CONFIDENTIAL
2011 QUALITY AND RESOURCE USE REPORT
MEDICARE FEE-FOR-SERVICE

Dr: [Physician Name]
National Provider Identifier: [#]
Specialty:

ABOUT THIS REPORT FROM MEDICARE	
WHY	• This report includes many of the quality and cost measures that Medicare plans to use for the physician value-based payment modifier. It will not affect your Medicare payments. • The report is intended as a preview and does not reflect some key aspects of the value-based payment modifier that will be incorporated into future Quality and Resource Use Reports. Those differences are described in the Terms/Definitions section of this report (see Key Differences entry). • For calendar year 2015, Medicare will apply a value-based payment modifier to groups of physicians (identified by a single Taxpayer Identification Number, or TIN) with 100 or more eligible professionals, based on their performance during calendar year 2013.
WHAT	• The value-based payment modifier will be based, in part, on those quality measures for which your medical group chooses to submit data as part of the Physician Quality Reporting System. Exhibit 1 shows performance on the quality measures for which you submitted data in 2011. • Medical groups that do not submit data as part of the Physician Quality Reporting System will be able to request that Medicare compute their performance based on a set of claims-based quality measures. Exhibit 2 shows performance on these and other measures, based on Medicare fee-for-service patients for whom you filed at least one claim in 2011. These measures would be used for the value-based payment modifier only if your medical group chooses this option. • The cost measures that will be used in the value-based payment modifier, and your 2011 performance on these measures, are shown in Exhibits 4 and 12.
WHO	• Medicare is providing 2011 Quality and Resource Use Reports to Medicare fee-for-service physicians who practiced during 2011 as part of a group of 25 or more eligible professionals in nine states: California, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, or Wisconsin. • According to Medicare's billing records, you submitted Medicare fee-for-service claims for services provided in 2011 as part of a medical group with 25 or more eligible professionals.
WHAT YOU CAN DO	• Review your performance in advance, before the value-based payment modifier is implemented in 2015, to identify areas that may positively or negatively affect your reimbursement. • Participate in the Physician Quality Reporting System, if you are not already doing so. • If you have questions about this report or want to share ways to improve its content and format, please e-mail cms_medicare_physician_feedback_program@mathematica-mpr.com or call 1-855-272-3635.

PERFORMANCE HIGHLIGHTS

Dr: [Physician Name]

YOUR MEDICARE PATIENTS AND THE PHYSICIANS TREATING THEM

Based on Medicare claims filed in 2011:

- 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 incentive-eligible PQRS participants nationwide, your 2011 performance rate was:

- Better than or equal to average for [#] out of [#] quality indicators with available benchmarks that you reported.
- Worse than average for [#] out of [#] quality indicators with available benchmarks that you reported.

Compared with all patients of physicians in the nine states, beneficiaries for whom you submitted a claim in 2011 received (from you or another physician) recommended services indicated by selected claims-based quality measures:

- More often than or the same as average for [#] out of [#] quality indicators for which you had at least one eligible patient.
- Less often than average for [#] out of [#] quality indicators for which you had at least one eligible patient.

MEDICARE'S COSTS FOR YOUR PATIENTS' CARE

- All cost data in this report have been risk adjusted to account for differences in patient characteristics (age, gender, Medicaid eligibility, history of medical conditions, and end-stage renal disease status).
- Based on your patients' characteristics, CMS risk adjusted total annual per capita costs for all your Medicare patients [downward/upward] by [#] percent.
- After risk adjustment, Medicare's total annual per capita costs for all Medicare patients for whom you submitted any claim in 2011 were [# percent higher than/# percent lower than/equal to] the risk-adjusted total annual per capita costs of physicians in your specialty in the nine states.
- The degree and direction of the risk adjustment applied to the total per capita cost measures for patients in different attribution categories (Exhibit 3) and chronic condition subgroups (Exhibit 12) in this report will differ from the risk-adjustment percentage shown above if those specific patient populations have different characteristics than your total Medicare patient population.

Quality Measures Used in the Physician Quality Reporting System

Exhibit 1 is based on information you personally reported about the patients you cared for as part of the 2011 Physician Quality Reporting System (PQRS) via registries, claims, or electronic health records.

Note: Whenever the number of patients is small (fewer than 20), please use caution in making comparisons. If fewer than 20 physicians reported the measure nationwide, the comparison group performance rate is not displayed.

Exhibit 1. Physician Performance on PQRS Quality Measures in 2011

PQRS Measure Number	Clinical Condition and PQRS Measure Specifications for PQRS clinical measures are posted at http://www.cms.gov/PQRS/Downloads/2011_PhysQualRptg_MeasuresList_033111.pdf	PQRS Performance			
		You		All PQRS Participants Nationwide	
		Number of Cases You Reported	Performance Rate for Cases You Reported	Number of Participating Physicians Reporting Cases	Mean Performance Rate
	Diabetes Mellitus (DM) Measures Group				
1	DM: Hemoglobin A1c Poor Control in Diabetes Mellitus		%		%
2	DM: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus				
3	DM: High Blood Pressure Control in Diabetes Mellitus				
117	DM: Dilated Eye Exam in Diabetic Patient				
119	DM: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients				
126	DM: Diabetic Foot and Ankle Care, Peripheral Neuropathy-Neurological Evaluation				
127	DM: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear				
163	DM: Foot Exam				
	Chronic Kidney Disease (CKD) Measures Group				
121	CKD: Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH), and Lipid Profile)				
122	CKD: Blood Pressure Management				
123	CKD: Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)				
153	CKD: Referral for Arteriovenous (AV) Fistula				
	Preventive Care Measures Group				
39	Screening or Therapy for Osteoporosis for Women ≥ 65				
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women ≥ 65				
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50				
111	Preventive Care and Screening: Pneumonia Vaccination for Patients ≥ 65				
112	Preventive Care and Screening: Screening Mammography				
113	Preventive Care and Screening: Colorectal Cancer Screening				
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up				
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening				
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention				
	Coronary Artery Bypass Graft (CABG) Measures Group				
43	CABG: Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery				
44	CABG: Preoperative Beta-Blocker in Patients with Isolated CABG Surgery				
164	CABG: Prolonged Intubation (Ventilation)				

165	CABG: Deep Sternal Wound Infection Rate				
166	CABG: Stroke/Cerebrovascular Accident (CVA)				
167	CABG: Postoperative Renal Insufficiency				
168	CABG: Surgical Re-exploration				
169	CABG: Antiplatelet Medications at Discharge				
170	CABG: Beta-Blockers Administered at Discharge				
171	CABG: Lipid Management and Counseling				
	Rheumatoid Arthritis (RA) Measures Group				
108	RA: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy				
176	RA: Tuberculosis Screening				
177	RA: Periodic Assessment of Disease Activity				
178	RA: Functional Status Assessment				
179	RA: Assessment and Classification of Disease Prognosis				
180	RA: Glucocorticoid Management				
	Perioperative Care Measures Group				
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician				
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin				
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)				
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)				
	Back Pain Measures Group				
148	Back Pain: Initial Visit				
149	Back Pain: Physical Exam				
150	Back Pain: Advice for Normal Activities				
151	Back Pain: Advice Against Bed Rest				
	Hepatitis C Measures Group				
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment				
85	Hepatitis C: HCV Genotype Testing Prior to Treatment				
86	Hepatitis C: Antiviral Treatment Prescribed				
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment				
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption				
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy				
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV				
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV				
	Coronary Artery Disease (CAD) Measures Group				
6	CAD: Oral Antiplatelet Therapy Prescribed for Patients with CAD				
7	CAD: Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)				
196	CAD: Symptom and Activity Assessment				
197	CAD: Drug Therapy for Lowering LDL-Cholesterol				
	Ischemic Vascular Disease (IVD) Measures Group				
201	IVD: Blood Pressure Management Control				
202	IVD: Complete Lipid Profile				
203	IVD: Low Density Lipoprotein (LDL-C) Control				
204	IVD: Use of Aspirin or Another Antithrombotic				
	Community-Acquired Pneumonia (CAP) Measures Group				
56	CAP: Vital Signs				
57	CAP: Assessment of Oxygen Saturation				
58	CAP: Assessment of Mental Status				
59	CAP: Empiric Antibiotic				
	Asthma Measures Group				
53	Asthma: Pharmacologic Therapy				
64	Asthma: Asthma Assessment				
231	Asthma: Tobacco Use: Screening – Ambulatory Care Setting				
232	Asthma: Tobacco Use: Intervention – Ambulatory Care Setting				
	Heart Failure (HF) Measures Group				
5	HF: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)				
8	HF: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)				
198	HF:Left Ventricular Function (LVF) Assessment				
199	HF: Patient Education				
200	HF: Warfarin Therapy for Patients with Atrial Fibrillation				
	HIV/AIDS Measures Group				

159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage				
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis				
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy				
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy				
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea				
206	HIV/AIDS: Screening for High Risk Sexual Behaviors				
207	HIV/AIDS: Screening for Injection Drug Use				
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis				
	Other (Non-Group) Measures				
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase				
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports				
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation				
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination				
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy				
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care				
24	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine, or Distal Radius for Men and Women ≥ 50				
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)				
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics				
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage				
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy				
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge				
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia				
36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services				
40	Osteoporosis: Management Following Fracture of Hip, Spine, or Distal Radius for Men and Women ≥ 50				
41	Osteoporosis: Pharmacologic Therapy for Men and Women ≥ 50				
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)				
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility				
47	Advance Care Plan				
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women ≥ 65				
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women ≥ 65				
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation				
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy				
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain				
55	12-Lead Electrocardiogram (ECG) Performed for Syncope				
65	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use				
66	Appropriate Testing for Children with Pharyngitis				
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow				
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy				
69	Multiple Myeloma: Treatment with Bisphosphonates				
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry				
71	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer				
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients				
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol				
79	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD				

81	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients				
82	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis				
83	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia				
91	Acute Otitis Externa (AOE): Topical Therapy				
92	Acute Otitis Externa (AOE): Pain Assessment				
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use				
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility				
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade				
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade				
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients				
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients				
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy				
106	Major Depressive Disorder (MDD): Diagnostic Evaluation				
107	Major Depressive Disorder (MDD): Suicide Risk Assessment				
109	Osteoarthritis (OA): Function and Pain Assessment				
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use				
118	CAD: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)				
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)				
130	Documentation of Current Medications in the Medical Record				
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up				
134	Screening for Clinical Depression and Follow-Up Plan				
135	CKD: Influenza Immunization				
137	Melanoma: Continuity of Care – Recall System				
138	Melanoma: Coordination of Care				
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement				
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care				
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications				
143	Oncology: Medical and Radiation – Pain Intensity Quantified				
144	Oncology: Medical and Radiation – Plan of Care for Pain				
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy				
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening				
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy				
154	Falls: Risk Assessment				
155	Falls: Plan of Care				
156	Oncology: Radiation Dose Limits to Normal Tissues				
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection				
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy				
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula				
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization				
181	Elder Maltreatment Screen and Follow-Up Plan				
182	Functional Outcome Assessment in Chiropractic Care				
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use				
186	Wound Care: Use of Compression System in Patients with Venous Ulcers				
187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy				

188	Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear				
189	Referral for Otologic Evaluation for Patients with History of Active Drainage From the Ear Within the Previous 90 Days				
190	Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss				
191	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery				
192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures				
193	Perioperative Temperature Management				
194	Oncology: Cancer Stage Documented				
195	Radiology: Stenosis Measurement in Carotid Imaging Studies				
209	Functional Communication Measure – Spoken Language Comprehension				
210	Functional Communication Measure – Attention				
211	Functional Communication Measure – Memory				
212	Functional Communication Measure – Motor Speech				
213	Functional Communication Measure – Reading				
214	Functional Communication Measure – Spoken Language Expression				
215	Functional Communication Measure – Writing				
216	Functional Communication Measure – Swallowing				
217	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments				
218	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments				
219	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot, or Ankle Impairments				
220	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments				
221	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments				
222	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist, or Hand Impairments				
223	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments				
224	Melanoma: Overutilization of Imaging Studies in Stage 0-IA Melanoma				
225	Radiology: Reminder System for Mammograms				
227	Heart Failure: Weight Measurement				
228	Heart Failure (HF): Left Ventricular Function (LVF) Testing				
229	Diabetes Mellitus: Hemoglobin A1c Testing				
230	Diabetes Mellitus: Lipid Profile				
233	Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection				
234	Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lunch Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)				
235	Hypertension (HTN): Plan of Care				
236	Hypertension (HTN): Blood Pressure Control				
237	Hypertension (HTN): Blood Pressure Management				
238	Drugs to be Avoided in the Elderly				
239	Weight Assessment and Counseling for Children and Adolescents				
240	Childhood Immunization Status				

These data reflect totals reported for your National Provider Identifier (NPI) by every organization through which you participated in PQRS and were eligible for an incentive payment. If you participated through more than one organization (that is, under more than one Taxpayer Identification Number, or TIN), see the appendix for a breakdown of performance by organization.

Quality Measures Derived from Medicare Claims

Exhibit 2 shows how many of the [#] Medicare patients for whom you filed at least one claim in 2011 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 20), please use caution in making comparisons.

Exhibit 2. Medicare Claims–Based Quality Measures
For All Patients for Whom a Physician Filed at Least One Medicare Claim in 2011

Clinical Condition and Measure	All Medicare Patients for Whom You Submitted a Claim		All Medicare Patients for Whom Physicians in the Nine States Submitted a Claim	
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 with Patients for Whom This Service Was Indicated	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				
Adherence to Statin Therapy for Beneficiaries with Coronary Artery Disease				
Persistence of Beta 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*				

Clinical Condition and Measure	All Medicare Patients for Whom You Submitted a Claim		All Medicare Patients for Whom Physicians in the Nine States Submitted a Claim	
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 with Patients for Whom This Service Was Indicated	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				
Viral Load Testing for Beneficiaries with Antiviral Therapy for Hepatitis C*				
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				

* Denotes measures that will not be used in the value-based payment modifier for medical groups choosing this option.

PART II. COSTS OF CARE

The cost data in this report are based on all Medicare fee-for-service (FFS) Part A and Part B claims, excluding hospice and Part D prescription drug data, submitted in calendar year 2011 by all providers caring for your patients. These include not only the cost of services billed by you for your patients but also the costs of your patients' hospital and skilled nursing facility stays, home health care, durable medical equipment, and services provided to your patients by other medical professionals (that is, other physicians, non-physician practitioners, and certain medical suppliers). Medicare cost data are shown on an annual per patient, or per capita, basis. All cost data have been risk adjusted to account for differences in patient characteristics and payment 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 2011, as measured by office or other outpatient evaluation and management (E&M) visits or total professional costs. (See the Key Differences entry in the Terms/Definitions section of this report on how Medicare plans to attribute beneficiaries to medical groups for the value-based payment modifier.)

1. Patients whose care you directed are those for whom you billed 35 percent or more of all of their office or other 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 the specialists to whom patients may be referred do.
2. Patients whose care you influenced are those for whom you billed fewer than 35 percent of their office or other outpatient E&M visits, but 20 percent or more of all costs billed by physicians and other medical professionals. 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 office or other outpatient E&M visits and less than 20 percent of all costs billed by physicians and other medical professionals. For all physicians, patients in this category are those seen episodically, whose care might be more dispersed.

Exhibit 3. Categories of Your Medicare Patients

	Number of Your Patients*	Number of Office or Other Outpatient E&M Visits You Billed Per Patient **	Your Share of Costs Billed by Medical Professionals for Your Patients**
Total for Whom You Filed Any Claim			%
Patients Whose Care You Directed			
Patients Whose Care You Influenced			
Patients to Whose Care You Contributed			

* The number of 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 on page 2 and in Exhibit 2.

** Numbers are approximate due to rounding. Because you may have treated many patients for whom you did not submit an office or other outpatient E&M code, the average number of office or other outpatient E&M visits across all patients whom you treated may be significantly less than one.

Per Capita Costs of All Patients You Treated

Exhibit 4 shows the annual total per capita costs of all your Medicare patients in 2011, by category, compared with other physicians in your specialty in the nine states.

Note: Whenever the number of patients or physicians is small (fewer than 20), please use caution in making comparisons.

Exhibit 4. Total Per Capita Costs for All Your Medicare Patients, 2011

	Total Per Capita Costs for Your Patients*	Per Capita Costs for Medicare Patients of Physicians in Your Specialty in the Nine States
Total for Whom Physician Filed Any Claim	$	$
Patients Whose Care Physician Directed		
Patients Whose Care Physician Influenced		
Patients to Whose Care Physician Contributed		

* Total per capita costs for your patients can be calculated only for the levels of care (directed, influenced, and/or contributed) that you provided.

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 all costs you billed in 2011.

Per Capita Costs of Patients Whose Care You Directed

Exhibit 5 shows the total risk-adjusted and payment-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 the nine states. Note: Whenever the number of patients or physicians is small (fewer than 20), please use caution in making comparisons.

Exhibit 5. 2011 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 the Nine States			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%	$		100%	$	$/($)
Evaluation and Management Services in All Non-Emergency Settings							
Provided by YOU for Your Patients		%	$		%	$	$/($)
Provided by OTHER Physicians Treating Your Patients							
Procedures in All Non-Emergency Settings							
Provided by YOU for Your Patients							
Provided by OTHER Physicians Treating Your Patients							
Hospital Services (Excluding Emergency Outpatient)							
All HospitalServices							
Inpatient Hospital Facility Services							
Outpatient Hospital Facility Services							
Emergency Services That Did Not Result in a Hospital Admission							
All Emergency Services							
Emergency Visits							
Procedures							
Laboratory and Other Tests							
Imaging Services							
Services in Non-Emergency 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, Rehabilitation, or Other Long-Term Facility							
Home Health							
Other Services							
All Other Services*							

Numbers are approximate due to rounding.

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

Per Capita Costs of Patients Whose Care You Directed

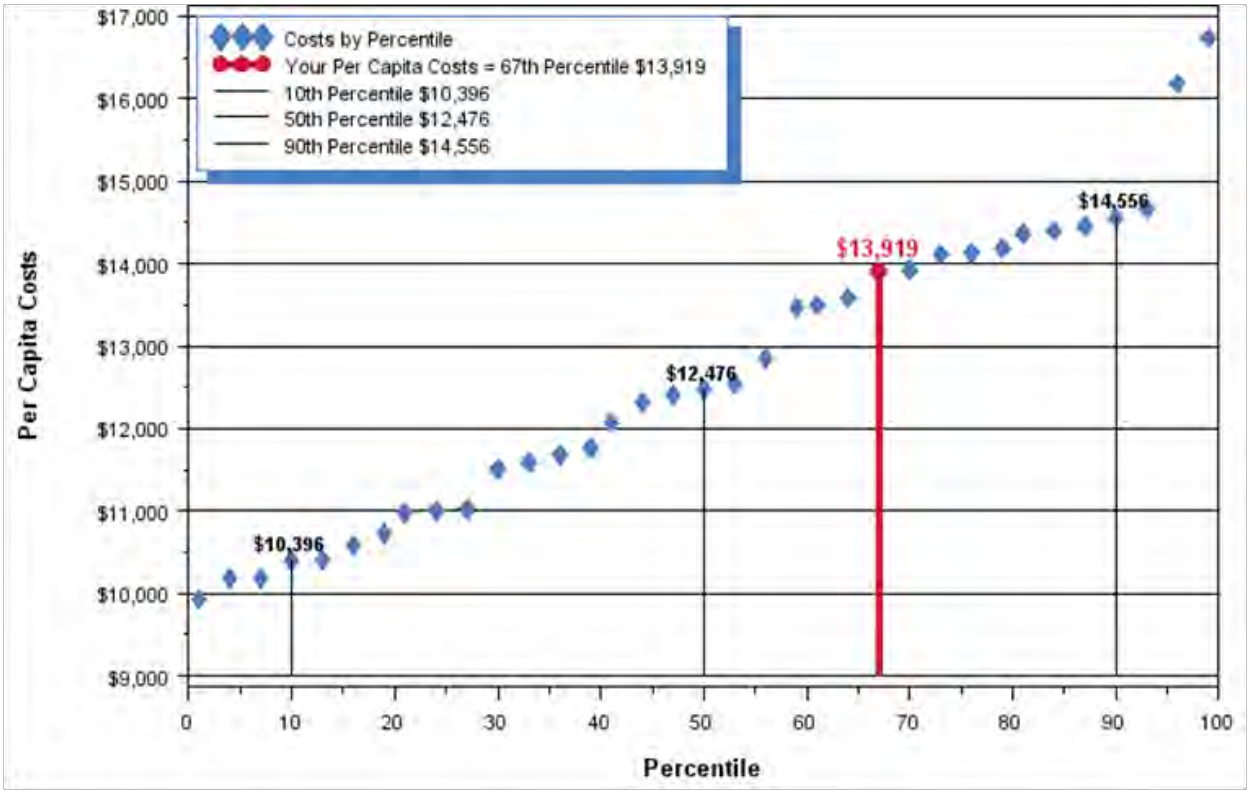
Exhibit 6 shows how many other physicians treated the patients whose care you directed, compared with other physicians in your specialty who also directed care in the nine states.

Exhibit 6. Number of Other Physicians Treating the Medicare Patients Whose Care Was Directed

	For Your Medicare Patients	Average for Medicare Patients Of [#] Physicians in Your Specialty in the Nine States	Average for Medicare Patients of All [#] Physicians in the Nine States
Number of Other Physicians Who Submitted Claims			

Exhibit 7 shows the distribution of total risk-adjusted and payment-standardized per capita costs, by percentile, among physicians in your specialty in the nine states, for patients whose care was directed.

Exhibit 7. Distribution of the 2011 Total Per Capita Costs of Patients Whose Care Was Directed by Physicians in Your Specialty in the Nine States



Per Capita Costs of Patients Whose Care You Influenced

Exhibit 8 shows the total risk-adjusted and payment-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 the nine states. Note: Whenever the number of patients or physicians is small (fewer than 20), please use caution in making comparisons.

Exhibit 8. 2011 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 the Nine States			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%	$		100%	$	$/($)
Evaluation and Management Services in All Non-Emergency Settings							
Provided by YOU for Your Patients		%	$		%	$	$/($)
Provided by OTHER Physicians Treating Your Patients							
Procedures in All Non-Emergency Settings							
Provided by YOU for Your Patients							
Provided by OTHER Physicians Treating Your Patients							
Hospital Services (Excluding Emergency Outpatient)							
All HospitalServices							
Inpatient Hospital Facility Services							
Outpatient Hospital Facility Services							
Emergency Services That Did Not Result in a Hospital Admission							
All Emergency Services							
Emergency Visits							
Procedures							
Laboratory and Other Tests							
Imaging Services							
Services in Non-Emergency 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, Rehabilitation, or Other Long-Term Facility							
Home Health							
Other Services							
All Other Services*							

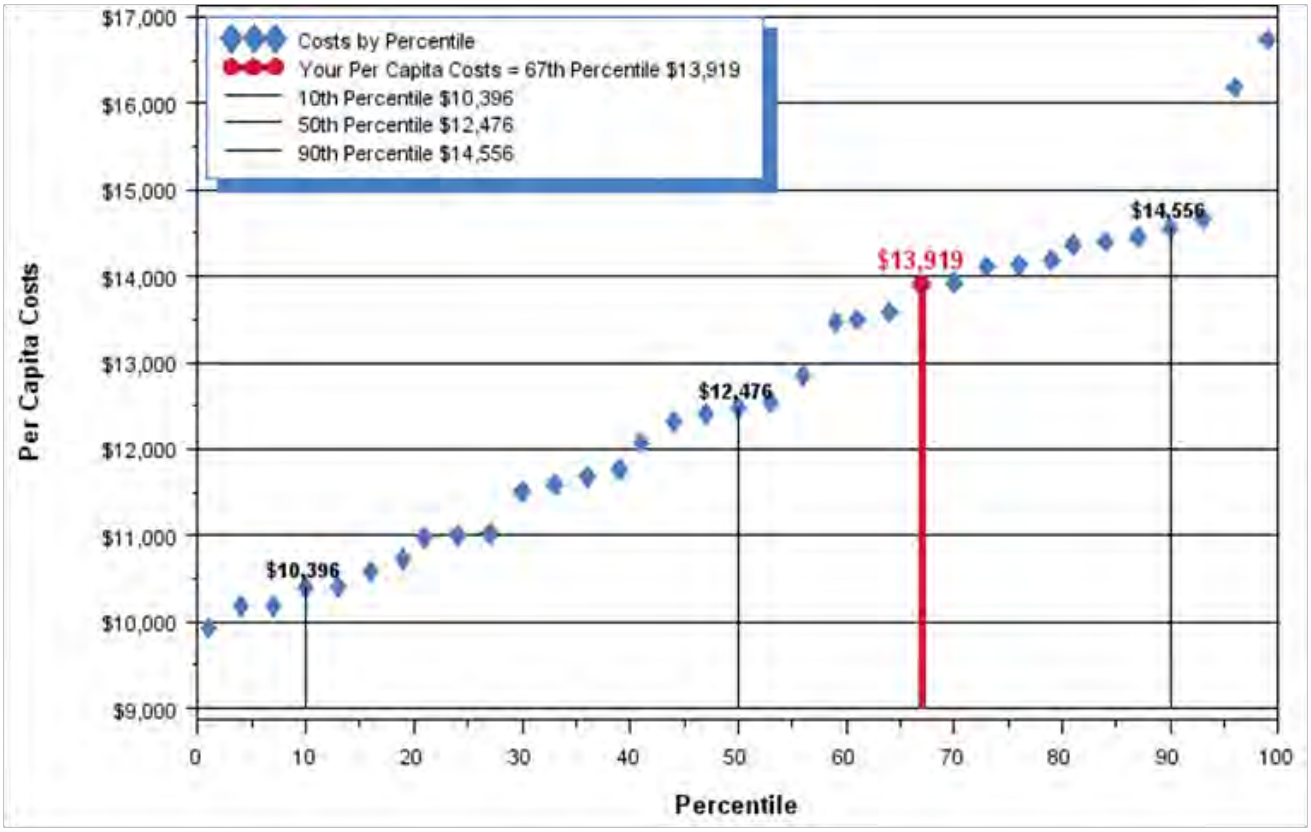
Numbers are approximate due to rounding.

* 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 9 shows the distribution of total risk-adjusted and payment-standardized per capita costs, by percentile, among physicians in your specialty in the nine states, for patients whose care was influenced.

Exhibit 9. Distribution of the 2011 Total Per Capita Costs of Patients Whose Care Was Influenced by Physicians in Your Specialty in the Nine States



Per Capita Costs of Patients To Whose Care You Contributed

Exhibit 10 shows the total risk-adjusted and payment-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 the nine states contributed. Note: Whenever the number of patients or physicians is small (fewer than 20), please use caution in making comparisons.

Exhibit 10. 2011 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 the Nine States			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%	$		100%	$	$/($)
Evaluation and Management Services in All Non-Emergency Settings							
Provided by YOU for Your Patients		%	$		%	$	$/($)
Provided by OTHER Physicians Treating Your Patients							
Procedures in All Non-Emergency Settings							
Provided by YOU for Your Patients							
Provided by OTHER Physicians Treating Your Patients							
Hospital Services (Excluding Emergency Outpatient)							
All Hospital Services							
Inpatient Hospital Facility Services							
Outpatient Hospital Facility Services							
Emergency Services That Did Not Result in a Hospital Admission							
All Emergency Services							
Emergency Visits							
Procedures							
Laboratory and Other Tests							
Imaging Services							
Services in Non-Emergency 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, Rehabilitation, or Other Long-Term Facility							
Home Health							
Other Services							
All Other Services*							

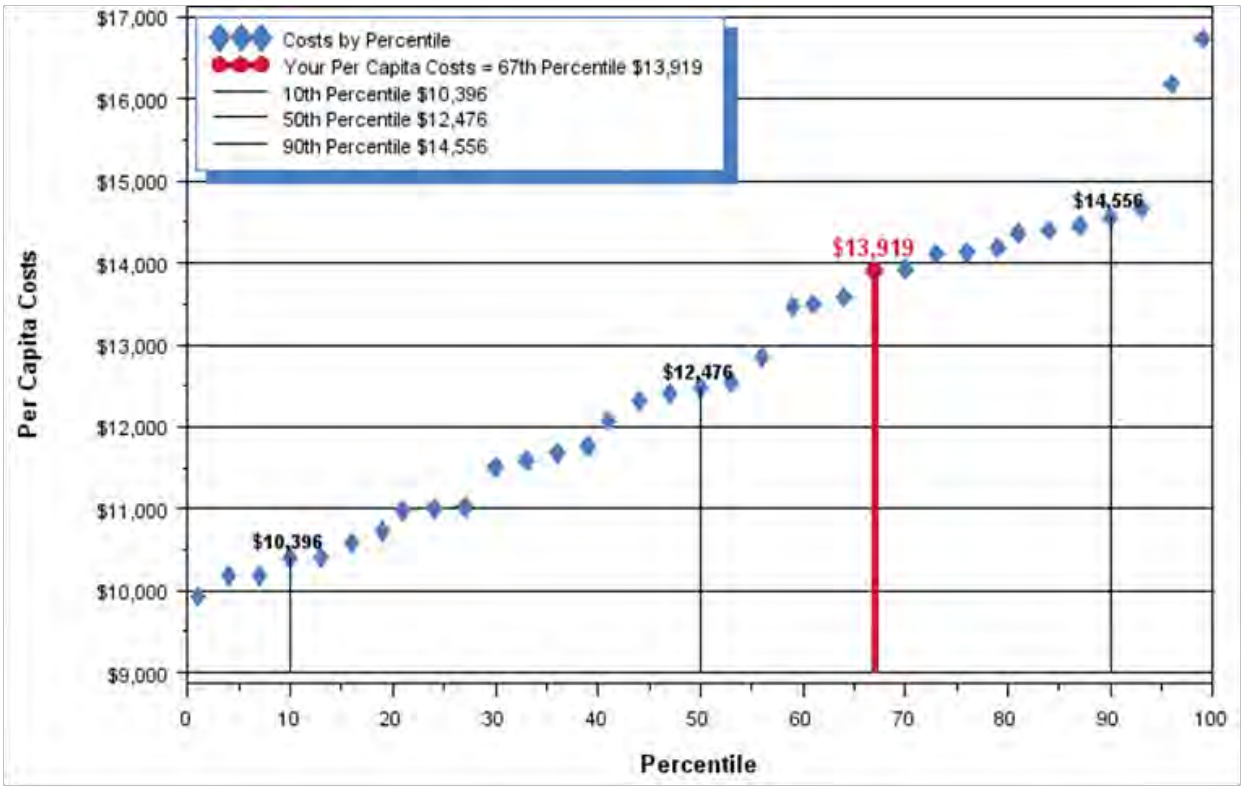
Numbers are approximate due to rounding.

* 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 11 shows the distribution of total risk-adjusted and payment-standardized per capita costs, by percentile, among physicians in your specialty in the nine states, for patients to whose care was contributed.

Exhibit 11. Distribution of the 2011 Total Per Capita Costs of Patients To Whose Care Physicians in Your Specialty in the Nine States Contributed



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

Exhibit 12 shows total risk-adjusted and payment-standardized per capita costs incurred by patients identified as having one or more of four specific chronic health conditions, based on all [#] Medicare patients[1] 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 12 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 20), please use caution in making comparisons.

Exhibit 12. 2011 Total Per Capita Costs for Medicare Patients with Specific Chronic Conditions, for All Patients for Whom You Filed at Least One Medicare Claim in 2011

	Medicare Patients for Whom You Filed a Claim		Medicare Patients Treated by [#] Physicians in Your Specialty in the Nine States	
	Number of Your Patients	Total Risk-Adjusted Per Capita Costs	Average Number of Patients Per Physician*	Average Total Risk-Adjusted Per Capita Costs*
Diabetes		$		$
Coronary Artery Disease				
Chronic Obstructive Pulmonary Disease				
Heart Failure				

* Includes only physicians who treated one or more patients with the condition.

To help Medicare improve future versions of this report or to ask questions about your report:

Please send an email (including your individual NPI) to

cms_medicare_physician_feedback_program@mathematica-mpr.com

or call 1-855-272-3635

More information about these reports and the value-based payment modifier is available at
http://www.cms.gov/physicianfeedbackprogram

[1] The number of Medicare patients is the number 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 on page 2 and in Exhibit 2.

APPENDIX

Exhibit A. Your Performance on PQRS Quality Measures by Taxpayer 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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
	Diabetes Mellitus (DM) Measures Group												
1	DM: Hemoglobin A1c Poor Control in Diabetes Mellitus												
2	DM: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus												
3	DM: High Blood Pressure Control in Diabetes Mellitus												
117	DM: Dilated Eye Exam in Diabetic Patient												
119	DM: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients												
126	DM: Diabetic Foot and Ankle Care, Peripheral Neuropathy-Neurological Evaluation												
127	DM: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear												
163	DM: Foot Exam												
	Chronic Kidney Disorder (CKD) Measures Group												
121	CKD: Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH), and Lipid Profile)												
122	CKD: Blood Pressure Management												
123	CKD: Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)												
153	CKD: Referral for Arteriovenous (AV) Fistula												
	Preventive Care Measures Group												
39	Screening or Therapy for Osteoporosis for Women ≥ 65												
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women ≥ 65												
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50												
111	Preventive Care and Screening: Pneumonia Vaccination for Patients ≥ 65												
112	Preventive Care and Screening: Screening Mammography												
113	Preventive Care and Screening: Colorectal Cancer Screening												
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up												
173	Preventive Care and Screening: Unhealthy Alcohol Use - Screening												
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention												
	Coronary Artery Bypass Graft (CABG) Measures Group												
43	CABG: Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery												
44	CABG: Preoperative Beta-Blocker in Patients with Isolated CABG Surgery												
164	CABG: Prolonged Intubation (Ventilation)												
165	CABG: Deep Sternal Wound Infection Rate												
166	CABG: Stroke/Cerebrovascular Accident (CVA)												
167	CABG: Postoperative Renal Insufficiency												
168	CABG: Surgical Re-exploration												
169	CABG: Antiplatelet Medications at Discharge												
170	CABG: Beta-Blockers Administered at Discharge												
171	CABG: Lipid Management and Counseling												
	Rheumatoid Arthritis (RA) Measures Group												
108	RA: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy												
176	RA: Tuberculosis Screening												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
177	RA: Periodic Assessment of Disease Activity												
178	RA: Functional Status Assessment												
179	RA: Assessment and Classification of Disease Prognosis												
180	RA: Glucocorticoid Management												
	Perioperative Care Measures Group												
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician												
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin												
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)												
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)												
	Back Pain Measures Group												
148	Back Pain: Initial Visit												
149	Back Pain: Physical Exam												
150	Back Pain: Advice for Normal Activities												
151	Back Pain: Advice Against Bed Rest												
	Hepatitis C Measures Group												
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment												
85	Hepatitis C: HCV Genotype Testing Prior to Treatment												
86	Hepatitis C: Antiviral Treatment Prescribed												
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment												
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption												
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy												
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV												
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
	Coronary Artery Disease (CAD) Measures Group												
6	CAD: Oral Antiplatelet Therapy Prescribed for Patients with CAD												
7	CAD: Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)												
196	CAD: Symptom and Activity Assessment												
197	CAD: Drug Therapy for Lowering LDL-Cholesterol												
	Ischemic Vascular Disease (IVD) Measures Group												
201	IVD: Blood Pressure Management Control												
202	IVD: Complete Lipid Profile												
203	IVD: Low Density Lipoprotein (LDL-C) Control												
204	IVD: Use of Aspirin or Another Antithrombotic												
	Community-Acquired Pneumonia (CAP) Measures Group												
56	CAP: Vital Signs												
57	CAP: Assessment of Oxygen Saturation												
58	CAP: Assessment of Mental Status												
59	CAP: Empiric Antibiotic												
	Asthma Measures Group												
53	Asthma: Pharmacologic Therapy												
64	Asthma: Asthma Assessment												
231	Asthma: Tobacco Use: Screening – Ambulatory Care Setting												
232	Asthma: Tobacco Use: Intervention – Ambulatory Care Setting												
	Heart Failure (HF) Measures Group												
5	HF: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)												
8	HF: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)												
198	HF:Left Ventricular Function (LVF) Assessment												
199	HF: Patient Education												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
200	HF: Warfarin Therapy for Patients with Atrial Fibrillation												
	HIV/AIDS Measures Group												
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage												
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis												
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy												
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy												
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea												
206	HIV/AIDS: Screening for High Risk Sexual Behaviors												
207	HIV/AIDS: Screening for Injection Drug Use												
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis												
	Other (Non-Group) Measures												
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase												
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports												
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation												
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination												
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy												
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care												
24	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine, or Distal Radius for Men and Women ≥ 50												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)												
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics												
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage												
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy												
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge												
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia												
36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services												
40	Osteoporosis: Management Following Fracture of Hip, Spine, or Distal Radius for Men and Women ≥ 50												
41	Osteoporosis: Pharmacologic Therapy for Men and Women ≥ 50												
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)												
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility												
47	Advance Care Plan												
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women ≥ 65												
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women ≥ 65												
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation												
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy												
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain												
55	12-Lead Electrocardiogram (ECG) Performed for Syncope												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
65	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use												
66	Appropriate Testing for Children with Pharyngitis												
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow												
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy												
69	Multiple Myeloma: Treatment with Bisphosphonates												
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry												
71	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer												
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients												
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol												
79	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD												
81	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients												
82	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis												
83	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia												
91	Acute Otitis Externa (AOE): Topical Therapy												
92	Acute Otitis Externa (AOE): Pain Assessment												
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use												
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade												
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade												
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients												
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients												
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy												
106	Major Depressive Disorder (MDD): Diagnostic Evaluation												
107	Major Depressive Disorder (MDD): Suicide Risk Assessment												
109	Osteoarthritis (OA): Function and Pain Assessment												
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use												
118	CAD: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)												
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)												
130	Documentation of Current Medications in the Medical Record												
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up												
134	Screening for Clinical Depression and Follow-Up Plan												
135	CKD: Influenza Immunization												
137	Melanoma: Continuity of Care – Recall System												
138	Melanoma: Coordination of Care												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement												
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care												
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications												
143	Oncology: Medical and Radiation – Pain Intensity Quantified												
144	Oncology: Medical and Radiation – Plan of Care for Pain												
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy												
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening												
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy												
154	Falls: Risk Assessment												
155	Falls: Plan of Care												
156	Oncology: Radiation Dose Limits to Normal Tissues												
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection												
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy												
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula												
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization												
181	Elder Maltreatment Screen and Follow-Up Plan												
182	Functional Outcome Assessment in Chiropractic Care												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use												
186	Wound Care: Use of Compression System in Patients with Venous Ulcers												
187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy												
188	Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear												
189	Referral for Otologic Evaluation for Patients with History of Active Drainage From the Ear Within the Previous 90 Days												
190	Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss												
191	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery												
192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures												
193	Perioperative Temperature Management												
194	Oncology: Cancer Stage Documented												
195	Radiology: Stenosis Measurement in Carotid Imaging Studies												
209	Functional Communication Measure – Spoken Language Comprehension												
210	Functional Communication Measure – Attention												
211	Functional Communication Measure – Memory												
212	Functional Communication Measure – Motor Speech												
213	Functional Communication Measure – Reading												
214	Functional Communication Measure – Spoken Language Expression												
215	Functional Communication Measure – Writing												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
216	Functional Communication Measure – Swallowing												
217	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments												
218	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments												
219	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot, or Ankle Impairments												
220	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments												
221	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments												
222	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist, or Hand Impairments												
223	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments												
224	Melanoma: Overutilization of Imaging Studies in Stage 0-IA Melanoma												
225	Radiology: Reminder System for Mammograms												
227	Heart Failure: Weight Measurement												
228	Heart Failure (HF): Left Ventricular Function (LVF) Testing												
229	Diabetes Mellitus: Hemoglobin A1c Testing												
230	Diabetes Mellitus: Lipid Profile												
233	Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection												
234	Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lunch Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)												
235	Hypertension (HTN): Plan of Care												

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 Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported	Number of Your Cases You Reported	Performance Rate for Cases you reported
236	Hypertension (HTN): Blood Pressure Control												
237	Hypertension (HTN): Blood Pressure Management												
238	Drugs to be Avoided in the Elderly												
239	Weight Assessment and Counseling for Children and Adolescents												
240	Childhood Immunization Status												

Note: If you were incentive-eligible under more than five TINs, data are displayed for the five TINs under which you reported the most cases.

ALL OTHER SERVICES. Exhibits 5, 8, and 10 display six categories of Medicare-covered services: evaluation and management (E&M) in all settings, procedures in all settings, hospital (excluding emergency outpatient), emergency services that did not result in a hospital admission, 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 six categories are captured as "All Other Services," along with services for which providers did not report a procedure code. 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 addition, 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."

AVERAGE. Peer group averages for the administrative claims-based quality measures and cost measures 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 included in the quality or cost measure.

ATTRIBUTION OF MEDICARE BENEFICIARIES TO PHYSICIANS. For calculation of the 2011 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 2011 are eligible for inclusion. Medicare beneficiaries are attributed to every 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 when they report those measures to CMS via claims, a qualified registry, or a qualified electronic health records product.

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 2011 office or other outpatient evaluation and management (E&M) visits (see Table 1 below for E&M Healthcare Common Procedure Coding System codes) or total physician and other medical professional costs:

1. Patients whose care the physician directed—those for whom that physician billed 35 percent or more of the patient's office or other 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 office or other outpatient E&M visits but 20 percent or more of all costs billed by physicians and other medical professionals.
3. Patients to whose care the physician contributed—those for whom the physician billed fewer than 35 percent of the patient's office or other outpatient E&M visits and less than 20 percent of all costs billed by physicians and other medical professionals.

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 2011, 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 2011, or (3) had any claims for which Medicare was not the primary payer during 2011 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		

SOURCE: RTI International.

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

BENCHMARKS. The benchmarks for the PQRS quality measures in Exhibit 1 are the national means of performance rates for each measure during the performance period, regardless of whether that measure was reported through claims, registries, or electronic health records. The benchmarks for the CMS-calculated claims-based quality measures (Exhibit 2) and the cost measures (Exhibits 4 and 12) are the case-weighted means across all physicians in the peer group in nine states (California, Iowa, Illinois, Kansas, Michigan, Missouri, Minnesota, Nebraska, and Wisconsin). The benchmarks for the claims-based quality measures and cost measures are not state-specific.

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 2011 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 subgroup were computed in the same manner as the per capita costs for all attributed beneficiaries (see Per Capita Costs), with the exception that expected costs for beneficiaries in each subgroup were computed based on a risk adjustment model that included only beneficiaries with the condition. These subgroup per capita costs include all costs and are not limited to costs associated with treating the condition itself.

CLAIMS-BASED QUALITY MEASURES. Claims-based quality measures shown in Exhibit 2 are calculated solely from claims submitted for medical services rendered and Part D prescription drug data. They are not enhanced with additional clinical information and may have limitations when additional clinical information seems warranted. For the calculation of these measures, 2011 (January 1, 2011, through December 31, 2011) 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/Downloads/QRURs_for_individual_physicians.pdf.

ELIGIBLE PROFESSIONALS. An eligible professional is any of the following: (1) a physician, (2) a practitioner, (3) a physical or occupational therapist or a qualified speech-language pathologist, or (4) a qualified audiologist.

INCENTIVE ELIGIBLE. In accordance with PQRS, eligible professionals who satisfactorily report data on PQRS quality measures are eligible to receive an incentive for all covered professional services furnished by the eligible professional or group practice during the applicable reporting period.

KEY DIFFERENCES. Key differences between the Quality Resource Use Reports and the value-based payment modifier are the following:

Quality Measures. The quality composite component of the value-based payment modifier will use the data that a group reports via the Physician Quality Reporting System (PQRS) during 2013. Groups of physicians with 100 or more eligible professionals will be able to report data through multiple options available through PQRS. A description of the options and associated deadlines are available at www.cms.gov/physicianfeedbackprogram. By contrast, quality measures in this Quality and Resource Use Report reflect the performance of an individual physician. Exhibit 1 of this report shows individual physician performance based on information that physician personally reported via PQRS during 2011. Exhibit 2 of this report provides a preview of the CMS-calculated claims-based quality measures for that physician. Performance on these claims-based quality measures will not be used for the value-based payment modifier unless the group elects this reporting option under the PQRS. In addition, this report does not include the outcome measures that will be used for all groups of physicians for the value-based payment modifier. Specifications for the outcome measures are available at www.cms.gov/physicianfeedbackprogram.

Attribution for Quality Measures. In this report, attribution for the CMS-calculated claims-based quality measures, as shown in Exhibit 2, is based on a "one-touch" rule. This means that Medicare beneficiaries are attributed to every physician who was the performing provider on at least one Medicare claim during 2011. If a group selects the CMS-calculated claims-based quality measures for the value-based payment modifier, CMS will instead use a two-step attribution rule that attributes beneficiaries to groups of physicians that provide the plurality of primary care services. This same attribution rule will also be used for the outcome measures.

Attribution for Cost Measures. For the five cost measures in this report, CMS used a "degree of involvement" attribution methodology at the individual physician level (see ATTRIBUTION OF MEDICARE BENEFICIARIES TO PHYSICIANS). For the value-based payment modifier, CMS will use the same two-step attribution rule used for the claims-based quality measures, which attributes beneficiaries to groups of physicians that provide the plurality of primary care services.

MEDICAL PROFESSIONALS. Medical professionals include physicians, physician assistants, clinical social workers, nurse practitioners, independent clinical laboratories, ambulance providers, free-standing ambulatory surgical centers, and all other non-institutional providers billing Medicare under the fee-for-service physician fee schedule. A physician's share of all costs billed by medical professionals for a patient is used to determine the level of care that the physician provided to the patient. (See ATTRIBUTION OF MEDICARE BENEFICIARIES TO PHYSICIANS.)

PAYMENT STANDARDIZATION. Payment standardization equalizes the costs associated with a specific service, such that a given service is paid at the same level across all providers of the same type, regardless of geographic location or differences in Medicare payment rates among some facilities (for example, payment rates for inpatient hospital services in Critical Access Hospitals or other cost-based settings versus payment rates based on diagnosis-related groups under the Inpatient Prospective Payment System). 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 payment standardized to allow for comparisons among peers who practice in locations or facilities where reimbursement rates are higher or lower. Costs for services are payment standardized before risk adjusting per capita costs. Both calculations smooth out large differences in costs that result from circumstances beyond physicians' control.

PER CAPITA COSTS. Per capita costs are the average (mean) of all 2011 Medicare fee-for-service (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 2011 administrative claims data using inpatient hospital, outpatient hospital, skilled nursing facility, home health, durable medical equipment, and Medicare carrier (non-institutional provider) claims. Hospice and Part D (outpatient prescription drug) costs were not included in the 2011 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 first summing the payment-standardized Medicare Parts A and B costs during the 2011 calendar year for all Medicare beneficiaries who were attributed to the physician and then dividing by the number of beneficiaries attributed to the physician to form a payment-standardized but non-risk-adjusted measure of per capita costs. Part-year beneficiaries (for example, those who became eligible for Medicare during the year, were enrolled in a Medicare Advantage program for part of the year, or who died in the year) and the costs associated with their care were excluded.

A ratio of observed to expected costs was then computed by dividing the physician's payment-standardized but non-risk-adjusted per capita costs by the physician's expected payment-standardized costs for all attributed beneficiaries. (Expected costs were computed by multiplying the coefficients of the risk adjustment model by the characteristics of the physician's attributed beneficiaries.) Finally, payment-standardized and risk-adjusted per capita costs were computed by multiplying this ratio by the mean per capita cost of all beneficiaries attributed to any physician in the sample. See ATTRIBUTION OF MEDICARE BENEFICIARIES TO PHYSICIANS and RISK ADJUSTMENT.

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 2011, the HCC model generates a 2010 score based on the presence of these conditions in 2010—and on sex, age, original reason for Medicare entitlement (either age or disability), and Medicaid entitlement—as a predictor of beneficiary costs in 2011. Risk adjustment of 2011 costs also takes into account the presence of end-stage renal disease (ESRD) in 2010.

The statistical risk adjustment model estimates the independent effects of these factors on payment-standardized beneficiary costs and adjusts 2011 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 5, 8, and 10, 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 2011, we used the physician's two-digit CMS medical specialty code listed most frequently on claims in the 2011 carrier claims file for which the physician was listed as a performing NPI. Only one specialty is assigned to a physician even if that physician routinely lists different specialties on different claims. Because specialties are assigned in this manner rather than relying on those reported by physicians in the National Plan and Provider Enumeration System (NPPES), the Provider Enrollment, Chain, and Ownership System (PECOS), or other databases, a physician's assigned specialty may differ from the specialty that the physician reported in these databases.

TOTAL COSTS. The 2011 total cost measures include all costs incurred in all health care settings (except for hospice and Part D outpatient prescription drug costs) for all attributed beneficiaries enrolled in both Parts A and B of original fee-for-service (FFS) Medicare for all 12 months of 2011. Medicare costs were obtained from 2011 Medicare administrative claims data using inpatient hospital, outpatient hospital, skilled nursing facility, home health, durable medical equipment, and Medicare carrier (non-institutional 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 claims-based medication management quality measures and is defined as the sum of the previous numerators divided by the sum of the previous denominators.

VALUE-BASED PAYMENT MODIFIER. The value based payment modifier is an adjustment to payments under the Medicare physician fee schedule that will reward higher quality care delivered at lower cost, as required under Section 3007 of the Affordable Care Act. The value-based payment modifier will begin in 2015 and will be based on performance during 2013. CMS will apply the value-based payment modifier only to physicians practicing in a medical practice group with 100 or more eligible professionals billing under a single Taxpayer Identification Number (TIN). CMS proposes to separate these groups into two categories, based on their satisfactory participation in the Physician Quality Reporting System (PQRS). Physicians may participate by submitting patient quality measure data under available PQRS reporting options or by requesting that CMS compute the group's performance on a defined set of administrative claims-based quality indicators. Those groups that have not met satisfactory reporting criteria or do not choose to participate would have a value-based payment modifier set at -1.0 percent for 2015. Groups that have satisfactorily participated would have their value-based modifier payment set at 0.0 percent, meaning that they would incur no negative payment adjustment under the physician fee schedule. CMS will offer all groups of physicians that satisfactorily report under the PQRS the ability to have their value-based payment modifier based on their performance using a quality-tiering approach that evaluates performance on the PQRS quality measures submitted and on five cost measures. The five cost measures include a total per capita cost measure for all attributed patients and four measures of total per capita costs incurred by patients identified as having one or more of four specific chronic health conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure).