missing data were dropped from the analysis during the risk-adjustment process, these numbers may be smaller than those shown in the Highlights section and in Exhibit 1.

PLEASE HELP US IMPROVE
FUTURE VERSIONS OF THIS REPORT

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MORE INFORMATION IS AVAILABLE AT
HTTP://WWW.CMS.GOV/PHYSICIANFEEDBACKPROGRAM

Appendix

Exhibit A. Your Performance on PQRS Quality Measures for Medicare Patients in All Organizations Through Which You Successfully Participated in 2010, by Tax Identification Number (TIN)

PQRS Measure Number	Clinical Condition and Measure	Total		Last Four Digits of TIN									
				[TIN #1]		[TIN #2]		[TIN #3]		[TIN #4]		[TIN #5]	
		Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service	Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service	Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service	Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service	Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service	Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service
Chronic Obstructive Pulmonary Disease (COPD)													
51	Spirometry Evaluation												
52	Bronchodilator Therapy												
Diabetes													
1	Hemoglobin A1c Poor Control												
2	Low-Density Lipoprotein Control												
3	High Blood Pressure Control												
117	Dilated Eye Exam in Diabetic Patient												
Coronary Artery Disease (CAD)													
6	Oral Antiplatelet Therapy Prescribed for Patients with CAD												
118	ACE or ARB Therapy for Patients with CAD and Diabetes and/or LVSD												
Heart Failure													
5	ACE Inhibitor or ARB Therapy for LVSD												
8	Beta-Blocker Therapy for LVSD												
198	LVF Assessment												
199	Patient Education												
200	Warfarin Therapy for Patients with Atrial Fibrillation												
Preventive Care and Screening													
110	Influenza Immunization for Patients ≥ 50 Years Old												
111	Pneumonia Vaccination for Patients ≥ 65 Years Old												
112	Screening Mammography for Women ≤ 69 Years Old												
113	Colorectal Cancer Screening for Patients 50–75 Years Old												
173	Unhealthy Alcohol Use Screening												

Terms/Definitions

ALL OTHER SERVICES. Exhibits 4, 7, and 9 display five categories of Medicare-covered services: Evaluation and Management, Procedures (all settings), Inpatient and Outpatient Facility Services, Services in Ambulatory Settings, and Post-Acute Care Services. With the exclusion of prescription drug costs covered under Medicare Part D, Medicare-covered services not included in those five categories are captured as "All Other Services." Anesthesia, ambulance services, chemotherapy, other Part B drugs, orthotics, chiropractic, enteral and parenteral nutrition, some vision services, some hearing and speech services, and influenza immunization are grouped as "All Other Services." In this report, costs for medical professionals who can bill Medicare but are not physicians—including physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists, clinical social workers, clinical psychologists, dieticians, audiologists, physical therapists, and speech therapists—are included under "All Other Services." Whenever physicians are compared with a peer group, the comparison group consists only of physicians.

AVERAGE. Peer group averages in this report are weighted means across all physicians included in the peer group, where each physician's weight is the number of Medicare beneficiaries attributed to that physician who are eligible for the quality or cost measure.

ATTRIBUTION OF MEDICARE BENEFICIARIES TO PHYSICIANS. For calculation of the 2010 claims-based quality indicators and the cost measures, only beneficiaries who were enrolled in both Parts A and B of original fee-for-service (FFS) Medicare for **all of calendar year 2010** are included. Medicare beneficiaries are attributed to **any physician who was the performing provider on at least one FFS Medicare claim** for that beneficiary during the calendar year, based on the National Provider Identifier (NPI) number indicated on the claim.

For the Physician Quality Reporting System (PQRS) quality measures, physicians self-identify Medicare beneficiaries as their patients by submitting a quality data code on each beneficiary's claim to CMS.

For the cost measures in this report, every Medicare beneficiary attributed to an individual physician is assigned to one of three categories, based on the amount of care that physician provided to the beneficiary, as measured by the proportion of the beneficiary's 2010 outpatient evaluation and management (E&M) office visits (see Table 1 below for E&M Healthcare Common Procedure Coding System codes) or total professional costs:

1. **Patients whose care the physician *directed*—**those for whom that physician billed 35 percent or more of the patient's outpatient E&M visits.
2. **Patients whose care the physician *influenced*—**those for whom that physician billed fewer than 35 percent of the patient's outpatient E&M visits but 20 percent or more of the patient's total professional costs.
3. **Patients to whose care the physician *contributed*—**those for whom the physician billed fewer than 35 percent of the patient's outpatient E&M visits and less than 20 percent of the patient's total professional costs.

Beneficiaries who were not enrolled in both Parts A and B of FFS Medicare for the full year (for example, because they first became eligible for Medicare during 2010, were enrolled in a Medicare Advantage program for part of the year, or died during the year) and the costs associated with their care were excluded from the claims-based quality indicators and the cost measures. Beneficiaries who (1) were enrolled in FFS Medicare via the Railroad Retirement Board, (2) used Medicare hospice benefits during 2010, or (3) had any claims for which Medicare was not the primary payer during 2010 also were excluded from the claims-based quality indicators and the cost measures.

Table 1. Medicare Part B Evaluation & Management Service Codes Included in Beneficiary Attribution Criteria

INCLUDED	Codes	Labels*
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
EXCLUDED		
Hospital Inpatient Services	Emergency Department Services	
Nursing Facility Services	Patient Transport	
Care Plan Oversight Services	Critical Care Services	
Home Care Services	Neonatal Intensive Services	
Consultations	Newborn Care	
Other Evaluation and Management Services	Special Evaluation and Management Services	
Preventive Medicine Services	Prolonged Services	
Case Management Services	Hospital Observation Services	
Domiciliary, Rest Home, or Custodial Care Services		

* Labels are approximate. See AMA, Current Procedural Terminology for detailed definitions.

CHRONIC CONDITIONS COSTS. Chronic health conditions are diseases or illnesses that are commonly expected to last six months or more, require ongoing monitoring to avoid loss of normal life functioning, and are not expected to improve or resolve without treatment. Per capita costs for each chronic condition subgroup are the 2010 Medicare fee-for-service Parts A and B payments per attributed beneficiary with the specified condition. Per capita costs are displayed in this report for the following four conditions:

1. Diabetes
2. Coronary Artery Disease
3. Chronic Obstructive Pulmonary Disease
4. Heart Failure

The per capita costs for each condition-specific subgroup were calculated by (1) summing the price-standardized risk-adjusted Medicare Part A and Part B costs for attributed beneficiaries identified as having the given chronic condition and (2) then dividing that sum by the number of attributed beneficiaries with the condition. These per capita costs for subgroups include **all costs** and **are not limited to costs associated with treating the condition itself.**

CLAIMS-BASED QUALITY MEASURES. Claims-based quality measures are calculated solely from claims submitted for medical services rendered. They are not enhanced with additional clinical information and may have limitations when additional clinical information seems warranted. For calculation of these measures, 2010 (January 1, 2010, through December 31, 2010) was the measurement year. If a look-back period was necessary to calculate the measure, claims were available for a one-year look-back period. For additional information, the detailed measure specifications are posted at **http://www.cms.gov/physicianfeedbackprogram**.

INSTITUTIONAL COSTS. Generally, Part A Medicare covers a stay in a hospital facility (acute care, long-term care, critical access, inpatient rehabilitation, psychiatric) and those costs incurred during a stay in another type of medical facility, such as a skilled nursing home. Some services provided in nonfacility settings, such as hospice care and some home health care, are also covered by Part A.

MEDICATION POSSESSION RATIO. The Medication Possession Ratio is a measure of medication adherence, defined as the number of days for which the beneficiary had a supply of the medication (based on prescriptions filled) divided by the number of days in the measurement period (from the date of a beneficiary's first statin prescription to the end of the measurement period).

PER CAPITA COSTS. Per capita costs are the average (mean) of all 2010 Medicare FFS Part A (Hospital Insurance) and Part B (Medical Insurance) payments to all providers for beneficiaries attributed to a physician.

Medicare costs were obtained from 2010 administrative claims data using inpatient hospital, outpatient hospital, skilled nursing facility, home health, durable medical equipment, and Medicare carrier (noninstitutional provider) claims. Part D (outpatient prescription drug) and hospice claims were not included in the 2010 cost measure calculations. To the extent that Medicare claims include such information, costs are composed of payments to providers from Medicare, from beneficiaries (copayments and deductibles), and from third-party private payers. Per capita costs were calculated by summing the price-standardized and risk-adjusted 2010 Medicare Parts A and B *costs* for all Medicare beneficiaries attributed to the physician (the numerator). This numerator was then divided by the *number of beneficiaries* attributed to the physician (the denominator). See the earlier definition ATTRIBUTION OF MEDICARE BENEFICIARIES TO PHYSICIANS.

PRICE STANDARDIZATION. Price standardization equalizes the costs associated with a specific service, such that a given service is priced at the same level across all providers of the same type, regardless of geographic location or differences in Medicare payment rates among facilities. For most types of medical services, Medicare adjusts payments to providers to reflect differences in local input prices (for example, wage rates, and real estate costs). The costs shown in this report are price standardized to allow for comparisons among peers who practice in locations or facilities where reimbursement rates are higher or lower. Costs for services are price standardized before risk adjusting per capita costs. Both calculations smooth out large differences in costs that result from circumstances beyond physicians' control.

RISK ADJUSTMENT. Risk adjustment takes into account patient differences that can affect their medical costs, regardless of the care provided. Patients' costs are risk adjusted so physicians can be compared more fairly. For physicians who have a higher than average proportion of patients with serious medical conditions or other higher-cost risk factors, risk-adjusted per capita costs will be lower than unadjusted costs (because costs associated with higher-risk patients are adjusted downward). For physicians who treat comparatively lower-risk patients, risk-adjusted per capita costs will be higher than unadjusted costs (because costs for lower-risk patients are adjusted upward).

For these reports, we used CMS' hierarchical condition categories (HCCs) model that assigns International Classification of Diseases, 9th edition (ICD-9) diagnosis codes (each with similar disease characteristics and costs) to 70 clinical conditions. For each Medicare beneficiary attributed to a physician in 2010, the HCC model generates a 2009 score based on the presence of these conditions in 2009—and on sex, age, original reason for Medicare entitlement (either age or disability), and Medicaid entitlement—as a predictor of beneficiary costs in 2010. Risk adjustment of 2010 costs also takes into account the presence of end-stage renal disease (ESRD) in 2009.

The statistical risk-adjustment model estimates the independent effects of these factors on price-standardized beneficiary costs and adjusts 2010 beneficiary costs for each beneficiary before calculating per capita risk-adjusted cost measures for a physician. To ensure that extreme outlier costs do not have a disproportionate effect on cost distributions, costs below the first percentile are eliminated from cost calculations, and costs above the 99th percentile are rounded down to the 99th percentile.

SERVICE-SPECIFIC PER CAPITA COSTS. In calculating per capita costs for each of the categories of services displayed in Exhibits 4, 7, and 9, the numerator is the total costs for a type of service for Medicare beneficiaries attributed to the physician under the level-of-care category (directed, influenced, or contributed) who used the service; the denominator is the total number of Medicare beneficiaries attributed to the physician under the level-of-care category, whether or not all attributed beneficiaries used the specific type of service.

SPECIALTY. A single medical specialty designation is required to compare a physician with others in the same specialty. To determine a physician's single medical specialty in 2010, we used the physician's medical specialty code (HCFA_Code) listed most frequently on claims in the 2010 carrier claims file for which the physician was listed as a performing NPI.

TOTAL COSTS. The 2010 total cost measures include all costs incurred in all health care settings (except for Part D outpatient prescription drug costs and hospice costs) for all attributed beneficiaries enrolled in both Parts A and B of original FFS Medicare for all 12 months of 2010. Medicare costs were obtained from 2010 Medicare administrative claims data using inpatient hospital, outpatient hospital, skilled nursing facility, home health, durable medical equipment, and Medicare carrier (noninstitutional provider) claims. To the extent that Medicare claims include such information, costs are composed of payments to providers from Medicare, from beneficiaries (copayments and deductibles), and from third-party private payers. In the case of professional services (and Part B drugs, laboratory and anesthesiology services, and other services described in the Part B file), this means that the allowable charges variables were used. For other types of services, such as home health and inpatient hospitalizations, total allowable payments were derived from the data elements provided in the files.

TOTAL RATE. Total rate is a composite used in two of the medication management measures and is defined as the sum of the previous numerators divided by the sum of the previous denominators.