Physician Profile

Revised For
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Physician Profile Overview

Profiles include two components:

1) Cost Comparison Report

Cost Comparison Profiles are generated for the following specialties:

- Allergy/Immunology
- Cardiology
  - Invasive (cardiac catheterizations)
  - Interventional (stent and angioplasty)
  - Electrophysiology
  - Non-Invasive
- Dermatology
- Endocrinology
- Family Medicine (Rural and Urban)
- Gastroenterology
- General Surgery (Rural and Urban)
- Internal Medicine (Rural and Urban)
- Neurology
- Neurosurgery
- Obstetrics/Gynecology
- Ophthalmology
- Otolaryngology
- Pediatrics (Rural and Urban)
- Pulmonary Medicine
- Urology

2) Quality of Care Measures

Quality of Care Profiles are generated for the following specialties:

- Allergy/Immunology
- Cardiology
- Endocrinology
- Primary Care (includes Family Medicine and Internal Medicine)
- Neurology
- Obstetrics/Gynecology
- Ophthalmology
- Otolaryngology
- Pediatrics
- Pulmonary Medicine
- Urology

Specialty Cost Comparison and Quality of Care reports contain data for the following product lines:

1) Health Advantage
2) Blue Cross
3) Blue Advantage
**Subspecialty Definitions**

**Urban/Rural Classification**
United States Census Bureau data is used to determine the population of each city.

- **Urban**: A classification code of U is assigned to the cities where the population is greater than 50,000 persons.
- **Rural**: A classification code of R is assigned to the cities where the population is less than 50,000 persons.

Using the criteria put forth above these are the areas that are designated urban. All others are rural.

### City | State
--- | ---
Conway | AR
Fayetteville | AR
Fort Smith | AR
Jonesboro | AR
Little Rock | AR
North Little Rock | AR
Memphis | TN
Pine Bluff | AR
Rogers | AR
Springdale | AR
Springfield | MO
Texarkana | AR/TX

**Cardiology subspecialties**
The rationale for splitting cardiology into distinct groups is the result of meetings held with three large central AR cardiology practices (Arkansas Heart, Little Rock Cardiology and Arkansas Cardiology.) The need to split the cardiologists was identified through the review of the Cost Efficiency Index initiative late 2007/early 2008. T-Tests were performed based on the efficiency index of the providers.

**Methodology:**
Cardiologists will be separated into the following groups based on the CPT codes in parentheses:

- Electrophysiology / Ablations (93650-93652) \(>=1\) during the measurement period
- Interventional (92980-92998) \(>=5\) during the measurement period
- Invasive (93508-93533) \(>=5\) during the measurement period
- Non-Invasive (all others)

This process will be run every time we update physician Cost of Care information. The providers will be grouped based on the claims contained in the extract BEFORE the group and load process. Once the provider groups have been identified then their specialties must ALSO be changed in the master provider files that we run for CRMS.

The process will be run in the order listed above. First, look for all claims specialty 06 (Cardiology) in the extract. If a provider has \(>=1\) claim in the ablation CPT code range, they are included in the EP / ablation group. If not, then run a second pass thru the data to look for the interventional code range. If they have \(>=5\) claims for interventional procedures then they are included in the interventional group. If not, then run a third pass thru the data to look for the invasive CPT code range. If they have \(>=5\) claims in the invasive category then label them invasive. If not, the rest of the providers fall into the non-invasive group.

The provider groups are mutually exclusive. A provider can only fall into one category. They are listed from most expensive to least expensive in terms of practice pattern. We want to ensure that we are grouping like providers together in terms of practice pattern cost, so the first category they meet the criteria for is where we will group them.
Cost of Care

Definitions

Episode - A series of health care services provided to a patient over time to treat a specific illness or condition (includes inpatient, outpatient, office, and pharmacy data).

Episode Treatment Group (ETG) – A classification system used to link a patient’s health care services into episodes by categorizing the patient’s condition or illness into one of 800+ clinically homogeneous groups.

Episode Risk Group (ERG) - Uses episodes of care as markers of risk rather than the diagnoses from individual medical encounters so the focus is placed on the key information describing a patient's underlying condition instead of the individual services.

Complete episode – An episode not exceeding 365 days that has known start and finish dates. Also, a full year episode that may or may not have known or unknown start and finish dates. An example of a full year episode would be a patient with diabetes.

Outlier Episode – For a full explanation an outlier episode and how an outlier episode is identified, please see page 10 of this document under “3. Outliers and Exclusions”.

Notes
♦ Based on the Ingenix Episode Treatment Groups (ETGs) and Episode Risk Groups (ERG). For more information visit: www.ingenix.com.
♦ ETG assignment is based upon diagnoses, procedures, complications, comorbidities, age and sex of the patient.
♦ An episode of care is initiated with an anchor record. An anchor record consists of an evaluation and management service or a defining surgery (can be facility service in absence of one of these two types of service).
♦ A patient can have multiple episodes open at the same time.
♦ Only complete episodes are included in the profiles.
♦ A provider must have at least 30 complete, non-outlier episodes in order for a profile to be generated.
♦ The portion of the complete episodes for which the provider was responsible (billed, ordered, or prescribed) is included in this report.
Cost Comparison Report Descriptions

The Cost Comparison report shows the distribution of the case-mix (complexity of care) and the efficiency index (relative efficiency of managing cost) for a provider and the specialty peer group over a 3-year period. The report also compares the provider's average cost per episode for specific ETGs to that of the peer group. The costs can also be reviewed by type of service: ancillary (x-ray, lab, DME), facility (hospital and ASC charges), management (E&M visits), pharmacy (prescriptions), and surgical (surgery procedures).

Report Heading

This section of the report provides general information such as the dates of service, product lines included, physician’s name, specialty to which the physician is compared, the physician’s provider number, the region of the physician and the number of unique patients treated by the provider for the reported episodes.

Cost Per Episode

ETG Case-mix Index
Provider's ETG case-mix index. The ETG case-mix index is a ratio that shows how complex the medical condition of a provider's patients are in relation to the peer group, based on the provider's mix of patients. (An ETG case-mix index greater than 1.0 indicates that the medical condition of the provider's patients are more complex than average within the peer group. An ETG case-mix index less than 1.0 indicates that the medical condition of the provider's patients are less complex than average within the peer group.)

ETG Cost Index
Provider's ETG cost index. The ETG cost index is a ratio that compares a provider's actual costs to expected costs, given the mix of patients. (An ETG cost index greater than 1.0 indicates that the provider's costs are higher than expected, given the case mix. An ETG cost index less than 1.0 indicates that the provider's costs are less than expected, given the case mix.)

Cost Per Patient

ERG Case-mix Index
Provider's ERG case-mix index. The ERG case-mix index is a ratio that shows how complex the medical condition of a provider's patients are in relation to the peer group, based on the provider's mix of patients. (A case-mix index greater than 1.0 indicates that the medical condition of the provider's patients are more complex than average within the peer group. A case-mix index less than 1.0 indicates that the medical condition of the provider's patients are less complex than average within the peer group.)

ERG Cost Index
Provider's ERG cost index. The ERG cost index is a ratio that compares a provider's actual costs to expected costs, given the mix of patients. (An ERG cost index greater than 1.0 indicates that the provider's costs are higher than expected, given the case mix. An ERG cost index less than 1.0 indicates that the provider's costs are less than expected, given the case mix.)

Cost of Care Index and Graph
The graph is a symbolic view of the Cost of Care Index and is what is reported on the secured member websites under Physician Connection for this provider (NOTE: provider has the option to suppress his Cost of Care Index graph on the website).

Note
- The statistical results are located under the Cost Index for each category and are based on one-sample, two-sided Z-test.
- See the Physician Connection Cost Comparison Methodology section for the calculation of the cost and case-mix indexes.
**Overall Cost Comparison for Provider and Top ETGs by Number of Episodes**

The information in the header section of the report can be used to determine whether the provider generates higher or lower costs than peers for all of the physician’s episodes. The next section provides information on the treatment of conditions within specific ETGs and lists the top six ETGs with non-outlier episodes.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETG</td>
<td>Identifying number of the non-outlier Episode Treatment Group.</td>
</tr>
<tr>
<td>Description</td>
<td>Description of the Episode Treatment Group.</td>
</tr>
<tr>
<td># Episodes</td>
<td>Number of non-outlier episodes within the ETG in which the provider was involved.</td>
</tr>
<tr>
<td>Your Excess Costs (Savings)</td>
<td>Difference in cost for the non-outlier episodes as compared to the specialty for the ETG.</td>
</tr>
<tr>
<td>Your cost per episode</td>
<td>Provider's average allowed cost per non-outlier episode for all medical and pharmacy claims from all sites of service for the ETG. The average allowed cost for each type of service for the physician is also provided.</td>
</tr>
<tr>
<td>Spec Avg per episode</td>
<td>Specialty's average allowed cost per non-outlier episode for all medical and pharmacy claims from all sites of service for the ETG. The average allowed cost for each type of service for the physician’s specialty is also provided.</td>
</tr>
</tbody>
</table>
## Provider Name


<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Region</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patients for this report: 367

<table>
<thead>
<tr>
<th>Cost Per Episode</th>
<th>ETG Case Mix Index</th>
<th>Cost Per Patient</th>
<th>ERG Case Mix Index</th>
<th>ERG Cost Index</th>
<th>Cost of Care Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.92</td>
<td>0.98</td>
<td>1.20</td>
<td>1.10</td>
<td>1.10</td>
<td></td>
</tr>
</tbody>
</table>

### Cost of Care Index

- **Lower Cost**
- **Higher Cost**

### ETG Overview

<table>
<thead>
<tr>
<th>ETG</th>
<th>Description</th>
<th>Number of Episodes</th>
<th>Your Costs</th>
<th>Spec Avg</th>
<th>Per Episode Cost by Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Cost</td>
<td>Comparison for Provider</td>
<td>1004</td>
<td>$21,656</td>
<td></td>
<td>$185</td>
</tr>
<tr>
<td>0331</td>
<td>Tonsillitis, adenoiditis or pharyngitis, w/o surgery</td>
<td>200</td>
<td>$3,700</td>
<td></td>
<td>$125</td>
</tr>
<tr>
<td>0384</td>
<td>Acute bronchitis, w/o concomitant, age 6 &amp; older</td>
<td>179</td>
<td>$3,397</td>
<td></td>
<td>$172</td>
</tr>
<tr>
<td>0333</td>
<td>Acute sinusitis</td>
<td>100</td>
<td>$3,341</td>
<td></td>
<td>$238</td>
</tr>
<tr>
<td>0574</td>
<td>Infections of lower genitourinary system, not sexually transmitted</td>
<td>49</td>
<td>$217</td>
<td></td>
<td>$119</td>
</tr>
<tr>
<td>0900</td>
<td>Isolated signs, symptoms &amp; non-specific diagnoses or conditions</td>
<td>47</td>
<td>($202)</td>
<td></td>
<td>$107</td>
</tr>
</tbody>
</table>

### Important Note

This report is based on claims filed by the provider (or other provider at the direction of the provider) that were grouped into categories (ETGs) using Episode Treatment Grouping (ETG) from Symmetry Health Data Systems or used to assign risk level retrospective risk scores using Risk Resource Grouped (RRG) from Symmetry Health Data Systems. This report represents a limited review of only (1) those services for which an episode has been developed for the ETG score and (2) those services reviewed for purposes of the ETG score. This report represents a limited review of only selective portions of the risk provider's practice, as reflected in claims data, and should not, therefore, be interpreted as a statement or evaluation of all claims listed or services performed. This report is not intended as a substitute for any other claims review or selection programs that may be conducted with respect to the risk provider's practice or claims acceptance, nor as indication that the risk provider's claims, billing or collection practices are deemed appropriate in all respects. Regardless of the specific Cost of Care ratings stated in this report, there may be other claims or utilization issues in the risk provider's practice that are not reflected in this report, and therefore may require further or separate analysis. The risk provider's organizations reserve the right to conduct separate or additional analyses of any risk provider's practice or claims utilization activities, including billing, coding, claims filing and utilization standards as referenced to applicable provider contracts. Providers' review claims, website postings or other written notices to providers.
Quality of Care Measures:

**General Information**

This initiative has been driven by the federal government’s commitment to promote transparent and higher quality health care. Specifically, the Bush administration has mandated that federal health-care agencies must implement programs measuring and comparing quality and cost of physician services. In addition, many employers have requested quality and cost information for the physicians in the networks utilized for their employee health-benefit plans. Consumers also are requesting more cost and quality information, especially with the growth of consumer-directed health plans.

**Goals and Objectives for Quality Measures**

- Educate members (in lay terms) on quality measures and how Arkansas physicians perform statewide
- Educate members on individual cost performance of network physicians and identify those physicians who are working to keep medical costs down
- Through new physician profiles, educate physicians on their specific quality and cost performance compared to peer benchmarks
- Link quality measures with care reminders for measurement consistency and to add value to the Personal Health Record

**Selecting Key Performance Indicators**

- Measures drawn from nationally accepted standards
- Measures with broad clinical acceptance
- Measures provide stable and reliable information
- Inform physicians about the development and validation of the measures, and give physicians the opportunity to provide feedback

- We favored *process* measures that are under control of the physician and are clearly linked to patient outcomes
- The measures were derived from claims data and not medical review of patient charts
- We used a method of generous attribution to all physicians treating the patient – if any physician performed the health intervention, then all treating physicians were acknowledged as having performed the intervention

**Development and Validation**

- Started with 140 MedVantage measures
- Selected 53 measures (12 specialties)
- Nationally accepted standards:
  - AQA (formerly the Ambulatory Care Quality Alliance)
  - National Quality Forum
  - National Committee for Quality Assurance
  - American Medical Association (AMA)
  - American College of Physicians
  - Agency for Healthcare Research and Quality
  - Healthcare Effectiveness Data and Information Set
- Extensive review of current guidelines of major specialty associations (American College of Cardiology, American College of Radiology, AMA, etc)
- Available from claims based data
- Multi-specialty University Medical School Advisory Group (selected by Dean)
- College of Public Health
- Arkansas American Academy of Pediatrics
- Arkansas American Academy of Obstetrics and Gynecology
- QIO: Arkansas Foundation for Medical Care
- CMS: Physician Quality Reporting Initiative
Health Conditions for Quality Measures

The quality of care measures are divided up into the following health conditions. This allows for the member to search for quality measures by health condition as well as by physician specialty.

- Coronary (Heart) Conditions
- Diabetes
- Drug Monitoring
- Ear, Nose, Throat Conditions
- Eye Conditions
- Neurological Conditions
- Pregnancy
- Respiratory Conditions
- Thyroid Condition
- Urologic Conditions
- Wellness screening

Quality Measures for Physician Connection by Health Condition

Coronary (Heart) Conditions

- Proportion of CAD patients who receive at least one blood glucose test over the 3 year measurement period.
- Proportion of MI patients who persist in anti-lipidemic agents.
- Proportion of MI patients who persist in B-blocker use (>135 days of B-blocker use in 180 days following discharge). Exclusions: Hypotension, conduction system disorder, asthma, COPD
- Proportion of patients who receive a B-blocker after an acute MI. (Exclusions: Hypotension, conduction system disorder, asthma, COPD)
- Proportion of patients who receive a lipid panel within 12 months of discharge after admit for CAD, MI, CABG, or PTCA.
- Proportion of patients with LVSD who receive a prescription for a B-blocker. (Exclusions: Hypotension, conduction system disorder, asthma, COPD)
- Proportion of patients with LVSD who receive a prescription for an ACEI or ARB. (Exclusions: Hypotension, chronic renal disease)

Diabetes

- Proportion of diabetics age 18-75 who received at least one eye exam annually.
- Proportion of diabetics who receive at least one creatinine within 12 months of care.
- Proportion of diabetics who receive at least one HbA1c during every 12 months of care.
- Proportion of diabetics who receive at least one lipid measurement.
- Proportion of diabetics who receive at least one microalbumin (or are already taking ACEI or ARB) within 12 months of care.
- Proportion of patients with diabetes and hypertension treated with ACE-I or ARB.
- Proportion of patients with diagnosis of impaired glucose or dysmetabolic syndrome who receive follow-up blood sugar.
Drug Monitoring

- Proportion of patients on diuretics who receive at least one K+ during every 12 months following initiation of therapy.
- Proportion of patients on methotrexate therapy who receive at least one liver function test and CBC annually.
- Proportion of patients with Rx for ACE-I or ARB who have K+ and creatinine or BUN annually.

Ear, Nose & Throat Conditions

- Proportion of patients who receive strept test within 3 days (before or after) antibiotics for pharyngitis.
- Proportion of tonsillectomy patients who had at least 3 scripts for antibiotics in previous 12 months.

Eye Conditions

- Proportion of patients with a diagnosis for open angle glaucoma that have a follow-up visit during measurement period. (Exclusions: Retinal and Ophthalmic Plastic Specialists)
- Proportion of patients with a diagnosis of diabetic retinopathy that have a follow-up visit at least once during measurement period. (Exclusions: Retinal and Ophthalmic Plastic Specialists)
- Proportion of patients with glaucoma who have at least one optic nerve exam and visual field during the measurement period.
- Proportion of patients with no YAG capsulotomy within 3 months after cataract surgery. (Exclusions: Retinal and Ophthalmic Plastic Specialists)

Neurological Conditions

- Percentage of out-patients with TIA or stroke who receive at least one lipid profile.
- Proportion of headache/migraine patients who do not receive long term narcotics or barbiturates.

Pregnancy

- Proportion of pregnant patients who receive chlamydia screening.
- Proportion of pregnant women screened for UTI or Asymptomatic bacteriuria.
- Proportion of pregnant women who are screened for anemia.
- Proportion of pregnant women who receive Group B strept screening.
- Proportion of pregnant women who receive Hep B screening.
- Proportion of pregnant women who receive HIV screening.
- Proportion of pregnant women who receive pap smear (credit for PAP smear one year prior to or during pregnancy).

Respiratory Conditions

- Proportion of adult out-patients with pneumonia who receive a CXR within 3 days of course of treatment begin date.
- Proportion of asthma patients who do not overuse short acting B agonists. (Exclusion: COPD)
- Proportion of asthma patients who receive inhaled steroid before long acting beta agonists. (Exclusion: Exercise induced asthma)
- Proportion of patients undergoing allergy testing for allergic rhinitis who receive intranasal steroids, or other appropriate medications: cromolyn sulfate, oral anti-histamines, leukotriene modifier
• Proportion of patients who receive no antibiotics for at least 3 days after initial visit for uncomplicated URI.
• Proportion of patients with both allergic rhinitis and asthma who receive at least one script for intranasal steroids. (Exclusion: Immunotherapy)
• Proportion of patients with persistent asthma who are prescribed inhaled steroids or an acceptable alternative for asthma control. (Exclusions: COPD, emphysema)

Thyroid Condition

• Proportion of patients on thyroid replacement medication who receive at least one TSH.

Urologic Conditions

• Proportion of out-patients with pyelonephritis who receive a urine culture within 2 days of diagnosis.
• Proportion of patients with kidney stone and UTI who receive urine culture.
• Proportion of patients with kidney stone treated with watchful waiting. No SWL, URS or PNL during the first 7 days. (Exclusions: Stricture or complete obstruction)
• Proportion of patients with kidney stones who receive U.A. and BUN or creatinine.
• Proportion of patients with prostate cancer who receive at least one PSA after DX of prostate cancer.
• Proportion of patients with ureteral stones who do not receive a stent within seven days of diagnosis. (Exclusions: UTI, abscess)

Wellness Screening

• Proportion of high risk patients age 35 or older who receive at least one cholesterol level during the three year measurement period. High Risk = CAD, Family History MI, Hypertension, Diabetes, PVD or AAA.
• Proportion of patients at high risk for renal failure who receive a creatinine or 24 hour urine study during the three year measurement period. High Risk = CHF, HTN, or Diabetes
• Proportion of patients who receive colon cancer screening within 12 months of turning 50. Screening Exams: FOBT, Sigmoidoscopy, Colonoscopy, Air Contrast BE.
• Proportion of women age 21-64 to receive at least one pap smear over 3 year measurement period. (Exclusion: Hysterectomy)
• Proportion of women age 40-50 who receive at least one mammogram every 2 years. (Exclusion: Bilateral Mastectomy)
• Proportion of women age 50-64 who receive at least one mammogram annually. (Exclusion: Bilateral Mastectomy)
Quality Measure Profiles

The Quality Measure report shows the number of treatment opportunities and the number of opportunities that met the measure criteria for the provider and the specialty peer group. The report also shows the physician’s adherence compared to the specialty peer group adherence to the measure.

Report Heading

This section of the report provides general information such as the dates of service, product lines included, physician’s name, specialty to which the physician is compared, the physician’s provider number, and the region of the physician.

The report (example below) shows each of the measure in each of the Health Conditions for that provider. The following information is shown on the individual physician’s quality report:

- Measure Number
- Measure Description
- # of Physician’s Patients Meeting Criteria
  - Number of Patients meeting the measure
  - Total Number of Patients
- # of Specialty’s Patients Meeting Criteria
  - Number of Patients meeting the measure
  - Total Number of Patients
- Physician Compliance
- Specialty Compliance
<table>
<thead>
<tr>
<th>Measure Description</th>
<th># Treatment Opportunities for Physician</th>
<th># Treatment Opportunities for Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coronary (Heart) Conditions Measures</strong></td>
<td>Met Measure</td>
<td>Total Treatment Opportunities</td>
</tr>
<tr>
<td>CV12 Proportion of patients who receive a lipid panel within 12 months of discharge after admit for CAD, MI, CABG, or PTCA</td>
<td>1</td>
<td>441</td>
</tr>
<tr>
<td><strong>Diabetes Measures</strong></td>
<td>Met Measure</td>
<td>Total Treatment Opportunities</td>
</tr>
<tr>
<td>E4 Proportion of patients with diagnosis of impaired glucose or dysmetabolic syndrome who receive follow-up blood sugar</td>
<td>25</td>
<td>727</td>
</tr>
<tr>
<td>E9 Proportion of diabetics who receive at least one HbA1c during every 12 months of care</td>
<td>70</td>
<td>4,649</td>
</tr>
<tr>
<td>E7 Proportion of diabetics age 19-75 who received at least one eye exam annually</td>
<td>69</td>
<td>1,539</td>
</tr>
<tr>
<td>E15 Proportion of diabetics who receive at least one lipid measurement annually</td>
<td>57</td>
<td>4,987</td>
</tr>
<tr>
<td>E10 Proportion of diabetics who receive at least one creatinine within 12 months of care</td>
<td>61</td>
<td>5,009</td>
</tr>
<tr>
<td>E18a Proportion of diabetics who receive at least one microalbumin (or are already taking ACEI or ARB) within 12 months of care</td>
<td>44</td>
<td>3,757</td>
</tr>
<tr>
<td>E13 Proportion of patients with diabetes and hypertension treated with ACEI or ARB</td>
<td>26</td>
<td>1,714</td>
</tr>
<tr>
<td><strong>Drug Monitoring Measures</strong></td>
<td>Met Measure</td>
<td>Total Treatment Opportunities</td>
</tr>
<tr>
<td>CV25 Proportion of patients on diuretics who receive at least one K+ during every 12 months following initiation of therapy</td>
<td>52</td>
<td>3,550</td>
</tr>
<tr>
<td>E14 Proportion of patients with Rx for ACE-I or ARB who have K+ and creatinine or BUN annually</td>
<td>56</td>
<td>3,433</td>
</tr>
<tr>
<td><strong>Neurologic Condition Measures</strong></td>
<td>Met Measure</td>
<td>Total Treatment Opportunities</td>
</tr>
<tr>
<td>N4 Proportion of headache/migraine patients who do not receive long term narcotics or barbiturates</td>
<td>51</td>
<td>3,009</td>
</tr>
<tr>
<td>N11a Proportion of outpatients with TIA or stroke who receive at least one lipid profile</td>
<td>4</td>
<td>210</td>
</tr>
<tr>
<td>N11b Proportion of outpatients with new TIA who receive appropriate evaluations. Acceptable evaluation: Transtemporal Doppler, Carotid U/S, Carotid Duplex, U/S</td>
<td>6</td>
<td>196</td>
</tr>
<tr>
<td><strong>Respiratory Condition Measures</strong></td>
<td>Met Measure</td>
<td>Total Treatment Opportunities</td>
</tr>
<tr>
<td>A10 Proportion of asthma patients who receive inhaled steroid before long acting beta agonists. (Exclusion: Exercise induced asthma)</td>
<td>0</td>
<td>04</td>
</tr>
<tr>
<td>A1111 Proportion of asthma patients who do not receive short acting B agonists. (Exclusion COPD)</td>
<td>0</td>
<td>209</td>
</tr>
<tr>
<td>R22 Proportion of patients with persistent asthma who are prescribed inhaled steroid or an acceptable alternative for asthma control. (Exclusions: COPD, emphysema)</td>
<td>6</td>
<td>922</td>
</tr>
<tr>
<td>R25 Proportion of adult outpatients with pneumonia who receive a CRX within 3 days of course of treatment begin date</td>
<td>2</td>
<td>575</td>
</tr>
<tr>
<td><strong>Thyroid Condition Measures</strong></td>
<td>Met Measure</td>
<td>Total Treatment Opportunities</td>
</tr>
<tr>
<td>E20 Proportion of patients on thyroid replacement medication who receive at least one TSH</td>
<td>30</td>
<td>3,135</td>
</tr>
</tbody>
</table>

**Important Note:** The quality measures rating reflected in this report is based on claims data of the rated physician, as compared to similar claims data on other participating physicians who practice in the same field or specialty. The quality measures themselves are not the opinion of the network-sponsoring organizations, but are derived from a consensus among medical experts as collected and reported by various national sources, such as the National Committee for Quality Assurance, the U.S. Department of Health and Human Services Center for Medicare and Medicaid Services, among others. This report is not intended and should not be interpreted as a generalized statement about the overall competency or quality of a rated physician, nor is it a specific quality rating in any given "quality measures" category intended to constitute an opinion about quality or competency of this physician in any specific case. It is entirely possible that a rated physician with a high quality measures rating in a given category or categories could have competency or quality lapses or issues in other areas, or even in specific cases covered by the rating category. Accordingly, regardless of the rankings in this report, the network-sponsoring organizations reserve the right to conduct additional or separate analyses or investigations of general or specific competency or quality issues or concerns with respect to any rated physician, including but not limited to member complaints, hospital privileging or peer review actions, malpractice history, Medical Board or other disciplinary action, and credentialing review. A high quality rating on any category reflected in this report is not intended and should not be interpreted as foreseeing any other quality or competency question, review or remedial action, up to and excluding termination of network participation, as appropriate.