

# Medicare Fee-For-Service

## 2015 Supplemental QRUR: Episodes of Care

### Sample Practice Name - 0000

Measurement Period: 01/01/2015 - 12/31/2015

The 2015 Supplemental Quality and Resource Use Reports (QRURs) provide information to medical group practices and solo practices on their resource utilization for the management of episodes of care (“episodes”) for their Medicare fee-for-service (FFS) patients. The 2015 Supplemental QRURs are for informational purposes only and provide actionable and transparent information on resource use to assist medical group practices and solo practices, as identified by their Medicare-enrolled tax identification number (TIN), in improving their practice efficiency. This report is limited to 23 major episode types and an additional 44 episode subtypes, resulting in 67 total reported episode types. The 67 reported episode types can be classified into condition episode types and procedural episode types and include the following:

#### Condition Episode Types

1. Acute Myocardial Infarction (AMI) (All)
  2. AMI NSTEMI without PCI/CABG
  3. AMI NSTEMI with PCI
  4. AMI NSTEMI with CABG
  5. AMI STEMI without PCI/CABG
  6. AMI STEMI with PCI
  7. AMI STEMI with CABG
8. Asthma/Chronic Obstructive Pulmonary Disease (COPD), Acute Exacerbation
9. Atrial Fibrillation (AFib)/Flutter, Acute Exacerbation
10. Cellulitis (All)
  11. Cellulitis in Diabetics
  12. Cellulitis in Patients with Wound, Non-Diabetic
  13. Cellulitis in Obese Patients, Non-Diabetic without Wound
  14. Cellulitis in All Other Patients
15. Gastrointestinal (GI) Hemorrhage (All)
  16. GI Hemorrhage, Upper and Lower
  17. GI Hemorrhage, Upper
  18. GI Hemorrhage, Lower
  19. GI Hemorrhage, Undefined
20. Heart Failure, Acute Exacerbation
21. Ischemic Stroke
22. Kidney and Urinary Tract Infection (UTI)
23. Pneumonia, Inpatient (IP)-Based

#### Procedural Episode Types

24. Aortic Aneurysm Procedure (All)
  25. Abdominal Aortic Aneurysm Procedure
  26. Thoracic Aortic Aneurysm Procedure
27. Open Heart Valve Surgery (All)
  28. Both Aortic and Mitral Valve Surgery
  29. Aortic or Mitral Valve Surgery
  30. Pulmonary or Tricuspid Valve Surgery
31. Cholecystectomy and Common Duct Exploration (All)
  32. Cholecystectomy
  33. Surgical Biliary Tract Procedure
34. Colonoscopy (All)
  35. Colonoscopy with Invasive Procedure
  36. Colonoscopy without Invasive Procedure
37. Coronary Artery Bypass Graft (CABG)
  38. CABG with AMI
  39. CABG without AMI
40. Hip/Femur Fracture or Dislocation Treatment, IP-Based
41. Hip Replacement or Repair (All)
  42. Hip Arthroplasty
  43. Hip Arthroscopy and Hip Joint Repair
44. Knee Arthroplasty
45. Knee Joint Repair (All)
  46. Meniscus Repair
  47. Knee Ligament Repair
48. Lens and Cataract Procedures (All)
  49. Cataract Surgery
  50. Discission
  51. Intraocular Lens (IOL) Removal/Repositioning or Secondary IOL Insertion
52. Mastectomy for Breast Cancer (All)
  53. Lumpectomy or Partial Mastectomy without Reconstruction
  54. Lumpectomy or Partial Mastectomy with Reconstruction
  55. Simple or Modified Radical Mastectomy without Reconstruction
  56. Simple or Modified Radical Mastectomy with Reconstruction
  57. Subcutaneous Mastectomy
58. Percutaneous Coronary Intervention (PCI) (All)
  59. PCI, IP-Based
  60. PCI, OP-Based
61. Spinal Fusion (All)
  62. Anterior Fusion - Single
  63. Anterior Fusion - Two Levels
  64. Posterior/Posterior-lateral Approach Fusion - Single
  65. Posterior/Posterior-lateral Approach Fusion - Two or Three Levels
  66. Combined Fusions
67. Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia

The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at CMS' discretion, including but not limited to, circumstances in which an error is discovered.

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*All results should be interpreted with caution for episode types with fewer than ten episodes attributed to your TIN.*

## ABOUT THE DATA IN THIS REPORT

The 2015 Supplemental QRURs provide actionable and transparent information on episodes to assist medical group practices and solo practices in improving their practice efficiency and care coordination. These reports are for informational purposes only. The introduction presented here provides a summary of key information needed to understand the reports. The final section describes where to find more information on the episode and report methodology.

An episode is a resource use measure that includes the set of services provided to diagnose, treat, manage, and follow-up on a specified clinical condition. The episode measures in the 2015 Supplemental QRURs are created through the following steps: i) open an episode and include, or “group,” clinically-related services during a specified time period to a specific episode; ii) adjust episode costs using payment standardization and risk adjustment to remove effects outside the control of the provider managing the episode, such as Medicare payment policy and patient health status; and iii) attribute responsibility to the provider or providers that are most involved in managing the episode. The remainder of this introduction describes each of the three steps in turn.

### EPISODE CONSTRUCTION

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Episodes are opened when specific billing codes on a claim indicate the presence of the episode condition or procedure. Once an episode is opened, episode grouping methodologies implement clinical logic to parse the services provided to the beneficiary and allocate clinically relevant services to one or more episodes. The clinical logic defines relatedness of a service to an episode based on diagnosis or service codes on the claims. The total episode cost to Medicare is the sum of the payments for all grouped services that occur during the specified episode time window. (Outpatient prescription drug (Part D) costs are not included in these episodes.) The episode grouping algorithms applied in this report are specially designed for constructing episodes in the Medicare population.

### PAYMENT STANDARDIZATION AND RISK ADJUSTMENT

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Payments presented in the 2015 Supplemental QRURs reflect Medicare allowed amounts, which include both Medicare trust fund payments and beneficiary deductible and coinsurance. Payments are standardized to eliminate geographic differences and special program payments unrelated to resource use, such as disproportionate share hospital (DSH) payments, except where explicitly noted. Payment standardization assigns a standardized allowed amount for each service to facilitate comparison across providers. Furthermore, each episode’s costs to Medicare are risk adjusted to account for differences in patient characteristics (such as the presence of certain pre-existing conditions) that may affect costs to Medicare. The risk adjustment model is prospective, meaning that it predicts episode costs to Medicare using only information about the patient available at the start of the episode. A full list of risk adjustment variables is available in the 2015 Supplemental QRURs Detailed Methodology document.

## **ATTRIBUTION**

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The 2015 Supplemental QRURs attribute responsibility and report each episode to one or more medical groups or solo practices. A medical group or solo practice is represented by the single TIN under which all physicians in the group or solo practice bill for Medicare services. Within the attributed medical group(s) or solo practice(s), the reports further identify one or more lead eligible professionals (EPs) managing the episode, identified by their National Provider Identifier (NPI). The attribution method is different for acute condition and procedural episodes. Acute condition episodes are attributed to the medical group(s) or solo practice(s) that performed at least 30 percent of the inpatient (IP) evaluation and management (E&M) visits during the episode's initial hospitalization. Within each attributed medical group or solo practice, the top three EPs billing the largest number of IP E&M visits during the initial hospitalization are identified in the report. Procedural episodes are attributed to the medical group(s) or solo practice(s) billing for the procedure that opened the episode, and the lead EP is identified in the same way.

## **MORE INFORMATION**

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Complete documentation of the 2015 Supplemental QRURs can be found in the Detailed Methods document and associated files at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html>. For questions about your report, please contact the Physician Value (PV) Helpdesk at 888-734-6433 (option 3), between 8AM and 8PM ET, Monday through Friday. To submit written comments and suggestions on the Supplemental QRURs, please send an email to [pvhelpdesk@cms.hhs.gov](mailto:pvhelpdesk@cms.hhs.gov).

## Appendix 1. Definitions for Terms used in the 2015 Supplemental QRURs

This appendix shows definitions for terms used in the Exhibits and Drill Down Tables included in the 2015 Supplemental QRURs.

Exhibit	Term	Definition
All	Episode	The set of services provided to treat, manage, diagnose, and follow up on a clinical condition or treatment.
Exhibit 2	Episode Frequency	For episodes with subtypes, the average percentage of that subtype occurring within the main episode type.
Exhibit 2	Avg. Risk-Adjusted Episode Cost to Medicare	The average episode cost to Medicare after adjusting for beneficiary characteristics.
Exhibit 3	Avg. Risk-Adjusted Episode Cost to Medicare	The average episode cost to Medicare after adjusting for beneficiary characteristics.
Exhibit 3	Avg. Beneficiary Risk Score Percentile	A relative measure of your beneficiaries' predicted episode cost to Medicare, based on the risk adjustment model. A higher risk score percentile indicates that on average, your beneficiaries were predicted to have relatively higher costs to Medicare for this episode type or subtype.
Exhibit 3	Avg. % Physician Fee Schedule Costs to Medicare Billed by Your TIN During Episode	Physician Fee Schedule Costs to Medicare include any Part B claim performed by an EP with a sum of work RVU, PE RVU, and MP RVU that is greater than zero.
Exhibit 3	Clinically Associated Services (CAS)	Episode period that contains all clinically relevant grouped costs to Medicare on days in which the managing provider within your TIN did not provide care for the beneficiary.
Exhibit 3	Treatment	Episode period that contains all costs to Medicare on days in which the managing provider within your TIN cared for the beneficiary.
Exhibit 4	Clinically Associated Services (CAS)	Episode period that contains all clinically relevant grouped costs to Medicare on days in which the managing provider within your TIN did not provide care for the beneficiary.
Exhibit 4	Treatment	Episode period that contains all costs to Medicare on days in which the managing provider within your TIN cared for the beneficiary.
Exhibit 4	Inpatient Hospital: Trigger	Category that contains all costs to Medicare from the inpatient hospitalization that opened the episode.

Exhibit 4	Inpatient Hospital: Non-Trigger	Category that contains costs to Medicare from any acute or psychiatric inpatient hospitalization that did not open the episode.
Drill Down Table 1	Risk-Adjusted Cost to Medicare	The episode's cost to Medicare after adjusting for beneficiary characteristics.
Drill Down Table 1	Risk-Adjusted Cost to Medicare Percentile	A relative measure of episode cost to Medicare after adjusting for beneficiary characteristics. A higher cost percentile indicates the episode was relatively more expensive to Medicare for this episode type or subtype after risk adjustment.
Drill Down Table 1	Risk Score Percentile	A relative measure of the beneficiary's predicted episode spending. A higher risk score percentile indicates that the beneficiary was predicted to have relatively higher costs to Medicare for this episode type or subtype.
Drill Down Table 2	Risk Score Percentile	A relative measure of the beneficiary's predicted episode spending. A higher risk score percentile indicates that the beneficiary was predicted to have relatively higher costs to Medicare for this episode type or subtype.
Drill Down Table 3	Risk Score Percentile	A relative measure of the beneficiary's predicted episode spending. A higher risk score percentile indicates that the beneficiary was predicted to have relatively higher costs to Medicare for this episode type or subtype.
Drill Down Table 3	Inpatient Hospital: Trigger	Costs to Medicare from the inpatient hospitalization that opened (triggered) the episode.
Drill Down Table 3	Inpatient Hospital: Non-Trigger	Costs to Medicare from any acute or psychiatric inpatient hospitalization other than the one that opened (triggered) the episode.

## Appendix 2. Service Category Definitions for Exhibits 3 and 4 of the 2015 Supplemental QRURs

This appendix shows the service category definitions for the categories listed in Exhibit 3 and Exhibit 4 of this report. For each service category, claim type shows which of the seven Medicare claim types is considered, the BETOS column shows the Berenson-Eggers Type of Service value that needs to appear on the claim, the Place of Service/Provider Number Criterion shows any place of service requirement, and Additional Criterion lists any other requirement for a claim to be included.

Service Category		Claim Type	Criteria for Including Claim (Line Item) in Category		
			BETOS	Place of Service/Provider Number Criterion	Additional Criterion
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	Evaluation & Management Services	OP, PB	All M Codes	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	No GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis). Eligible professional or facility for PB claims.
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	Major Procedures	OP, PB	P1, P2, P3, P7	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	No GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis). Eligible professional or facility for PB claims.
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	Ambulatory/ Minor Procedures	OP, PB	P4, P5, P6, P8	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	No GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis). Eligible professional or facility for PB claims.
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	OP, PB	Not P0, P9, O1A, O1D, O1E, or D1G	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	Has a GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis).
Ancillary Services	Lab, Pathology and Other Tests	OP, PB	All I codes	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	No GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis).
Ancillary Services	Imaging Services	DM	All I codes	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	No GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis).
Ancillary Services	Durable Medical Equipment and Supplies	DM	All codes except O1D (chemotherapy), O1E and D1G (drugs)	-	-
Hospital Inpatient Services	Inpatient Hospital: Trigger	IP	-	Provider number has 00-08 in third and fourth position (Acute hospitals) or has 3rd and 4th digit = "13" (Critical Access Hospitals) or has 3rd and 4th digits in [40 - 44] or has 3rd digit in ("M", "S") (psychiatric hospitals and psychiatric distinct part units)	Acute or psychiatric inpatient hospitalization that triggered the episode
Hospital Inpatient Services	Inpatient Hospital: Non-Trigger	IP	-	Provider number has 00-08 in third and fourth position (Acute hospitals) or has 3rd and 4th digit = "13" (Critical Access Hospitals) or has 3rd and 4th digits in [40 - 44] or has 3rd digit in ("M", "S") (psychiatric hospitals and psychiatric distinct part units)	Any acute or psychiatric inpatient hospitalization other than the one that triggered the episode
Hospital Inpatient Services	Physician Services During Hospitalization	PB	Not P0-P9, O1A, O1D, O1E, or D1G	If between from_dt and thru_dt (exclusive) of IP claim, no place of service restriction. If on from_dt or thru_dt of IP claim, then place of service must be 21 or 51.	Eligible professional.
Emergency Services That Did Not Result in a Hospital Admission	Emergency Evaluation & Management Services	OP, PB	All M Codes	Outpatient revenue center line code is 0450-0459 or 0981, or PB claim occurring with place of service=23.	Type of Bill NOT 72x (Dialysis). Eligible professional for PB claims.
Emergency Services That Did Not Result in a Hospital Admission	Procedures	OP, PB	All P Codes	Outpatient revenue center line code is 0450-0459 or 0981, or PB claim occurring with place of service=23.	Type of Bill NOT 72x (Dialysis). Eligible professional for PB claims.

Emergency Services That Did Not Result in a Hospital Admission	Lab, Pathology and Other Tests	OP, PB	All T Codes	Outpatient revenue center line code is 0450-0459 or 0981, or PB claim occurring with place of service=23.	Type of Bill NOT 72x (Dialysis). Eligible professional for PB claims.
Emergency Services That Did Not Result in a Hospital Admission	Imaging Services	OP, PB	All I Codes	Outpatient revenue center line code is 0450-0459 or 0981, or PB claim occurring with place of service=23.	Type of Bill NOT 72x (Dialysis). Eligible professional for PB claims.
Post-Acute Services	Home Health	HH, OP	-	-	For OP, Type of Bill must be 33x or 34x, BETOS is not P0, P9, O1A, O1D, O1E, or D1G. Revenue Center line code is NOT 0450-0459 or 0981.
Post-Acute Services	Skilled Nursing Facility	SNF, OP	-	-	For OP, Type of Bill must be 33x or 34x, BETOS is not P0, P9, O1A, O1D, O1E, or D1G. Revenue Center line code is NOT 0450-0459 or 0981.
Post-Acute Services	Inpatient Rehabilitation or Long Term Care Hospital	IP	-	Provider number ends in 2000-2299 or 3025-3099, or its third position is either R or T.	-
Hospice Care	Hospice	HS	-	-	-
All Other Services	Ambulance Services	OP, PB	O1A	-	For OP, type of bill is NOT 72x (dialysis).
All Other Services	Chemo. And Part B Drugs	OP, PB, DM	O1D, O1E, D1G	-	For OP, type of bill is NOT 72x (dialysis).
All Other Services	Dialysis	OP, PB	P9	For OP, also count Type of Bill equal to 72x.	-
All Other Services	Anesthesia Services	OP, PB	P0	-	For OP, type of bill is NOT 72x (dialysis).
All Other Services	All Other Services Not Otherwise Classified	All Parts A and B claim types	-	-	All remaining costs from all Parts A and B claim types.



### Appendix 3. Service Category Definitions for the Drill Down Tables of the 2015 Supplemental QRURs

This appendix shows the service category definitions for the categories listed in Exhibit 3 and Exhibit 4 of this report. For each service category, claim type shows which of the seven Medicare claim types is considered, the BETOS column shows the Berenson-Eggers Type of Service value that needs to appear on the claim, the Place of Service/Provider Number Criterion shows any place of service requirement, and Additional Criterion lists any other requirement for a claim to be included.

Drilldown Categories		Claim Type	Criteria for Including Claim (Line Item) in Category		
PB	Non-PB		BETOS	Place of Service Criterion	Additional Criterion
E&M Services	Outpatient Hospital Services - E&M Services	OP, PB	All M Codes	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	No GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis). Eligible professional or facility for PB claims.
Major Procedures	Outpatient Hospital Services - Major Procedures	OP, PB	P1, P2, P3, P7	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	No GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis). Eligible professional or facility for PB claims.
Ambulatory/Minor Procedures	Outpatient Hospital Services - Ambulatory/Minor Procedures	OP, PB	P4, P5, P6, P8	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	No GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis). Eligible professional or facility for PB claims.
All Other Services	Outpatient Hospital Services - Outpatient PT/ OT/ SLP	OP, PB	Not P0, P9, O1A, O1D, O1E, or D1G	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	Has a GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis).
Lab/ Pathology/ Other Tests	Other Services - All Other Services Not Otherwise Classified	OP, PB	All T codes	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	No GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis).
Imaging	Other Services - All Other Services Not Otherwise Classified	OP, PB	All I codes	Place of Service not equal to 23 (emergency department), and not concurrent to IP Stay (not under service category '02').	No GN, GO, or GP modifier (outpatient therapy). Revenue Center line code is NOT 0450-0459 or 0981 (emergency department). OP cannot have Bill type 22, 23, 33, 34, or 72 (SNF, HH and dialysis).
-None-	Other Services - DME/Supplies	DM	All codes except O1D (chemotherapy), O1E and D1G (drugs)	-	-
-None-	Inpatient Hospital: Trigger	IP	-	Provider number has 00-08 in third and fourth position (Acute hospitals) or has 3rd and 4th digit = "13" (Critical Access Hospitals) or has 3rd and 4th digits of 40 - 44 or has 3rd digit of M or S (psychiatric hospitals and psychiatric distinct part units).	Acute or psychiatric inpatient hospitalization that triggered the episode
-None-	Inpatient Hospital Services - Non-Trigger	IP	-	Provider number has 00-08 in third and fourth position (Acute hospitals) or has 3rd and 4th digit = "13" (Critical Access Hospitals) or has 3rd and 4th digits of 40 - 44 or has 3rd digit of M or S (psychiatric hospitals and psychiatric distinct part units).	Any acute or psychiatric inpatient hospitalization other than the one that triggered the episode.
Service During Hospitalization	-None-	PB	Not P0-P9, O1A, O1D, O1E, or D1G	If between from_dt and thru_dt (exclusive) of IP claim, no place of service restriction. If on from_dt or thru_dt of IP claim, then place of service must be 21 or 51.	Eligible professional.
Emergency Services That Did Not Result in Hospitalization	Emergency Services That Did Not Result in Hospitalization - E&M Services	OP, PB	All M Codes	Outpatient revenue center line code is 0450-0459 or 0981, or PB claim occurring with place of service=23.	Type of Bill NOT 72x (Dialysis). Eligible professional for PB claims.
Emergency Services That Did Not Result in Hospitalization	Emergency Services That Did Not Result in Hospitalization - Procedures	OP, PB	All P Codes	Outpatient revenue center line code is 0450-0459 or 0981, or PB claim occurring with place of service=23.	Type of Bill NOT 72x (Dialysis). Eligible professional for PB claims.

Emergency Services That Did Not Result in Hospitalization	Emergency Services That Did Not Result in Hospitalization - Lab/ Pathology/ Other Tests	OP, PB	All T Codes	Outpatient revenue center line code is 0450-0459 or 0981, or PB claim occurring with place of service=23.	Type of Bill NOT 72x (Dialysis).
Emergency Services That Did Not Result in Hospitalization	Emergency Services That Did Not Result in Hospitalization - Imaging	OP, PB	All I Codes	Outpatient revenue center line code is 0450-0459 or 0981, or PB claim occurring with place of service=23.	Type of Bill NOT 72x (Dialysis).
-None-	Post-Acute Care - Home Health	HH, OP	-	-	For OP, Type of Bill must be 33x or 34x, BETOS is not P0, P9, O1A, O1D, O1E, or D1G. Revenue Center line code is NOT 0450-0459 or 0981.
-None-	Post-Acute Care - Skilled Nursing Facility	SNF, OP	-	-	For OP, Type of Bill must be 33x or 34x, BETOS is not P0, P9, O1A, O1D, O1E, or D1G. Revenue Center line code is NOT 0450-0459 or 0981.
-None-	Post-Acute Care - Inpatient Rehabilitation or Long Term Care Hospital	IP	-	Provider number ends in 2000-2299 or 3025-3099, or its third position is either R or T.	-
-None-	Hospice Care - Hospice	HS	-	-	-
All Other Services	Other Services - All Other Services Not Otherwise Classified	OP, PB	O1A	-	For OP, type of bill is NOT 72x (dialysis).
Part B Covered Drugs	Other Services - All Other Services Not Otherwise Classified	OP, PB, DM	O1D, O1E, D1G	-	For OP, type of bill is NOT 72x (dialysis).
All Other Services	Other Services - All Other Services Not Otherwise Classified	OP, PB	P9	For OP, also count Type of Bill equal to 72x.	-
Anesthesia Services	Other Services - Anesthesia Services	OP, PB	P0	-	For OP, type of bill is NOT 72x (dialysis).
All Other Services	Other Services - All Other Services Not Otherwise Classified	All Parts A and B claim types	-	-	All remaining costs from all Parts A and B claim types.

## EXHIBIT 1. Summary of All Episode Types

This exhibit summarizes the cost to Medicare for each episode type of all episodes attributed to your TIN compared to the national average. All costs are risk-adjusted and payment-standardized.

### % Difference between Your TIN's Average Risk-Adjusted Episode Cost to Medicare and National Average Risk-Adjusted Episode Cost to Medicare

 Lower Cost to Medicare than National Average

<i>PROCEDURAL EPISODE TYPES</i>	-100%	-80%	-60%	-40%	-20%	0%	20%	40%	60%	80%	100%
<b>Cholecystectomy and Common Duct Exploration (All)</b>						<b>0%</b>					
Cholecystectomy						<b>0%</b>					
<b>Hip/Femur Fracture or Dislocation Treatment, IP-Based</b>						<b>0%</b>					
<b>Hip Replacement or Repair (All)</b>						<b>0%</b>					
Hip Arthroplasty						<b>0%</b>					
<b>Knee Arthroplasty</b>						<b>0%</b>					

## EXHIBIT 2. Frequency and Cost to Medicare for All Episode Types

This exhibit summarizes the number, frequency, and cost to Medicare of all episodes attributed to your TIN compared to the national average. All costs are risk-adjusted and payment-standardized.

	EPISODE FREQUENCY†		AVG. RISK-ADJUSTED EPISODE COST TO MEDICARE†		
	Your TIN	National	Your TIN	National	% Cost Difference
<b>PROCEDURAL EPISODE TYPES</b>					
<b>Cholecystectomy and Common Duct Exploration (All)</b>	0 (0%)	0%	\$0	\$0	0%
Cholecystectomy	0 (0%)	0%	\$0	\$0	0%
Surgical Biliary Tract Procedure	0 (0%)	0%	\$0	\$0	0%
<b>Hip/Femur Fracture or Dislocation Treatment, IP-Based</b>	0 (0%)	0%	\$0	\$0	0%
<b>Hip Replacement or Repair (All)</b>	0 (0%)	0%	\$0	\$0	0%
Hip Arthroplasty	0 (0%)	0%	\$0	\$0	0%
Hip Arthroscopy and Hip Joint Repair	0 (0%)	0%	\$0	\$0	0%
<b>Knee Arthroplasty</b>	0 (0%)	0%	\$0	\$0	0%

### EXHIBIT 3 - Cholecystectomy Episode Type Summary

This exhibit summarizes the cost to Medicare of episodes of this type attributed to your TIN. In the episode component and service category breakdowns, all costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level.

Cholecystectomy episodes include all services clinically-related to the episode that start within the episode window of 90 days.

#### EXHIBIT 3.A: Your Episode Type Summary

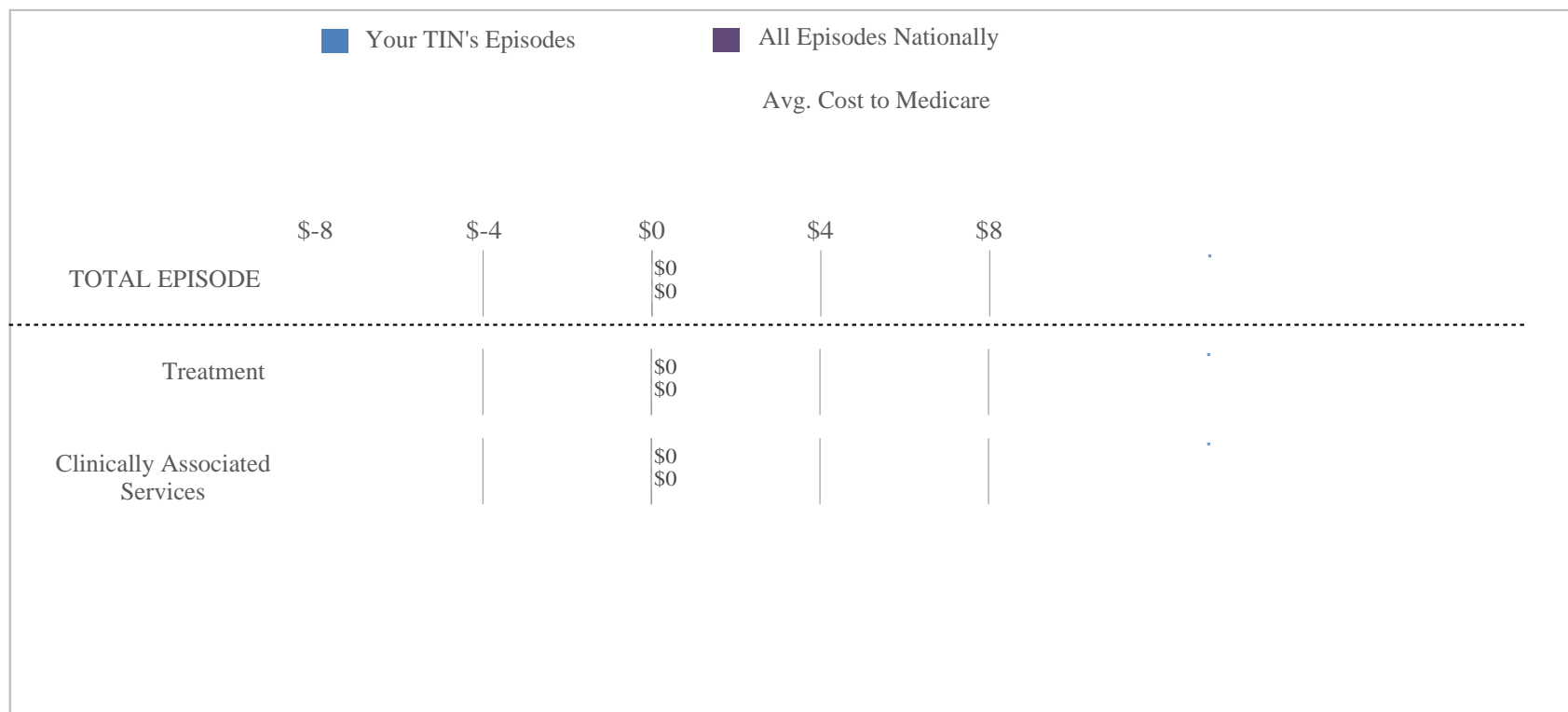
This exhibit presents summary information about your episodes. If your patient population is less complex relative to the patient population nationally within the same episode type, then your average non-risk-adjusted, payment standardized episode cost to Medicare will be lower than your average risk-adjusted episode cost to Medicare.

Your TIN's # Episodes	Your TIN's # Beneficiaries	Avg. Beneficiary Risk Score Percentile †	Avg. Non-Risk-Adjusted Episode Cost to Medicare			Avg. Risk-Adjusted Episode Cost to Medicare†			Avg. % Physician Fee Schedule Costs Billed by Your TIN During Episode†
			Your TIN	National	% Cost Difference	Your TIN	National	% Cost Difference	
0	0	0th	\$0	\$0	0%	\$0	\$0	0%	0%

† Crosses indicate terms defined through the hover-over function.

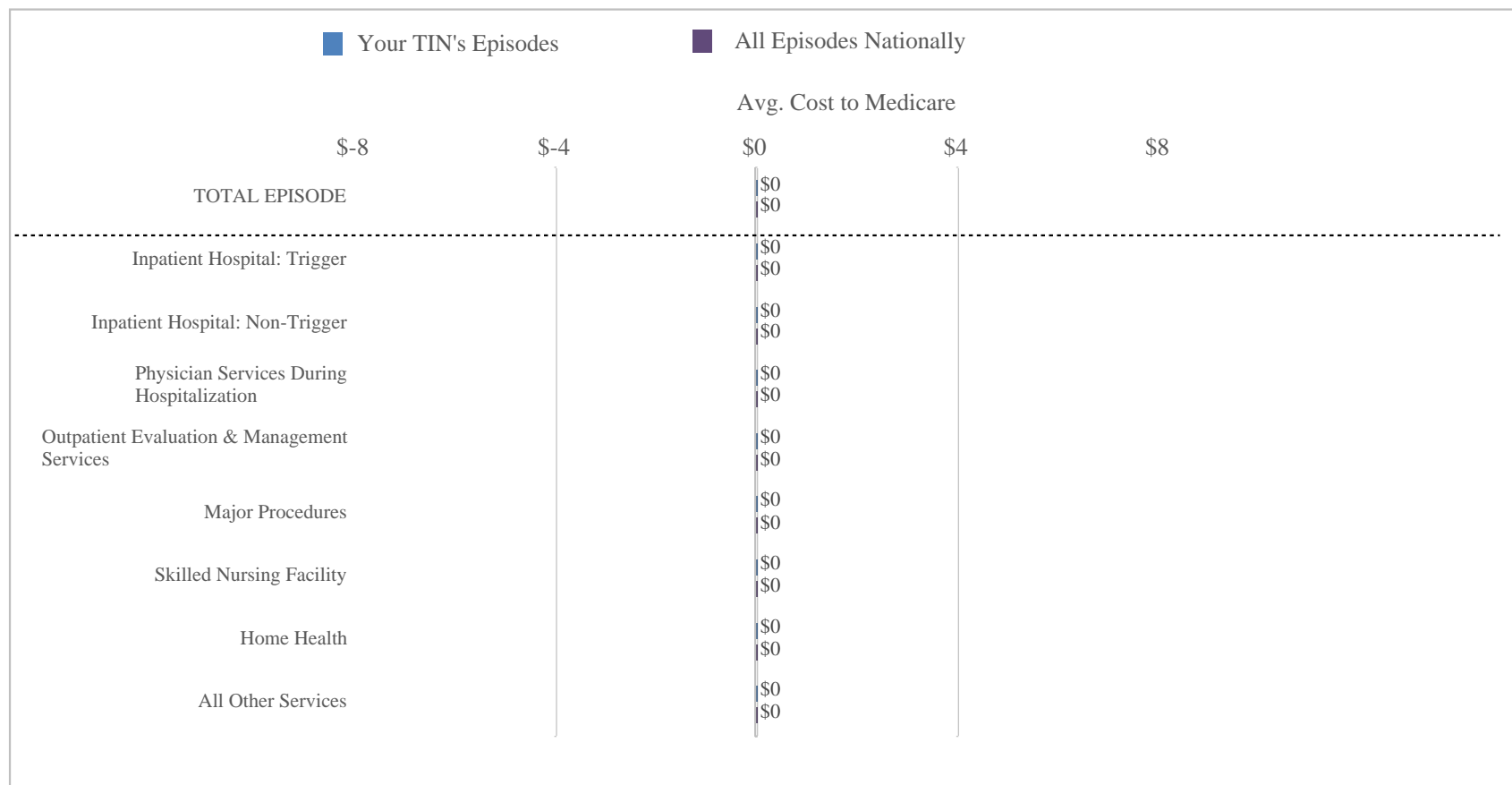
### EXHIBIT 3.B: Average Cost to Medicare for Episode Components

This exhibit presents the average non-risk-adjusted, payment standardized cost to Medicare of the Treatment and CAS episode components for your TIN and for the national average. Additional service category breakdowns can be found in Exhibit 4.A - 4.C, and definitions of Treatment and CAS can be found in Appendix 1 of this report.



### EXHIBIT 3.C: Average Cost to Medicare for Select Service Categories in Episode

This exhibit presents the average non-risk-adjusted, payment standardized cost to Medicare of select service categories for your TIN and for the national average. Additional details can be found in Exhibit 4.A - 4.C. Service categories are defined in Appendix 2 of this report.



“All Other Services” is composed of all service costs to Medicare not accounted for in the above service categories. Accordingly, “All Other Services” is defined differently in this exhibit than in other exhibits.

EXHIBIT 3.D: Top Five Highest Average-Billing Providers Treating Episode		
Category	Within Your TIN	Not in Your TIN
Hospitals	HOSPITAL A	HOSPITAL B
SNFs	SNF A	SNF B
HHAs	HH A	HH C
	HH B	

Category	Within Your TIN	Not in Your TIN
Top 5 Physician/ Non-Physician Practitioners	Dr. A	Dr.B
		Dr. C
		Dr. D



### EXHIBIT 3 - Hip/Femur Fracture or Dislocation Treatment, IP-Based Episode Type Summary

This exhibit summarizes the cost to Medicare of episodes of this type attributed to your TIN. In the episode component and service category breakdowns, all costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level.

Hip/Femur Fracture or Dislocation Treatment, IP-Based episodes include all services clinically-related to the episode that start within the episode window of 90 days.

#### EXHIBIT 3.A: Your Episode Type Summary

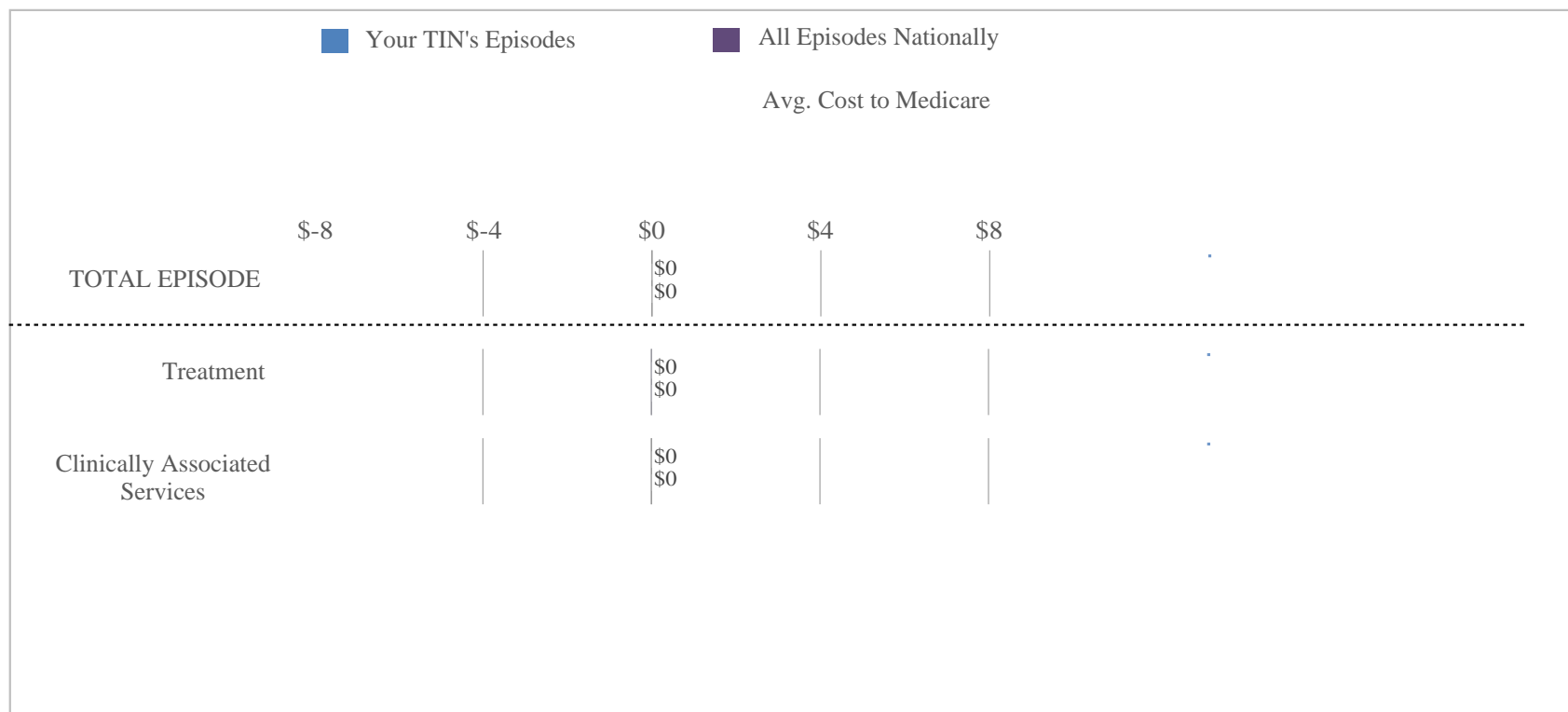
This exhibit presents summary information about your episodes. If your patient population is less complex relative to the patient population nationally within the same episode type, then your average non-risk-adjusted, payment standardized episode cost to Medicare will be lower than your average risk-adjusted episode cost to Medicare.

Your TIN's # Episodes	Your TIN's # Beneficiaries	Avg. Beneficiary Risk Score Percentile †	Avg. Non-Risk-Adjusted Episode Cost to Medicare			Avg. Risk-Adjusted Episode Cost to Medicare†			Avg. % Physician Fee Schedule Costs Billed by Your TIN During Episode†
			Your TIN	National	% Cost Difference	Your TIN	National	% Cost Difference	
0	0	0th	\$0	\$0	0%	\$0	\$0	0%	0%

† Crosses indicate terms defined through the hover-over function.

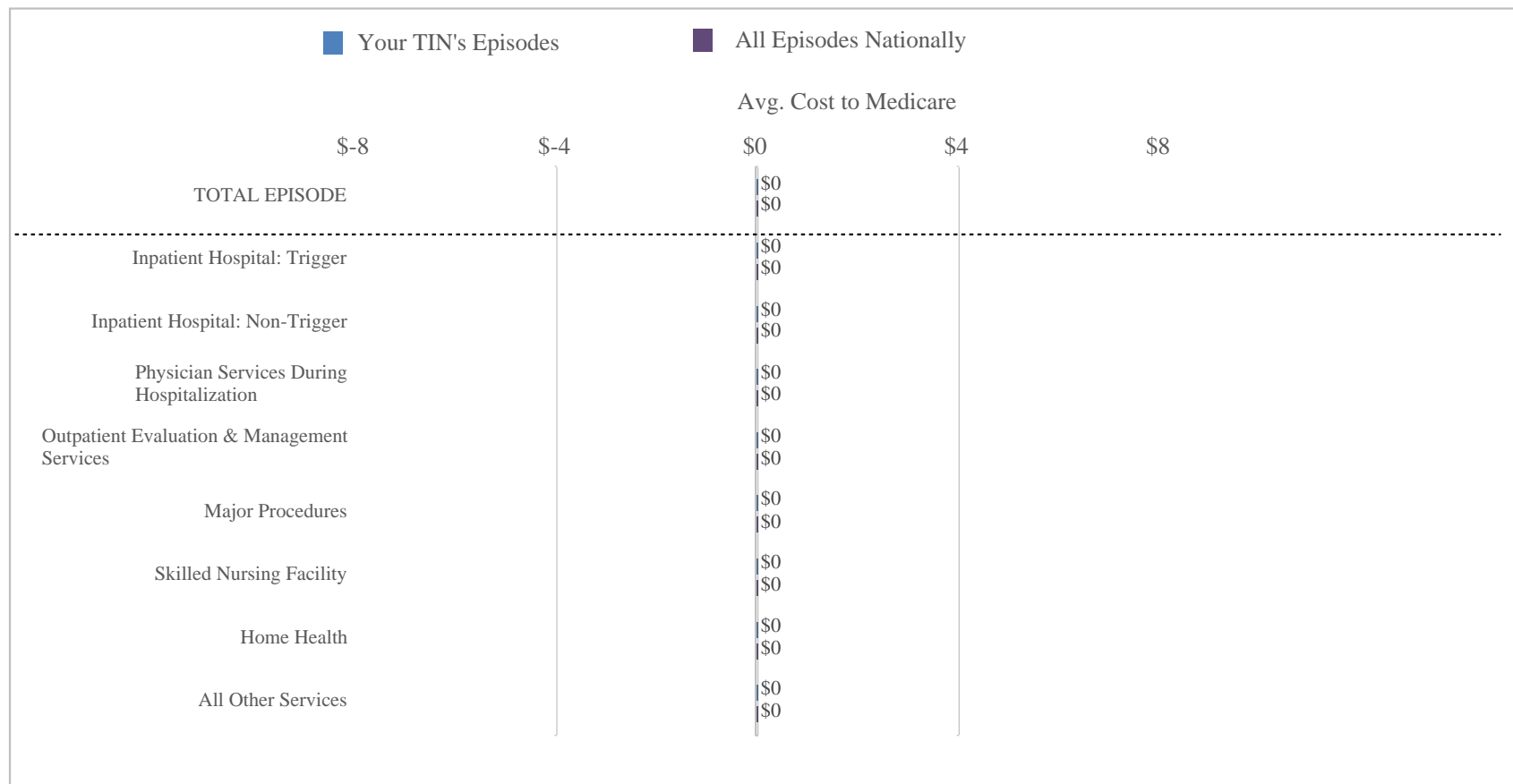
### EXHIBIT 3.B: Average Cost to Medicare for Episode Components

This exhibit presents the average non-risk-adjusted, payment standardized cost to Medicare of the Treatment and CAS episode components for your TIN and for the national average. Additional service category breakdowns can be found in Exhibit 4.A - 4.C, and definitions of Treatment and CAS can be found in Appendix 1 of this report.



### EXHIBIT 3.C: Average Cost to Medicare for Select Service Categories in Episode

This exhibit presents the average non-risk-adjusted, payment standardized cost to Medicare of select service categories for your TIN and for the national average. Additional details can be found in Exhibit 4.A - 4.C. Service categories are defined in Appendix 2 of this report.



“All Other Services” is composed of all service costs to Medicare not accounted for in the above service categories. Accordingly, “All Other Services” is defined differently in this exhibit than in other exhibits.

EXHIBIT 3.D: Top Five Highest Average-Billing Providers Treating Episode		
Category	Within Your TIN	Not in Your TIN
Hospitals	HOSPITAL A	HOSPITAL B
SNFs		Skilled Nurse A
HHAs		Home Health A

Category	Within Your TIN	Not in Your TIN
Top 5 Physician/ Non-Physician Practitioners	Dr. A	Dr. B
		Dr. C
		Dr. D
		Dr. E
		Dr. F

### EXHIBIT 3 - Hip Arthroplasty Episode Type Summary

This exhibit summarizes the cost to Medicare of episodes of this type attributed to your TIN. In the episode component and service category breakdowns, all costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level.

Hip Arthroplasty episodes include all services clinically-related to the episode that start within the episode window of 90 days.

#### EXHIBIT 3.A: Your Episode Type Summary

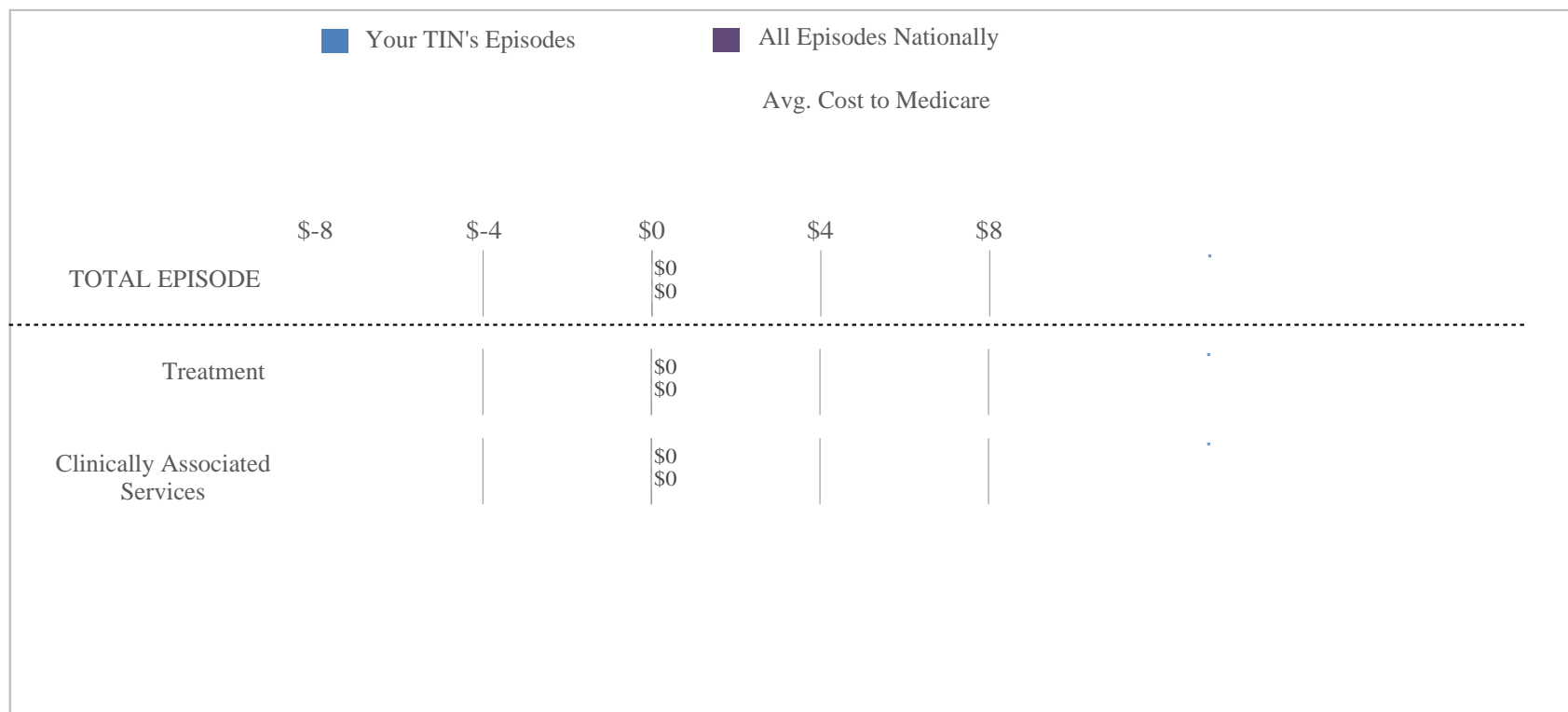
This exhibit presents summary information about your episodes. If your patient population is less complex relative to the patient population nationally within the same episode type, then your average non-risk-adjusted, payment standardized episode cost to Medicare will be lower than your average risk-adjusted episode cost to Medicare.

Your TIN's # Episodes	Your TIN's # Beneficiaries	Avg. Beneficiary Risk Score Percentile †	Avg. Non-Risk-Adjusted Episode Cost to Medicare			Avg. Risk-Adjusted Episode Cost to Medicare†			Avg. % Physician Fee Schedule Costs Billed by Your TIN During Episode†
			Your TIN	National	% Cost Difference	Your TIN	National	% Cost Difference	
0	0	0th	\$0	\$0	0%	\$0	\$0	0%	0%

† Crosses indicate terms defined through the hover-over function.

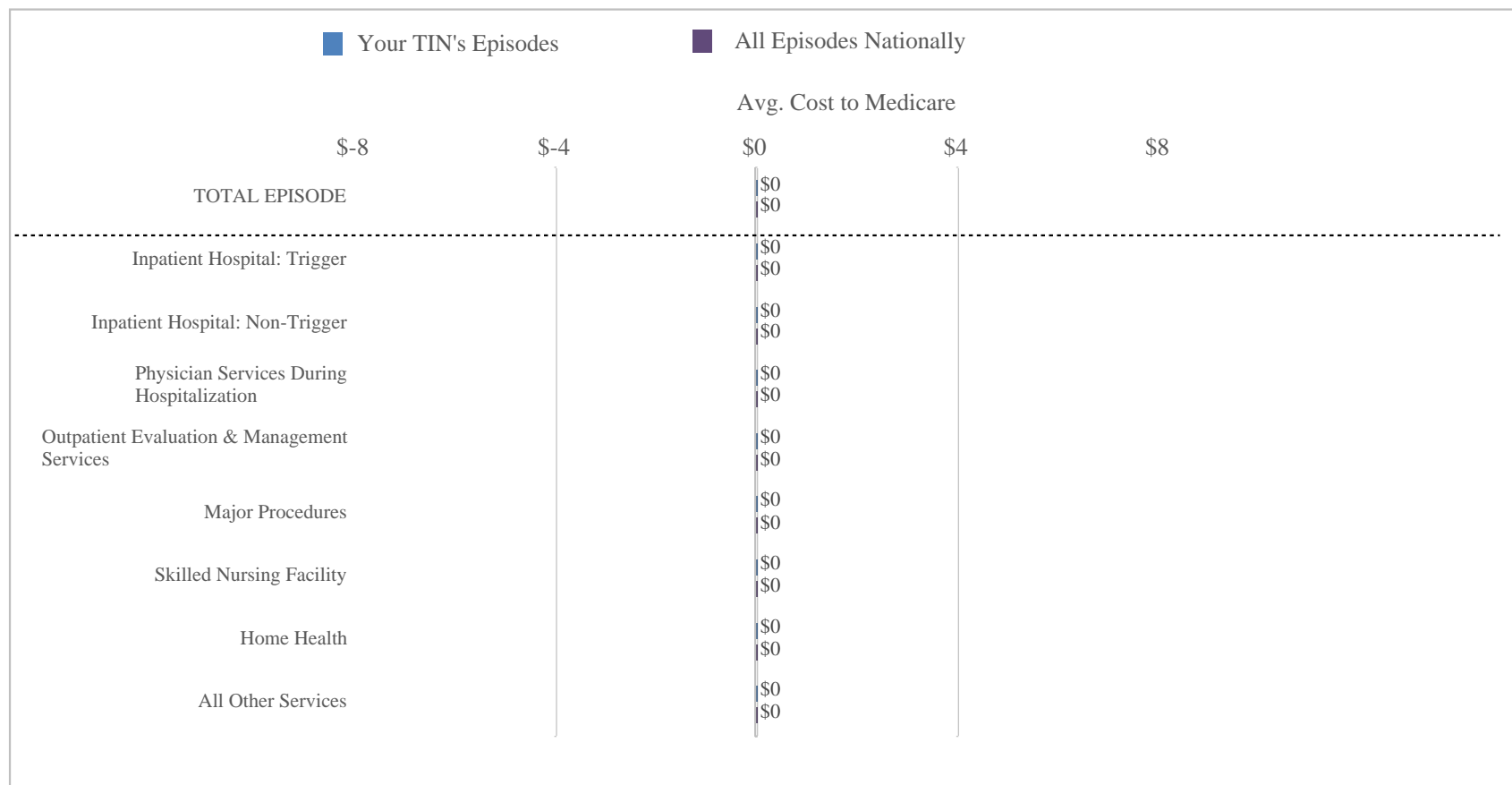
### EXHIBIT 3.B: Average Cost to Medicare for Episode Components

This exhibit presents the average non-risk-adjusted, payment standardized cost to Medicare of the Treatment and CAS episode components for your TIN and for the national average. Additional service category breakdowns can be found in Exhibit 4.A - 4.C, and definitions of Treatment and CAS can be found in Appendix 1 of this report.



### EXHIBIT 3.C: Average Cost to Medicare for Select Service Categories in Episode

This exhibit presents the average non-risk-adjusted, payment standardized cost to Medicare of select service categories for your TIN and for the national average. Additional details can be found in Exhibit 4.A - 4.C. Service categories are defined in Appendix 2 of this report.



“All Other Services” is composed of all service costs to Medicare not accounted for in the above service categories. Accordingly, “All Other Services” is defined differently in this exhibit than in other exhibits.

EXHIBIT 3.D: Top Five Highest Average-Billing Providers Treating Episode		
Category	Within Your TIN	Not in Your TIN
Hospitals	HOSPITAL A	
SNFs		
HHAs		Home Health A

Category	Within Your TIN	Not in Your TIN
Top 5 Physician/ Non-Physician Practitioners	Dr. A	Dr. B
		Dr. C
		Dr. D
		Dr. E
		Dr. F



**EXHIBIT 3 - Knee Arthroplasty Episode Type Summary**

This exhibit summarizes the cost to Medicare of episodes of this type attributed to your TIN. In the episode component and service category breakdowns, all costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level.

Knee Arthroplasty episodes include all services clinically-related to the episode that start within the episode window of 90 days.

**EXHIBIT 3.A: Your Episode Type Summary**

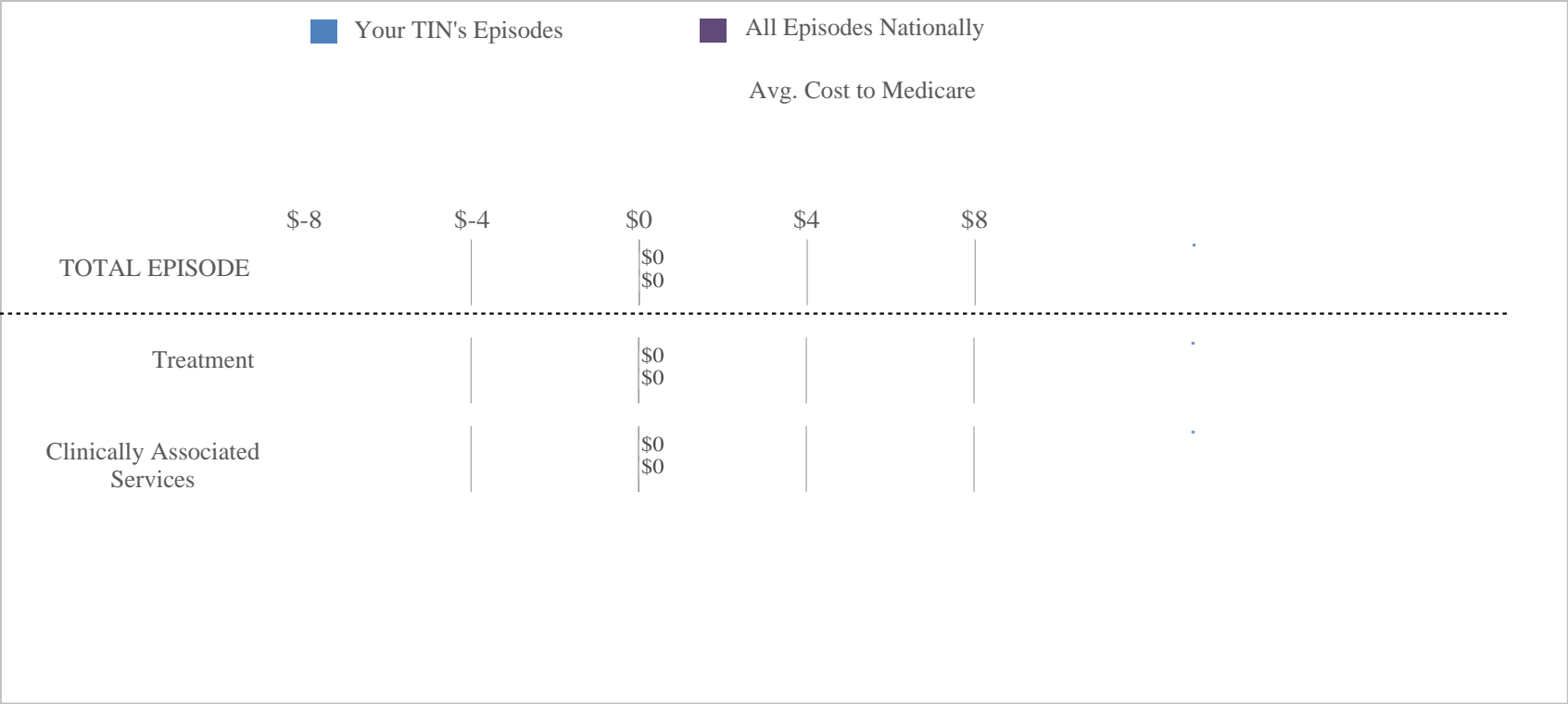
This exhibit presents summary information about your episodes. If your patient population is less complex relative to the patient population nationally within the same episode type, then your average non-risk-adjusted, payment standardized episode cost to Medicare will be lower than your average risk-adjusted episode cost to Medicare.

Your TIN's # Episodes	Your TIN's # Beneficiaries	Avg. Beneficiary Risk Score Percentile †	Avg. Non-Risk-Adjusted Episode Cost to Medicare			Avg. Risk-Adjusted Episode Cost to Medicare†			Avg. % Physician Fee Schedule Costs Billed by Your TIN During Episode†
			Your TIN	National	% Cost Difference	Your TIN	National	% Cost Difference	
0	0	0th	\$0	\$0	0%	\$0	\$0	0%	0%

† Crosses indicate terms defined through the hover-over function.

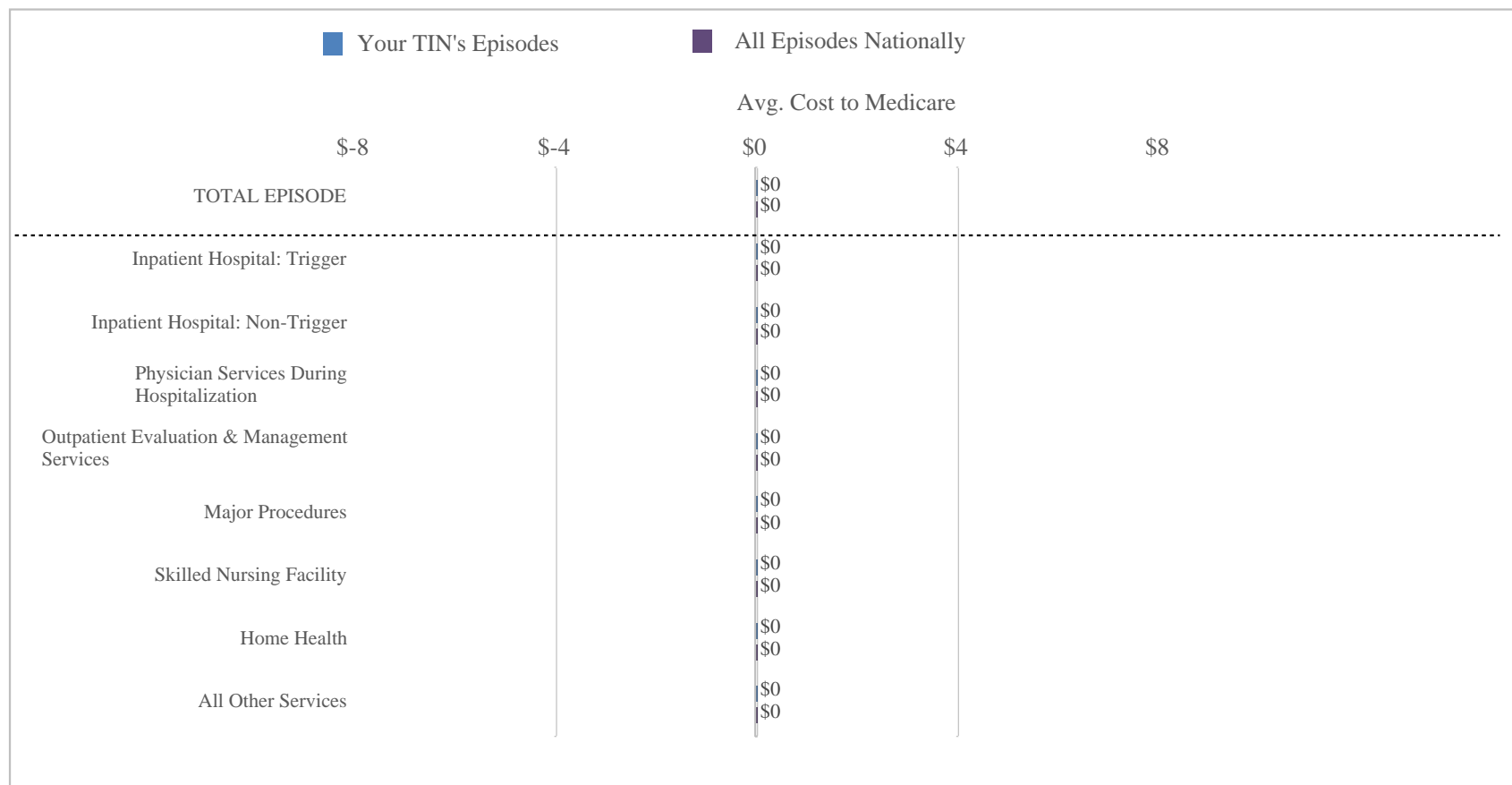
**EXHIBIT 3.B: Average Cost to Medicare for Episode Components**

This exhibit presents the average non-risk-adjusted, payment standardized cost to Medicare of the Treatment and CAS episode components for your TIN and for the national average. Additional service category breakdowns can be found in Exhibit 4.A - 4.C, and definitions of Treatment and CAS can be found in Appendix 1 of this report.



### EXHIBIT 3.C: Average Cost to Medicare for Select Service Categories in Episode

This exhibit presents the average non-risk-adjusted, payment standardized cost to Medicare of select service categories for your TIN and for the national average. Additional details can be found in Exhibit 4.A - 4.C. Service categories are defined in Appendix 2 of this report.



“All Other Services” is composed of all service costs to Medicare not accounted for in the above service categories. Accordingly, “All Other Services” is defined differently in this exhibit than in other exhibits.

EXHIBIT 3.D: Top Five Highest Average-Billing Providers Treating Episode		
Category	Within Your TIN	Not in Your TIN
Hospitals	HOSPITAL A	HOSPITAL C
	HOSPITAL B	HOSPITAL D
SNFs		Skilled Nurse A
		Skilled Nurse B
HHAs		Home Health A
		Home Health B

Category	Within Your TIN	Not in Your TIN
Top 5 Physician/ Non-Physician Practitioners	Dr. A	Dr. B
		Dr. C
		Dr. D
		Dr. E
		Dr. F

# **EXHIBIT 4.A - Cholecystectomy Episode Type Service Category Cost to Medicare Breakdown - Total Episode**

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

## **EXHIBIT 4.A: Total Episode Service Category Cost to Medicare Breakdown**

Cholecystectomy (n=1)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services

Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days

Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00

# **EXHIBIT 4.A - Hip/Femur Fracture or Dislocation Treatment, IP-Based Episode Type Service Category Cost to Medicare Breakdown - Total Episode**

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

## **EXHIBIT 4.A: Total Episode Service Category Cost to Medicare Breakdown**

Hip/Femur Fracture or Dislocation Treatment, IP-Based (n=1)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services



Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days

Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00

### EXHIBIT 4.A - Hip Arthroplasty Episode Type Service Category Cost to Medicare Breakdown - Total Episode

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

EXHIBIT 4.A: Total Episode Service Category Cost to Medicare Breakdown							
Hip Arthroplasty (n=1)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services

Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days

Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00

# **EXHIBIT 4.A - Knee Arthroplasty Episode Type Service Category Cost to Medicare Breakdown - Total Episode**

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

## **EXHIBIT 4.A: Total Episode Service Category Cost to Medicare Breakdown**

Knee Arthroplasty (n=1)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services

Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days

Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00



### EXHIBIT 4.B - Cholecystectomy Episode Type Service Category Cost to Medicare Breakdown - Treatment

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

EXHIBIT 4.B: Treatment Service Category Cost to Medicare Breakdown							
Cholecystectomy (n=0)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests

Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>

Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00

# **EXHIBIT 4.B - Hip/Femur Fracture or Dislocation Treatment, IP-Based Episode Type Service Category Cost to Medicare Breakdown - Treatment**

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

## **EXHIBIT 4.B: Treatment Service Category Cost to Medicare Breakdown**

Hip/Femur Fracture or Dislocation Treatment, IP-Based (n=0)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests

Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>

Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00

### EXHIBIT 4.B - Hip Arthroplasty Episode Type Service Category Cost to Medicare Breakdown - Treatment

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

EXHIBIT 4.B: Treatment Service Category Cost to Medicare Breakdown							
Hip Arthroplasty (n=0)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests

Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>



Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00

# **EXHIBIT 4.B - Knee Arthroplasty Episode Type Service Category Cost to Medicare Breakdown - Treatment**

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

## **EXHIBIT 4.B: Treatment Service Category Cost to Medicare Breakdown**

Knee Arthroplasty (n=0)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests

Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>

Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00

### EXHIBIT 4.C - Cholecystectomy Episode Type Service Category Cost to Medicare Breakdown - Clinically Associated Services

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

#### EXHIBIT 4.C: CAS Service Category Cost to Medicare Breakdown

Cholecystectomy (n=0)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests

Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services

<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00

# **EXHIBIT 4.C - Hip/Femur Fracture or Dislocation Treatment, IP-Based Episode Type Service Category Cost to Medicare Breakdown - Clinically Associated Services**

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

EXHIBIT 4.C: CAS Service Category Cost to Medicare Breakdown							
Hip/Femur Fracture or Dislocation Treatment, IP-Based (n=0)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests



Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services

<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00

### EXHIBIT 4.C - Hip Arthroplasty Episode Type Service Category Cost to Medicare Breakdown - Clinically Associated Services

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

#### EXHIBIT 4.C: CAS Service Category Cost to Medicare Breakdown

Hip Arthroplasty (n=0)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests

Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services

<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00

### EXHIBIT 4.C - Knee Arthroplasty Episode Type Service Category Cost to Medicare Breakdown - Clinically Associated Services

This exhibit summarizes the cost to Medicare, by service category, of episodes of this type attributed to your TIN. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Exhibit 4.A provides the service category breakdown of cost to Medicare for the entire episode. Exhibit 4.B and 4.C show the breakdown of cost to Medicare for the treatment and clinically associated services (CAS) component of the episode, respectively. Service category definitions are located in Appendix 2 of this report.

#### EXHIBIT 4.C: CAS Service Category Cost to Medicare Breakdown

Knee Arthroplasty (n=0)	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost Difference	Your TIN	National	Your TIN	National
All Services	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	\$0	\$0	0%	0%	0%	N/A	N/A
Outpatient Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Major Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Ambulatory/Minor Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Ancillary Services	\$0	\$0	0%	0%	0%	N/A	N/A
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests

Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services
Durable Medical Equipment and Supplies	\$0	\$0	0%	0%	0%	0.00 DME/Supplies	0.00 DME/Supplies
<b>Hospital Inpatient Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Inpatient Hospital: Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Hospital: Non-Trigger	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Physician Services During Hospitalization	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>Emergency Room Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Emergency Evaluation & Management Services	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Procedures	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Laboratory, Pathology, and Other Tests	\$0	\$0	0%	0%	0%	0.00 Tests	0.00 Tests
Imaging Services	\$0	\$0	0%	0%	0%	0.00 Imaging Services	0.00 Imaging Services

<b>Post-Acute Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Home Health	\$0	\$0	0%	0%	0%	0.00 Visits	0.00 Visits
Skilled Nursing Facility	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
Inpatient Rehabilitation or Long-Term Care Hospital	\$0	\$0	0%	0%	0%	0.00 Days	0.00 Days
<b>Hospice</b>	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
<b>All Other Services</b>	\$0	\$0	0%	0%	0%	<i>N/A</i>	<i>N/A</i>
Ambulance Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Anesthesia Services	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
Chemotherapy and Other Part B-Covered Drugs	\$0	\$0	0%	0%	0%	0.00 Units	0.00 Units
Dialysis	\$0	\$0	0%	0%	0%	0.00 Services	0.00 Services
All Other Services Not Otherwise Classified	\$0	\$0	0%	0%	0%	0.00	0.00