Low Back Pain Cost Measure Field Test Report

Provider Name
Taxpayer Identification Number (TIN): XXXXXXXXX
National Provider Identifier (NPI): XXXXXXXXXX
Measurement Period: January 1, 2019 – December 31, 2019

1 MEASURE SCORE

This report shows your performance on the Low Back Pain measure for field testing. Field testing is a chance for stakeholders to provide feedback on the cost measures being developed in 2021-2022. For more information about field testing, please refer to the MACRA Feedback Page.[1]

The field testing period is from **January 10 to February 25, 2022**. To provide feedback on this measure, please navigate to the 2022 Cost Measures Field Testing Feedback Survey.

Contents

The information in this report is for field testing only. It doesn't affect any scoring or payment adjustments in the Merit-based Incentive Payment System (MIPS). The information in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicare Services (CMS), including but not limited to circumstances in which an error is discovered. Only clinicians (identified by their unique Taxpayer Identification Number [TIN] and National Provider Identifier [NPI] combination, or TIN-NPI) and clinician groups (identified by their TIN) with at least 20 episodes during the measurement period have received a field test report.[2]

[1] CMS, MACRA Feedback Page, https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback.
[2] Individuals using assistive technology may not be able to fully access information in this file. To request a fully accessible report, contact macra-cost-measures-info@acumenllc.com.

What is the Low Back Pain Cost Measure?

The Low Back Pain cost measure assesses the care for patients with a low back pain diagnosis. The measure identifies the start of a clinician-patient relationship by looking for a TIN billing a pair of services within 60 days of each other. Once the relationship starts, this opens up a period where the TIN is being monitored for the patient's care. That initial period can be extended if there are more services showing a continuing relationship. This ongoing care is then divided into episodes, or segments of at least 120 days so that a clinician can be assessed in a measurement period.

The measure includes clinically related costs to low back pain, including routine management for caring for low back pain (such as clinician visits, physical and occupational therapy, and medication) and (post)acute care services. It doesn't include services that are clinically unrelated to low back pain. In this report, "cost" generally means the Medicare allowed amount.[3] Costs are payment-standardized to facilitate comparisons of resource use. Payment standardization assigns a comparable allowed amount for the same service by removing geographic differences and payment adjustments from special Medicare programs, such as add-on payments for medical education.[4]

In addition, the actual episode costs are scaled to a 120-day period to enable meaningful comparison of costs between episodes of different length. The episode observed cost is also risk-adjusted to ensure fair comparisons. Risk adjustment neutralizes the effects of risk factors deemed to be outside of a clinician's influence (e.g., pre-existing conditions, age, or indicators of clinical severity). Finally, the measure adjusts for cost variation across specialties and across TINs with varying specialty compositions.

Please refer to Section 4 for high-level measure specifications. For more details, please refer to the Measure Information Form and the Measure Codes List file on the MACRA Feedback Page.

Your Field Testing Cost Measure Score

Table 1 shows how you performed on this measure in field testing. The score represents your average risk-adjusted cost to Medicare across all of your episodes for the Low Back Pain measure and adjusted for your specialty. You can compare it to the national average score to see how you performed compared to all clinicians with a least one Low Back Pain measure episode. This is an inverse measure, so a lower score indicates a lower cost.

[3] The Medicare allowed amount on Medicare claims data includes both Medicare and trust fund payments and any applicable patient deductible and coinsurance amounts.
[4] CMS, Price (Payment) Standardization Overview, https://www.resdac.org/articles/cms-price-payment-standardization-overview.

Table 1: Your Field Testing Cost Measure Score

	Low Back Pain Measure
Number of Episodes	48
Your Cost Measure Score (TIN-NPI)	$1,901
National Average Cost Measure Score	$1,992
Your Cost Measure Score Percentile (TIN-NPI)	57

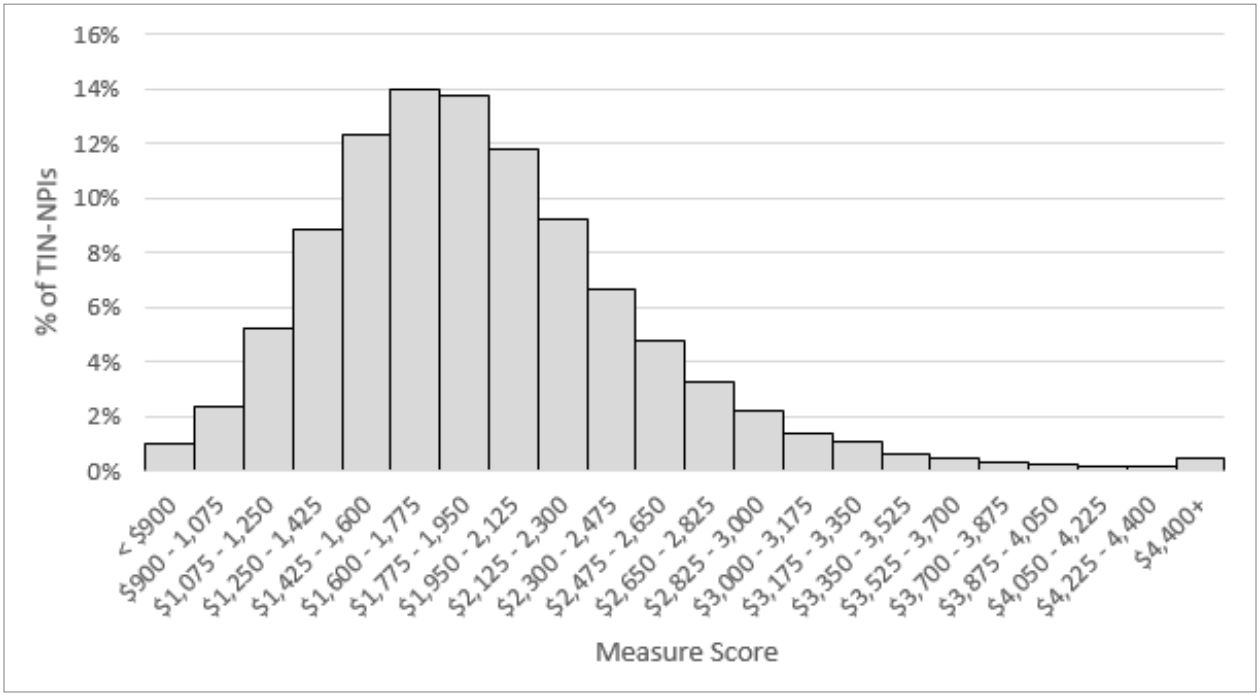
Note: Refer to the Glossary, Table A1 for definitions of metrics

The score percentile shows where you rank among all clinicians receiving a field test report. It represents the percentage of clinicians that had an equal or lower risk-adjusted cost to Medicare. Since this is an inverse measure, a lower percentile means that you performed at a lower cost than more clinicians. For example, if you're in the 25th score percentile, it means that your score was lower and you performed at a lower cost than 75% of clinicians for this measure.

Histogram of National Cost Measure Scores

Figure 1 shows a histogram of how clinicians performed on the Low Back Pain measure in field testing. Specifically, the distribution includes measure scores for all TIN-NPIs with at least 20 Low Back Pain measure episodes. There were 69,742 clinicians that met this volume threshold in field testing.

Figure 1: National Distribution of Field Testing Measure Scores



2 BREAKDOWN OF COST MEASURE PERFORMANCE

There are many ways of looking at where costs are coming from in your measure. This section has information about types of services and clinicians who are contributing to your episode costs.

Utilization and Cost of Different Types of Services

This section shows what types of costs are being captured by the measure. The tables show your performance compared with the national average and for TIN-NPIs in your risk bracket. A risk bracket represents clinicians likely to have a similar patient case-mix as you.

Risk brackets are constructed in several steps:

- We calculate a risk score for each episode that indicates the complexity of your patient.
    - It's calculated as the episode's expected cost (as predicted through risk adjustment) divided by the national average observed cost for the measure.
    - This yields a ratio, where a higher value indicates that the episode is expected to be more costly, based on the patient characteristics in the risk adjustment model.
- We then calculate your average risk score. This is the average of the risk scores for all your episodes.
- Finally, we create a distribution for the average risk score across all clinicians with at least 20 episodes for this measure.
    - We divide the distribution into deciles to create risk brackets.
    - Each risk bracket has clinicians who, on average, have a similar average episode risk score as you.

Table 2 provides a breakdown of service use and cost by setting and various categorizations. The table includes Medicare Parts A, B, and D services. For Part B and outpatient services, the table uses the Restructured BETOS Classification System (RBCS). This is a taxonomy that allows researchers to group Medicare Part B healthcare service codes into clinically meaningful categories.[5]

You can use this table to see how often your episodes have particular services, and compare this to the national average and to clinicians with a similar case-mix. You can also see the average observed cost of those services for all episodes with at least one service in a particular category.

Tables 2 and 3 highlight values where your performance is more markedly different from clinicians in your risk bracket with:

- An asterisk (*), which indicates that your performance was more than 1 standard deviation above the average for clinicians in your risk bracket; and
- A caret (^), which indicates that your performance was more than 2 standard deviations above the average for clinicians in your risk bracket.

[5] CMS, Restructured BETOS Classification System, https://data.cms.gov/provider-summary-by-type-of-service/provider-service-classifications/restructured-betos-classification-system.

Table 2: Service Use and Cost by Medicare Setting and Service Category

Medicare Setting and Service Category	Share of Episodes with ≥1 Service			Average Observed Cost of Services among Episodes with ≥ 1 Service		
	Your TIN-NPI	National Average	Your Risk Bracket	Your TIN-NPI	National Average	Your Risk Bracket
All Services	100.0%	100.0%	100.0%	$3,752	$1,949	$5,075
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding Emergency Department)	100.0%	100.0%	99.9%	$1,268	$862	$1,288
Outpatient Evaluation & Management Services	100.0%	90.0%	95.5%	$366	$325	$375
Major Procedures	2.1%	13.2%	14.5%	$1,421	$4,352	$4,860
Ambulatory/Minor Procedures	29.2%	32.7%	36.3%	$1,238	$835	$921
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	83.3%	67.6%	54.8%	$614	$503	$664
Ancillary Services	77.1%	69.1%	77.0%	$319	$262	$358
Laboratory, Pathology, and Other Tests	16.7%	41.4%	41.8%	$203	$117	$118
Imaging Services	70.8%	58.9%	67.1%	$276	$182	$238
Durable Medical Equipment and Supplies	8.3%	19.0%	21.1%	$197	$525	$639
Hospital Inpatient Services	12.5%	18.3%	24.5%	$9,959	$9,307	$18,313
Facility Services	10.4%	14.4%	20.7%	$10,626	$18,149	$20,433
Physician Services During Hospitalization	10.4%	18.2%	24.4%	$1,325	$1,333	$2,513
Emergency Department Services	8.3%	22.7%	20.9%	$565	$585	$638
Emergency Evaluation & Management Services	8.3%	22.4%	20.6%	$429	$563	$615
Procedures	2.1%	8.2%	7.3%	$221	$141	$153
Laboratory, Pathology, and Other Tests	4.2%	13.1%	11.3%	$6	$7	$7
Imaging Services	8.3%	19.3%	17.2%	$78	$44	$48
Post-Acute Services	8.3%	25.4%	26.9%	$10,487*	$3,269	$4,709
Home Health	4.2%	22.1%	23.9%	$2,934	$2,583	$2,515
Skilled Nursing Facility	0.0%	20.2%	16.9%	$0	$3,298	$5,167
Inpatient Rehabilitation or Long-Term Care Hospital	4.2%	9.4%	12.8%	$18,040	$13,253	$13,688
Part D Services	39.6%	65.3%	66.1%	$22	$134	$134
All Other Services	47.9%	73.1%	78.0%	$150	$275	$350
Ambulance Services	6.3%	15.6%	15.6%	$460	$419	$427
Anesthesia Services	10.4%	22.1%	29.9%	$323	$204	$301
Chemotherapy and Other Part B-Covered Drugs	12.5%	36.1%	34.3%	$6	$291	$294
Dialysis	0.0%	10.2%	6.9%	$0	$186	$243
All Other Services Not Otherwise Classified	0.0%	8.5%	6.9%	$0	$647	$981

Refer to the Glossary, Table A2 for definitions of metrics.

Table 3 provides a breakdown of service use and cost by clinical themes. Clinical themes are another way of categorizing the services that may be assigned in the measure.

Table 3: Service Use and Cost by Low Back Pain Clinical Theme

Clinical Theme	Share of Episodes with ≥1 Service			Average Observed Cost of Services among Episodes with ≥ 1 Service		
	Your TIN-NPI	National Average	Your Risk Bracket	Your TIN-NPI	National Average	Your Risk Bracket
Behavioral Health and Ancillary Services	2.1%	17.4%	14.6%	$35	$51	$53
Durable Medical Equipment	10.4%	23.1%	25.7%	$158	$348	$421
Hospitalizations	10.4%	14.4%	20.7%	$10,889	$18,395	$20,663
Imaging, Diagnostics, and Labs	72.9%	68.9%	77.1%	$363	$215	$290
Medications	12.5%	34.7%	32.6%	$6	$278	$278
Outpatient Visits	100.0%	88.3%	94.2%	$406	$371	$425
Part D Drugs	39.6%	65.3%	66.1%	$22	$134	$134
Patient Transport	6.3%	18.3%	16.8%	$460	$366	$398
Post-acute Care Services	16.7%	34.4%	32.7%	$5,312	$1,882	$3,402
Spinal Injections and Neurostimulators	29.2%	36.3%	38.4%	$1,238	$741	$875
Spinal Surgeries and Procedures	10.4%	22.5%	30.7%	$1,304	$1,430	$2,399
Telehealth	0.0%	11.6%	11.5%	$0	$132	$140
Therapy Services and Manipulation	83.3%	68.3%	56.3%	$611	$521	$681

Refer to the Glossary, Table A3 for definitions of metrics.

Clinicians Contributing to Your Episode Costs

Table 4 lists the clinicians that contributed the most to your Part B Physician/Supplier episode costs for the Low Back Pain measure. The table is divided into columns for clinicians within and outside your TIN.

Table 4: Top Clinicians Within and Outside Your TIN Contributing to Your Part B Physician/Supplier Episode Costs

NPIs Within Your TIN	NPIs Outside Your TIN
(1) Name 1 - 123456789	(1) Name A - 123456789
(2) Name 2 - 123456789	(2) Name B - 123456789
(3) Name 3 - 123456789	(3) Name C - 123456789
(4) Name 4 - 123456789	(4) Name D - 123456789
(5) Name 5 - 123456789	(5) Name E - 123456789

Refer to the Glossary, Table A4 for definitions of metrics

3 EPISODE COSTS

Your measure score reflects how you performed on at least 20 episodes. This section shows episode cost distributions and the share of your episodes in each of the measure sub-groups.

Your Risk-Adjusted Episode Costs

Table 5 shows how your risk-adjusted episode costs are spread out across the distribution. Risk-adjusted costs are costs that have been calculated to take into account risk factors such as patient health characteristics, age, reason for enrollment, and others.

Table 5: Distribution of the Risk-Adjusted Costs for Your Episodes

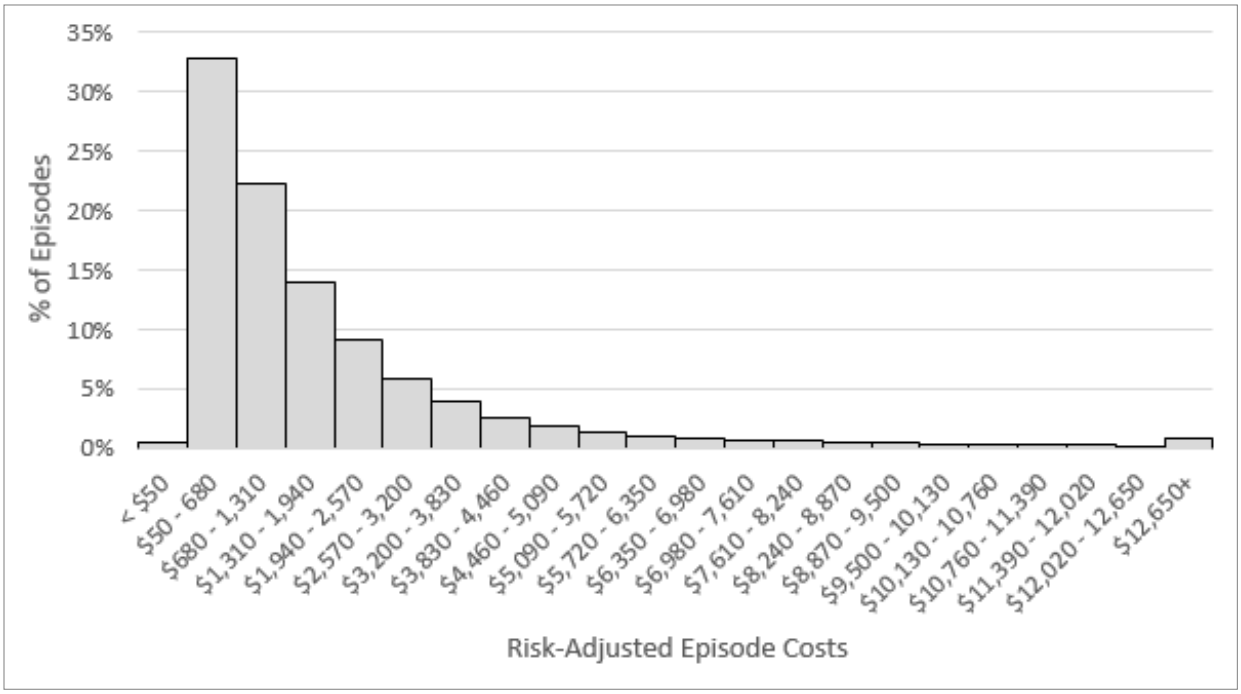
	Mean	Percentiles				
		5th (Least Expensive)	25th	50th (Median)	75th	95th (Most Expensive)
Your Episodes	$2,160	$579	$1,204	$1,703	$2,794	$4,547

Refer to the Glossary, Table A5 for definitions of metrics

Histogram of National Risk-Adjusted Episode Costs

Figure 2 shows a histogram of resource use for Low Back Pain measure episodes in field testing. Specifically, the distribution includes risk-adjusted episode costs for all episodes among clinicians with at least 20 Low Back Pain measure episodes. Note that Figure 1 shows provider-level scores, whereas this figure shows episode-level costs.

Figure 2: National Distribution of Risk-Adjusted Episode Costs



Episode Sub-Groups

The Low Back Pain measure is stratified into sub-groups. These represent clinically distinct patient cohorts and are defined to be mutually exclusive and exhaustive stratifications. The risk adjustment model is run separately within each sub-group. This means that episodes within each sub-group are only compared with other episodes within that same sub-group.

Table 6 shows how many of your episodes are within each sub-group. The table also shows your performance on episodes within each sub-group, represented by the weighted mean ratio of observed to expected cost (as predicted through a risk adjustment model) and specialty adjusted across your episodes for each sub-group, alongside the national average for comparison.[6]

Table 6: Breakdown of Measure Performance by Sub-Group

Low Back Pain Sub-Group	Number of Episodes	Share of Episodes		Weighted Mean Ratio of Observed to Expected Cost with Specialty Adjustment	
		Your TIN-NPI	National Average	Your TIN-NPI	National Average
All	48	100.0%	100.0%	0.99	1.04
Spinal surgery during episode and history of complex low back pain	5	10.4%	1.4%	0.63	0.96
Spinal surgery during episode without history of complex low back pain	0	0.0%	0.5%	0.00	0.99
No spinal surgery during episode but history of complex low back pain	26	54.2%	34.7%	0.87	1.00
No spinal surgery during episode or history of complex low back pain	17	35.4%	63.4%	1.33	1.07

Refer to the Glossary, Table A6 for definitions of metrics

Episode-Level File (CSV)

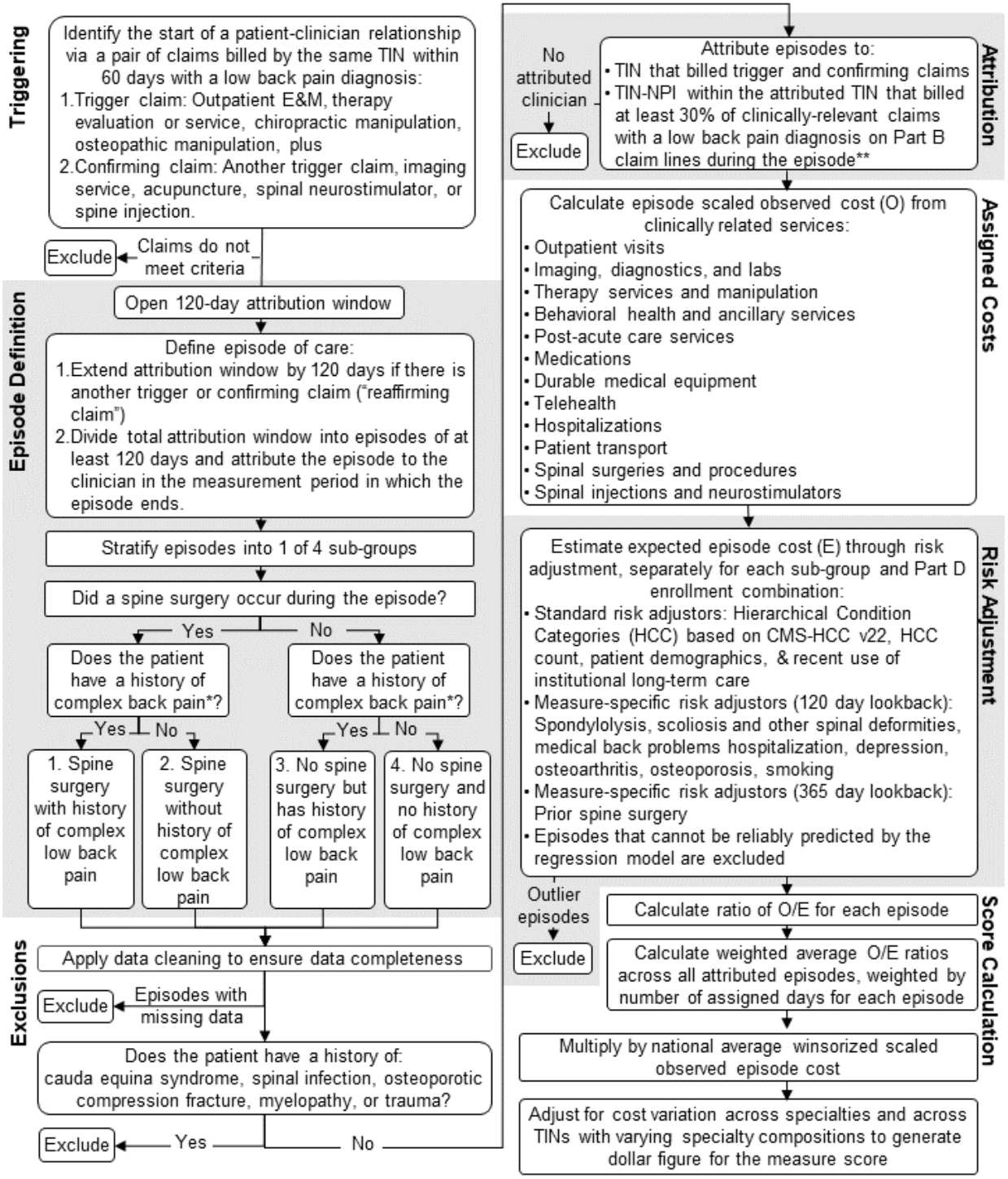
For the most granular information for each episode, you have an episode-level file in the same ZIP file as this report. This file lists each episode used to calculate your field testing measure score and provides information to help you understand the costs of care for each episode. It includes details to help you identify your patient and which providers furnished services during the episode of care. The file also has detailed breakdowns of what types of services in each episode counted towards your cost measure score. Finally, there's a data dictionary in the format of an excel workbook that has definitions for all the metrics in the episode-level file.

[6] Please note that we provide the weighted mean ratio of observed to expected cost with specialty adjustment instead of your risk-adjusted cost for each sub-group, since ratios are more helpful when you compare your performance across sub-groups.

4 ADDITIONAL INFORMATION

Measure Flowchart

Low Back Pain



* Complex low back pain is defined as one of: radiculopathy, spinal stenosis, or spondylolisthesis
**To ensure that TIN-NPIs are appropriately attributed, TIN-NPIs meeting the 30% threshold must also have billed at least 1 relevant Part B claim with a low back pain diagnosis within 1 year prior to the start of the episode.

Where Can I Find More Information?

The MACRA Feedback Page[7] has all the field testing resources. Materials include:

- An online field testing survey (embedded in some of the field testing resources) where you can provide feedback about the measures,
- Frequently Asked Questions (FAQ),
- An overview of the measure development process,
- Draft measure specifications (Measure Information Form, Measure Codes List file), and
- Testing results.

If you have further questions, please contact the Quality Payment Program Service Center:

- Email: qpp@cms.hhs.gov
- Telephone: 1-866-288-8292, Monday – Friday, 8 a.m. – 8 p.m. ET
    - To receive assistance more quickly, please consider calling during non-peak hours – before 10 a.m. and after 2 p.m. ET.
    - Customers who are hearing impaired can dial 711 to be connected to a Telecommunications Relay Services Communications Assistant.

[7] CMS, MACRA Feedback Page, https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback.

Appendix A – Glossary

Table A1: Definitions for Your Cost Measure Score Performance (Report: Table 1)

Term	Description
Number of Episodes	The number of episodes attributed to your TIN-NPI within the measurement period.
Your TIN-NPI's Cost Measure Score	Your TIN-NPI's average risk-adjusted cost for the measure. Method of calculation: The weighted average ratio of the observed cost to expected cost (as predicted through a risk adjustment model) across all your episodes, multiplied by the national average observed episode cost. The weighting factor for each episode's number of assigned days.
National Average Cost Measure Score	Average risk-adjusted cost across all clinicians nationally for this episode-based cost measure. Method of calculation: The mean ratio of observed cost to expected cost (as predicted through a risk adjustment model) across all clinicians nationally, multiplied by the national average observed episode cost. The mean ratio is calculated by taking the weighted average of the observed to expected ratio for each clinician (the weighting factor for each episode's number of assigned days) and then calculating the average of these ratios across all clinicians.
Your TIN-NPI's Cost Measure Score Percentile	The percentile for your TIN-NPI's cost measure score among all cost measure scores for all clinicians nationally. Interpretation: Higher values indicate that your episodes are relatively more expensive than episodes attributed to other clinicians (and the inverse for lower values). Example: If your cost measure score percentile is in the 40th percentile, then that means your cost measure score was higher than the scores for 40% of all clinicians nationally and lower than the scores for 60% of all clinicians. This is an inverse measure, so a lower score indicates a lower cost.

Table A2: Definitions for Cost and Use by Medicare Setting and Service Category (Report: Table 2)

Term	Description
Medicare Setting and Service Category	The settings and service categories available from the claims data. This includes RBCS categorizations.
Share of Episodes with ≥ 1 Service	Your TIN-NPI: The share of episodes with any cost from a setting/category across all episodes for your TIN-NPI. National Average: The average share of episodes with any cost from a setting/category across all clinicians nationally. TIN-NPIs in Your Risk Bracket: The share of episodes with any cost from a setting/category across all clinicians in your risk bracket.
Average Observed Cost of Services among Episodes with ≥ 1 Service	Your TIN-NPI: The average cost of services from a setting/category across all episodes for your TIN-NPI. Note that this average is calculated out of all your TIN-NPI's episodes that include at least 1 service from the given setting/category. National Average: The average cost of services for a setting/category across all episodes for all clinicians nationally. Note that this average is calculated out of all episodes that include at least 1 service from the given setting/category. TIN-NPIs in Your Risk Bracket: The average cost of services for a setting/category across all episodes for clinicians in your risk bracket. Note that this average is calculated out of all episodes that include at least 1 service from the given setting/category.

Table A3: Definitions for Cost and Use by Clinical Theme (Report: Table 3)

Term	Description
Clinical Theme	Clinical themes are clinical categorizations that organize all assigned services into broader categories. They are mutually exclusive and exhaustive of all service assignment rules, which were developed with input from the Low Back Pain Clinician Expert Workgroup. To see which service assignment rules fall within each clinical theme, you may review the Draft Measure Codes List file for the measure.
Share of Episodes with ≥ 1 Service	Your TIN-NPI: The share of episodes with any cost from a given clinical theme across all episodes for your TIN-NPI. National Average: The average share of episodes with any cost from a given clinical theme across all clinicians nationally. TIN-NPIs in Your Risk Bracket: The average share of episodes with any cost from a given clinical theme across all clinicians in your risk bracket.
Average Observed Cost of Services among Episodes with ≥ 1 Service	Your TIN-NPI: The average cost calculated per episode for the clinical theme (i.e., for all billed items within that clinical theme). Note that this average is calculated out of all your episodes that include at least 1 service from the given clinical theme. National Average: The average cost calculated per episode for the clinical theme out of all episodes for all clinicians nationally (calculated only for episodes that include at least 1 service from the given clinical theme). TIN-NPIs in Your Risk Bracket: The average cost calculated per episode for the clinical theme out of all episodes for TIN-NPIs in your risk bracket (calculated only for episodes that include at least 1 service from the given clinical theme).

Table A4: Definitions for Top Clinicians Within and Outside Your TIN Contributing to Your Part B Physician/Supplier Episode Costs (Report: Table 4)

Term	Description
NPIs Within Your TIN	List of the top 5 clinicians (i.e., NPIs) within your TIN that contributed the most Part B Physician/Supplier costs to your episodes.
NPIs Outside Your TIN	List of the top 5 clinicians (i.e., NPIs) outside your TIN that contributed the most Part B Physician/Supplier costs to your episodes.

Table A5: Distribution of the Risk-Adjusted Costs for Your Episodes (Report: Table 5)

Term	Description
Risk-adjusted cost	This is the episode cost after accounting for risk factors deemed to be outside of a clinician's influence (e.g., pre-existing conditions, age, or indicators of clinical severity). The episode cost is risk-adjusted to ensure fair comparisons and neutralize the effects of these risk factors. The distribution statistics of the risk-adjusted costs for your episodes are shown (including mean and various percentiles).

Table A6: Definitions for Cost Measure Performance by Episode Sub-Group (Report: Table 6)

Term	Description
Episode Sub-Group	The episode sub-group. Episode sub-groups are mutually exclusive and exhaustive stratifications, which means that episodes in each sub-group are only compared with other episodes within that same sub-group. Sub-grouping aims to enable meaningful clinical comparisons by allowing risk-adjustment models to be run separately for each sub-group. For this cost measure, episodes are stratified by each subgroup and Part D enrollment status combination. However, for simplicity, this table only stratifies by sub-group.
Your Episode Count	The number of episodes attributed to your TIN-NPI within the measurement period for each sub-group.
Share of Episodes	Your TIN-NPI: Share of episodes (across all episodes for your TIN-NPI) by sub-group. National Average: Average share of episodes (for all clinicians nationally) by sub-group.
Mean Ratio of Observed to Expected Cost	Your TIN-NPI: Your weighted average ratio of observed to expected cost (as predicted through a risk adjustment model) and specialty adjusted across your episodes for each sub-group. The weighting factor for each episode's number of assigned days. National Average: The mean ratio of observed to expected cost (as predicted through a risk adjustment model) and specialty adjusted across all clinicians nationally for each sub-group. This is calculated by taking the weighted average of the observed to expected ratio with specialty adjustment for each clinician (the weighting factor for each episode's number of assigned days) and then calculating the average of these ratios across all clinicians for each sub-group.