INTERPRETATION OF PROVIDER PROFILE REPORTS

YOUR PERFORMANCE

The performance of your practice over the semi-annual interval being reported is shown as a blue bar, with previous intervals to the left. The most recent interval is on the right.

DATA USED FOR THIS REPORT

The information contained in your report is drawn from client eligibility and claims data submitted by your practice for services provided to Family PACT (Planning, Access, Care, and Treatment) clients. Great care has been taken to insure that the data set regarding your practice is complete, accurately analyzed, and clearly reported. However, in provider profiles of this type, the possibility exists that the findings of one or more indicators may be inaccurate because of errors in the billing or eligibility information submitted to Family PACT. In addition to the specific factors listed in the "Interpretation" sections for each of the nine indicators, the possibility of errors in submitted information must be considered as an alternative explanation of provider performance.

PEER GROUP

In the initial iteration of this report, two peer groups were defined: "Private Sector Providers" and "Public Sector Providers." Your designation as a public or private sector provider is determined by the "provider type" that your practice was assigned when you enrolled as a Medi-Cal provider. In general, "public sector" providers are licensed as governmental, non-profit agencies, and community clinics; and "private sector" providers are the remainder of the network.

The solid line for each graph indicates the median performance (50th percentile) of your peer group and the broken line refers to either the 95th or 5th percentile performance of your peer group. If the top of one of your performance bars is higher than the 95th percentile line, it means that your score is higher than at least 95 percent of the providers in your peer group. Likewise, if the top of one of your performance bars is lower than the 5th percentile line, it means that your score is lower than at least 95 percent of providers in your peer group.

AVERAGE FAMILY PACT REIMBURSEMENT PER CLIENT

Purpose: Utilization Measure

Family PACT is a limited benefit program focused on family planning and detection and treatment of some sexually transmitted infections (STI). This measure is intended to capture utilization of all Family PACT services including office visits, procedures, prescription drugs, laboratory tests, and supplies, by clients who have been seen only in your practice during the measurement period.

Interpretation: If your results are higher than the peer-group median for average annual reimbursement per client, it could imply relative over-utilization of any combination of office visits, specialized procedures (such as colposcopy), prescription drugs (dispensed on-site or at pharmacies), laboratory tests, or supplies. An alternative explanation that may apply to a few providers is that their practice is recognized as a referral site for clients needing more complex procedures, resulting in higher average reimbursement per client.

Methodology*

Although the average reimbursement per client is calculated for a six-month period, the measure is annualized to provide a more meaningful, easier to interpret number. To accomplish this, an annual client cohort is constructed from the clients served by a clinician provider over 12 months -- the six-month period of interest plus the previous six months.

Next, all paid claims including clinical, laboratory, and pharmacy claims attributable to the annual client cohort during the six-month period of interest are summed and then divided by the number of clients within the cohort.

* A detailed description of methodology will be provided on request or can be accessed at the Family PACT Web site http://www.familypact.org/en/Providers/provider-profiles.aspx.

The resulting average reimbursement per client is then multiplied by two to produce an annualized measure. So that paid claims for a particular client may be reasonably assumed to be the result of a particular provider's care, clients served by more than one enrolled clinician provider are excluded from the cohort.

FAMILY PACT ENCOUNTERS PER CLIENT

Purpose: Utilization Measure

A "typical" client receiving family planning services has two and one-half visits per year; one for periodic health screening and one or two "problem oriented" or follow-up visits. If the ***average*** client seen in practice has many visits over the course of a year, it may signify that clients are being asked to return too often or that clinical services other than Family PACT benefits are being provided. This indicator measures the average number of visits (encounters), over the course of the six month measurement period, of clients who have been seen in your practice ***only***. The number of encounters is then adjusted to reflect an annual rate of encounters per client per year.

Interpretation: High numbers of Family PACT encounters per client per year may imply over-utilization of Family PACT services (contraception, STI, cervical dysplasia, etc.) or the use of Family PACT visits for medical conditions that are not covered by the program. Provider sites that serve specialized populations (such as Teen Clinics) where frequent follow-up is expected to improve method adherence may be justified in having relatively higher encounters per client than sites that serve a more general group of Family PACT clients. However, given the narrow scope of Family PACT benefits and the fact that most Family PACT clients are healthy, it is unlikely that certain clinical sites will have a higher rate of encounters per client.

Methodology*

An "encounter" is defined as a claim submitted for an Evaluation and Management (E&M) or Education and Counseling (E&C) visit. As with the average reimbursement per client, the number of encounters per client is best understood when annualized. An annual client cohort is constructed of all clients who have had a clinician encounter under your NPI within a 12-month period -- the six-month period of interest plus the previous six months. Next, the number of encounters attributable to this client cohort is calculated and then divided by the number of clients in the cohort. The result is then multiplied by two to produce an annualized measure.

CHLAMYDIA SCREENING RATE FOR SEXUALLY ACTIVE WOMEN AGE 25 OR YOUNGER

Purpose: Quality Measure

This indicator measures the percentage of women in your practice who were age 25 and younger and who have a Family PACT claim (paid or denied) for chlamydia screening within one year of the semi-annual observation period. Detection and treatment of women with chlamydial cervicitis will reduce rates of Pelvic Inflammatory Disease (PID) by as much as 60 percent, which in the long term will lessen the likelihood of tubal infertility and chronic pelvic pain. Guidelines issued by the Centers for Disease Control, the U.S. Preventive Services Task Force, the California Department of Public Health Sexually Transmitted Disease Control Branch, and the Family PACT Program, recommend that all sexually active women age 25 and younger should be screened annually for lower genital tract chlamydial infections.

Interpretation: Higher percentage rates of women age 25 and younger screened for chlamydia indicates better performance. The Family PACT Program goal is a rate of 95 percent or higher.

Methodology*

The chlamydia screening rate among sexually active women age 25 and younger is calculated by constructing a cohort of eligible clients served by a Family PACT provider during a six-month interval. A client is considered screened if she has had a Family PACT claim for a chlamydia test within 12 months prior to her last date of service within the period. Note that your practice is credited with the screening even if the screening is performed by a different provider, as long as it is billed to Family PACT.

* A detailed description of methodology will be provided on request or can be accessed at the Family PACT Web site http://www.familypact.org/en/Providers/provider-profiles.aspx.

CHLAMYDIA SCREENING RATE FOR SEXUALLY ACTIVE WOMEN OVER AGE 25

Purpose: Quality and Utilization Measure

This indicator measures the percentage of women in your practice who were over age 25 who have a Family PACT claim (paid or denied) for a chlamydia test within one year of the semi-annual observation period. Guidelines issued by the Centers for Disease Control, the U.S. Preventive Services Task Force, the California Department of Public Health Sexually Transmitted Disease Control Branch, and the Family PACT Program all state that chlamydia screening for women in this age group should be targeted based on risk factors, rather than routine screening, if prevalence is less than 3 percent. Additionally, routine screening in a low prevalence population increases the risk of false positive results. Analysis of data available from California family planning clinics indicate that specific risk factors for "targeted screening" include a history of chlamydia or gonorrhea in the previous two years, more than one sex partner in the previous 12 months, or suspicion that someone they are having sex with has more than one partner. Chlamydia diagnostic testing also is indicated in women who have genital tract signs consistent with chlamydia infection (cervicitis, PID signs), those who report contact with a partner diagnosed with a STI, women newly diagnosed with other STIs, and those being retested three months after chlamydia treatment. Data from family planning settings indicate that less than half of women over age 25 meet these criteria.

Interpretation: Family PACT data in 2006 show that chlamydia positivity in women over age 25 was less than two percent, which is below the minimum level for cost-effective screening. If the report for your practice shows that the rate of chlamydia screening in "women over age 25" is over 50 percent, it is likely that this group is being over-screened. An alternative explanation is that certain provider sites that attract high risk clients with very high STI rates (e.g., STD clinics) may be justified in having high rates of chlamydia screening in both younger and older reproductive-aged women. Your laboratory should be able to provide your overall client positivity rate by age.

Methodology*

The chlamydia screening rate among sexually active women over age 25 is calculated by constructing a cohort of eligible clients served by a Family PACT provider during a six-month period of interest. A client is considered screened if she has had a paid or denied Family PACT claim for a chlamydia test within 12 months prior to her last date of service within the period. Note that your practice is credited with the screening even if the screening is performed by a different provider, as long as it is billed to Family PACT.

PERCENT OF FAMILY PACT E&M VISITS CODED 99204

Purpose: Utilization Measure

The Family PACT Program offers four levels of E&M codes for office visits by new patients: 99201 through 99204. The 99204 level office visit should be necessary only for medically complex patient care encounters and must be justified by an entry into the medical record that contains either the requisite number of elements of history, physical exam, and medical decision making or face-to-face time with counselor(s) and a clinician that is documented to be 45 minutes or longer.

Interpretation: Because a large majority of visits of Family PACT services should be of a routine nature, a report of a high percentage of E&M codes claimed as 99204 visits may be due to "upcoding" of routine family planning or STI visits. An alternative explanation for high rates of 99204 claims may be that a large proportion of patients seen by the provider are receiving non-reproductive primary care services or specialized gynecologic care for complex medical conditions that are not a benefit of the program.

Methodology*

The percent of E&M visits that are at the highest level is constructed by first counting the number of paid claims for E&M visits with Current Procedural Terminology (CPT) code 99204 during the period of interest. That number is then divided by the total of all E&M visits (CPT codes 99201 through 99204). The result is multiplied by 100 to produce the percentage at the highest level.

* A detailed description of methodology will be provided on request or can be accessed at the Family PACT Web site http://www.familypact.org/en/Providers/provider-profiles.aspx.

PERCENT OF FAMILY PACT E&M VISITS CODED 99214

Purpose: Utilization Measure

The Family PACT Program offers four levels of E&M codes for office visits by established patients: 99211 through 99214. The 99214 level office visit should be necessary only for medically complex patient care encounters and must be justified by an entry into the medical record that contains either the requisite number of elements of history, physical exam, and medical decision making or face-to-face time with counselor(s) and a clinician that is documented to be 25 minutes or longer.

Interpretation: Because a large majority of visits for Family PACT services should be of a routine nature, a report of a high percentage of E&M codes claimed as 99214 visits may be due to "upcoding" of routine family planning or STI visits. An alternative explanation for high rates of 99214 claims may be that a large proportion of patients seen by the provider are receiving non-reproductive primary care services or specialized gynecologic care for complex medical conditions that are not a benefit of the program.

Methodology*

The percent of E&M visits that are at the highest level is constructed by first counting the number of paid claims for E&M visits with CPT code 99214 during the period of interest. That number is then divided by the total of all E&M visits (CPT codes 99211 through 99214). The result is multiplied by 100 to produce the percentage at the highest level.

PERCENT OF FAMILY PACT E&C VISITS CODED Z9754

Purpose: Utilization Measure

The Family PACT Program offers five levels of E&C office visit codes, Z9750 through Z9754, when the purpose of the visit is family planning and reproductive health counseling and education. The Z9754 level E&C code is necessary only for complex counseling encounters, including a face-to-face visit with a clinician and/or counselor that is documented to be 31-45 minutes or longer. Office visits with a clinician that are intrinsically clinical, but which also include counseling, should be claimed with the use of E&M codes. However, in one instance a lower level E&C code (Z9750 or Z9751) can be claimed on the same day as an E&M visit, for example, to introduce the client to the practice and to the Family PACT Program. Subsequent E&C visits cannot be claimed on the same date of service as an E&M visit with a clinician, as it is assumed that counseling will occur during the clinical visit. While laboratory, medication, and contraceptive supply codes may be billed with an E&C visit, justification for the level of E&C selected for claiming, including documentation of time spent, applies only to the education and counseling component of the visit.

Interpretation: Because a large majority of visits of Family PACT services are of a routine nature, a report of a high percentage of E&C codes of Z9754 may be due to "upcoding" of E&C visit claims submitted to Family PACT. Alternative explanations for a high rates of Z9754 visits may be that a provider has special expertise in reproductive health counseling, and thus may receive many referrals from other providers in the community, or that because of the special nature of the practice (for example, a teen clinic), there may be an unusual number of clients requiring extensive counseling.

Methodology*

The percent of E&C visits that are at the highest level is constructed by first counting the number of paid claims for E&C visits with the CPT code Z9754 during the period of interest. That number is then divided by the total of all E&C visits (CPT codes Z9750 through Z9754). The result is multiplied by 100 to produce the percentage at the highest level.

* A detailed description of methodology will be provided on request or can be accessed at the Family PACT Web site http://www.familypact.org/en/Providers/provider-profiles.aspx.

Social Security Number (SSN) Reporting Among U.S.-Born Family PACT Adults

Purpose: Administrative compliance measure

A Centers for Medicare and Medicaid Services (CMS) requirement for ongoing financial support to the Family PACT Program is that a good faith effort must be made to determine the SSN of each Family PACT client and to enter it into the Client Eligibility Certification (CEC) form and Heath Access Program (HAP) system. While there will be occasional circumstances where U.S.-born adult clients are either unwilling or unable to provide a SSN during the eligibility screening process, this should be the exception rather than the rule. Non-U.S.-born Family PACT clients and those 17 years old and younger are excluded from this measure because it is recognized that many of these individuals do not have SSNs or may not be able to provide a SSN. Performance on this indicator measures the effectiveness of your "front office" staff in obtaining this information from U.S.-born adult clients who are expected to know (or have access to) their SSNs.

Interpretation: The higher the percentage reported in your profile, the more effective your practice has been in obtaining this important administrative information. A low percentage of SSN reporting among U.S.-born adults relative to your peer group indicates the need to improve administrative compliance in this area. However, it is recognized that not all clients will supply this information and it must be noted that Family PACT services shall be provided even if a client does not supply a SSN. If your score is lower than you expected, it may be due to CEC data entry errors that incorrectly identified clients as being U.S.-born.

Methodology*

A client is considered to be U.S.-born if they self-indicated as such during the enrollment process. The number of clients whose HAP record contains a validly formatted SSN is divided by the number of U.S.-born adult clients certified/recertified during the six-month period of interest. The result is multiplied by 100 to produce the percentage with a valid SSN.

Pregnancy Tests Per 100 Encounters -- This graph is only available online found on your PDF *Provider Profile* available on the Family PACT web site (www.familypact.org)

Purpose: Quality and Utilization Measure

Pregnancy tests are medically indicated under certain clinical circumstances such as delay of menses, amenorrhea, abnormal vaginal bleeding, physical pregnancy symptoms, acute pelvic pain, and "off cycle" initiation of hormonal contraceptives. However, "screening" pregnancy tests that are routinely performed on all clients are considered to be unnecessary in women who are asymptomatic and do not have any of the findings listed above. This measure is included to identify providers who routinely screen most or all contraceptive clients at each visit versus those who perform pregnancy tests on an "as needed" basis.

Interpretation: Pregnancy test rates that are near the peer group median imply appropriate patterns of pregnancy test use. Rates that are much higher than the peer group median may mean that most or all women are receiving "routine" pregnancy tests at each visit, a practice that is discouraged.

Methodology*

The number of pregnancy tests per 100 encounters is constructed by dividing the number of paid claims for a pregnancy test (CPT code 81025) by the number of encounters, as defined by E&M or E&C visits. The result is multiplied by 100. Note that if your practice does not successfully bill Family PACT for pregnancy tests and encounters under the same provider number, your result will be inaccurate.

* A detailed description of methodology will be provided on request or can be accessed at the Family PACT Web site http://www.familypact.org/en/Providers/provider-profiles.aspx.