Criteria for
2009 BCBSIL PPO Practitioner Profile

The Blue Cross Blue Shield of Illinois PPO Practitioner Profile summarizes performance for selected quality-related indicators. The profile includes indicators in the following categories:

1. Cost Efficiency
   A. Cost Efficiency Score
   B. Case Mix
   C. Total Number of Episodes
   D. MEGs Driving Efficiency

2. Clinical Quality Indicators
   A. Standardized Indicators
   B. Informational Indicators

3. Administrative Efficiency
   A. Electronic Claims

4. Radiology Quality Initiative (RQI)
   A. RQI percentage

For additional details see http://www.bcbsil.com/provider/umqi/ppo_practioner_profile.htm

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1. Cost Efficiency

Data sources: BCBSIL claims 12/1/06 – 11/30/08

The Cost Efficiency methodology uses Thomson Reuters' Medical Episode Grouper® (MEG). MEG incorporates demographic and diagnosis data from claims to link inpatient, outpatient, and pharmacy services into disease-related episodes of care and classifies the severity of disease within an episode. MEG uses the Medstat Disease Staging® patient classification system to construct homogenous, disease specific episode groups. Because the Medstat Episode Grouper is based solely on diagnosis codes and does not take into account procedure codes, the accuracy of disease classification is increased.

The following items are displayed in your Efficiency report.

A. Cost Efficiency Score - Efficiency is the ratio of the provider's actual cost to the provider's expected cost, adjusted for MEGs. A Cost Efficiency Score is calculated for each contracted provider. A Cost Efficiency score above or below 1.00 (average) indicates a higher or lower resource usage when compared to your peers for treatment of patients with similar conditions.

B. Case Mix - A measure of the degree to which a provider's patient mix is more or less complex to treat. Case mix is a ratio of the provider's expected cost, adjusted for MEGs to the unadjusted mean cost for the specialty. Severity adjustment is incorporated into the cost efficiency analysis. A case-mix score is calculated for each contracted provider. A score above the average (1.00) indicates a patient panel with a higher level of severity than that of peers. A score below the average (1.00) indicates a patient panel with a lower level of severity than that of peers.

C. Total Number of Episodes - This measure includes inpatient, outpatient and professional services.

D. MEGs Driving Efficiency - The list of top MEGs for a provider is based on volume, the most efficient MEGs for a provider by total cost variance, and the least efficient MEGs for a provider by total cost variance. Each section shows the providers' costs relative to the specialty peer cost for the MEG.

2. Clinical Quality Indicators

Data Source: BCBSIL claims through 12/31/08 (See individual indicator abstract for specific time frame)

There are two types of Quality Indicators: Standardized Indicators and Informational Indicators.

The methodology used for reporting the Clinical Quality Indicators includes all specialty-appropriate practitioners involved in the care of a member during the relevant time frame as that member's "team." Ideally, each practitioner should either provide recommended services or confirm that recommended services have been provided. Therefore, if data confirm that a member received a service, all team members receive credit. If the member did not receive the service, no member of the team receives credit for the service. The specific criteria for defining which practitioners to include in the team vary by indicator. All of the Clinical Quality Indicators have been structured so that higher rates represent better performance.

A. Standardized Clinical Quality Indicators

1. Breast Cancer Screening
2. Colorectal Cancer Screening
3. Cervical Cancer Screening
4. Glycosylated Hemoglobin (HbA1c) For Diabetics
5. Medical Attention for Diabetic Nephropathy
6. LDL Monitoring for Diabetes
7. Childhood Immunization: Varicella-Zoster Virus (VZV)
8. Childhood Immunization: Measles, Mumps, Rubella (MMR)
9. Use of Long-Term Control Drugs for Persistent Asthma
10. Treatment of Cardiovascular Conditions: Monitoring Lipid Levels
11. Use of Spirometry Testing in the Assessment and Diagnosis of COPD
12. Conservative Use of Imaging for Low Back Pain
13. Appropriate Testing for Children with Pharyngitis
14. Appropriate Treatment for Children with Upper Respiratory Infections
15. Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis

Standardized Clinical Quality Indicators are specifications adapted from the National Committee for Quality Assurance (NCQA).

B. Informational Clinical Quality Indicators

1. Chlamydia Screening for Women
2. Appropriate Monitoring for Angiotensin Converting Enzyme Inhibitors and Angiotensin Receptor Blockers
3. Appropriate Monitoring for Diuretics
4. Diagnosis and Follow-up of Prostate Cancer
5. Hepatic Enzyme Monitoring Before Initiating Statin Therapy
6. Adherence to Anti-Hypertensive Medication
7. Adherence to Lipid-Lowering Medication

Informational indicators are supplemental measures that address areas of measurement for which national standards do not yet exist. Some informational indicators are based on medical specialty society guidelines.

3. Administrative Efficiency

Data Source: BCBSIL claims received from 07/1/08 through 06/31/09.

Minimum claim volume for reporting is > 300 claims submitted during the reporting period.

According to a study by Milliman, the costs of a physician office to submit a claim electronically is significantly lower than paper claims. In 2006, Milliman estimated the physician office cost for a manual claim to be $6.63 and the cost for an electronic claim to be $ 2.90

According to a 2007 summary from the American Medical Association and the Connecticut State Medical Society, there are several advantages to electronic claims submission for a physician office. Electronic claims submission can:

- Reduce the amount of time and resources devoted to administrative functions
- Pre-audit claim fields automatically for potential errors
- Identify claim issues and provide online claim resolution before processing by a health plan payer
- Submit claims almost instantaneously
- Reduce postage and supplies
- Track a claim's progress
- Confirm a health plan's receipt of a claim
- Expedite a health plan's claims processing turnaround time
- Improve the practice's accounts receivable

4. Radiology Quality Initiative (RQI)

BCBSIL has partnered with American Imaging Management (AIM) to manage a quality improvement program for outpatient diagnostic imaging services. The 2009 BCBSIL PPO Practitioner Profile contains information about the percent of requested tests that did not require RN or MD consultation for an RQI to be issued.

An RQI number is required by BCBSIL prior to performing any of the high-tech, elective, non-emergency diagnostic imaging services listed below for BCBSIL PPO and Blue*Choice* Select members:

- CT and CTA scans
- MRI and MRA scans
- Nuclear Cardiology studies
- PET scans

The RQI program applies to all of the above imaging services when performed in a physician's office, the outpatient department of a hospital or a freestanding imaging center. Ordering physicians can obtain, and imaging service providers can confirm, a patient's RQI number via AIM's Web site www.americanimaging.net. Additional information about AIM and the RQI process may be found on our Web site at *www.bcbsil.com/provider*