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PRACTICE FEEDBACK REPORT TECHNICAL REFERENCE GUIDE

Overview

The Centers for Medicare & Medicaid Services (CMS) is one of several payers participating in your state's multi-payer patient-centered medical home (PCMH) initiative. As a payer participant, CMS is providing participating practices with a feedback report that provides data related to quality of care, utilization, and Medicare expenditures for Medicare fee-for-service (FFS) beneficiaries assigned to your practice. This **Technical Reference Guide** has been created to provide more information on the methodology that was used to produce the report.

The report includes your practice's results for three data categories:

Utilization measures—Summary information for hospital and emergency room (ER) utilization measures

Medicare expenditures—Summary information on the share of care that you provide your Medicare FFS patients, average total Medicare expenditures per beneficiary, and average Medicare expenditures by type of service

Quality of care measures—Summary information about selected quality of care measures, such as LDL-cholesterol (LDL-C), HbA1c screening, retinal eye examinations, nephropathy screening, and total lipid panel screening. For these measures, total lipid panel screening is among beneficiaries with heart disease, and HbA1c testing, retinal eye exam, LDL-C screening, and nephropathy screening test rates are among beneficiaries with diabetes.

Data Sources and Beneficiaries

To create the practice feedback report, we used Medicare Parts A and B billing data. Note we did not include Medicare Part D (prescription drug) nor Medicare Advantage billing data for any of the analyses.

Note that these data may not be current or complete because of time lags in receiving Medicare claims data. Thus, the information in these files should not replace other efforts by your practice to obtain more timely information on the services your patients have received (e.g., getting discharge reports from your local hospitals, referral reports from other providers, or follow-up with your patients).

Beneficiaries are not always eligible for Medicare for the full time period. To account for incomplete eligibility, eligibility fractions were created quarterly using the number of days eligible per quarter divided by the total number of days in that quarter. These fractions were calculated at the beneficiary level then applied at the practice level. Application of these fractions causes data for beneficiaries with less than a full quarter of eligibility to be downweighted.

Hierarchical Conditions Category (HCC) Group and Comparison Practices

A practice's the Hierarchical Conditions Category grouping is based on the average of all beneficiaries' health risk scores, which are calculated using CMS's Hierarchical Conditions Categories (HCC) risk adjustment model.[1] The HCC risk adjustment model uses beneficiary demographic information (e.g., gender, age, Medicaid status, disability status) and diagnosis codes reported in Medicare claims data from the previous year to predict

[1] More information about the HCC risk adjustment model can be found at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads//Advance2011.pdf and https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads//Evaluation_Risk_Adj_Model_2011.pdf

expenditures for the current year.[2] This risk score often is used as a proxy for a beneficiary's health status (severity of illness). Participating MAPCP practices were assigned to one of the following categories based on the average calculated HCC risk score of all of their beneficiaries: Low <= 0.771; High > 0.771. The value 0.771 represents the median HCC value for assigned beneficiaries at participating MAPCP practices.

Therefore, if the average HCC risk score of a practice's assigned Medicare FFS beneficiaries was less than or equal to 0.771, then that practice was grouped into the "LOW HCC" group. Similarly, if the average HCC risk score of a practice's assigned Medicare FFS beneficiaries was greater than 0.771, then that practice was grouped into the "HIGH HCC" group.

If your practice was in the "LOW HCC" group, the comparison group shown in the practice feedback report tables and graphs is comprised of all participating practices in your state that also were defined as "LOW HCC" practices. Similarly, if your practice was in the "HIGH HCC" group, the comparison group shown in the practice feedback report tables and graphs is comprised of all participating practices in your state that also were defined as "HIGH HCC" practices.

Selected Measures

The practice feedback report includes performance metrics on three important aspects of health care: Healthcare Utilization, Medicare Expenditures, and Quality of Care.

Utilization. Utilization measures provided in this report include:

- All-cause hospitalizations
- Hospitalizations based on ambulatory care sensitive conditions (ACSCs) (see pages 3-4 for descriptions of ambulatory care sensitive conditions, as defined by the Agency for Healthcare Research and Quality's (AHRQ's) Chronic Prevention Quality Indicators (PQIs))
- All-cause visits to an emergency room (ER)
- Percent of all ER Visits that were "observational" in nature and ultimately did not result in a hospitalization (which can be thought of as a "potentially preventable" ER visit).

*Medicare Expenditures***.** The practice feedback report summarizes information for your practice on key measures of Medicare expenditures (presented as the average annual "per beneficiary"):

- Total annual Medicare expenditures
- Medicare expenditures by type of provider
- Inpatient hospitalization expenditures for ambulatory care sensitive conditions (see pages 3-4 for descriptions of ambulatory care sensitive conditions, as defined by AHRQ's Chronic PQIs)

It is important to note that we did *not* risk-adjust the payments or perform any price standardization. Also, the cost measures include individuals with no claims. Because the expenditures are presented as average per beneficiary, the proportion of beneficiaries with $0 costs will lower the averages.

*Quality of Care***.** We define quality of care as adherence to evidence-based, guideline-concordant care and have selected measures from the National Quality Forum (NQF)-endorsed National Voluntary Consensus Standards for Physician-Focused Ambulatory Care. These measures have been extensively tested and are widely accepted as clinically important measures. They are used by other CMS pay-for-performance initiatives, such as the Physician Quality Reporting System, or in evaluations of other pay-for-performance demonstrations (e.g., Physician Group Practice Demonstration) or pilot programs (e.g., Medicare Health Support).

[2] Beneficiaries with less than a full year of Medicare enrollment were assigned a risk score based on only their demographic information. Beneficiaries with end-stage renal disease were always assigned to the "high" risk category.

This report provides the percentage of beneficiaries assigned to your practice location that received one of the following seven recommended evidence-based, quality-of-care measures during the measurement year:

For beneficiaries with a claims-based diagnosis of diabetes, we present the percent that had:

- LDL-C screening
- HbA1c testing
- Retinal eye examination
- Nephropathy screening (measured by microalbumin test)
- Composite Measure: All 4 diabetes quality measures
- Composite Measure: None of the 4 diabetes quality measures

See pages 9-12 for descriptions of how the diabetes quality-of-care measures were calculated.

For beneficiaries with heart disease, we present the percent that had:

- Total lipid panel test

See pages 13-14 for descriptions of how the ischemic vascular disease (IVD) quality-of-care measures were calculated.

We include quality of care services billed by your practice and any other Medicare FFS provider, including laboratories. If the service was provided by an entity that does not bill Medicare, such as a free clinic providing LDL-C screening services, the provision of the service was not captured in the reported rate.

Ambulatory Care Sensitive Conditions

In the feedback report, we provide information on hospitalizations that occurred for one of the 9 ambulatory care sensitive conditions (ACSCs) that we defined based on AHRQ's Prevention Quality Indicators (PQIs). These are shown in Table 1 below. ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. PQIs can be used as a "screening tool" to help flag potential health care quality problem areas that need further investigation. For more information, see http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx.

Table 1. Chronic Care Prevention Quality Indicators used to represent Ambulatory Care Sensitive Conditions

PQI 01 Diabetes Short-Term Complications (ketoacidosis, hyperosmolarity, coma)
PQI 03 Diabetes Long-Term Complications (renal, eye, neurological, or circulatory)
PQI 05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults
PQI 07 Hypertension
PQI 08 Congestive Heart Failure (CHF)
PQI 13 Angina without Procedure
PQI 14 Uncontrolled Diabetes
PQI 15 Asthma in Younger Adults
PQI 16 Lower-Extremity Amputation Among Patients With Diabetes

Reporting period

How to Read the Tables

Table 1. Utilization and Expenditure Measures: (DATE – DATE)

Measure category and measures within each category, for which results are displayed. Numbers in the **Utilization** section represent rates per 1000 beneficiaries. Numbers in the **Annual Expenditures** section represent the average dollars per beneficiary paid by Medicare.

Number of beneficiaries assigned to the practice, on which calculations are based (i.e., N included in denominator)

Number of participating practices in the state that are in the same risk group category as your practice.

Measure	Your Practice (N beneficiaries = N)	Comparison State "High HCC" Practices (N practices = N (N beneficiaries = N)
Utilization		
Hospitalization Rate For Any Cause (rate per 1,000 beneficiaries per quarter)		
Hospitalization Rate For ACSCs (rate per 1,000 beneficiaries per quarter)		
ER Visits / Observation Stays Rate For Any Cause (rate per 1,000 beneficiaries per quarter)		
Percent of ER Visits / Observation Stays Not Leading to a Hospital Admission		
Annual Expenditures (Average $ per beneficiary)		
Total Medicare ($)		
Acute Care Hospital (all-cause) ($)		
Acute Care Hospital (for ACSCs) ($)		
All other Inpatient Facilities [1] ($)		
ER/Observation Stay ($)		
Outpatient Department ($)		
Federally Qualified Health Centers (FQHC) and Rural Health Center ($)		
Primary Care Provider Services ($)		
Specialty Care Provider Services ($)		
Laboratory ($)		
Imaging ($)		
Home Health ($)		
Other[2] ($)		

1. **Other inpatient facilities** include psychiatric and rehabilitation hospitals and hospital units, as well as skilled nursing units long-term care hospitals.

2.**Other expenditures** = Part B (non-laboratory or imaging tests, ambulance, psychiatric visits, chiropractic visits, immunizations and vaccinations, physical therapy visits, other minor procedures, and pain management), Durable Medical Equipment, Hospice

Table 2. Quality of Care Measures

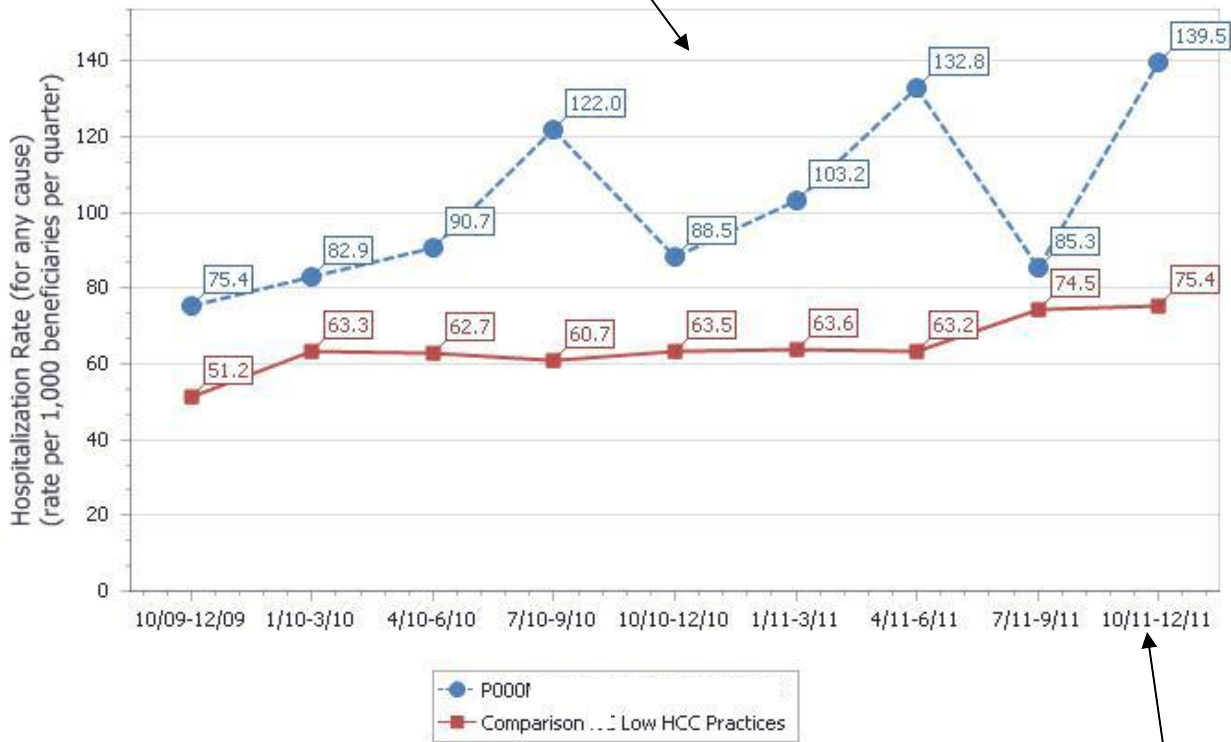
N = Number with diabetes or heart disease (the denominator on which the percentages are based).

Quality of Care Measure (% beneficiaries with the disease)	Your Practice (N beneficiaries)	Comparison Practices (N practices; (N beneficiaries)
N assigned beneficiaries with claims-based diagnosis of diabetes		
% had HbA1c testing		
% had retinal eye examinations		
% had microalbumin screening tests		
% had LDL-C screening		
% had all 4 diabetes process measures		
% had none of the diabetes process measures		
N assigned beneficiaries with claims-based diagnosis of ischemic vascular disease (IVD)		
% had total lipid panel test		

Quality measures for which results are displayed (6 diabetes measures and 1 IVD measure). Numbers in the **Quality of Care Measures** represent the % of beneficiaries with the disease that had the quality measure.

Figure 1. Trends in Hospitalizations for Any Cause (Rate per 1000 beneficiaries): DATE – DATE

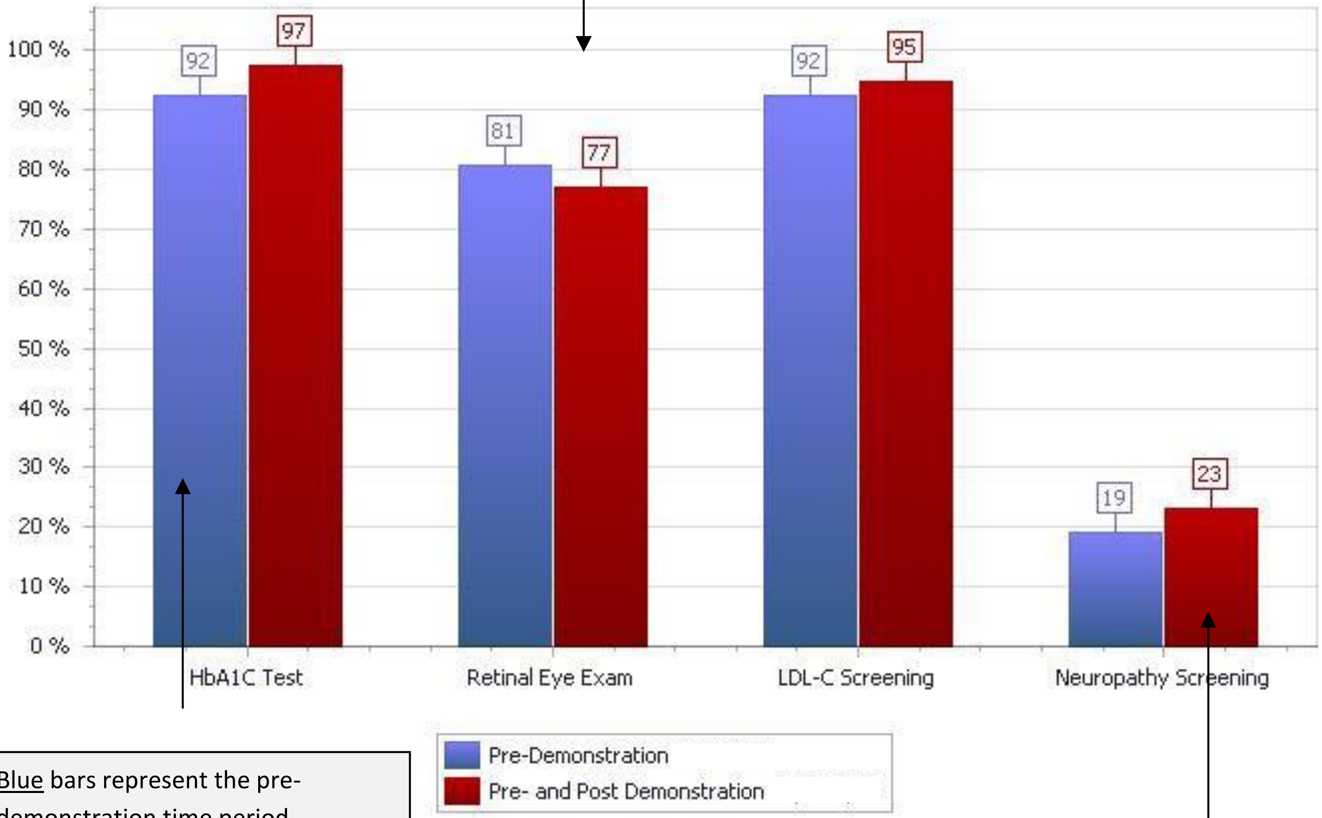
These “trend” line graphs are designed to show changes over time in your practice and comparison practices in utilization and expenditure measures. Quarterly rates per 1000 beneficiaries (for utilization measures) or quarterly dollars per beneficiary (for expenditure measures) are shown.



The most recent data point shown is for the most recent quarter on which we are reporting measures- corresponding to the data shown in Table 1 of the report.

Figure 17. Trend in Quality Measures for Medicare FFS Beneficiaries with Diabetes: DATE - DATE

These column graphs are designed to show changes over time in your practice in quality measures. Because quality measures are by definition annual measures, we show two annual time periods. One is pre-demonstration and one is partially pre-demonstration and one quarter of the demonstration. As the demonstration progresses and more quarters of demonstration data are available, we will be able to show a full year of pre-demonstration data and a full year of demonstration data.



Blue bars represent the pre-demonstration time period.

Red bars represent the pre-demonstration + 1 quarter of post-demonstration time periods.

QUALITY OF CARE MEASURE SPECIFICATIONS

We define quality of care as adherence to evidence-based, guideline-concordant care. These measures have been extensively tested and are widely accepted as clinically important measures. They are endorsed by the National Quality Forum (NQF) National Voluntary Consensus Standards for Physician-Focused Ambulatory Care. They are used by other CMS pay-for-performance initiatives, such as the Physician Quality Reporting System, or in evaluations of other pay-for-performance demonstrations (e.g., Physician Group Practice Demonstration) or pilot programs (e.g., Medicare Health Support).

To calculate these measures, we include services billed by your practice and any other Medicare FFS provider, including laboratories. If the service was provided by an entity that does not bill Medicare, such as a free clinic providing LDL-C screening services, the provision of the service was not captured in the reported rate.

Comprehensive Adult Diabetes Care (CDC)

Description

The percentage of patients 18–75 years of age with type 1 or type 2 diabetes who had any of the following during the measurement year

- Hemoglobin A1c (HbA1c) testing
- Eye exam (retinal) performed
- LDL-C screening
- Medical attention for nephropathy

Eligible Population

Age	18–75 years of age at the beginning of the measurement year.
Patient inclusion criteria	Continuous FFS Part A and Part B enrollment in the measurement year. Did not have any months of Medicare Advantage (HMO flag from Denominator file) in the year. Did not have any months of Medicare as a secondary payer due to working aged in the year.
Event/ diagnosis	Use claims data to identify diabetic patients. **Claims data.** Patients who had two face-to-face encounters in an outpatient setting or nonacute inpatient setting on different dates of service, with a diagnosis of diabetes (Table CDC-A), or one face-to-face encounter in an acute inpatient or ED setting, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. Services that occur over both years may be counted. Refer to the tables below for codes to identify the visit type. To clarify, a patient is considered to have diabetes if he/she has, **in the measurement year or the year prior to the measurement year** (2 years): • At least two outpatient or nonacute encounters in the Part A outpatient claims or Part B Carrier claims with a diabetes diagnosis, ***or*** • At least one acute inpatient visit in the Part A inpatient claims with a diabetes diagnosis

Codes to Identify Diabetes

Description	ICD-9-CM Diagnosis
Diabetes	250, 357.2, 362.0, 366.41, 648.0

CPT Codes to Identify Visit Type in the Outpatient or Nonacute Inpatient Setting

Description	CPT
Outpatient	92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
ED	99281-99285

Revenue Center Codes to Identify Visit Type in the Outpatient or Nonacute Inpatient Setting

Description	UB Revenue Center
Outpatient	051x, 0520-0523,0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
ED	045x, 0981

CPT Codes to Identify Visit Type in the Acute Inpatient Setting

Description	CPT
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

Revenue Center Codes to Identify Visit Type in the Acute Inpatient Setting

Description	UB Revenue Center
Acute inpatient	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987

Exclusions Exclude from the sample if the following diagnoses are found:

- Polycystic ovaries (any time in the patient's history)
- Gestational diabetes (during the measurement period or year prior)
- Steroid induced diabetes (during the measurement period or year prior)

Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Polycystic ovaries	256.4
Steroid induced	249, 251.8, 962.0
Gestational diabetes	6488

Numerators

HbA1c Testing

An HbA1c test performed during the measurement year as identified by claim/ encounter or electronic laboratory data. Use any code listed below.

Codes to Identify HbA1c Tests

CPT
83036, 83037

Eye Exam

An eye screening for diabetic retinal disease as identified by electronic data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist (specialty = 41) or ophthalmologist (specialty = 18)) in the measurement year

Refer to the table below for codes to identify eye exams.

Codes to Identify Eye Exams*

CPT	HCPCS	ICD-9-CM Procedure
67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225- 92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	S0620, S0621, S0625**, S3000	14.1-14.5, 14.9. 95.02-95.04, 95.11, 95.12, 95.16

* Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there is no electronic way to determine that a dilated exam was performed.
** The organization does not need to limit HCPCS S0625 to an optometrist or an ophthalmologist. These codes indicate an eye exam was performed by an eye care professional.

LDL-C Screening

An LDL-C test performed during the measurement year, as identified by claim/ encounter or automated laboratory data.

Codes to Identify LDL-C Screening

CPT*
80061, 83700, 83701, 83704, 83721

Medical Attention for Nephropathy

A nephropathy screening test ***or*** evidence of nephropathy, as documented through electronic data.

Codes to Identify Nephropathy Screening Tests

Description	CPT
Nephropathy screening test	82042, 82043, 82033, 84156

Codes to Identify Evidence of Nephropathy

Any of the following meet criteria for evidence of nephropathy:

- A claim/encounter with a code to indicate evidence of nephropathy during the measurement year.
- A nephrologist (specialty = 39) visit during the measurement year, as identified by specialty provider codes (no restriction on the diagnosis or procedure code submitted).

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Evidence of treatment for nephropathy	36145, 36147, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512	G0257, G0392, G0393, S9339	250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6

Comprehensive Ischemic Vascular Disease Care (IVD)

Description
The percentage of patients 18 years of age and older who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and who had the following during the measurement year. • Complete lipid profile

Eligible Population	
Age	18 years or older years of age at the beginning of the measurement year.
Patient inclusion criteria	Continuous FFS Part A and Part B enrollment in the measurement year. Did not have any months of Medicare Advantage (HMO flag from Denominator file) in the year. Did not have any months of Medicare as a secondary payer due to working aged in the year.
Diagnosis	*Diagnosis.* Identify patients as having IVD who met at least one of the two criteria below, during the measurement year. • At least one outpatient visit (Table IVD-B or Table IVD-C) in the Part A outpatient claims or Part B Carrier claims with an IVD diagnosis (Table IVD-A), ***or*** • At least one acute inpatient visit (Table IVD-B or Table IVD-C) in the Part A inpatient claims with an IVD diagnosis (Table IVD-A)
Exclusions	None

Codes to Identify IVD

Description	ICD-9-CM Diagnosis
IVD	410.x1, 411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433, 434, 440.1, 440.2, 440.4, 444, 445

CPT Codes to Identify Visit Type

Description	CPT
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

Revenue Center Codes to Identify Visit Type

Description	UB Revenue
Outpatient	051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983
Acute inpatient	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-021x, 072x, 0987

Electronic Specification

Denominator The eligible population.

Numerators A complete lipid profile performed during the measurement year, as identified by claim/encounter or electronic laboratory data.

Codes to Identify a Complete Lipid Profile

Description	CPT
Lipid panel	80061

OR

Description	CPT
Total cholesterol	82465
AND	
High density lipoprotein (HDL)	83701
AND	
Triglycerides	84478