Approving Provider Performance Measurement Methodology

Determining the Approving Provider

As part of their medical management activities, Managed Care Organizations (MCOs) are responsible for determining which medical provider certifies disability in State Agency claims. This provider is deemed to be the Approving Provider. MCOs are also responsible for maintaining a history of Approving Providers in every State Agency claim. Claim outcomes (days of absence, return to work status, relapses, and cost) are assigned to Approving Providers on the basis of that history.

Determining the Principle ICD

In claims with more than one allowed condition, the principle ICD is determined using the Official Disability Guideline (ODG) values. Specifically, ICDs are ranked from low to high using the following sort sequence, and the ICD with the highest rank is deemed principle:

1. Days absent at the 50th percentile for all claims
2. Days absent at the 90th percentile for all claims
3. Days absent at the 50th percentile for claims with 7 or more days of absence
4. Days absent at the 90th percentile for claims with 7 or more days of absence
5. Numeric value of the ICD code (e.g., 722.10 is lower than 847.2)

Claim Population

State Agency claims are included in the population if they have a Last Day Worked (LDW), return to work date, day(s) of absence, or a date of medical service during the 12-month measurement period. Dates of absence and dates of service outside of the 12-month measurement period are excluded from measurement.

All claim data (i.e., allowed conditions, days absent, relapses, medical costs etc.) are evaluated as of 3 (three) months after the measurement date. For example, a measurement date of 12/31/2008 would generate an evaluation date of 3/31/2009. Claims with the aforementioned activity within the measurement year are excluded if they are disallowed, dismissed, settled, combined, or not assigned to a State Agency policy as of the Evaluation Date.

Days Absent (for Duration)

Days absent are calculated for each episode of disability. In each episode, days absent are counted as the number of days *between* the Last Day Worked (LDW) and stop dates, but neither the LDW nor the stop date are counted as a day of absence. If there was a different approving provider in the claim at an earlier time, then the date on which the physician became accountable for the claim replaces the LDW for purposes of computing a duration measurement for that physician. The stop date is the earliest of:

- the actual return to work date (ARTW)
- the date on which the injured worker was released to work (RRTW)
- the day after the measurement date

Relapses and Relapse Rate

A relapse is defined as an actual return to work which is followed by a subsequent LDW less than 90 days later. A single claim can include more than one relapse. The relapse rate is then calculated as the total number of relapses divided by the total number of claims for which the physician is accountable, but not more than 100%. For example, if a physician is accountable for three claims and one of those claims had four relapses, that physician would have a 100% relapse rate (4/3) even though two of the claims had no relapses.

RTW Status and RTW Rate

Claims are evaluated as of the earlier of the Evaluation Date or the date on which a provider ceased to be accountable in a claim to determine whether the injured worker was released to return to work (RTW) or "not" released to return to work (RTW). The RTW rate is then calculated as the total number of claims released to work divided by the total number of claims for which the physician is accountable.

Duration Calculation

Claims are evaluated individually and the results are summarized by Approving Provider. The days absent (as defined earlier) are compared with the ODG days absent at the 50th and 90th percentiles based on the Principle ICD (as defined earlier). To get a score of 100%, an approving provider would need to manage their caseload such that at least 50% of their claims had days absent at or below the ODG days absent at the 50th percentile, and at least 90% of their claims had days absent at or below the ODG days at the 90th percentile. The duration score is the average of these two parts, with neither part exceeding 100%. Some examples:

Provider	Total Claims	Claims <= 50th	Claims <= 90th	50th Score	90th Score	Average Score
A	10	4	8	80%	89%	84%
B	10	5	9	100%	100%	100%
C	10	6	10	100%	100%	100%

Provider A is responsible for 10 claims, of which 4 had days absent at or below the number of days shown at the 50th percentile by ODG. Eight of the 10 claims also had days absent at or below the number of days shown at the 90th percentile by ODG.

Provider A's score at the 50th mark is 80% (4 / 10 = 40%, which is 80% of the expected 50% outcome), and their score at the 90th mark is 89% (8 / 10 = 80%, which is 89% of the expected 90% outcome).

Provider B's score of 100% reflects the fact that their claims were managed so that exactly 50% had days absent at or below the ODG 50th percentile values, and exactly 90% had days absent at or below the ODG 90th percentile values.

Provider C managed a greater percentage of their claims to ODG values than one would expect. However, each portion of their score is capped at 100%.

Total Medical Cost and Score

Each claim's medical costs for dates of service during the 12-month measurement year are summed as of the Evaluation Date. Claims are then arranged by their principle ICD, and the median cost is calculated for any principle ICD present in two or more claims. For each Approving Provider, the number of claims whose medical costs exceed the median for that principle ICD are counted and divided by the number of claims for which that physician is accountable. That percentage is subtracted from 100 to obtain the medical score. For example, assume a physician is accountable for 10 claims. Of those, 7 claims have costs that are greater than the median for all claims with the same Principle ICDs. The physician would receive a score of 30 (7 / 10 = 70%). Claims with principle ICDs that are present in only one claim are deemed to be at or below the median for that ICD.

Overall Approving Provider Scores

The four measure raw scores are multiplied by the following weights:

Duration	40%
RTW Rate	30%
Relapse Rate	20%
Medical Score	10%

Physician Outcomes

Approving providers will be placed into one of four outcome categories based on their overall weighted scores. Scores over 90 are deemed exceptional; over 80 and up to 90 are acceptable; over 50 and up to 80 are in need of improvement, and scores under 50 are unacceptable. Providers that are accountable for fewer than 5 claims cannot be placed in the exceptional category, as that claim volume is too small to provide a credible prediction of future performance.

Category	Scores	5+ Claims	1-4 Claims
Exceptional	Over 90	X	
Acceptable	Over 80 up to 90	X	X
Opportunity for Improvement	Over 50 up to 80	X	X
Unacceptable	50 or Under	X	X

Of those providers that do have one or more claims assigned to them, historical data suggests that roughly 6% will be placed in the exceptional and 64% in the acceptable categories. While the remaining 30% have historical data that is below acceptable levels, more than 2/3 of those will have the opportunity to bring performance up to acceptable levels.