

BlueChoice® Solutions Cost and Utilization Components Compared to Peers Report Guide and Definitions

The charts included with this report provide more detailed information to help you understand the factors that push the allowed cost for the episodes attributed to you above the expected cost.

Five clusters were selected to serve as illustrations. The five clusters selected are those where the Total Cost exceeds the Total Expected Cost by the greatest amount. A report consisting of two sections is generated for each cluster.

1. **Section 1** provides comparisons to peers in the rating area and statewide, on components of cost and utilization for inpatient and ambulatory services.
2. **Section 2** shows what services (CPT and HCPCS codes) appear in higher or lower proportions in your episodes compared to peers.

A cluster consists of one of 557 medical episode groups (MEG), one level of severity, one of five comorbidity groups and one time period.

Definitions of the following fields:

Solutions ID: Group provider IDs affiliated at the level of the Tax Identification Number. Solo provider IDs identified by UPIN or BPIN.

Working Specialty: The specialty by which you are compared to your peers.

Report Date: The date that the report was generated.

Rating Area: One of 22 geographic regions in Texas used to adjust for regional differences.

MEG# / MEG (Medical Episode Group) description: The Thomson Medical Episode Group numeric code and description identifying a clinically homogenous episode of care.

Incurred Claims Date Range: Data for this analysis includes services incurred between these dates.

Severity: Indicates the clinical level of severity observed in episodes of a specific clinical condition (Medical Episode Group). Subdivisions (x.xx) indicate more precise classification. For some Medical Episode Groups, severity is further classified using age, gender, and type of episode.

0	History of a significant predisposing factor for the disease, but no current pathology, e.g. history of carcinoma or neonate born to mother suspected of infection at time of delivery
1	Conditions with no complications or problems with minimal severity
2	Problems limited to a single organ or system; significantly increased risk of complications than Stage 1
3	Multiple site involvement; generalized systemic involvement; poor prognosis

Time Period: The time period within the 2-year incurred period to which the episode has been assigned. Time period 1 relates to the first year of the incurred period, time period 2 relates to the second (most recent) year of the incurred period.

Comorbidity Group: Reflects the relative number and complexity of coexisting illnesses of the patients in the episodes. Group I includes healthier individuals; Group V includes the most ill and complex. A linear relationship does not exist between Comorbidity group and episode cost (i.e. the cost for episodes of patients in Group II is not twice that of those in Group I).

Allowed per Episode: This is based on the average allowed (physician payment and patient liability) charges for all services provided by all physicians, ancillary providers and facilities related to the episodes of care.

Expected per Episode: This is based on the average allowed cost of qualified episodes partitioned by MEG, severity, comorbidity group, and time period for a specialty in a geographic region.

Note:

- All comparisons are made to specialty peers in the same geographic area on episodes in the same Medical Episode Group at the same level of Severity, in the same Comorbidity Group, and in the same time period.
- All statewide comparisons are made to the specialty peers in Texas on episodes in the same Medical Episode Group at the same level of Severity, in the same Comorbidity Group, and in the same time period.

SECTION 1

Components of Cost and Utilization

Allow Amt Per Epis Total: The average allowed amount per episode of care, for all facility and professional services that are included in an episode of care.

Episode Count: The number of qualified episodes attributed to your Solutions ID.

INPATIENT SERVICES OVERVIEW

Admits per 100 Episodes: The number of acute inpatient admissions observed in these episodes per 100 episodes.

Admit Days per 100 Episodes: The number of acute inpatient days observed in these episodes per 100 episodes.

Average Length of Stay: Acute Inpatient days divided by number of inpatient admissions.

Allowed Admit Amount Per Episode: Total allowed amount divided by the number of episodes.

Allowed Amount per Admit: Total allowed amount for all acute inpatient admissions divided by the number of inpatient admissions.

AMBULATORY SERVICES OVERVIEW

Allow Amt Per Epis Amb Prof: Average allowed amount for ambulatory professional services.

Allow Amt Per Epis Amb Fac: Average allowed amount for ambulatory facility services.

Visits Per 100 Epis Amb Fac: Average number of ambulatory visits in an episode of care provided in facility, per 100 episodes of care.

AMBULATORY SERVICES COMPONENTS

Allow Amt Per Epis Amb Off: Average allowed amount for ambulatory professional services provided in an office setting.

Visits Per 100 Epis Amb Off: Average number of ambulatory professional visits in an episode of care provided in an office setting, per 100 episodes of care.

Allow Amt Per Epis Amb ER: Average allowed amount for ambulatory emergency room services.

Visits Per 100 Epis Amb ER: Average number of ambulatory emergency room facility visits included in an episode of care, per 100 episodes of care.

Allow Amt Per Epis Amb Lab: Average allowed amount per episode of care for ambulatory laboratory and pathology services included in an episode of care.

Svcs Per 100 Epis Amb Lab: Average number of ambulatory laboratory and pathology services included in an episode of care, per 100 episodes of care.

Allow Amt Per Epis Amb Rad: Average allowed amount, per episode of care, for ambulatory radiology and imaging services.

Svcs Per 100 Epis Amb Prof Rad: Average number of ambulatory professional radiology and imaging services included in an episode of care, per 100 episodes of care.

SECTION 2

CPT Level Detail

This section shows which CPT codes are used by the physician(s)/provider(s) compared to peers for episodes in this Medical Episode Group at this level of Severity for patients in this Comorbidity Group during this time period. It provides

perspective on the variability of the mix of professional services, imaging, and laboratory testing being done during these episodes of care. It shows where the CPT codes used by the physician(s)/provider(s) in the Solutions ID and the peer group converge or diverge. This section will indicate the percent of episodes in which a service is being provided for a given clinical condition (e.g. glycosylated hemoglobin in chronic episodes of Diabetes Mellitus) or the percent of episodes in which a more intensive service is used relative to peers (e.g. laparoscopic cholecystectomy with intraoperative cholangiography in episodes of Cholecystitis and Cholelithiasis where peers perform laparoscopic cholecystectomy without intraoperative cholangiography).

% of Episodes: The number of episodes in which a given CPT code appears divided by the number of episodes in this Medical Episode Group/Severity/Comorbidity/Time Period Group. If a CPT code appears more than once in an episode, the episode is counted one time.

Comparison is the number of episodes in which a given CPT code appears for specialty peers in the same rating area for the same Medical Episode Group at the same level of Severity and patients in the same Comorbidity Group in the same time period divided by the number of episodes across the peer group.

TX State Comparison % of Episodes is the number of episodes in which a given CPT code appears for specialty peers in Texas for the same Medical Episode Group at the same level of Severity and patients in the same Comorbidity Group in the same time period divided by the number of episodes across the peer group.

Relative Cost represents the relative cost for that service within the following divisions of a standard fee schedule based on ranking from low to high:

- Supplies
- Imaging
- Evaluation & Management
- Procedures
- Tests
- Ambulance
- Drugs
- Hearing and speech services
- Immunizations/Vaccinations
- Other

\$ lowest quintile of cost within division
\$\$ second quintile
\$\$\$ middle quintile
\$\$\$\$ fourth quintile
\$\$\$\$\$ highest cost services within division