

Addendum to *October 15, 2015 NPC* *“How to Interpret Your 2014 Supplemental Quality and Resource Use Report (QRUR)”*

Summary of the 2014 Supplemental QRURs

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Addendum Outline

- **Addendum A:** Summary Statistics on the 2014 Reports
- **Addendum B:** Attribution to Medical Group Practice(s) and Solo Practitioner(s)
- **Addendum C:** Cost Distribution of Episode Types

Addendum A: Summary Statistics

Addendum A provides summary statistics on:

- Demographics of beneficiaries included in the 2014 Supplemental QRURs
- Average payment-standardized, risk-adjusted costs by episode type
- Breakdown of episode costs by service categories for high-cost episodes (90th cost percentile) and all other episodes
- Percent of episode costs billed by attributed medical group or solo practitioner

Addendum A: Summary Statistics

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Summary of Beneficiary Demographics

- The 2014 Supplemental QRURs provide episode results for medical group practices and solo practitioners to evaluate their performance relative to the national population
 - 63,733 medical group practices and solo practitioners had at least one episode and received a 2014 Supplemental QRUR
- The national population includes all Medicare fee for service (FFS) beneficiaries who had a claim in 2014 that triggered one of the episode types reported in the 2014 Supplemental QRURs

Table A.1: Demographics of Beneficiaries With At Least One Episode

Type	# of Beneficiaries	Average Age	% Female
National Benchmark	5,622,367	72.2	56.6%
Acute Condition Episodes	1,478,474	75.2	57.3%
Procedural Episodes	4,416,616	71.2	56.1%

Beneficiary Demographics (1 of 2)

Table A.2: Demographics of Beneficiaries, Acute Condition Episodes

Major Episode Type	# of Beneficiaries	Average Age	% Female
Acute Myocardial Infarction (AMI) (All)	146,021	75.0	48.1%
Asthma/Chronic Obstructive Pulmonary Disease (COPD), Acute Exacerbation	233,035	71.3	60.8%
Atrial Fibrillation (AFib)/Flutter, Acute Exacerbation	52,295	76.8	61.3%
Cellulitis (All)	127,318	70.4	53.9%
Gastrointestinal (GI) Hemorrhage (All)	182,899	76.1	53.7%
Heart Failure, Acute Exacerbation	286,708	77.5	54.5%
Ischemic Stroke	166,013	76.9	57.5%
Kidney and Urinary Tract Infection (UTI)	207,575	77.6	72.3%
Pneumonia, Inpatient (IP)-Based	243,593	75.4	55.1%

Episodes names are numbered in the same order as in the 2014 Supplemental QRURs, which lists all condition episodes and their subtypes alphabetically and then all procedural episodes and their subtypes alphabetically. This table and the following table only include major episode types and do not include episode subtypes.

Beneficiary Demographics (2 of 2)

Table A.3: Demographics of Beneficiaries, Procedural Episodes

Major Episode Type	# of Beneficiaries	Average Age	% Female
Aortic Aneurysm Procedure (All)	8,516	71.3	36.9%
Aortic/Mitral Valve Surgery (All)	19,275	72.1	47.3%
Carotid Endarterectomy	34,184	73.2	42.7%
Cholecystectomy and Common Duct Exploration (All)	132,957	68.1	59.2%
Colonoscopy (All)	2,000,257	68.9	54.6%
Coronary Artery Bypass Graft (CABG)	39,740	70.0	28.0%
Hip/Femur Fracture or Dislocation Treatment, IP-Based	103,041	80.3	73.7%
Hip Replacement or Repair (All)	138,114	72.0	62.0%
Knee Arthroplasty	249,498	70.7	64.0%
Knee Joint Repair (All)	78,806	67.1	58.6%
Lens and Cataract Procedures (All)	1,387,945	73.8	60.8%
Mastectomy for Breast Cancer (All)	45,498	72.3	99.8%
Pacemaker (All)	140,840	78.6	49.0%
Percutaneous Coronary Intervention (PCI) (All)	196,568	71.2	36.7%
Prostatectomy for Prostate Cancer	10,386	67.1	0.0%
Spinal Fusion (All)	72,812	68.0	59.6%
Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia	77,382	74.1	0.0%

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- **Average payment-standardized, risk-adjusted costs by episode type**
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Summary of Average Risk-Adjusted Costs for Acute Condition and Procedural Episode Types

- The TINs referenced on this and the following slides are restricted to medical group practices and solo practitioners that received a report and had at least 10 episodes of the given episode type
 - Medical group practices or solo practitioners are identified by their Medicare-enrolled tax identification number (TIN)
 - National average risk-adjusted costs are calculated as an arithmetic mean using all episodes nationally
- For acute condition episode types, less than half (41%) of the TINs with at least 10 episodes have an average risk-adjusted episode cost above the national mean
- For procedural episode types, about half (47%) of the TINs with at least 10 episodes have an average risk-adjusted episode cost above the national mean
- Addendum C provides further information on episode cost distributions

Average Risk-Adjusted Costs for Acute Condition Episode Types (1 of 2)

Table A.4: Average Risk-Adjusted Costs, Acute Condition Episodes

Episode Type	Episode Count	National Average Risk-Adjusted Cost	% of Attributed TINs Above National Average	TIN Count
1. AMI (All)	148,190	\$19,422	42.7%	3,471
2. AMI without PCI / CABG	83,190	\$14,893	44.1%	2,422
3. AMI with PCI	56,361	\$21,086	42.3%	1,704
4. AMI with CABG	8,639	\$52,197	32.8%	253
5. Asthma/COPD, Acute Exacerbation	253,502	\$11,704	48.1%	6,291
6. AFib/Flutter, Acute Exacerbation	53,997	\$12,691	46.4%	1,708
7. Cellulitis (All)	140,600	\$11,527	45.0%	3,466
8. Cellulitis in Diabetics	38,035	\$12,057	42.6%	1,028
9. Cellulitis in Patients with Wound, Non-Diabetic	74,743	\$12,141	43.5%	1,953
10. Cellulitis in Obese Patients, Non-Diabetic without Wound	3,017	\$10,621	14.3%	7
11. Cellulitis in All Other Patients	24,805	\$8,973	39.5%	613

Episode count is taken after attribution and episode exclusions. Episode costs presented are payment-standardized unless otherwise noted. For this and the following slides, the % of attributed TINs and TIN count calculations were restricted to those that received a report and had at least 10 episodes of the given episode type. An "N/A" means that no included TINs were attributed episodes of that subtype.

Average Risk-Adjusted Costs for Acute Condition Episode Types (2 of 2)

Table A.4 (cont.): Average Risk-Adjusted Costs, Acute Condition Episodes

Episode Type	Episode Count	National Average Risk-Adjusted Cost	% of Attributed TIN Above National Average	TIN Count
12. Gastrointestinal (GI) Hemorrhage (All)	203,522	\$11,859	40.4%	4,681
13. <i>GI Hemorrhage, Upper and Lower</i>	64,498	\$11,879	40.1%	1,915
14. <i>GI Hemorrhage, Upper</i>	82,192	\$12,353	39.8%	2,318
15. <i>GI Hemorrhage, Lower</i>	39,283	\$10,723	41.2%	1,217
16. <i>GI Hemorrhage, Undefined</i>	17,549	\$12,024	47.6%	359
17. Heart Failure, Acute Exacerbation	309,257	\$15,833	47.0%	6,886
18. Ischemic Stroke	168,274	\$23,260	42.7%	3,606
19. Kidney and Urinary Tract Infection (UTI)	226,918	\$13,116	47.1%	5,290
20. Pneumonia, Inpatient (IP)-Based	248,595	\$13,002	47.4%	6,078

Average Risk-Adjusted Costs for Procedural Episode Types (1 of 4)

Table A.5: Average Risk-Adjusted Costs, Procedural Episodes

Episode Type	Episode Count	National Average Risk-Adjusted Cost	% of Attributed TIN Above National Average	TIN Count
21. Aortic Aneurysm Procedure (All)	8,589	\$54,346	46.7%	225
22. <i>Abdominal Aortic Aneurysm Procedure</i>	2,389	\$40,209	53.3%	30
23. <i>Thoracic Aortic Aneurysm Procedure</i>	6,200	\$59,776	47.7%	174
24. Aortic/Mitral Valve Surgery (All)	19,292	\$51,597	46.8%	504
25. <i>Both Aortic and Mitral Valve Surgery</i>	1,422	\$62,356	40.0%	20
26. <i>Aortic or Mitral Valve Surgery</i>	17,870	\$50,741	46.4%	489
27. Carotid Endarterectomy	34,547	\$11,935	46.9%	1,033
28. Cholecystectomy and Common Duct Exploration (All)	132,993	\$9,328	44.4%	3,302
29. <i>Cholecystectomy</i>	132,840	\$9,324	44.5%	3,299
30. <i>Surgical Biliary Tract Procedure</i>	153	\$13,206	N/A	0
31. Colonoscopy (All)	2,023,392	\$1,245	61.1%	7,721
32. <i>Colonoscopy with Invasive Procedure</i>	1,593,809	\$1,326	58.9%	7,460
33. <i>Colonoscopy without Invasive Procedure</i>	429,583	\$945	61.5%	4,317
34. CABG	39,745	\$42,881	47.9%	783

Average Risk-Adjusted Costs for Procedural Episode Types (2 of 4)

Table A.5 (cont.): Average Risk-Adjusted Costs, Procedural Episodes

Episode Type	Episode Count	National Average Risk-Adjusted Cost	% of Attributed TIN Above National Average	TIN Count
35. Hip/Femur Fracture or Dislocation Treatment, IP-Based	103,760	\$37,722	49.4%	2,452
36. Hip Replacement or Repair (All)	141,851	\$24,095	51.5%	2,442
37. Hip Arthroplasty	141,200	\$24,161	51.4%	2,438
38. Hip Arthroscopy and Hip Joint Repair	651	\$8,029	80.0%	5
39. Knee Arthroplasty	257,497	\$21,381	54.1%	3,271
40. Knee Joint Repair (All)	79,516	\$3,484	51.3%	2,011
41. Meniscus Repair	79,402	\$3,469	51.3%	2,009
42. Knee Ligament Repair	114	\$13,998	N/A	0
43. Lens and Cataract Procedures (All)	1,476,926	\$2,728	49.9%	6,037
44. Cataract Surgery	1,035,807	\$3,512	47.9%	5,598
45. Discission	435,488	\$845	47.0%	5,044
46. Intraocular Lens (IOL) Removal/Repositioning or Secondary IOL Insertion	5,631	\$3,568	41.4%	87

Average Risk-Adjusted Costs for Procedural Episode Types (3 of 4)

Table A.5 (cont.): Average Risk-Adjusted Costs, Procedural Episodes

Episode Type	Episode Count	National Average Risk-Adjusted Cost	% of Attributed TIN Above National Average	TIN Count
47. Mastectomy for Breast Cancer (All)	45,723	\$7,860	45.9%	1,197
48. Lumpectomy or Partial Mastectomy without Reconstruction	30,862	\$6,831	45.4%	877
49. Lumpectomy or Partial Mastectomy with Reconstruction	565	\$11,486	0.0%	5
50. Simple or Modified Radical Mastectomy without Reconstruction	12,637	\$9,480	36.7%	297
51. Simple or Modified Radical Mastectomy with Reconstruction	1,659	\$13,503	36.4%	11
52. Pacemaker (All)	141,187	\$15,050	43.2%	2,270
53. Pacemaker Placement, IP-Based	49,552	\$23,121	46.7%	1,360
54. Pacemaker Placement, OP-Based	47,393	\$11,866	45.7%	1,255
55. Pulse Generator Replacement	44,242	\$9,253	45.5%	1,202

Average Risk-Adjusted Costs for Procedural Episode Types (4 of 4)

Table A.5 (cont.): Average Risk-Adjusted Costs, Procedural Episodes

Episode Type	Episode Count	National Average Risk-Adjusted Cost	% of Attributed TIN Above National Average	TIN Count
56. Percutaneous Coronary Intervention (PCI) (All)	201,913	\$16,117	43.0%	2,394
57. <i>PCI, IP-Based</i>	103,546	\$20,060	45.8%	1,919
58. <i>PCI, OP-Based</i>	98,367	\$11,910	44.3%	1,832
59. Prostatectomy for Prostate Cancer	10,386	\$11,715	39.1%	289
60. Spinal Fusion (All)	73,857	\$40,454	41.9%	1,709
61. <i>Lumbar and/or Thoracic Spinal Fusion</i>	68,788	\$40,706	41.9%	1,622
62. <i>Cervical Spinal Fusion</i>	3,867	\$25,698	34.7%	75
63. <i>Long-Segment Spinal Fusion for Deformity</i>	1,202	\$74,756	65.2%	23
64. Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia	78,444	\$5,993	47.3%	1,715

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Summary of Service Category Breakdown for Acute Condition Episodes

- Acute condition episodes in the top decile of the cost distribution tend to have higher cost from post-acute care services
 - Costs from readmissions, skilled nursing facility (SNF), rehabilitation/long term care hospital (LTCH)
- The average acute condition episode has cost driven by the inpatient (IP) trigger event
 - The “trigger event” is the IP stay that opened the episode
- Only major episode types are listed for the service category cost breakdown
 - Table A.6 shows the average non-risk-adjusted cost for each episode type and for service categories within the episode type
 - Figure A.1 shows a graphical representation of average non-risk-adjusted episode cost broken out into service categories
 - Both Table A.6 and Figure A.1 show average costs for episodes in the top cost decile and for all other episodes

Breakdown of Acute Condition Episode Costs by Highest Cost Service Categories (1 of 4)

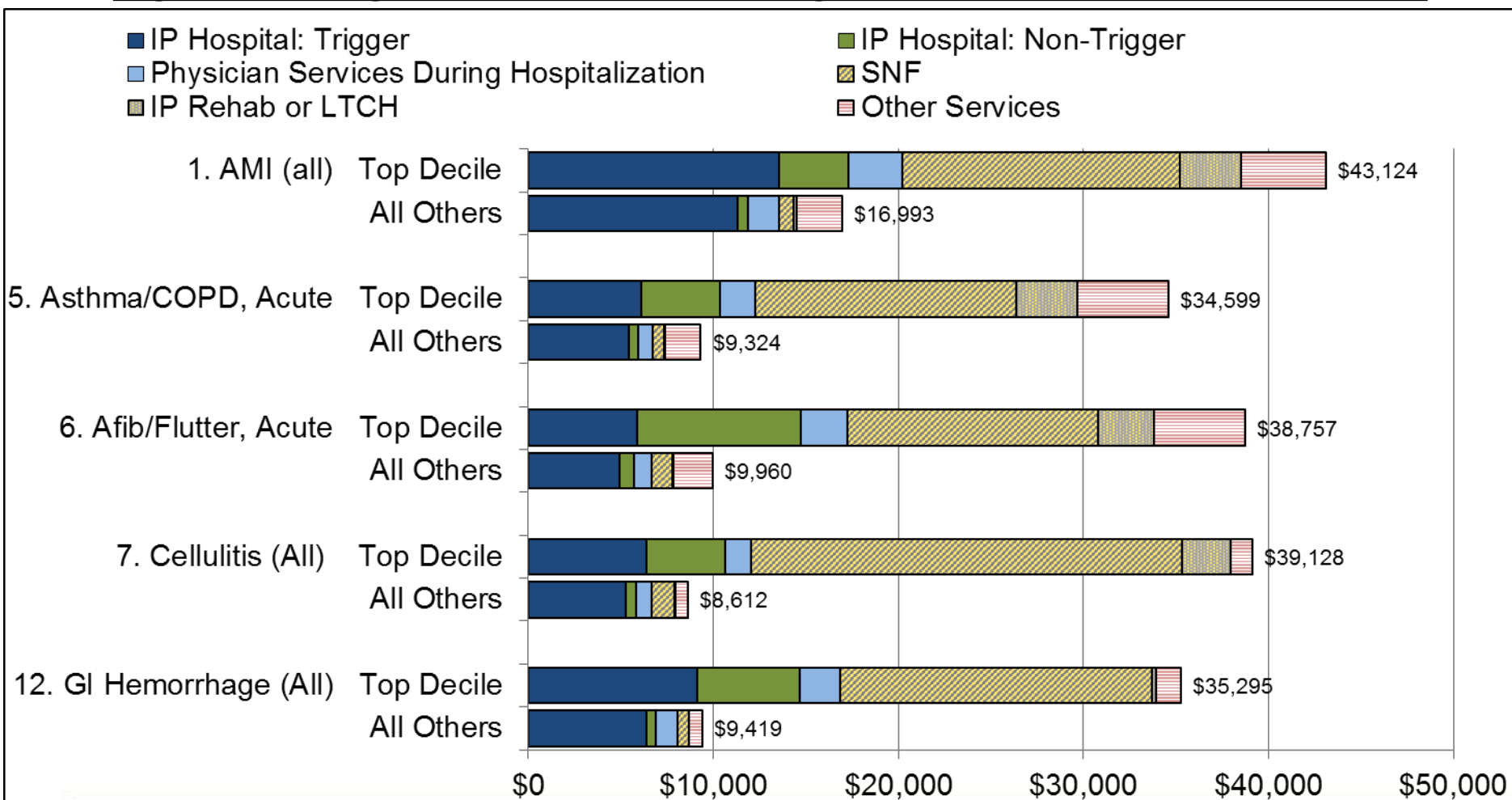
Table A.6: Highest Cost Service Categories, Acute Condition Episodes

Major Episode Type		Average Non-Risk-Adjusted Cost	IP Hospital: Trigger	IP Hospital: Non-Trigger	Phys. Services During Hospitalization	SNF	IP Rehab or Long Term Care Hospital
1. AMI (All)	<i>Top Decile</i>	\$43,124	\$13,569	\$3,719	\$2,933	\$15,025	\$3,278
	<i>All Others</i>	\$16,993	\$11,305	\$568	\$1,684	\$798	\$165
5. Asthma/COPD, Acute	<i>Top Decile</i>	\$34,599	\$6,112	\$4,258	\$1,895	\$14,090	\$3,339
	<i>All Others</i>	\$9,324	\$5,429	\$506	\$793	\$627	\$26
6. AFib/Flutter, Acute	<i>Top Decile</i>	\$38,757	\$5,870	\$8,863	\$2,513	\$13,540	\$3,034
	<i>All Others</i>	\$9,960	\$4,949	\$764	\$951	\$1,113	\$87
7. Cellulitis (All)	<i>Top Decile</i>	\$39,128	\$6,392	\$4,249	\$1,418	\$23,281	\$2,625
	<i>All Others</i>	\$8,612	\$5,267	\$538	\$832	\$1,265	\$23
12. GI Hemorrhage (All)	<i>Top Decile</i>	\$35,295	\$9,152	\$5,506	\$2,185	\$16,877	\$195
	<i>All Others</i>	\$9,419	\$6,397	\$506	\$1,153	\$613	\$1

For this and the following slides, “Top Decile” episodes are those in the top decile of the distribution of the average of the ratios of each episode’s observed costs to its expected costs. Service category costs may not sum to the total cost, as some low-cost service categories are not displayed.

Breakdown of Acute Condition Episode Costs by Highest Cost Service Categories (2 of 4)

Figure A.1: Highest Cost Service Categories, Acute Condition Episodes



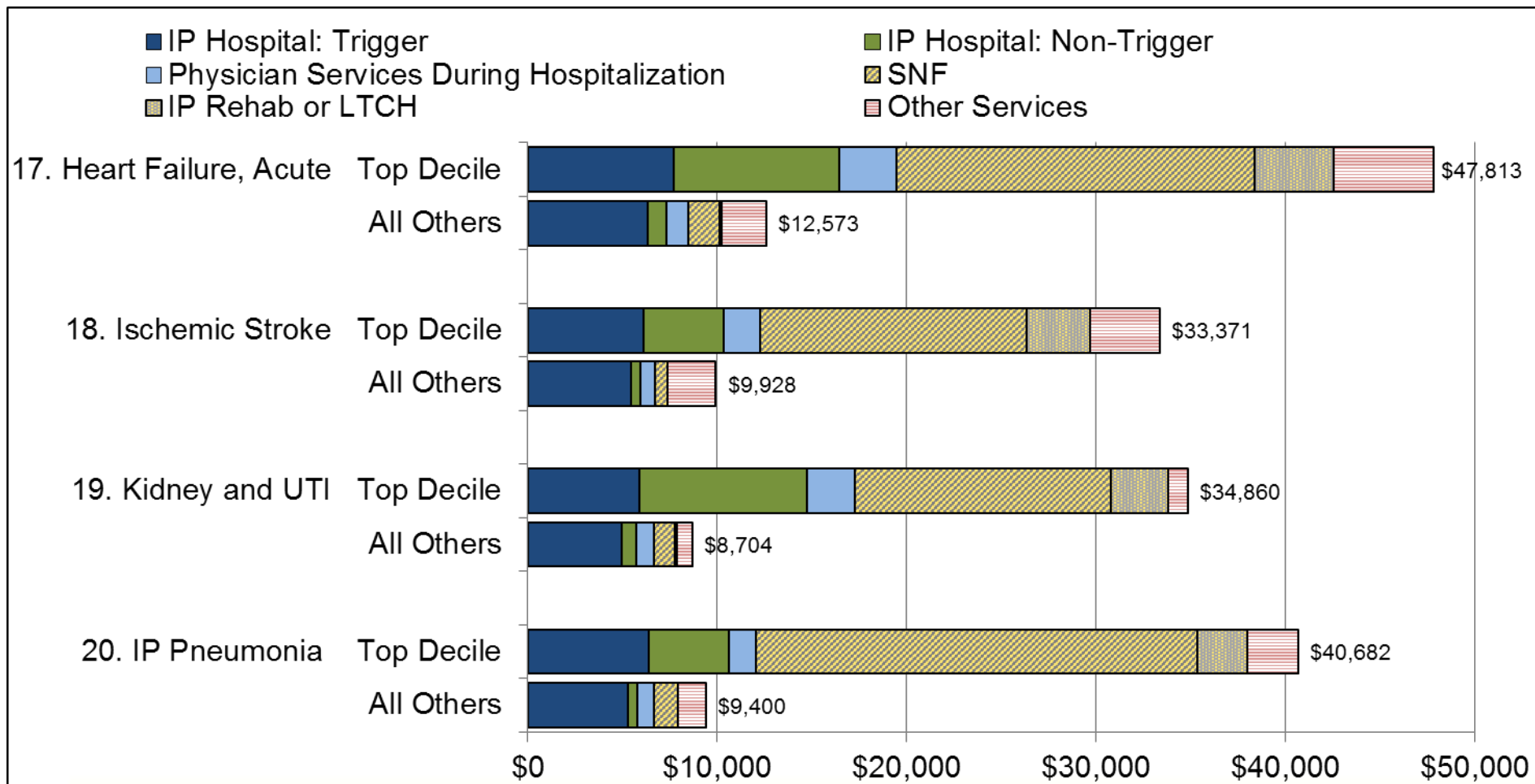
Breakdown of Acute Condition Episode Costs by Highest Cost Service Categories (3 of 4)

Table A.6 (cont.): Highest Cost Service Categories, Acute Condition Episodes

Major Episode Type		Average Non-Risk-Adjusted Cost	IP Hospital: Trigger	IP Hospital: Non-Trigger	Phys. Services During Hospitalization	SNF	IP Rehab or Long Term Care Hospital
17. Heart Failure, Acute	<i>Top Decile</i>	\$47,813	\$7,712	\$8,755	\$3,008	\$18,919	\$4,178
	<i>All Others</i>	\$12,573	\$6,341	\$997	\$1,129	\$1,636	\$125
18. Ischemic Stroke	<i>Top Decile</i>	\$68,886	\$8,716	\$2,079	\$2,726	\$34,150	\$17,537
	<i>All Others</i>	\$18,378	\$6,865	\$388	\$1,327	\$3,792	\$3,460
19. Kidney and UTI	<i>Top Decile</i>	\$43,364	\$5,540	\$3,694	\$1,082	\$30,900	\$1,108
	<i>All Others</i>	\$9,888	\$4,897	\$692	\$740	\$2,701	\$18
20. IP Pneumonia	<i>Top Decile</i>	\$39,592	\$7,384	\$2,251	\$1,809	\$21,240	\$4,192
	<i>All Others</i>	\$10,240	\$6,148	\$252	\$867	\$1,446	\$54

Breakdown of Acute Condition Episode Costs by Highest Cost Service Categories (4 of 4)

Figure A.1 (Cont.): Highest Cost Service Categories, Acute Condition Episodes



Summary of Service Category Breakdown for Procedural Episodes

- Procedural episodes in the top decile of cost tend to have either higher cost from the IP trigger event or post-acute care services
 - Costs from readmissions, skilled nursing facility (SNF), rehabilitation/long term care hospital (LTCH)
- Only major episode types are listed for the service category cost breakdown

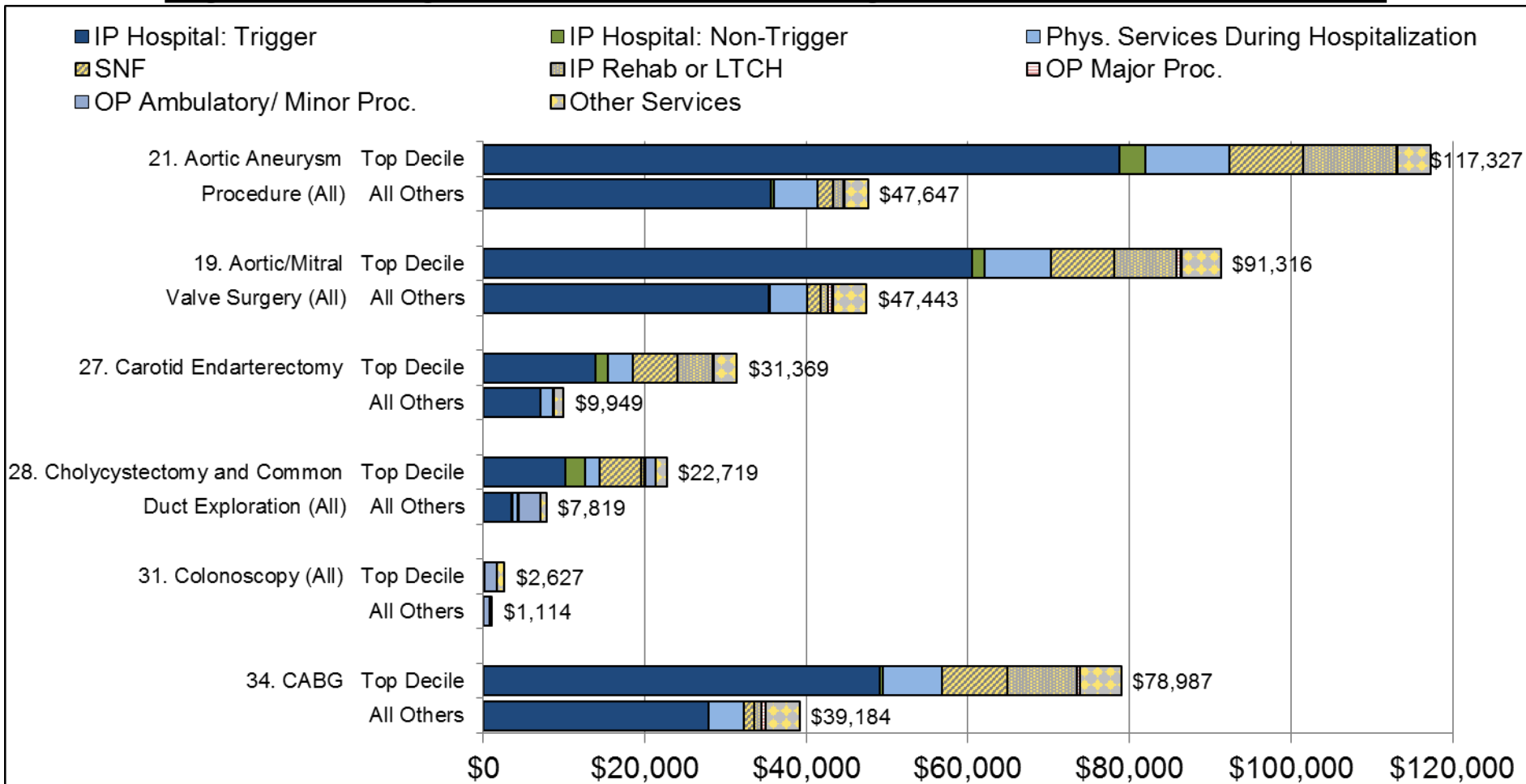
Breakdown of Procedural Episode Costs by Highest Cost Service Categories (1 of 6)

Table A.7: Highest Cost Service Categories, Procedural Episodes

Major Episode Type		Average Non-Risk-Adjusted Cost	IP Hospital: Trigger	IP Hospital: Non-Trigger	Phys. Services During Hospitalization	SNF	IP Rehab or LTCH	OP Major Proc.	OP Ambulatory/ Minor Proc.
21. Aortic Aneurysm Procedure (All)	Top Decile	\$117,327	\$78,751	\$3,242	\$10,335	\$9,141	\$11,642	\$107	\$21
	All Others	\$47,647	\$35,647	\$387	\$5,388	\$1,911	\$1,266	\$100	\$15
24. Aortic/Mitral Valve Surgery (All)	Top Decile	\$91,316	\$60,527	\$1,481	\$8,227	\$7,938	\$7,714	\$487	\$91
	All Others	\$47,443	\$35,391	\$54	\$4,701	\$1,600	\$930	\$562	\$54
27. Carotid Endarterectomy	Top Decile	\$31,369	\$13,931	\$1,534	\$3,108	\$5,433	\$4,473	\$101	\$18
	All Others	\$9,949	\$7,089	\$49	\$1,531	\$85	\$15	\$50	\$3
28. Cholecystectomy and Common Duct Exploration (All)	Top Decile	\$22,719	\$10,126	\$2,461	\$1,803	\$5,170	\$335	\$124	\$1,392
	All Others	\$7,819	\$3,532	\$86	\$641	\$151	\$1	\$48	\$2,649
31. Colonoscopy (All)	Top Decile	\$2,627	\$0	\$127	\$27	\$11	\$2	\$25	\$1,557
	All Others	\$1,114	\$0	\$0	\$2	\$0	\$0	\$0	\$795
34. CABG	Top Decile	\$78,987	\$49,152	\$360	\$7,234	\$8,098	\$8,676	\$363	\$48
	All Others	\$39,184	\$27,857	\$57	\$4,318	\$1,342	\$886	\$479	\$19

Breakdown of Procedural Episode Costs by Highest Cost Service Categories (2 of 6)

Figure A.2: Highest Cost Service Categories, Procedural Episodes



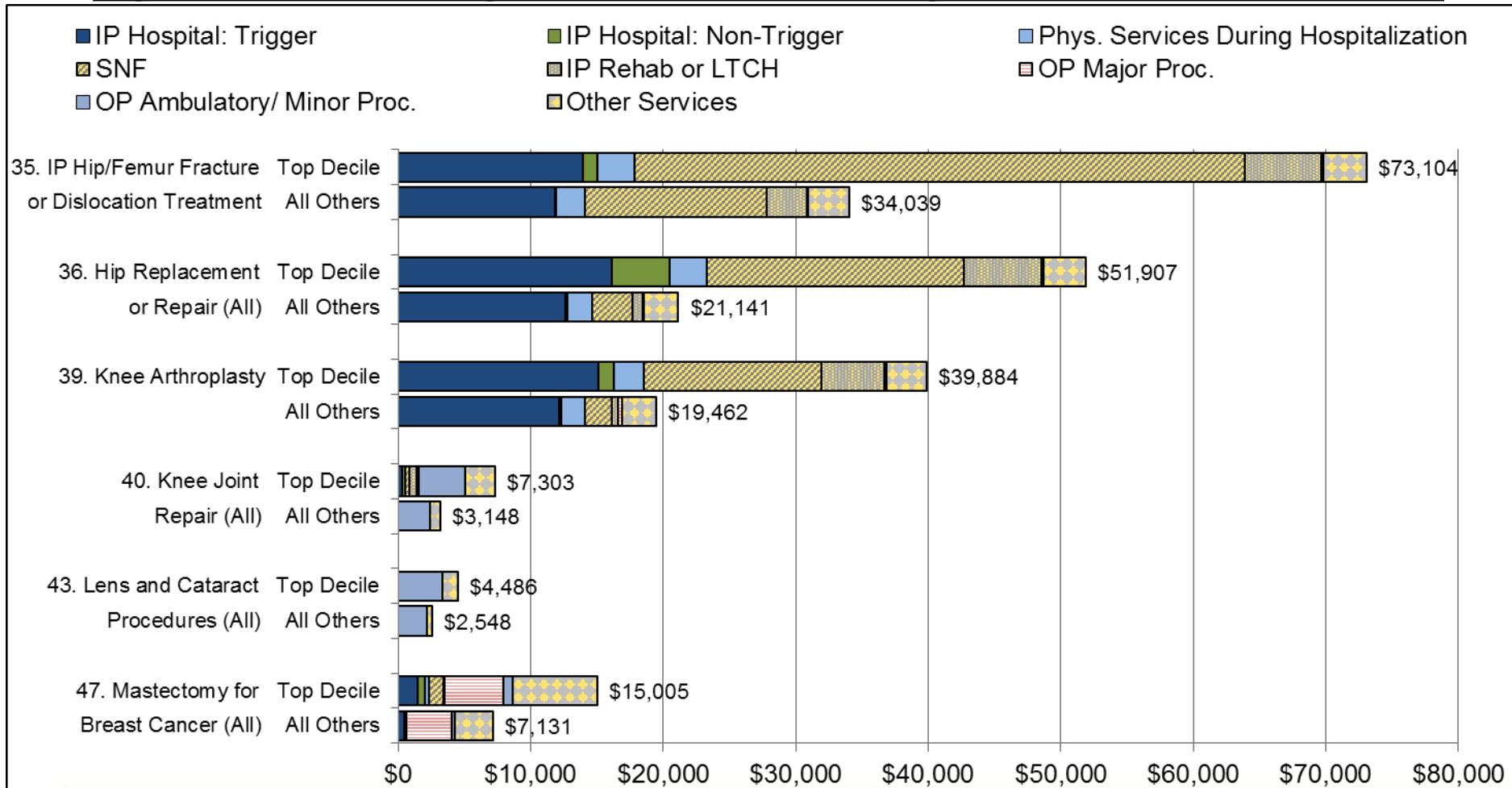
Breakdown of Procedural Episode Costs by Highest Cost Service Categories (3 of 6)

Table A.7 (cont.): Highest Cost Service Categories, Procedural Episodes

Major Episode Type		Average Non-Risk-Adjusted Cost	IP Hospital: Trigger	IP Hospital: Non-Trigger	Phys. Services During Hospitalization	SNF	IP Rehab or LTCH	OP Major Proc.	OP Ambulatory/ Minor Proc.
35. IP Hip/Femur Fracture or Dislocation Treatment	<i>Top Decile</i>	\$73,104	\$13,943	\$1,100	\$2,757	\$46,054	\$5,785	\$88	\$113
	<i>All Others</i>	\$34,039	\$11,811	\$87	\$2,213	\$13,670	\$3,095	\$23	\$46
36. Hip Replacement or Repair (All)	<i>Top Decile</i>	\$51,907	\$16,084	\$4,388	\$2,853	\$19,347	\$5,844	\$51	\$112
	<i>All Others</i>	\$21,141	\$12,589	\$147	\$1,881	\$3,081	\$756	\$38	\$36
39. Knee Arthroplasty	<i>Top Decile</i>	\$39,884	\$15,119	\$1,165	\$2,236	\$13,452	\$4,752	\$73	\$61
	<i>All Others</i>	\$19,462	\$12,181	\$101	\$1,782	\$2,030	\$460	\$304	\$38
40. Knee Joint Repair (All)	<i>Top Decile</i>	\$7,303	\$260	\$244	\$60	\$285	\$507	\$154	\$3,513
	<i>All Others</i>	\$3,148	\$2	\$0	\$2	\$3	\$0	\$10	\$2,361
43. Lens and Cataract Procedures (All)	<i>Top Decile</i>	\$4,486	\$0	\$0	\$0	\$1	\$0	\$16	\$3,343
	<i>All Others</i>	\$2,548	\$0	\$0	\$0	\$0	\$0	\$0	\$2,152
47. Mastectomy for Breast Cancer (All)	<i>Top Decile</i>	\$15,005	\$1,484	\$490	\$383	\$1,035	\$126	\$4,410	\$734
	<i>All Others</i>	\$7,131	\$487	\$19	\$112	\$3	\$0	\$3,430	\$235

Breakdown of Procedural Episode Costs by Highest Cost Service Categories (4 of 6)

Figure A.2 (Cont.): Highest Cost Service Categories, Procedural Episodes



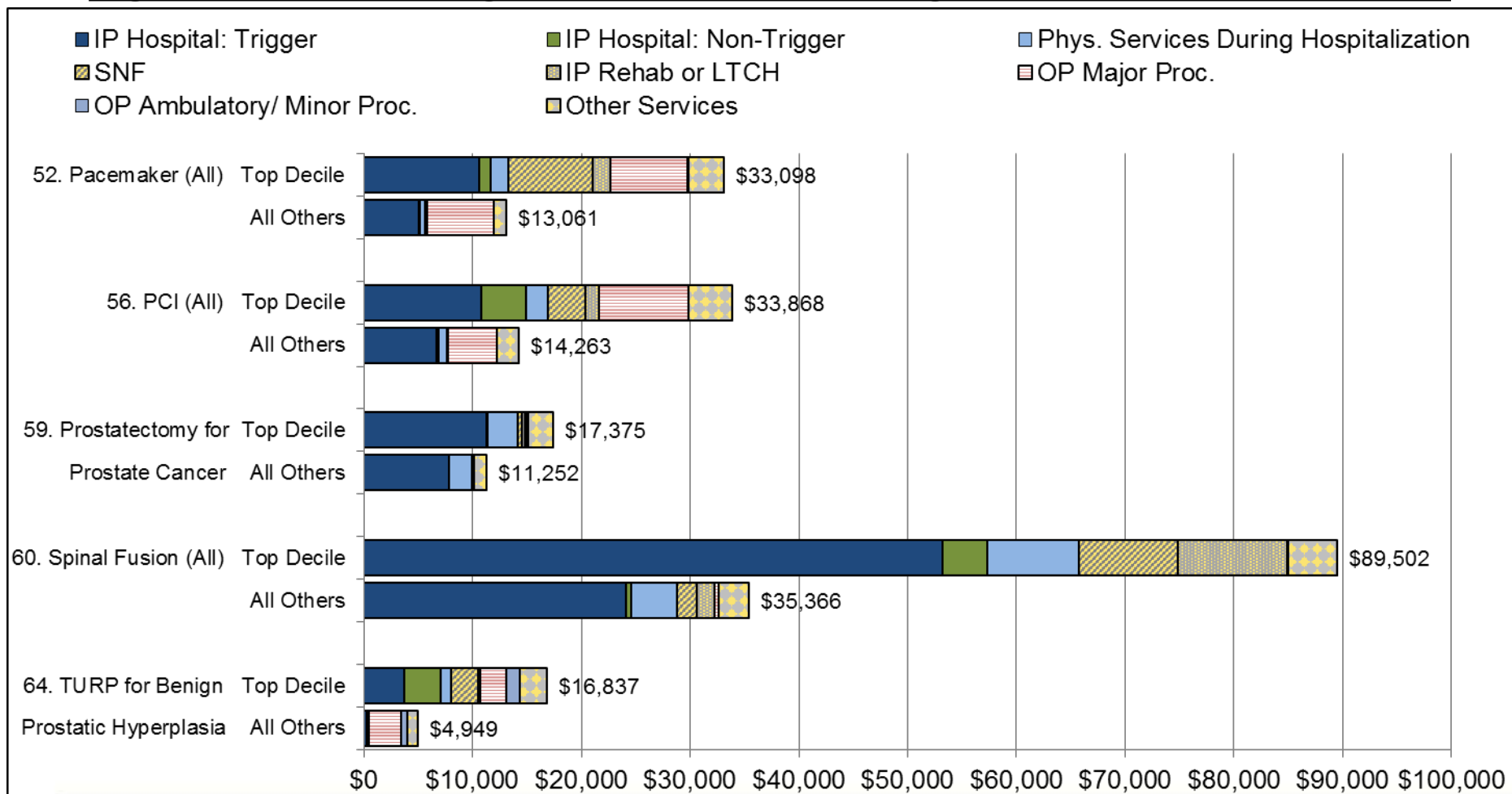
Breakdown of Procedural Episode Costs by Highest Cost Service Categories (5 of 6)

Table A.7 (cont.): Highest Cost Service Categories, Procedural Episodes

Major Episode Type		Average Non-Risk-Adjusted Cost	IP Hospital: Trigger	IP Hospital: Non-Trigger	Phys. Services During Hospitalization	SNF	IP Rehab or LTCH	OP Major Proc.	OP Ambulatory/ Minor Proc.
52. Pacemaker (All)	<i>Top Decile</i>	\$33,098	\$10,642	\$1,030	\$1,611	\$7,746	\$1,617	\$7,076	\$83
	<i>All Others</i>	\$13,061	\$5,072	\$38	\$503	\$220	\$12	\$6,099	\$31
56. PCI (All)	<i>Top Decile</i>	\$33,868	\$10,818	\$4,117	\$2,001	\$3,402	\$1,283	\$8,223	\$51
	<i>All Others</i>	\$14,263	\$6,713	\$141	\$818	\$98	\$7	\$4,460	\$22
59. Prostatectomy for Prostate Cancer	<i>Top Decile</i>	\$17,375	\$11,298	\$76	\$2,801	\$360	\$293	\$114	\$189
	<i>All Others</i>	\$11,252	\$7,791	\$0	\$2,181	\$0	\$2	\$121	\$71
60. Spinal Fusion (All)	<i>Top Decile</i>	\$89,502	\$53,239	\$4,074	\$8,443	\$9,095	\$10,024	\$106	\$32
	<i>All Others</i>	\$35,366	\$24,071	\$467	\$4,306	\$1,731	\$1,659	\$380	\$26
64. TURP for Benign Prostatic Hyperplasia	<i>Top Decile</i>	\$16,837	\$3,701	\$3,350	\$966	\$2,486	\$159	\$2,459	\$1,226
	<i>All Others</i>	\$4,949	\$256	\$89	\$84	\$3	\$0	\$3,007	\$529

Breakdown of Procedural Episode Costs by Highest Cost Service Categories (6 of 6)

Figure A.2 (Cont.): Highest Cost Service Categories, Procedural Episodes



Addendum A: Summary Statistics

Addendum A provides summary statistics on:

- Demographics of beneficiaries included in the 2014 Supplemental QRURs
- Average payment-standardized, risk-adjusted costs by episode type
- Breakdown of episode costs by service categories for high-cost episodes (90th cost percentile) and all other episodes
- **Percent of episode costs billed by attributed medical group or solo practitioner**

Summary of Acute Condition Episode Costs Billed By Attributed TIN

- The attributed TIN tends to bill roughly 80% of costs in acute condition episode types
 - Most of the cost comes from the trigger IP event
 - Opportunities for care coordination can be identified for some acute condition episode types where the outside TINs bill higher post-acute care costs than the attributed TIN
- Only major episode types are listed for the attributed TIN cost breakdown
- Exhibit 3D of the Supplemental QRURs displays the highest billing providers by setting both within and outside the TIN
- Appendix C of the Detailed Methods document lists the criteria for services billed, ordered, or referred by the TIN

Acute Condition Episode Costs Billed By Attributed TIN (1 of 2)

Table A.8: Average Costs Billed By Attributed TIN, Acute Condition Episodes

Episode Type		% of All Costs	Trigger IP Stay	IP Hospital: Non-Trigger	Phys. Services During Hospitalization	SNF	IP Rehab or LTCH
1. AMI(All)	Inside	81.4%	\$11,364	\$617	\$1,075	\$1,070	\$309
	Outside	18.6%	\$0	\$292	\$693	\$1,123	\$121
5. Asthma/COPD, Acute	Inside	79.3%	\$5,528	\$654	\$619	\$1,077	\$285
	Outside	20.7%	\$0	\$237	\$353	\$897	\$93
6. AFib/Flutter, Acute	Inside	76.5%	\$5,035	\$1,105	\$674	\$1,204	\$270
	Outside	23.5%	\$0	\$480	\$458	\$1,104	\$100
7. Cellulitis (All)	Inside	82.1%	\$5,384	\$287	\$599	\$1,522	\$196
	Outside	17.9%	\$0	\$630	\$335	\$1,891	\$107
12. GI Hemorrhage (All)	Inside	82.6%	\$6,568	\$437	\$730	\$849	\$10
	Outside	17.4%	\$0	\$555	\$484	\$1,318	\$9

For this and the following slides, all attributed episodes are included. The term “Inside” refers to average costs billed by the attributed TIN. This table does not display all service categories.

Acute Condition Episode Costs Billed By Attributed TIN (2 of 2)

**Table A.8 (Cont.): Average Costs Billed By Attributed TIN,
Acute Condition Episodes**

Episode Type		% of All Costs	Trigger IP Stay	IP Hospital: Non-Trigger	Phys. Services During Hospitalization	SNF	IP Rehab or LTCH
17. Heart Failure, Acute	<i>Inside</i>	76.7%	\$6,458	\$1,216	\$774	\$1,747	\$380
	<i>Outside</i>	23.3%	\$0	\$583	\$562	\$1,535	\$135
18. Ischemic Stroke	<i>Inside</i>	73.3%	\$6,954	\$360	\$813	\$2,592	\$3,956
	<i>Outside</i>	26.7%	\$0	\$196	\$636	\$4,070	\$901
19. Kidney and UTI	<i>Inside</i>	77.3%	\$4,966	\$291	\$550	\$2,353	\$85
	<i>Outside</i>	22.7%	\$0	\$729	\$269	\$3,116	\$51
20. IP Pneumonia	<i>Inside</i>	81.7%	\$6,335	\$335	\$659	\$1,878	\$376
	<i>Outside</i>	18.3%	\$0	\$124	\$354	\$1,480	\$103

Summary of Procedural Episode Costs Billed By Attributed TIN

- The attributed TIN tends to bill roughly 90% of costs in procedural episode types
 - TINs not attributed the episode do not bill costs during the trigger IP stay, which accounts for the majority of episode costs on average

Procedural Episode Costs Billed By Attributed TIN (1 of 3)

Table A.9: Average Costs Billed By Attributed TIN, Procedural Episodes

Episode Type		% of All Costs	Trigger IP Stay	IP Hospital: Non-Trigger	Phys. Services During Hospitalization	SNF	IP Rehab or LTCH	OP Major Proc.	OP Ambulatory/ Minor Proc.
21. Aortic Aneurysm Procedure (All)	Inside	89.8%	\$40,073	\$294	\$4,980	\$217	\$458	\$67	\$4
	Outside	10.2%	\$0	\$377	\$906	\$2,422	\$1,853	\$35	\$11
24. Aortic/Mitral Valve Surgery (All)	Inside	89.5%	\$37,907	\$145	\$4,286	\$453	\$401	\$205	\$14
	Outside	10.5%	\$0	\$51	\$768	\$1,780	\$1,209	\$350	\$44
27. Carotid Endarterectomy	Inside	92.4%	\$7,775	\$181	\$1,429	\$95	\$106	\$52	\$2
	Outside	7.6%	\$0	\$16	\$260	\$525	\$354	\$4	\$3
28. Cholecystectomy and Common Duct Exploration (All)	Inside	90.9%	\$4,192	\$18	\$446	\$59	\$4	\$54	\$2,446
	Outside	9.1%	\$0	\$306	\$311	\$594	\$30	\$2	\$78
31. Colonoscopy (All)	Inside	89.8%	\$0	\$5	\$2	\$0	\$0	\$2	\$796
	Outside	10.2%	\$0	\$8	\$2	\$1	\$0	\$1	\$75
34. CABG	Inside	86.8%	\$29,988	\$40	\$3,570	\$413	\$375	\$154	\$4
	Outside	13.2%	\$0	\$47	\$1,041	\$1,604	\$1,291	\$313	\$17

Procedural Episode Costs Billed By Attributed TIN (2 of 3)

Table A.9 (Cont.): Average Costs Billed By Attributed TIN, Procedural Episodes

Episode Type		% of All Costs	Trigger IP Stay	IP Hospital: Non-Trigger	Phys. Services During Hospitalization	SNF	IP Rehab or LTCH	OP Major Proc.	OP Ambulatory/ Minor Proc.
35. IP Hip/Femur Fracture or Dislocation Treatment	Inside	52.1%	\$11,983	\$140	\$1,526	\$2,401	\$532	\$17	\$13
	Outside	47.9%	\$43	\$50	\$742	\$14,507	\$2,829	\$13	\$40
36. Hip Replacement or Repair (All)	Inside	81.0%	\$12,939	\$324	\$1,738	\$402	\$176	\$37	\$36
	Outside	19.0%	\$0	\$247	\$241	\$4,307	\$1,088	\$3	\$7
39. Knee Arthroplasty	Inside	85.0%	\$12,476	\$90	\$1,685	\$278	\$107	\$276	\$36
	Outside	15.0%	\$0	\$117	\$143	\$2,894	\$784	\$5	\$4
40. Knee Joint Repair (All)	Inside	94.7%	\$28	\$3	\$6	\$3	\$0	\$24	\$2,416
	Outside	5.3%	\$0	\$22	\$2	\$28	\$51	\$1	\$61
43. Lens and Cataract Procedures (All)	Inside	93.7%	\$0	\$0	\$0	\$0	\$0	\$1	\$2,139
	Outside	6.3%	\$0	\$0	\$0	\$0	\$0	\$1	\$132
47. Mastectomy for Breast Cancer (All)	Inside	83.6%	\$556	\$41	\$119	\$24	\$2	\$3,420	\$227
	Outside	16.4%	\$32	\$25	\$20	\$82	\$10	\$108	\$58

Procedural Episode Costs Billed By Attributed TIN (3 of 3)

Table A.9 (Cont.): Average Costs Billed By Attributed TIN, Procedural Episodes

Episode Type		% of All Costs	Trigger IP Stay	IP Hospital: Non-Trigger	Phys. Services During Hospitalization	SNF	IP Rehab or LTCH	OP Major Proc.	OP Ambulatory/ Minor Proc.
52. Pacemaker (All)	Inside	90.4%	\$5,617	\$93	\$382	\$322	\$68	\$5,975	\$17
	Outside	9.6%	\$28	\$43	\$234	\$653	\$106	\$215	\$20
56. PCI (All)	Inside	89.0%	\$7,108	\$443	\$712	\$198	\$79	\$4,572	\$9
	Outside	11.0%	\$24	\$97	\$226	\$231	\$57	\$263	\$15
59. Prostatectomy for Prostate Cancer	Inside	97.3%	\$8,142	\$4	\$2,183	\$9	\$11	\$120	\$69
	Outside	2.7%	\$0	\$4	\$61	\$28	\$20	\$1	\$14
60. Spinal Fusion (All)	Inside	88.4%	\$27,639	\$388	\$4,273	\$151	\$363	\$332	\$14
	Outside	11.6%	\$0	\$462	\$558	\$2,322	\$2,166	\$10	\$12
64. TURP for Benign Prostatic Hyperplasia	Inside	89.9%	\$601	\$56	\$101	\$19	\$1	\$2,888	\$574
	Outside	10.1%	\$0	\$359	\$71	\$232	\$15	\$64	\$25

Addendum Outline

- **Addendum A:** Summary Statistics on the 2014 Reports
- **Addendum B:** Attribution to Medical Group Practice(s) and Solo Practitioner(s)
- **Addendum C:** Cost Distribution of Episode Types

Addendum B: Attribution of Episodes

- Rules for attributing episodes to medical group practice(s) and/or solo practitioner(s) and identifying the lead eligible professional(s)
- Summary statistics on:
 - Percentage of inpatient (IP) Evaluation & Management (E&M) visits during the trigger event of an acute condition episode billed by attributed TIN
 - Percentage of acute condition episodes attributed to multiple TINs
 - Percentage of procedural episodes attributed to multiple TINs

Addendum B: Attribution of Episodes

- Rules for attributing episodes to medical group practice(s) and/or solo practitioner(s) and identifying the lead eligible professional(s)
- Summary statistics on:
 - Percentage of inpatient (IP) Evaluation & Management (E&M) visits during the trigger event of an acute condition episode billed by attributed TIN
 - Percentage of acute condition episodes attributed to multiple TINs
 - Percentage of procedural episodes attributed to multiple TINs

Rules for Attribution to TIN(s) and Identification of Lead Eligible Professional(s)

- An episode is assigned to the TIN(s) determined to be the most responsible for the patient's initial care
- A lead eligible professional (EP) within the attributed TIN(s) is identified for informational purposes
 - Lead EP is identified by their National Provider Identifier (NPI)

Table B.1: Summary of Medical Group Practice Attribution Methodology

Episode Type	TIN(s) Attribution	Lead EP(s) Identified within Attributed TIN
Acute Condition	TIN(s) billing at least 30% of IP E&M visits during trigger event	Top three EPs with highest number of IP E&M visits during trigger event
Procedural	TIN(s) listed on physician claims concurrent with trigger event	Performing EP(s) on physician claims concurrent with trigger event

More information can be found in the Detailed Methods documentation on this [CMS webpage](#).

Addendum B: Attribution of Episodes

- Rules for attributing episodes to medical group practice(s) and/or solo practitioner(s) and identifying the lead EP(s)
- Summary statistics on:
 - Percentage of inpatient (IP) Evaluation & Management (E&M) visits during the trigger event of an acute condition episode billed by attributed TIN
 - Percentage of acute condition episodes attributed to multiple TINs
 - Percentage of procedural episodes attributed to multiple TINs

Attribution of Acute Condition Episodes (1 of 4)

- Acute condition episodes are attributed to all TINs that bill at least 30% of inpatient E&M visits during the trigger event
 - The “trigger event” is the inpatient (IP) stay that opens the episode
 - **IP E&M visits** are identified using CPT-4 codes
- In the national sample, acute condition episodes had an average of 6-8 IP E&M visits during the trigger event, and the attributed TIN billed an average of 5 IP E&M visits during the trigger event
- The specific codes that define an IP E&M visit are listed in Appendix D of the *Detailed Methods* documentation on this [CMS webpage](#).

Attribution of Acute Condition Episodes (2 of 4)

Table B.2: Summary of IP E&M Visits, Acute Condition Episodes

Episode Name	Average IP E&M Visits During Trigger Event	Average IP E&M Visits Billed by Attributed TIN
1. AMI (All)	8.8 Visits	5.2 Visits
5. Asthma/COPD, Acute Exacerbation	6.8 Visits	4.6 Visits
6. AFib/Flutter, Acute Exacerbation	7.4 Visits	4.5 Visits
7. Cellulitis (All)	7.4 Visits	4.9 Visits
12. GI Hemorrhage (All)	8.3 Visits	4.9 Visits
17. Heart Failure, Acute Exacerbation	8.7 Visits	5.3 Visits
18. Ischemic Stroke	8.5 Visits	5.3 Visits
19. Kidney and UTI	6.3 Visits	4.5 Visits
20. Pneumonia, IP-Based	7.7 Visits	5.2 Visits

Attribution of Acute Condition Episodes (3 of 4)

- About two-thirds of acute condition episodes were attributed to one TIN that billed at least 30% IP E&M visits during the trigger event (i.e., triggering IP stay)
- About one-third of acute condition episodes were attributed to more than one TIN because multiple TINs billed at least 30% IP E&M visits during the trigger event
- A low percentage of acute condition episodes were unattributed because no IP E&M claims were billed during the trigger event or if no TIN billed at least 30% IP E&M visits during the trigger event

Attribution of Acute Condition Episodes (4 of 4)

Table B.3: Summary of Attribution Methodology

Episode Name	Attributed to One TIN <i>Only one TIN billed IP E&M visits during trigger event</i>	Attributed to One TIN <i>2+ TINs billed IP E&M visits during trigger event but only one TIN billed at least 30%</i>	Attributed to Multiple TINs <i>2+ TINs billed at least 30% IP E&M visits during trigger event</i>	Unattributed
1. AMI (All)	28.8%	29.1%	37.7%	4.4%
5. Asthma/COPD, Acute Exacerbation	48.5%	20.7%	27.2%	3.6%
6. Afib/Flutter, Acute Exacerbation	33.3%	24.7%	38.6%	3.4%
7. Cellulitis (All)	44.1%	24.2%	27.4%	4.3%
12. GI Hemorrhage (All)	23.8%	36.7%	35.2%	4.2%
17. Heart Failure, Acute Exacerbation	36.4%	25.1%	34.3%	4.2%
18. Ischemic Stroke	29.2%	35.5%	31.5%	3.8%
19. Kidney and UTI	52.1%	22.4%	21.5%	3.9%
20. Pneumonia, IP-Based	49.4%	23.0%	23.7%	3.9%

Addendum B: Attribution of Episodes

- Rules for attributing episodes to medical group practice(s) and/or solo practitioner(s) and identifying the lead eligible professional (EP)
- Summary statistics on:
 - Percentage of inpatient (IP) Evaluation & Management (E&M) visits during the trigger event of an acute condition episode billed by attributed TIN
 - Percentage of acute condition episodes attributed to multiple TINs
 - Percentage of procedural episodes attributed to multiple TINs

Attribution of Procedural Episodes (1 of 2)

- Most procedural episode types (95-100%) were attributed to one TIN
- Episodes are typically attributed to more than one TIN in the case of co-surgeons
- Episodes can be unattributed if there was no physician claim concurrent with the trigger event

Attribution of Procedural Episodes (2 of 2)

Table B.4: Summary of Attribution Methodology

Episode Name	Attributed to One TIN	Attributed to 2+ TINs	Unattributed
21. Aortic Aneurysm Procedure (All)	97.7%	2.3%	0.0%
24. Aortic/Mitral Valve Surgery (All)	93.0%	0.0%	7.0%
27. Carotid Endarterectomy	98.1%	0.0%	1.8%
28. Cholecystectomy and Common Duct Exploration (All)	100.0%	0.0%	0.0%
31. Colonoscopy (All)	100.0%	0.0%	0.0%
34. CABG	98.5%	0.0%	1.5%
35. Hip/Femur Fracture or Dislocation Treatment, IP-Based	100.0%	0.0%	0.0%
36. Hip Replacement or Repair (All)	95.6%	0.2%	4.2%
39. Knee Arthroplasty	100.0%	0.0%	0.0%
40. Knee Joint Repair (All)	100.0%	0.0%	0.0%
43. Lens and Cataract Procedures (All)	100.0%	0.0%	0.0%
47. Mastectomy for Breast Cancer (All)	97.4%	0.0%	2.5%
52. Pacemaker (All)	96.6%	0.4%	3.1%
56. PCI (All)	96.6%	0.1%	3.3%
59. Prostatectomy for Prostate Cancer	98.2%	0.1%	1.8%
60. Spinal Fusion (All)	94.5%	5.5%	0.0%
64. TURP for Benign Prostatic Hyperplasia	100.0%	0.0%	0.0%

Addendum Outline

- **Addendum A:** Summary Statistics on the 2014 Reports
- **Addendum B:** Attribution to Medical Group Practice(s) and Solo Practitioner(s)
- **Addendum C:** Cost Distribution of Episode Types

Summary of Acute Condition and Procedural Episode Cost Distribution Tables

- The following slides show episode costs for the 1st, 25th, 50th, 75th, and 99th cost percentiles within an episode type
 - All costs displayed are risk-adjusted
- Major episode types with subtypes only have distributions displayed for the subtypes to facilitate more accurate comparison between episodes, as higher cost episode subtypes could skew the major episode cost distribution

Episode Cost Distribution Percentiles (1 of 3)

Table C.1: Acute Condition Episode Cost Percentile Distribution

Episode Name	Count	1 st	25 th	50 th	75 th	99 th
AMI without PCI/CABG	83,190	\$4,655	\$8,510	\$11,761	\$16,882	\$56,973
AMI with PCI	56,361	\$13,285	\$16,430	\$18,332	\$22,687	\$50,722
AMI with CABG	8,639	\$31,822	\$43,007	\$47,384	\$56,896	\$108,788
Asthma/COPD, Acute Exacerbation	253,502	\$4,082	\$6,953	\$8,929	\$12,859	\$47,355
Afib/Flutter, Acute Exacerbation	53,997	\$3,685	\$6,213	\$8,855	\$15,178	\$52,316
Cellulitis in Diabetics	38,035	\$3,631	\$6,300	\$7,970	\$13,149	\$55,179
Cellulitis in Patients with Wound, Non-Diabetic	74,743	\$3,770	\$6,115	\$7,669	\$13,375	\$55,649
Cellulitis in Obese Patients, Non-Diabetic without Wound	3,017	\$3,709	\$6,569	\$7,710	\$10,353	\$54,434
Cellulitis in All Other Patients	24,805	\$3,175	\$5,600	\$6,769	\$8,605	\$43,523
GI Hemorrhage, Upper and Lower	64,498	\$4,557	\$7,367	\$8,873	\$13,002	\$49,022
GI Hemorrhage, Upper	82,192	\$4,233	\$7,515	\$9,234	\$13,816	\$50,234
GI Hemorrhage, Lower	39,283	\$3,974	\$6,682	\$8,226	\$11,262	\$45,071
GI Hemorrhage, Undefined	17,549	\$3,765	\$6,980	\$9,030	\$13,687	\$47,911
Heart Failure, Acute Exacerbation	309,257	\$4,447	\$8,109	\$11,396	\$19,088	\$63,236
Ischemic Stroke	168,274	\$5,003	\$9,199	\$16,098	\$31,503	\$87,087
Kidney and UTI	226,918	\$3,579	\$5,854	\$7,920	\$16,023	\$57,566
Pneumonia, IP-Based	248,595	\$4,075	\$7,324	\$9,809	\$14,387	\$53,359

This and the following tables do not include the major episode type if there are any subtypes for that episode type, as noted on the previous slide.

Episode Cost Distribution Percentiles (2 of 3)

Table C.2: Procedural Episode Cost Percentile Distribution

Episode Name	Count	1 st	25 th	50 th	75 th	99 th
Abdominal Aortic Aneurysm Procedure	2,389	\$19,224	\$27,621	\$33,296	\$44,586	\$129,996
Thoracic Aortic Aneurysm Procedure	6,200	\$27,353	\$42,615	\$52,419	\$68,630	\$165,780
Both Aortic and Mitral Valve Surgery	1,422	\$35,725	\$47,967	\$57,780	\$69,142	\$158,994
Aortic or Mitral Valve Surgery	17,870	\$30,308	\$40,726	\$46,838	\$57,120	\$109,986
Carotid Endarterectomy	34,547	\$5,231	\$9,080	\$10,129	\$12,828	\$41,360
Cholecystectomy	132,840	\$1,823	\$6,652	\$8,427	\$10,229	\$29,950
Surgical Biliary Tract Procedure	153	\$1,741	\$6,672	\$9,786	\$15,740	\$54,270
Colonoscopy with Invasive Procedure	1,593,809	\$554	\$958	\$1,195	\$1,551	\$3,473
Colonoscopy without Invasive Procedure	429,583	\$414	\$726	\$876	\$1,077	\$2,221
CABG	39,745	\$24,819	\$33,695	\$39,304	\$48,258	\$95,763
Hip/Femur Fracture or Dislocation Treatment, IP-Based	103,760	\$13,384	\$25,436	\$35,159	\$46,790	\$84,074
Hip Arthroplasty	141,200	\$10,634	\$17,784	\$21,280	\$27,407	\$65,041
Hip Arthroscopy and Hip Joint Repair	651	\$1,369	\$5,565	\$7,594	\$10,126	\$17,956
Knee Arthroplasty	257,497	\$6,793	\$16,829	\$19,625	\$24,293	\$48,465
Meniscus Repair	79,402	\$1,864	\$2,661	\$3,217	\$3,926	\$9,050
Knee Ligament Repair	114	\$2,020	\$5,399	\$7,925	\$13,787	\$69,837

Episode Cost Distribution Percentiles (3 of 3)

Table C.2 (Cont.): Procedural Episode Cost Percentile Distribution

Episode Name	Count	1 st	25 th	50 th	75 th	99 th
Cataract Surgery	1,035,807	\$2,322	\$2,902	\$3,128	\$4,014	\$7,559
Discission	435,488	\$345	\$552	\$720	\$917	\$3,707
IOL Removal/Repositioning or Secondary IOL Insertion	5,631	\$1,162	\$2,292	\$3,023	\$4,116	\$11,341
Lumpectomy or Partial Mastectomy without Reconstruction	30,862	\$1,394	\$4,564	\$6,377	\$8,765	\$15,305
Lumpectomy or Partial Mastectomy with Reconstruction	565	\$3,429	\$7,679	\$10,843	\$14,636	\$24,763
Simple or Modified Radical Mastectomy without Reconstruction	12,637	\$3,626	\$6,712	\$8,786	\$11,198	\$27,834
Simple or Modified Radical Mastectomy with Reconstruction	1,659	\$4,770	\$10,933	\$13,017	\$15,615	\$26,104
Pacemaker Placement, IP-Based	49,552	\$13,026	\$16,410	\$19,365	\$25,809	\$65,820
Pacemaker Placement, OP-Based	47,393	\$1,183	\$10,484	\$11,818	\$12,892	\$25,588
Pulse Generator Replacement	44,242	\$896	\$8,115	\$9,088	\$10,103	\$18,723
PCI, IP-Based	103,546	\$11,943	\$14,466	\$16,884	\$22,514	\$57,759
PCI, OP-Based	98,367	\$1,492	\$9,450	\$11,098	\$13,545	\$28,393
Prostatectomy for Prostate Cancer	10,386	\$9,359	\$10,518	\$11,099	\$12,441	\$18,722
Lumbar and/or Thoracic Spinal Fusion	68,788	\$5,588	\$29,494	\$34,045	\$46,994	\$115,078
Cervical Spinal Fusion	3,867	\$2,564	\$5,180	\$10,224	\$42,203	\$120,049
Long-Segment Spinal Fusion for Deformity	1,202	\$14,619	\$49,076	\$67,161	\$92,512	\$196,660
TURP for Benign Prostatic Hyperplasia	78,444	\$1,612	\$4,065	\$5,192	\$6,612	\$22,989

Reference: Further Information

- For further information on the 2014 Supplemental QRURs, please see: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html>
- Documents available on this webpage include:
 - Detailed methodology for the 2014 Supplemental QRURs
 - Tips for understanding and using the Supplemental QRURs
 - Responses to frequently asked questions (FAQs)
 - Instructions to access the 2014 Supplemental QRURs
 - Episode definitions
 - A sample 2014 Supplemental QRUR

Reference: Giving Feedback on the 2014 Supplemental QRURs

- To submit written comments and suggestions, please send an email to PVHelpdesk@cms.hhs.gov
 - Do not include any personally identifiable information