

MARCH 2012 – FREQUENTLY ASKED QUESTIONS on Quality and Resource Use Reports (QRUR) for Individual Physicians

- 1. Exhibit 1 includes quality measures for conditions I do not treat (or Exhibit 11 displays information for patients whose conditions I do not treat).** Exhibits 1 and 11 are based on all claims submitted for all fee-for-service Medicare patients whom the physician treated at least once and submitted a claim to Medicare.
- 2. I participated in PQRS in 2010, but Exhibit 2 says that I did not.** The QRUR includes only data for physicians who participated in the individual physician claims-based option of PQRS. Thus, physicians who successfully participated in PQRS via the group option, or electronic health record or registry reporting mechanisms will not have those data displayed in Exhibit 2.
- 3. I provided evaluation and management (E&M) services to my patients but Exhibit 3 says that I did not.** The numbers reported here are averages (based on the number of visits per attributed beneficiary) and not totals for all attributed beneficiaries. A physician could have provided a sizable number of E&M office visits, but the average per patient number could be very low. Since the numbers have been rounded, if the number of E&M office visits per beneficiary was less than 0.5, the number was rounded down to zero.
- 4. How is it possible for Exhibit 3 to show that I provided few or no E&M services to my patients while Exhibit 4 (or Exhibit 7 or Exhibit 9) indicates that I provided E&M services to most or all of my patients?** Exhibit 3 reports data for only E&M office visits (specifically, office and other outpatient E&M services, as indicated by current procedural terminology, or CPT, codes 99201-99205 and 99211-99215), whereas subsequent exhibits report data for *all* E&M codes, including emergency department visits, visits provided to hospitalized patients or those in nursing homes, and consultations.
- 5. How can my report indicate in Exhibit 3 that I billed for at least 10 percent of the costs of patients whose care I directed (or influenced) but then subsequently tell me that detailed directed (or influenced) care information is not displayed because these patients did not account for at least 10 percent of my total costs?** The percentage in Exhibit 3 shows, for the physician's typical directed (or influenced) patient, the percentage of that patient's overall costs billed by the physician. By contrast, whether the subsequent breakdown for directed (or influenced) care is displayed depends in part on whether the physician's per capita costs for patients whose care the physician directed (or influenced) exceeded 10 percent of all costs the physician billed for all patients treated. For example, suppose that a physician influenced the care of a single patient with total costs of \$10,000, billing for 25 percent (or \$2,500) of all professional costs billed by any physician for that patient in 2010. Suppose further that the same physician also directed or contributed to the care of an additional 50 patients and billed a total of \$125,000 in professional services claims to Medicare during 2010. Then, even though the physician billed for 25 percent of the influenced patient's total costs, the \$2,500 billed for that patient represented less than 10 percent ($\$2,500/\$125,000 = 2$ percent) of all costs billed by the physician for all patients. Consequently, no subsequent cost breakdown would be reported for the physician's influenced care patient.
- 6. It seems inconsistent for the Highlights page to show that my risk-adjusted costs are above average while Exhibit 4 (or Exhibit 7 or Exhibit 9) indicates that my risk-adjusted costs are below average.** Risk-adjusted costs reported on the Highlights page capture the costs of all treated beneficiaries, whereas risk-adjusted costs reported elsewhere are specific to levels of care (directed, influenced, or contributed) or chronic condition subgroups. It is conceivable that a physician could have lower risk-adjusted costs compared to one benchmark but higher risk-adjusted costs on measures reflecting different patient population. This is most likely to cause confusion among physicians who neither

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direct nor influence care. For example, suppose that a physician did not direct or influence care in 2010 but contributed to the care of patients with a risk-adjusted cost of \$10,000 per patient. Suppose further that the physician's peer group contributed to the care of a few patients with a risk-adjusted cost of \$12,000 per patient but also directed or influenced the care of many patients with a risk-adjusted per capita cost of \$4,000 per patient, resulting in a per capita cost for the physician's peers when all of the physician's peers' patients are considered together (without regard to level of care) of \$6,000. In such a situation, the physician who only contributed to care will have higher than average costs—\$10,000 versus \$6,000—when compared with peers' overall costs (the Highlights page) but lower than average costs—\$10,000 versus \$12,000—when compared with peers' costs for contributed care.

- 7. Why is the number of patients attributed to me in the quality section of the report higher than the number attributed to me in the cost section?** For the purpose of computing claims-based measures, physicians are given data for all patients whom they treated, i.e., submitted a claim to Medicare. For cost measures, however, physicians are given data only for those patients whose costs were risk adjusted. Prior to risk adjusting, beneficiaries whose total costs were in the bottom one percent of all beneficiaries' costs were dropped due to concerns about the accuracy of their claims. Thus, for many physicians, the number of patients included in cost measures will be lower than the number included in quality measures by about one percent.
- 8. My costs are high because my patients are sicker; this program appears to encourage physicians to drop their sickest patients.** All costs have been payment-standardized and risk-adjusted wherever possible to make comparisons fair.
- 9. The total number of physicians treating my attributed patients seems very high.** Other profiling efforts may cite a smaller number of physicians treating a typical patient. However, these efforts often do not include radiologists, anesthesiologists, and pathologists, whereas the QRURs do. For example, a patient who has two blood tests on different dates might have those tests interpreted by two different pathologists. By contrast, a patient who sees a cardiologist on two different dates more likely will see the same cardiologist both times.
- 10. Why is the number of physicians treating my attributed patients significantly higher on the Highlights page than in Exhibit 5?** The number of physicians on the Highlights page is the average number of physicians treating all patients whom the physician saw during the year, whereas Exhibit 5 reports the number of other physicians treating only those patients whose care the physician directed.
- 11. Why does Exhibit 1 report a different number of diabetes patients (for the diabetes measures) than Exhibit 11?** Somewhat different definitions are used to define diabetes in the two exhibits, which results in different total numbers of diabetes patients. In particular, the claims-based quality measures in Exhibit 1 use a more restrictive set of conditions to identify diabetes than the per capita cost measures in Exhibit 11.
- 12. My QRUR identifies me with a different specialty than I list in the National Plan and Provider Enumeration System (NPPES) and/or the Provider Enrollment, Chain, and Ownership System (PECOS).** For the purposes of the QRUR, a physician's medical specialty was determined by the two-digit CMS specialty code that physician listed most frequently on claims billed to Medicare in 2010. This most frequently reported specialty might or might not match the specialty that the physician reported to NPPES and/or PECOS.