  P.O. Box 30449   
Salt Lake City, UT 84130-0449

[DATE]

[Provider Name]

[Address1]

[Address2]

[City], [State] [ZIP Code]

**RE: Variations in Practice Patterns and Opportunities for Improvement**

Dear Dr. <Name>:

Health care is at a pivotal point. Significant gaps remain in health care quality, patient experience and affordability and it is incumbent on all of us to close these gaps. As an important step, the Choosing Wisely initiative sponsored by the American Board of Internal Medicine Foundation with the support of many national specialty societies has provided lists of tests and treatments that they believe are of limited benefit to patients. In addition, many organizations have developed evidence-based guidelines for physicians on what the best circumstances are to utilize procedures and prescribe medications. Now many consumers and employers are encouraging payers to quantify the cost of the tests and treatments that may not be necessary or of little value in diagnosing or treating conditions under certain circumstances, and potentially not pay for them.

UnitedHealthcare’s physician network plays an important role in addressing these gaps and opportunities by utilizing health care resources as efficiently as possible while providing our members with quality care. To support physicians in their efforts, when practice patterns are identified that may represent opportunities to improve quality and decrease unwarranted variation in utilization, UnitedHealthcare will work hard to identify those practice patterns and provide identified physicians with the tools and information to improve resource utilization in a way that is consistent with evidence-based medicine guidelines.

To further complement and advance these efforts, ***UnitedHealthcare has developed the enclosed health care management summary according to evidence-based medicine guidelines, claims data, other UnitedHealthcare databases and an extensive list of services and procedures used in the care of patients.*** The health care management summary provides physicians with reports that outline their adherence to evidence-based guidelines compared to their peers on a risk- and geographically-adjusted basis; how they are using health care resources; and how they compare to physicians in their markets when it comes to treating patients pursuant to the relevant clinical care guidelines and utilization patterns.

We are sharing your health care management summary with you to support your continued efforts to provide quality care to your patients while improving outcomes and appropriately decreasing health care costs.

Based on a review of our member data, the following areas have been identified for you as a good starting place to address your practice’s adherence opportunities. More details for each of these areas of opportunity can be found in the enclosed health care management summary.

* <placeholder 1>
* <placeholder 2>
* <placeholder 3> top non-compliant Evidence Based Medicine (EBM) rule
* <placeholder 4>
* <placeholder 5>

**What we are asking you to do**

As we all work toward better health care outcomes at reduced costs, we ask you to take a look at this health care management summary and use the information as an opportunity to improve on overutilization of services. Please know that we will update the data in the health care management summary and share that information with you every six months over an 18-month period. We look forward to working with you during this time to support you in your improvement efforts.

We continue to incentivize quality care provided by our network physicians through programs such as the UnitedHealth Premium® physician designation program and pay-for-performance contracts. Please read your health care management summary and note the opportunities for improvement.

**If, over the course of the next 18 months, the data continues to show unexplained variation from the benchmarks without improvements that bring the practice pattern(s) closer to the norm, UnitedHealthcare will evaluate its next steps which could impact your:**

* **Participation in future UnitedHealthcare products and programs;**
* **Participation or compensation in our performance-based contracting (if applicable); and**
* **Designation under the UnitedHealth Premium Designation program as that program evolves over time.**

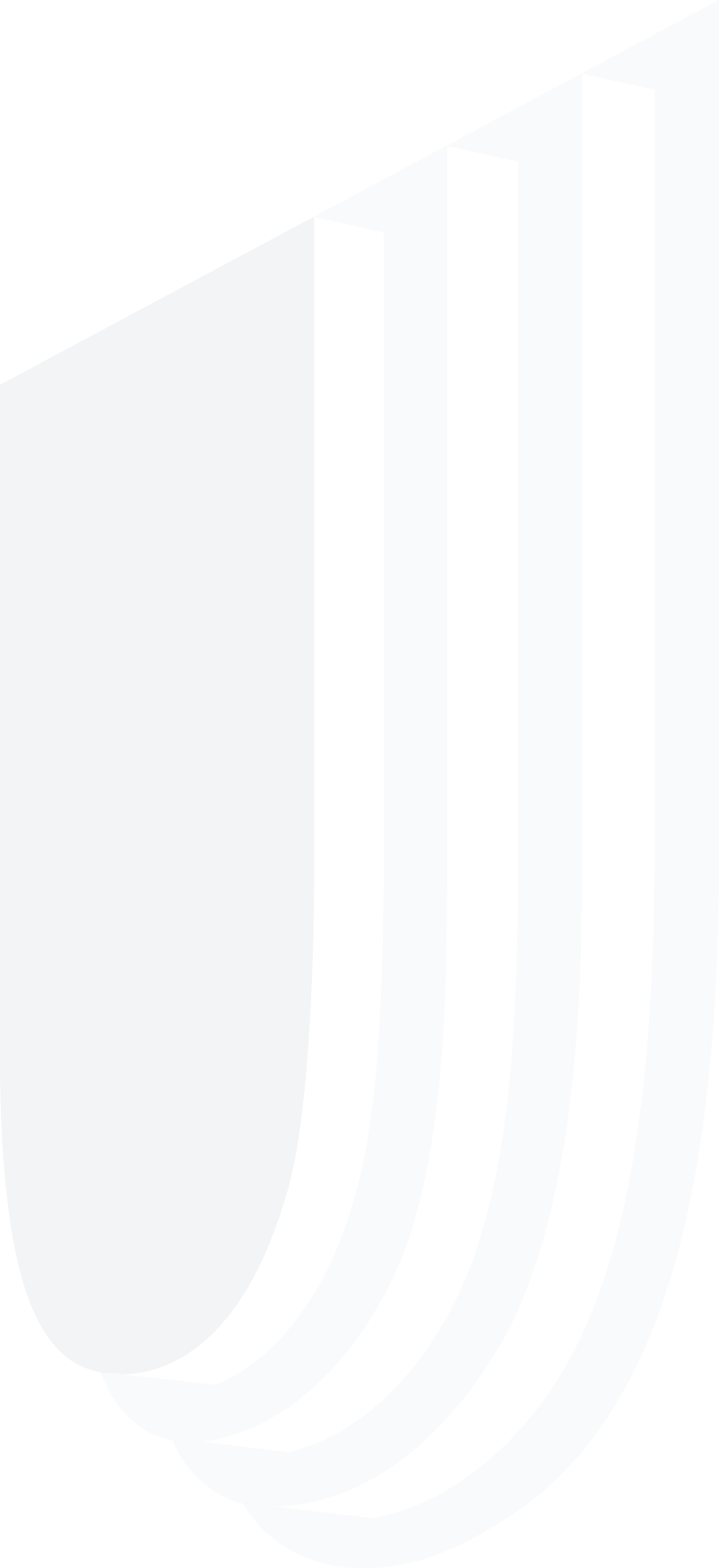
If you have questions, please call the Physician Support Center at <insert telephone number> or email [physician\_engagement@uhc.com](mailto:physician_engagement@uhc.com) or call me directly at SIGNATORY’S DIRECT CONTACT INFO.   
Thank you.

Sincerely,

/s/

<MMD name>

<MMD title>



**healthcare management   
summary**

**Table of Contents**

Section 1: Episodes of Care Data

Section 2: Evidence-based Medicine Summary

Section 3: Out-of-Network Utilization

Section 4: Office Practice

Section 5: Prescribing Practice

Section 6: Antibiotic Utilization

**Appendix**

Glossary

Methodological Detail

Description of Measures

Section 1: Episodes of Care Data

Population:Commercial, Medicare

Dates of Service: <Date Range>

Episodes of Care Summary: This information includes a summary of your Episode Treatment Groups® (ETG®). ETGs create episodes by collecting all inpatient, outpatient, and ancillary services into mutually exclusive and extensive categories. At the patient level, ETGs recognize co-morbidities, complications, and treatments that may change the patient’s clinical profile, health care utilization, and costs. ETGs enable powerful and accurate case mix adjustment. The following table summarizes your care as the responsible provider who is primarily accountable for all episodes, with expected costs matched by specialty and severity for the management of similar episodes. This measure is geographically adjusted using market specific benchmarks.



**KEY:** RED-SHADED – HIGHEST VALUES; YELLOW-SHADED – MEDIAN VALUES; GREEN-SHADED – LOWEST VALUES.

GREEN-SHADED (LOWEST) VALUES ARE CLOSEST TO THE PEER BENCHMARK.

**Inpatient Facility** – claims submitted by a treatment facility for room & board services as noted by room & board revenue codes

**Laboratory/Pathology** – claims submitted   
by any provider for laboratory and pathology services

**Management** – claims submitted by a clinician for the evaluation of a member’s condition, primarily consisting of CPT®-4 E&M codes

**Other Ancillary** – claims submitted by any provider for ‘other’ and miscellaneous outpatient services

**Outpatient Facility** – claims submitted by any provider for outpatient surgery, anesthesia and related services

**Pharmaceutical** – claims for a   
prescription drug, HCPC drug administration code, specialty pharmacy (non-chemotherapy) or DME

**Radiology** – claims submitted by any provider for radiological or similar services

**Surgery** – claims submitted by a clinician   
for procedural CPT®-4 codes for surgical or related procedures



Observed to expected ratio: The observed to   
expected (O:E) ratio is the ratio of the physician’s observed (actual) rate/value to the expected (risk adjusted) benchmark rate/value. For ETG data, this benchmark is calculated using information from physicians of the same specialty in the same   
geographic area, similar disease states, severity level and treatment status (for ETG data), pharmacy coverage status and product (Commercial or Medicare). Benchmark data are further refined to be inclusive of a least 50 episodes for at least three physicians. If the benchmark criteria are not met (i.e. less than 50 episodes and/or less than three physicians for a given ETG combination), the benchmark average cost is considered not valid and the physician is not evaluated for the specific ETG combination.

Episodes of Care Details: The table below lists your care for the top episode treatment groups by volume

Your overall observed to expected (O:E) ratio is XX% higher than the expected rate for your market, specialty, episode types and severity. The areas noted below have higher O:E ratios.

* **Management:** The O:E ratio is XX% higher than expected, driven by [physician visits, etc.].
* **Surgery:** The O:E ratio is x% higher than expected, driven by [outpatient surgery, etc.].
* **Inpatient Facility:** The O:E ratio for inpatient facility is more than x times higher than expected.
* **Outpatient Facility:** The O:E ratio for outpatient facility is more than x times higher than expected.
* **Laboratory/Pathology:** The O:E ratio is xx% higher than expected, driven by [freestanding clinical lab, etc.].
* **Radiology:** The O:E ratio is xx% higher than expected, driven by [freestanding clinical lab, etc.].
* **Other Ancillary:** The O:E ratio is xx% higher than expected, driven by [freestanding clinical lab, etc.].
* **Pharmaceutical:** The O:E ratio is x% higher than expected, driven by [pharmacy, etc.].

with costs matched by specialty for the management of similar episodes:



**Key:** Red-shaded – highest values; Yellow-shaded – median values; Green-shaded – lowest values.

* The O:E ratio for [ETG1] is X% higher than expected. This is driven by [category 1] and [category 2].
* The O:E ratio for [ETG2] is X% higher than expected. This is driven by [category 1] and [category 2].
* The O:E ratio for [ETG3] is X% higher than expected. This is driven by [category 1] and [category 2].
* The O:E ratio for [ETG4] is X% higher than expected. This is driven by [category 1] and [category 2].
* The O:E ratio for [ETG5] is X% higher than expected. This is driven by [category 1].

Section 2: Evidence-based Medicine Summary

Evidence-based Medicine Summary:Evidence-based medicine (EBM) integrates the available scientific literature, clinical experience, and patient values to help to improve physician adherence with treatment guidelines and member adherence with prescribed treatment. The data below identifies your top EBM conditions or procedures by total patient volume. This measure is not geographically adjusted.

Population: Commercial

Dates of Service: <Date Range>





HEDIS/Star Measures:The National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by health plans and regulators to evaluate the health plan’s performance on many aspects of their service. Stemming from the measures set forth by HEDIS, the Centers for Medicare & Medicaid Services (CMS) deployed its Star Rating system that rates a health plan’s Medicare Advantage programs. The Star Ratings are awarded based on a variety of quality measures that fall into member-centric categories. These categories include a focus on areas such as managing long term conditions, preventative care, member experiences with drug plans and customer service/plan responsiveness. For the clinically indicated HEDIS Star measures, we derive the HEDIS Star measures from data we obtain from you about the care you supplied for our Medicare Advantage members and that is what is reflected in the following table and charts.

Population: Medicare

Dates of Service: <Date Range>



Section 3: Out-of-Network Utilization

Population: Commercial

Dates of Service: <Date Range>

Out-of-Network Utilization: The information in this summary is sourced from your episode treatment group (ETG) data. It outlines the percentage of the total claims we paid for care for members attributed to you when those members saw out-of-network providers. The assigned provider types associated with these out-of-network costs as well as the percentages of the out-of-network cost are also summarized. This measure is not geographically adjusted or compared to a benchmark; it is a straight percentage.


* Among all Commercial ETG episodes, your percentage of cost for care provided by out of   
  network providers is X%.
* X% of your Commercial episodes has out of network activity.
* Provider types that are noted as having out of network costs include spec1, spec2 and spec3.

Section 4: Office Practice

Population: Commercial

Dates of Service: <Date Range>

Your Office Practice: This summary uses reimbursements for patient care made directly to you as one way to evaluate practice resource usage by comparing aggregates with those of your peers. The table below summarizes some of your resource usage measures compared to other doctors in your specialty, based on 12 months of claims data, and geographically adjusted. The utilization measures are compared to a national benchmark by specialty while the office practice cost measures are compared to a market benchmark for your geography.



**Key:** Red-shaded – highest values; Yellow-shaded – median values; Green-shaded – lowest values.

* Your cost per patient is x% higher/lower compared to the expected rate.
* Your cost per visit is X% higher/lower than expected.
* Your visit per patient ratio is X% higher/lower than expected.
* Your procedures per patient ratio is X% higher/lower than expected.
* Your level 4 visit percentage is x% higher/lower than expected.
* Your level 5 visit percentage is y% higher/lower than expected.
* Your utilization of modifier 25 is X% higher/lower than expected.

Population: Medicare

Dates of Service: <Date Range>



**Key:** Red-shaded – highest values; Yellow-shaded – median values; Green-shaded – lowest values.

* Your cost per patient is x% higher/lower compared to the expected rate.
* Your cost per visit is X% higher/lower than expected.
* Your visit per patient ratio is X% higher/lower than expected.
* Your procedures per patient ratio is X% higher/lower than expected.
* Your level 4 visit percentage is x% higher/lower than expected.
* Your level 5 visit percentage is y% higher/lower than expected.
* Your utilization of modifier 25 is X% higher/lower than expected.

Section 5: Prescribing Practice

Population: Commercial

Dates of Service: <Date Range>

Prescribing Practice: This report outlines how your prescribing patterns affect the cost paid by your patients and compares you with your peers. The table and graph below summarize some of your resource usage measures compared to other doctors in your specialty, based on 12 months of claims data. This measure uses a national benchmark.



**Key:** Red-shaded – highest values; Yellow-shaded – median values; Green-shaded – lowest values.

* Your scripts per patient ratio is X% higher/lower than expected.
* Your percentage of Tier 3 prescriptions is X% higher/lower than expected.

Section 6: Antibiotic Utilization

Population: Commercial

Dates of Service: <Date Range>

Antibiotics in Upper Respiratory Infections (URI), Bronchitis and Otitis Media:   
The information in this section summarizes the utilization of anti-infective prescription medications in treating upper respiratory infections, bronchitis and otitis media. Claims records submitted by you for members identified with these infections were compiled and matched with prescription claims for anti-infective medications filled within three days of the infection diagnosis to determine the antibiotic utilization rate. This measure uses a national market benchmark.

Antibiotic overutilization continues to be a problem in the health care setting despite literature on the risks associated with unnecessary prescribing. According to a recent study, the prescribing rate for a sore throat should be 10% and for bronchitis 0%.[[1]](#footnote-1) With the increase of antibiotic resistant super bugs, the burden on the patient and the health care system is expected to continue to rise.



* Your antibiotic utilization rate for <condition 1> is xx% higher than the market rate and yy% higher than the national rate.
* Your antibiotic utilization rate for <condition 2> is xx% higher than the market rate and yy% higher than the national rate.
* Your antibiotic utilization rate for <condition 3> is xx% higher than the market rate and yy% higher than the national rate.
* Your antibiotic utilization rate for <condition 4> is xx% higher than the market rate and yy% higher than the national rate.
* Your antibiotic utilization rate for <condition 5> is xx% higher than the market rate and yy% higher than the national rate.

Appendix

****Glossary****

Case mix adjustment – ETGs have been developed to account for differences in member severity, including variations in complicating conditions, comorbidities and major surgeries. This is usually accomplished by identifying discrete units of conditions which differ from one another with respect to resource consumption. Once these discrete groups of conditions are identified, any subsequent analysis based upon these discrete units can be said to be case mix adjusted.

Clinical homogeneity – ETGs are designed to be clinically homogeneous, which means each member’s illness and its severity are medically consistent with others belonging to the same ETG. This is important for two reasons: physicians and other direct care providers can relate to the illness groupings, allowing for meaningful communication regarding treatment; and, for observed differences in treatment patterns within an ETG, clinical homogeneity minimizes the argument of someone having sicker patients, providing the basis for substantive comparison and detailed drill-down analysis.

Episode – A complete treatment episode incorporates inpatient, outpatient, professional, and ancillary services, including pharmaceutical services. Once treatment for an episode has begun, all clinically relevant information is collected until an absence of treatment or clean period is detected. Thus, all appropriate procedural and cost information is collected and correctly assigned to one complete treatment episode.

Episode Treatment Groups® (ETG®) - Component: ETGs create episodes by collecting all inpatient, outpatient and ancillary services into mutually exclusive and extensive categories. At the patient level, ETGs recognize co-morbidities, complications and treatments that change the patient’s clinical profile, health care utilization, and costs. ETGs enable accurate case mix adjustment. The summary includes providers’ top episode treatment groups by volume, with costs matched by specialty for the management of similar episodes

Geographical adjustment, market – For the office practice cost measures only (cost per visit and cost per patient), a benchmark is established within each specialty based on the market peer average and serves as   
the basis of an expected value. The expected value in the cost-related claims view is an unweighted overall market average.

Geographical adjustment, national –For the office practice utilization measures only(visits per patient and procedures per patient), a benchmark is established within each specialty based on a national peer average and serves as the basis of an expected value. The expected value in the claims view is an unweighted overall national average.

Observed to expected ratio calculation – The observed to expected (O:E) ratio is calculated by   
aggregating the costs (observed) values for the episodes attributed to the physician against a benchmark of their peer groups’ patients (physicians of the same specialty in the same geographic area, similar disease state (ETG), severity level, treatment status, pharmacy coverage status, and product - Commercial or Medicare). Benchmark data are further refined to be inclusive of at least 50 episodes for at least three physicians. If the benchmark criteria are not met (i.e. less than 50 episodes and/or less than three physicians for a given ETG combination), the benchmark average cost is considered not valid and the physician is not evaluated for the specific ETG combination.

Responsible provider for an episode – The responsible provider is primarily accountable for the episode. This provider gets credit for the episode’s cost and utilization within the analysis. Only one provider is deemed the responsible provider for the episode. The determination of responsible provider for an episode is based on which provider has the highest combined charges for management and surgery records in the episode.



**Methodological Detail**

Section 1: Episodes of Care Category Descriptions:Below are the various categories of clinical services that may be grouped into an episode.



**Description of Measures**

Evidence-based Medicine (EBM) – EBM integrates available scientific literature and clinical experience. By integrating clinically relevant research evidence with actual care patterns, areas of care can be identified in which physicians can intervene to improve their compliance with treatment guidelines and member compliance with prescribed treatment.

Below are the specific EBM measures and the applicable specialties.











**HEDIS Star Measures**

Description of Measures:Below are the HEDIS Star measures and their specifications.



**Out-of-Network Utilization**

Description of Measures:Below are the measures for calculating out of network utilization.



**Office Practice**

Description of Measures: Below are the measures for calculating office practice data.



**Prescribing Practice**

Description of Measures:Below are the measures for pharmacy utilization.



**Antibiotic Utilization in Upper Respiratory Infections (URI), Bronchitis   
and Otitis Media**

Description of Measures:Below are the measures for antibiotic utilization.



Additional clinical information about antibiotic use and evidence based medicine:

Antibiotic resistance is a quickly growing, dangerous problem. World health leaders have described antibiotic-resistant bacteria as "nightmare bacteria" that "pose a catastrophic threat" to people in every country in the world. Each year in the United States, at least two million people become infected with bacteria that are resistant to antibiotics, and at least 23,000 people die each year as a direct result of these infections. Many more people die from other conditions that were complicated by an antibiotic-resistant infection.1

The Centers for Disease Control is arguing for a four-pronged approach to the issue2:

1. Preventing infections - by such things as immunization, infection control in health care settings,   
   safe food handling, and better hand hygiene — so that antibiotics will be used less often
2. Tracking antibiotic-resistant infections to understand the causes of resistance and to develop   
   preventive strategies
3. Changing the way antibiotics are employed to eliminate inappropriate use both in   
   humans and animals
4. Developing new drugs and diagnostics. Bacterial evolution ensures that the development of  
   antibiotic resistance can be slowed but not stopped, so new drugs are needed, as well as   
   tests to track resistance.

Please avoid unnecessary antibiotics for viral infections and prescribe first-line agents whenever appropriate. This will help improve health outcomes in your community and promote the quality and efficiency of care of   
your practice.

[[2]](#footnote-2)

1. http://.healthday.com/infectious-disease-information-21/antibiotics-news-30/too-many-antibiotics-still-prescribed consumer -for-sore-throats-bronchitis-studies-680798.html [↑](#footnote-ref-1)
2. ‘Antibiotic Resistance Threats in the US’, Centers for Disease Control; <http://www.cdc.gov/features/AntibioticResistanceThreats/>; updated: September 16, 2013.

   2 ‘CDC Sounds Alarm on Drug-Resistant Bugs’, MedPage Today; published: Sep 16, 2013, updated: Sep 17, 2013.

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   UHC2821j\_20140224 [↑](#footnote-ref-2)