MLN Connects™

National Provider Call

How to Interpret Your 2012 Supplemental Quality and Resource Use Report (QRUR)

August 13, 2014

National Provider Call

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

- **Introduction**
- CMS' Approach to Episodes of Care
- Interpreting Your 2012 Supplemental Quality and Resource Use Report
- Summary of the 2012 Reports
- Accessing Your Report
- Providing Feedback
- Questions & Answers

Introduction to the 2012 Supplemental QRURs

- Distributed to medical group practices with 100 or more eligible professionals (EPs)
  - Confidential and for informational purposes
- Supplement the per capita total cost and quality information provided in the 2012 QRURs
- Medicare fee-for-service patients only
- 26 episode types
  - Chronic condition episodes
  - Acute condition episodes
  - Procedure-based episodes

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- **CMS' Approach to Episodes of Care**
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Why CMS is Developing Episodes of Care

- CMS's quality strategy:
  - Improve health
  - Improve quality of care
  - Lower medical costs
- Episodes of care
  - Organize medical claims into clinically relevant units for analysis
  - Provide actionable information on resource use
  - Can be linked to meaningful outcomes
  - Can be used to improve care
- Medicare-specific episodes of care
  - Ensure transparency
  - Address complexity of Medicare patients and Medicare's unique payment rules

Basic Model of an Episode

1. Begin episode:
   - Clinical “trigger” event, such as:
     - Inpatient hospital admission
     - Claim with diagnosis/procedure information indicating the presence of the index condition/procedure
2. Collect (group) services and procedures:
   - Clinically relevant
   - Occur during the episode time period
     - Some episodes include services and procedures occurring a few days prior to the ‘trigger’ event
3. End episode:
   - A break in service, or
   - A fixed time period after the trigger event

Clinically Relevant Services

- Clinical reviewers identified relevant services specific to each episode
- Types of services considered for relevance:
  - treatments
  - care for typical signs and symptoms
  - complications of the condition itself or its usual treatments
  - diagnostic tests
  - post-acute care

CMS's Approach to Episodes

- Two methods are used to group clinically relevant services
- Both group clinically related medical services to specific conditions and procedures within a given length of time
- Differences in grouping criteria:

  Method A (20 episodes):
  - Based on relevant services and diagnostic codes on any type of claim (not service or setting specific)
  - Includes complementary services grouped to specific services (e.g., IV contrast to CT scan with contrast)

  Method B (6 episodes):
  - Based on context of medical events occurring during episode
  - Adapted from the basic episode model used for the Medicare Spending Per Beneficiary (MSPB) measure

Episodes in the 2012 Supplemental QRURs *(1 of 2)*

Condition Episodes (Subtypes Indented)	Method
1. Acute coronary syndrome (ACS) (all) 2. ACS with coronary artery bypass graft (CABG) 3. ACS with percutaneous coronary intervention (PCI) 4. ACS without PCI or CABG	A
5. Cellulitis	B
6. Chronic atrial fibrillation/flutter	A
7. Chronic congestive heart failure (CHF)	A
8. Chronic obstructive pulmonary disease (COPD)/asthma	A
9. Acute COPD/asthma, inpatient exacerbation	A
10. Gastrointestinal (GI) hemorrhage	B
11. Ischemic heart disease (IHD) (all) 12. IHD without ACS 13. IHD with ACS	A
14. Kidney/urinary tract infection	B
15. Pneumonia (all) 16. Pneumonia without inpatient (IP) hospitalization 17. Pneumonia with IP hospitalization	A

Episodes in the 2012 Supplemental QRURs *(2 of 2)*

Procedural Episodes (Subtypes Indented)	Method
18. Bilateral cataract removal with lens implant*	A
19. CABG (all) 20. CABG without ACS	A
21. Hip replacement/revision	B
22. Knee replacement/revision	B
23. Lumbar spine fusion/refusion	B
24. PCI (all) 25. PCI without ACS	A
26. Permanent pacemaker system replacement/insertion	A

**Bilateral cataract removal with lens implant episode include both sequential and same-day procedures; 2.4 percent of bilateral cataract surgery episodes were same-day procedures*

Medical Group Attribution

- Episodes are assigned to the group practice (TIN) determined to be the most responsible for the patient's care
- Criteria for assignment:
  - **Chronic condition episodes**:
    - The plurality of outpatient evaluation and management (E&M) visits during the episode
  - **Acute condition episodes**:
    - **Inpatient:** the plurality of inpatient hospital E&M visits during the trigger event
    - **Outpatient:** the plurality of outpatient E&M visits during the episode
  - **Procedural episodes:**
    - Performance of specific procedures
- More information on medical group attribution can be found in the *Detailed Methods* documentation on this CMS webpage

Comparing to the National Sample

- Episode costs are reported relative to a national sample
  - All Medicare FFS beneficiaries nationally who had a claim in 2012 that triggered an episode
  - Approximately 8.8 million beneficiaries

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Supplemental QRURs Overview

- Reports include 3 Exhibits and 3 Drill Down Tables
  - The 2012 Supplemental QRURs (or **Exhibits**) provide results for the sum of all instances of the episodes attributed to the group
  - The 2012 Supplemental QRURs Drill Down Tables (or **Drill Down Tables**) provide detailed information for each instance of the episodes attributed to the group
- Episode costs are payment-standardized and risk-adjusted, unless otherwise noted
- Results should be interpreted with caution, especially when based on small numbers

Introductory Page

Medicare Fee-For-Service
2012 Supplemental QRUR: Episodes of Care

June 2, 2014

The Centers for Medicare & Medicaid Services (CMS), through its contractor Acumen, LLC (Acumen), is provi
these supplemental reports regarding episode-based payments related to the 2012 Group Quality and Resource U
Reports (QRURs) to HIPAA Covered Entity (CE) providers and providers under a HIPAA Business Associate (
agreement.

This report is limited to 17 major episode types and an additional 9 episode subtypes, resulting in 26 total reporte
episodes. The 26 reported episodes can be classified into condition episodes and procedural episodes and include
following:

Condition Episodes
1. Acute coronary syndrome (ACS) (all)
2. ACS without PCI/CABG
3. ACS with PCI
4. ACS with CABG
5. Cellulitis
6. Chronic atrial fibrillation/flutter
7. Chronic congestive heart failure (CHF)
8. Chronic obstructive pulmonary disease (COPD)/asthma
9. Acute COPD/asthma, inpatient exacerbation
10. Gastrointestinal (GI) hemorrhage
11. Ischemic heart disease (IHD) (all)
12. IHD without ACS
13. IHD with ACS
14. Kidney/urinary tract infection
15. Pneumonia (all)
16. Pneumonia without IP hospitalization
17. Pneumonia with IP hospitalization

Procedural Episodes:
18. Bilateral cataract removal with lens implant
19. Coronary artery bypass graft (CABG) (all)
20. CABG without ACS
21. Hip replacement/revision
22. Knee replacement/revision
23. Lumbar spine fusion/refusion
24. Percutaneous coronary intervention (PCI) (all)
25. PCI without ACS
26. Permanent pacemaker system replacement/ins

Complete technical documentation for this report, including definitions for terms in bold below, can be found in the Detailed Methods documentation.
All payment data use payment standardization to remove differences in episode cost due to geographic variation in Medicare payment rates. All payment data reflect allowed charges, which include Medicare trust fund payments as well as beneficiary deductible and coinsurance. Selected payment data are risk-adjusted to account for differences in patient characteristics that may affect costs.

- Complete technical documentation for the reports is available in the Detailed Methods, which can be found by clicking on the link in the reports
- These reports are for informational purposes only and do not currently impact Medicare payments or Physician Fee Schedule Value-based Payment Modifier calculations.

Exhibit Tables

- **Exhibit 1:** Summary information for all episodes attributed to your medical group practice
  - Your group's frequency and average risk-adjusted cost
  - National frequency and average risk-adjusted cost
- **Exhibit 2:** Service category breakdown
  - Your group's utilization and non-risk-adjusted cost
  - National utilization and non-risk-adjusted cost
- **Exhibit 3:** Reserved for future use
- **Exhibit 4:** Highest-billing facilities and EPs
  - Highest-billing hospitals, SNFs, HHAs, and EPs inside and outside your medical group practice

Exhibit 1: Episode Group Performance Compared to National Averages *(1 of 2)*

- Reports the group's average risk-adjusted cost for each episode type
- Compares to the national average

	EPISODE FREQUENCY			EPISODE COST		Percent Cost Difference from National Average for Your Group's Episodes
	Your Group's Number of Episodes	Your Group's Subtype Frequency	National Subtype Frequency	Your Group's Average Risk-Adjusted Cost	National Average Risk-Adjusted Cost	← Better than National Average
CONDITION EPISODES						
Pneumonia (all)	116	100%	100%	$16,990	$13,292	28%
-Pneumonia w/o IP hospitalization	18	16%	30%	$1,585	$819	94%
-Pneumonia with IP hospitalization	98	84%	70%	$19,671	$18,039	9%

The terms "cost," "spending," and "resource use" are used interchangeably, and all denote Medicare FFS paid claims. Episode costs presented are payment-standardized unless otherwise noted.

Exhibit 1: Episode Group Performance Compared to National Averages *(2 of 2)*

National Cost Comparisons

Percent Cost Difference

	EPISODE FREQUENCY			EPISODE COST		Percent Cost Difference from National Average for Your Group's Episodes
	Your Group's Number of Episodes	Your Group's Subtype Frequency	National Subtype Frequency	Your Group's Average Risk-Adjusted Cost	National Average Risk-Adjusted Cost	← Better than National Average
CONDITION EPISODES						
Pneumonia (all)	116	100%	100%	**$16,990**	**$13,292**	28%
-Pneumonia without IP hospitalization	18	16%	30%	**$1,585**	**$819**	94%
-Pneumonia with IP hospitalization	98	84%	70%	**$19,671**	**$18,039**	9%

Exhibit 2: Service Category Breakdown *(1 of 3)*

- Reports the contribution of various services to total costs within each episode type
- Non-risk-adjusted costs are shown in this exhibit because risk adjustment occurs at the entire episode level
  - See Section 6 and Appendix F in the *Detailed Methods* document on this CMS webpage for more information on risk adjustment (and other technical details)

Exhibit 2: Service Category Breakdown *(2 of 3)*

Group's Percent Beneficiaries Receiving Service

All Episodes Nationally

Service Category	EPISODES ATTRIBUTED TO YOUR MEDICAL GROUP PRACTICE					ALL EPISODES NATIONALLY		
	Average Utilization	% Beneficiaries Receiving Service	Average Non-Risk-Adjusted Cost	% Difference in Average Non-Risk-Adjusted Cost from National Average	% Cost Ordered by Other Groups	Average Utilization	% Beneficiaries Receiving Service	Average Non-Risk-Adjusted Cost
CONDITION EPISODE TYPES								
All pneumonia (n=116)								
All Services	n/a	*n/a*	$16,434	18%	14%	*n/a*	*n/a*	$13,878
Post-Acute Care								
Home Health	5.1 Visits	18%	$618	65%	22%	2.2 Visits	13%	$374
Skilled Nursing	1.4 Days	10%	$674	-74%	49%	5.3 Days	18%	$2,578
Inpatient Rehabilitation or Long Term Care Hospital	2.1 Days	11%	$2,930	115%	24%	0.9 Days	4%	$1,360

An "n/a" occurs for the "All Services" category because the columns are not relevant at the cumulative service level.

Exhibit 2: Service Category Breakdown *(3 of 3)*

Percent Difference from National Average

All Episodes Nationally

Service Category	EPISODES ATTRIBUTED TO YOUR MEDICAL GROUP PRACTICE					ALL EPISODES NATIONALLY		
	Average Utilization	% Beneficiaries Receiving Service	Average Non-Risk-Adjusted Cost	% Difference in Average Non-Risk-Adjusted Cost from National Average	% Cost Ordered by Other Groups	Average Utilization	% Beneficiaries Receiving Service	Average Non-Risk-Adjusted Cost
CONDITION EPISODE TYPES								
All pneumonia (n=116)								
All Services	n/a	*n/a*	$16,434	18%	14%	*n/a*	*n/a*	$13,878
Post-Acute Care								
Home Health	5.1 Visits	18%	$618	65%	22%	2.2 Visits	*13%*	$374
Skilled Nursing	1.4 Days	10%	$674	-74%	49%	5.3 Days	*18%*	$2,578
Inpatient Rehabilitation or Long Term Care Hospital	2.1 Days	11%	$2,930	115%	24%	0.9 Days	*4%*	$1,360

Non-risk-adjusted costs are shown because risk adjustment occurs at the entire episode level. Averages include episodes with no utilization in that service category.

Exhibit 4: Five Highest-Billing Facilities and EPs Within and Outside Your Group Practice

- Combine this data with the episode-specific information provided in the Drill Down Tables to pinpoint facilities and EPs that have the greatest influence on the episode costs

Exhibit 3 is reserved for future use and is not included in this presentation.

Category	Billed, Ordered, or Referred By EPs Within Your Medical Group Practice	Billed, Ordered, or Referred By EPs Not in Your Medical Group Practice
ALL EPISODE TYPES		
Hospitals	HOSPITAL A	HOSPITAL B
	HOSPITAL C	HOSPITAL A
	HOSPITAL D	HOSPITAL E
	HOSPITAL E	HOSPITAL C
	HOSPITAL F	HOSPITAL F
SNFs	SKILLED NURSING A	SKILLED NURSING B
	SKILLED NURSING B	SKILLED NURSING C
	SKILLED NURSING D	
	SKILLED NURSING E	
HHAs	HOME HEALTH A	HOME HEALTH B
	HOME HEALTH C	HOME HEALTH D
	HOME HEALTH B	HOME HEALTH A
	HOME HEALTH D	HOME HEALTH C
	HOME HEALTH E	
CONDITION EPISODE TYPES		
All ACS (# of EPs =595)		
Top 5 EPs	Dr. A	Dr. B
	Dr. C	Dr. D
	Dr. E	Dr. F
	Dr. G	Dr. H
	Dr. I	Dr. J

Drill Down Tables

- Detailed episode-specific information
  - Supplements the group-level information in Exhibits 1 through 4
  - Can be exported as a spreadsheet for filtering or sorting to identify trends in the use of a specific service or hospital
- **Table 1:** Attribution and total cost information
  - Understand and verify episode attribution
- **Table 2:** Episode costs within your group practice
  - Analyze episode costs from claims billed, ordered, or referred by EPs within your group practice
- **Table 3:** Episode costs outside your group practice
  - Analyze episode costs from claims billed, ordered, or referred by EPs outside your group practice

To accommodate space constraints, some slides in this presentation show only part of the Drill Down Table.

Drill Down Tables: Beneficiary/Episode Information

- **Information about the beneficiary and episode is presented at the start of each of the Drill Down Tables**
- The episode start date, beneficiary Health Insurance Claim (HIC) number, and beneficiary date of birth is reported as blank in this presentation and on the sample report to protect patient privacy

Beneficiary/Episode Information					
Episode ID	**Beneficiary HIC**	**Gender**	**Date of Birth**	**Episode Type**	**Episode Start Date**
1000000000000010		F		GI hemorrhage	
1000000000000011		M		Chronic CHF	
1000000000000012		M		IHD with ACS	
1000000000000013		F		IHD without ACS	
1000000000000014		F		Kidney/urinary tract infection	
1000000000000018		M		Pneumonia with IP hospitalization	
1000000000000019		M		Pneumonia without IP hospitalization	

The episode ID and beneficiary HIC appear on each line of the Drill Down Tables and act as unique identifiers.

Drill Down Table 1 *(1 of 4)*

- **Details attribution and total cost information for each episode attributed to your medical group practice**
  - Documents why the episode was attributed to your group
  - Summarizes each patient's relative health status
  - Provides each episode's risk-adjusted cost compared with the national sample of episodes of the same type and subtype

Drill Down Table 1: Attribution *(2 of 4)*

Procedural Episode Attribution: Based on who performed the triggering procedure.

Condition Episode Attribution: Based on evaluation and management (E&M) visits billed by your medical group.

TABLE 1. Attribution Information

Apparent Lead Eligible Professional (EP)	Apparent Lead EP's Specialty	Total Physician Fee Schedule (PFS) Cost (Non-Standardized)	PFS Cost Billed by Your Group (Non-Standardized)	% of PFS Costs Billed by Your Group	Total E&M Visits	E&M Visits Billed by Your Group	% of E&M Visits Billed by Your Group
Dr. L	Cardiology	$1,389	$542	39%	13	7	54%
Dr. J	Cardiology	$99	$99	100%	2	2	100%
Dr. B	Cardiology	$63	$63	100%	1	1	100%
Dr. H	Internal Medicine	$301	$194	65%	3	3	100%
Dr. D	Cardiology	$665	$355	53%	1	1	100%
Dr. K	Pulmonary Disease	$2,724	$2,220	82%	15	14	93%
Dr. G	Pulmonary Disease	$630	$413	66%	1	1	100%

See Section 5 in the Detailed Methods document on this CMS webpage for more information on the attribution methodology. The episode ID and beneficiary HIC appear on each line of the Drill Down Tables and act as unique identifiers.

Drill Down Table 1: Attribution *(3 of 4)*

Your Medical Group Involvement:

The percent of physician fee schedule (PFS) costs and E&M visits billed by your group may help your group identify potential drivers of cost and utilization.

TABLE 1. Attribution Information

Apparent Lead Eligible Professional (EP)	Apparent Lead EP's Specialty	Total Physician Fee Schedule (PFS) Cost (Non-Standardized)	PFS Cost Billed by Your Group (Non-Standardized)	% of PFS Costs Billed by Your Group	Total E&M Visits	E&M Visits Billed by Your Group	% of E&M Visits Billed by Your Group
Dr. L	Cardiology	$1,389	$542	39%	13	7	54%
Dr. J	Cardiology	$99	$99	100%	2	2	100%
Dr. B	Cardiology	$63	$63	100%	1	1	100%
Dr. H	Internal Medicine	$301	$194	65%	3	3	100%
Dr. D	Cardiology	$665	$355	53%	1	1	100%
Dr. K	Pulmonary Disease	$2,724	$2,220	82%	15	14	93%
Dr. G	Pulmonary Disease	$630	$413	66%	1	1	100%

See Section 5 in the Detailed Methods document on this CMS webpage for more information on the attribution methodology. The episode ID and beneficiary HIC appear on each line of the Drill Down Tables and act as unique identifiers.

Drill Down Table 1: Total Costs *(4 of 4)*

Episode Risk Score Ranking: A higher risk score indicates that the patient is more complex relative to other patients with episodes of the same subtype.

Risk-Adjusted Cost Percentile: Examine how costs for an episode compare to the national average cost for its major episode type and within its subtype.

TABLE 1 (cont.). Total Cost Information

Risk Score Percentile in Episode Subtype Nationally (99 is highest)	Non-Risk-Adjusted Cost	Risk-Adjusted Cost Percentile in Major Episode Type Nationally (99 is highest)	Risk-Adjusted Cost Percentile in Episode Subtype Nationally (99 is highest)
97	$8,434	6	6
19	$237	15	15
3	$3,016	96	47
33	$1,569	84	86
26	$7,246	17	17
20	$74,280	99	98
11	$1,722	29	96

The episode ID and beneficiary HIC appear on each line of the Drill Down Tables and act as unique identifiers.

Drill Down Table 2 *(1 of 3)*

- **Details the episode costs from services billed, ordered, or referred by EPs <u>within</u> your medical group practice**
  - Find opportunities for improvement in care coordination
  - Identify facilities or providers **<u>within</u>** your medical group practice that are high cost, high utilization, and
  - Identify which services contribute most to the costs of each episode

See Section 6 and Appendix F in the Detailed Methods document on this CMS webpage for more information on how costs were identified as costs billed or ordered within your medical group.

Drill Down Table 2: Episode Costs Within Your Medical Group Practice *(2 of 3)*

Your Group's Facilities:
Find opportunities for improvement in care coordination and management by identifying facilities in which **your medical group practice** billed, ordered, referred, or provided care for the patient.

Total Cost Within Your Medical Group:
Examine the sum of costs from services billed, ordered, or referred by **your medical group practice.**

TABLE 2. Breakdown of Episode Costs from Claims Billed, Ordered, or Referred by EPs WITHIN YOUR MEDICAL GROUP PRACTICE

# EPs Within Your Medical Group Practice Treating Episode	Hospital Where Your Medical Group Practice Provided Care Earliest in Episode	Hospital Where Your Medical Group Practice Provided Care Second in Episode	Skilled Nursing Facilities or Home Health Agencies Referred/ Ordered by Your Medical Group Practice Earliest in Episode	Skilled Nursing Facilities or Home Health Agencies Referred/ Ordered by Your Medical Group Practice Second in Episode	All Cost (Non-Risk-Adjusted)
1	HOSPITAL A	HOSPITAL F			$7,237
1	HOSPITAL A				$237
1	HOSPITAL A				$3,016
2	HOSPITAL A				$1,367
1	HOSPITAL B				$6,947
2	HOSPITAL A	HOSPITAL J			$74,092
1	HOSPITAL A				$1,710

The episode ID and beneficiary HIC appear on each line of the Drill Down Tables and act as unique identifiers.

Drill Down Table 2: Service Costs Within Your Medical Group Practice *(3 of 3)*

Service Categories:
Examine the total cost and cost breakdown, by service category, from services billed, ordered, or referred by **your medical group practice.**

TABLE 2 (cont.). Breakdown of Episode Costs from Claims Billed, Ordered, or Referred by EPs WITHIN YOUR MEDICAL GROUP PRACTICE

Inpatient Hospital			Post-Acute Care			Outpatient Hospital and Physician Office Services				
Inpatient Hospital: Trigger	Inpatient Hospital: Readmission	Physician Services During Hospitalization	Skilled Nursing	Home Health	Inpatient Rehabilitation or Long Term Care Hospital	Outpatient PT/OT/SLP	Dialysis	Evaluation & Management Services	Major Procedures and Anesthesia	Ambulatory/ Minor Procedures
$6,551	$0	$663	$0	$0	$0	$0	$0	$0	$0	$0
$0	$0	$0	$0	$0	$0	$0	$0	$214	$0	$0
$0	$2,888	$0	$0	$0	$0	$0	$0	$129	$0	$0
$0	$0	$0	$0	$0	$0	$0	$0	$422	$0	$0
$6,613	$0	$334	$0	$0	$0	$0	$0	$0	$0	$0
$30,598	$0	$1,975	$0	$0	$41,518	$0	$0	$0	$0	$0
$0	$0	$702	$0	$0	$0	$0	$0	$606	$0	$0

The episode ID and beneficiary HIC appear on each line of the Drill Down Tables and act as unique identifiers.

Drill Down Table 3

- **Similar to Drill Down Table 2**
- **Details the episode costs from services billed, ordered, or referred by EPs outside your medical group practice**
  - Find opportunities for improvement in care coordination and management
  - Identify which facilities or providers **outside** your medical group are high cost, high utilization, and
  - Identify which services contribute most to the costs of each episode

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Summary of the 2012 Reports *(1 of 2)*

- The Addendum on this CMS webpage has detailed summary statistics of the 2012 Supplemental QRURs
  - Summary statistics on average risk-adjusted costs and service category cost drivers
  - Attribution to medical group practice and identification of apparent lead eligible professional (EP)
  - Results of reliability testing
- The Addendum will also be available approximately one week following the call on the Call Details webpage

Summary of the 2012 Reports *(2 of 2)*

- **High-cost episodes driven by certain service categories**
  - **Acute condition and procedural episodes:** post-acute care spending and readmissions
  - **Chronic condition episodes:** acute exacerbation and post-acute care spending
- **Attribution to medical group practices**
  - Majority of episodes were attributed based on the plurality of evaluation & management (E&M) visits during the trigger event or episode
- **Reliability testing**
  - Most episodes have a high or moderate reliability, indicating that the episode grouping and attribution methodologies consistently distinguish performance between groups

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Accessing the Reports *(1 of 2)*

- Authorized representatives of group practices can view the Supplemental QRURs at https://portal.cms.gov using their Individuals Authorized Access to the CMS Computer Services (IACS) user ID and password
- Authorized representatives of group practices will need an IACS account with one of the following group-specific PV-PQRS Registration System roles to get the group's Supplemental QRUR:
  - Primary PV-PQRS Group Security Official
  - Backup PV-PQRS Group Security Official
  - PV-PQRS Group Representative

Accessing the Reports *(2 of 2)*

- If you have an existing IACS account,
  - Ensure your account is still active by contacting the QualityNet Help Desk
  - Add a group-specific PV-PQRS Registration System role to your account
- If you do not have an IACS account with a group-specific PV-PQRS Registration System role, sign up for a new IACS account
  - IACS website: https://applications.cms.hhs.gov/
- Quick reference guide for obtaining an IACS account or modifying an existing account is on this CMS webpage
- For questions about your report, please contact the Physician Value (PV) Helpdesk at 888-734-6433, option 3, 8 AM – 8 PM ET Monday through Friday

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Giving Feedback on the 2012 Supplemental QRURs

- Potential topics for feedback include:
  - **Episode types and subtypes**: Clinically-defined conditions or procedures that have similar expected medical resource use
  - **Episode clinical logic:** Clinical reasoning used in the grouping algorithms, such as episode windows, the medical diagnoses, services, or procedures included within an episode
  - **Attribution to medical group practices**: Assignment of episodes to the responsible medical group practice
  - **Report content and structure:** Types and adequacy of information included in the reports, understandability of the reports, and actionability of the information
- To submit written comments and suggestions on the above topics, please send an email QRUR@cms.hhs.gov

Further Information

- For further information on the 2012 Supplemental QRURs, please see: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html
- Documents available on this webpage include:
  - Detailed methodology for the 2012 Supplemental QRURs
  - Tips for understanding and using the Supplemental QRURs
  - Responses to frequently asked questions (FAQs)
  - Instructions for medical group practices with 100+ EPs to access their 2012 Supplemental QRURs
  - Episode Definitions
  - Episode Risk Factors
  - A sample 2012 Supplemental QRUR

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Question & Answer Session

Evaluate Your Experience

- Please help us continue to improve the MLN Connects™ National Provider Call Program by providing your feedback about today's call
- To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call

CME and CEU

- This call is being evaluated by CMS for CME and CEU continuing education credit. For more information about continuing education credit, review CE Activity Information & Instructions available at the link below for specific details:

  http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TC-L08132014-Marketing-Materials.pdf

Thank You

- For more information about the MLN Connects™ National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html

- For more information about the Medicare Learning Network® (MLN), please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html