Overview

The UnitedHealth Premium physician designation program uses clinical information from health care claims and other sources to assist physicians in their continuous practice improvement and to help consumers make more informed and personally appropriate choices for their medical care. The program uses evidence-based, medical society, and national industry standards with a transparent methodology and robust data sources to evaluate physicians across 27 specialties. The program works to advance safe, timely, effective, efficient, equitable and patient-centered care. The program supports practice improvement and provides physicians with access to information on how their clinical practice compares with national and specialty-specific measures for quality, and with cost efficiency peer groups in the same geographic area.

Evaluation for quality compares a physician’s observed practice to the UnitedHealthcare national rate among other physicians who are responsible for the same interventions. Cost efficiency is assessed by comparing the case-mix adjusted cost of care attributed to the physician to a benchmark and applying a statistical test to determine if the difference is statistically significant.

Quality is the fundamental measurement, demonstrating our commitment to evidence-based practice. The quality designation is separate from the cost efficiency designation. Although the quality and cost efficiency evaluations are performed separately, the results are used together to determine the physician’s designation. Quality and cost efficiency evaluations each incorporate adjustments for the case mix of the physician and the level of the patient’s severity of illness where appropriate.

Physicians who meet both the quality and cost efficiency designation criteria will receive the quality and cost efficiency designation. Physicians who meet the quality designation criteria will receive the quality designation regardless of their cost efficiency evaluation. Physicians who meet the cost efficiency designation criteria will receive the cost efficiency designation if they do not have enough data to assess quality.
Example of the Quality and Cost Efficiency Assessment

The designation process is depicted in the image below, showing a fictional Dr. Pratt being evaluated for quality and cost efficiency.

Quality Assessment for Dr. Pratt

From claims data, we identify all of Dr. Pratt’s patients for the conditions measured in the program. We then compare the number of times his/her patients received recommended care with a benchmark number based on the UnitedHealthcare national rate of the same recommended care for each quality measure. We use a statistical test to determine if the difference between Dr. Pratt’s results and the peer group’s results are significant. In this example, Dr. Pratt met the criteria for the quality designation because his result was statistically significantly higher than the peer group’s results.

Cost Efficiency Assessment for Dr. Pratt

In this example, Dr. Pratt met the criteria for the quality designation and will now be assessed for cost efficiency. Based on Dr. Pratt’s specialty of internal medicine, there are two measurements used for the assessment of cost efficiency: population cost measurement and episode cost measurement. The physician’s specialty determines if population cost measurement is used. Although Dr. Pratt’s example does not include an explanation of episode cost measurement, the process is explained later in this document.

Population cost measurement evaluates all of the costs of Dr. Pratt’s patients and applies appropriate risk adjustment methodology. We use a statistical test to determine if the difference between Dr. Pratt’s costs and the peer group’s costs are significant. In these statistical tests there are three possible outcomes.

- Physicians whose results are far enough below the benchmark have statistically lower cost.
- Physicians whose results are not far enough from the benchmark have costs that are not statistically different.
- Physicians whose results are far enough above the benchmark have statistically higher cost.

In this example, Dr. Pratt’s costs are statistically significantly lower than his peers and he receives the cost efficiency designation. Therefore, Dr. Pratt’s final Premium assessment designation is “Quality & Cost Efficiency.”

We regularly review and enhance our program, including the methodology used to evaluate quality and cost efficiency for the Premium physician designation program. This document describes the methodology for the 2015 version of the Premium program.
UnitedHealth Premium Physician Designation Program Summary Methodology

Criteria used for Measurement

The criteria used to measure physician practices are based on the following aspects of care:

- **Preventive care** – cancer screening and other indicated screening interventions
- **Appropriate care** – appropriate use of medications and diagnostic tests
- **Chronic disease care** – monitoring for control, progression, and complications
- **Patient safety** – avoiding duplicate testing or adverse drug interactions, and monitoring safety
- **Sequencing of care** – diagnostic tests and procedures, treatment, and monitoring
- **Effectiveness of procedures** – lack of failed therapy and complications

Physician Eligibility

Individual physicians are evaluated for the Premium program designation if they have an active Commercial contract with UnitedHealthcare, are credentialed by UnitedHealthcare, practice in a specialty and geographic location that are included in the Premium program, and have an unencumbered license at the time of the designation. Physicians who are being tracked for potential fraud and abuse are not eligible for Premium designation.

Markets included in Assessment

UnitedHealthcare defines markets based on the Metropolitan Statistical Area (MSA) market definition. MSAs are defined by the United States Office of Management and Budget, a division of the U.S. Government. MSAs are used to group counties and cities into specific geographic areas for the purposes of a population census and the compilation of related statistical data. The Premium program is available in 42 states (160 markets) across the United States. A complete list of markets is available upon request.

Data Sufficiency Requirements

**Quality Assessment**

Sufficient data for the quality assessment requires a minimum of five unique patients and 20 quality measure opportunities across all conditions or procedures. “Opportunities” are the number of times a measurement criterion could have been met.

**Cost Efficiency Assessment**

Population cost measurement requires a minimum of 10 patients. Episode cost measurement requires a minimum of 10 medical cases and/or surgical cases. Both medical and surgical cases can be used to calculate the 10 cases. Therefore, for those specialties that provide medical care as well as perform procedures, the episode cost minimum can be met through a combination of medical and procedure episodes. For example, cardiologists who provide non-procedural care as well as perform cardiac catheterization and percutaneous revascularization can meet the cost efficiency minimum through a combination of medical and procedure episodes.

Data used for Assessment

UnitedHealthcare relies primarily on paid claims data to assess quality and cost efficiency. Paid claims data are commonly used by many types of organizations including health plans, academia, regulatory agencies, public health, health service research, specialty societies, and others to analyze and understand many aspects of health care delivery. The data are readily available, comprehensive, and can provide detailed information about the type, quantity, and cost of services that patients receive. The measures used in the Premium program have been designed specifically for use with administrative claims data. Wherever possible, we use claims-based measures that are nationally standardized, such as National Quality Forum NQF-Endorsed® measures. Many of the NQF standards have been in use for decades. While no data are 100 percent accurate, we continually validate and improve the data set through internal work, comments by our advisory committees and scientific advisory boards, and feedback from medical groups and individual physicians.

The Premium program counts several non-claims-based programs towards quality designation for the specialties appropriate to each program. These include National Committee for Quality Assurance (NCQA) recognition programs, Bridges to Excellence (BTE) programs, and American Board of Internal Medicine (ABIM) Practice Improvement Modules®.
UnitedHealth Premium Physician Designation Program Summary Methodology

The Premium program uses claims for patients enrolled in UnitedHealthcare's commercial fee-for-service products. In addition, for the quality assessment only, the Premium program uses UnitedHealthcare Medicare and Retiree claims. (UnitedHealthcare Medicare and Retiree claims are not used for the cost efficiency assessment.) Claims for patients where benefits were administered under a coordination of benefits process or for patients identified as receiving hospice services are not considered in the assessment of physician performance. The data used in this designation cycle include claims that were incurred and paid from Jan. 1, 2011 through Feb. 28, 2014.

The program includes paid claims data from members who were disenrolled from UnitedHealthcare on the end date of the data collection window as long as those members had a sufficient window of coverage to satisfy the criteria for the particular measure. However, HEDIS-based NCQA quality measures use data only from members enrolled as of Dec. 31, 2013. Such measures include breast cancer screening, cervical cancer screening, chlamydia screening, and pharyngitis in children.

Sources of Clinical Quality Measures

The clinical quality measures consist first of the National Quality Forum's NQF-Endorsed® standards when available for the conditions being evaluated, and in accordance with the principles of the Consumer-Purchaser Disclosure Project’s Patient Charter. Consistent with the Patient Charter, those measures are supplemented with others as necessary to evaluate clinically important conditions and specialties. Additional measures are developed using published literature and information from organizations such as the following:

- The AQA® Alliance (formerly the Ambulatory Care Quality Alliance)
- The National Committee for Quality Assurance (NCQA)
- American Medical Association Physician Consortium for Performance Improvement® (PCPI®)
- Specialty societies relevant to a specific disease and clinical condition
- Government agencies
- Other national expert panels

Specialties included in the Premium Program

**Primary Care Specialty Areas**

- Family Medicine*
- Internal Medicine*
- Obstetrics and Gynecology*
- Pediatrics*

**Other Specialty Areas**

- Allergy*
- Cardiology*
- Cardiology - Electrophysiology*
- Cardiology - Interventional*
- Ear, Nose and Throat
- Endocrinology*
- Gastroenterology
- General Surgery
- General Surgery - Colon/Rectal
- Nephrology*
- Neurology*
- Neurosurgery - Spine
- Ophthalmology
- Orthopaedics - Foot/Ankle
- Orthopaedics - General
- Orthopaedics - Hand
- Orthopaedics - Hip/Knee
- Orthopaedics - Shoulder/Elbow
- Orthopaedics - Spine
- Orthopaedics - Sports Medicine
- Pulmonology*
- Rheumatology*
- Urology

*These specialties are eligible for population cost measurement.

Designation Criteria

The designation process starts with the physician’s individual quality and cost efficiency outcomes. The initial individual outcome is determined by comparing a physician’s own results to that of his/her peer group. The process concludes with the public designation that is displayed online and in online physician directories and reports available to physicians.

The designation rules determine a physician’s assessment based on the physician’s individual outcomes, participation in qualifying recognition programs, or the assessment results for their specialty in an affiliated group practice, when applicable.
1. If physicians do not meet the quality criteria because they do not have enough data for assessment, they can meet quality criteria through non claims-based methods including NCQA recognition programs, Bridges to Excellence (BTE) programs, and American Board of Internal Medicine (ABIM) Practice Improvement Modules®.

2. If physicians do not receive quality recognition through a qualifying recognition program, do not have enough data for assessment, and are affiliated with a group practice that has met the criteria for the quality designation, they may benefit through application of their group’s assessment result for their specialty.

3. Quality is assessed first. Physicians are eligible for the cost efficiency designation as long as they have met the quality criteria or do not have enough data to assess quality.

4. Physicians who do not have enough data for the cost efficiency assessment can benefit if their specialty in their affiliated group meets the cost efficiency criteria.

5. The final designation results are displayed publicly in the UnitedHealthcare physician directories unless there are other reasons that they should not be displayed (e.g., the physician is under investigation for fraud).

### Public Designation Displays

The following designation results are displayed publicly in UnitedHealthcare’s physician directories for use by members when making health care choices and by physicians when making referrals.

We do not publicly display the designation results for physicians until we have provided the required time for them to submit a reconsideration of their results. We communicate the reconsideration time frame in the physician designation result letter. Designations include:

- Quality & Cost Efficiency
- Cost Efficiency & Not Enough Data to Assess Quality
- Quality & Not Enough Data to Assess Cost Efficiency
- Quality & Did Not Meet Cost Efficiency
- Not Enough Data to Assess Quality & Did Not Meet Cost Efficiency
- Not Enough Data to Assess
- Not Evaluated
- Did Not Meet Quality & Cost Efficiency

### Quality Assessment

A physician’s quality individual outcome is determined by comparing the number of times his/her patients received recommended care with a benchmark number based on the UnitedHealthcare national rate of the same recommended care for each quality measure.

The 50th percentile performance rate for quality is a benchmark for comparing the physician’s quality measure result rates to national rates, after adjusting for the physician’s mix of patients and the number of eligible quality measures in the physician’s panel (sample size). All quality measures are based on nationally recognized and established evidence-based performance measurements from organizations such as the National Quality Forum (NQF), the AQA Alliance, the National Committee for Quality Assurance, and specialty societies such as the American College of Cardiology®, as well as measures developed by national expert panels. This aspect of the Premium designation program only incorporates those clinical measures that can be assessed from paid claims data. We also focus on measures that are actionable by a physician.

The flow chart on this page describes the quality evaluation process. First, measures that evaluate adherence to evidence-based practices are mapped to specific specialties. For example, measures related to asthma are mapped to allergists, primary care physicians and pulmonologists. Appendix 1 shows the conditions and procedures measured for each specialty.

Next, we analyze the level of involvement of each physician with each patient’s care to determine how the care should be attributed. If the measure is analyzing a procedure, the procedure is attributed to the physician who performed it. If the measure is analyzing a course of treatment over time for
an ongoing condition, one or more physicians who saw the patient may be attributed the measure for the patient’s care. Quality measures for inpatient procedures are severity adjusted for severity of illness by the 3M™ All Patient Refined DRG (APR DRG) Classification System.

Then, for each physician, we compare the number of instances observed to the number generated by applying the national rate for each measure to the physician’s opportunities for that measure. If the sample size is adequate (number of attributed quality measures), the chi-square test is applied to determine statistical significance, an individual quality outcome is assigned, and a quality designation is determined. A quality designation means the physician met or exceeded the 50th percentile rate of recommended care for his or her patient mix and sample size.

Cost Efficiency Assessment

The evaluation of physicians for cost efficiency uses population cost and/or episode cost measurement as appropriate depending on the specialty being assessed. Population cost measurement is used for the cost efficiency evaluation for both primary care physicians and for select specialty physicians.

Population Cost Measurement

The specialties that are eligible for population cost are indicated by an asterisk in the “Specialties Included in the Premium Program” section in this document. For population cost, patients can be attributed to more than one eligible physician based on the hierarchy of clinical services and type of specialty. Physicians who provide primary surgical care are not eligible for patient attribution for population cost.

For population cost, the physician’s annualized risk-adjusted patients’ costs are organized into sets of patients. These are then grouped with patients from other physicians in the physician’s peer group according to the same types of patients (e.g., risk category, benefit plan that includes a prescription drug benefit). The measured physician’s patients’ costs are evaluated against their peer group’s patients by organizing the patients’ costs from lowest to highest. These costs are then converted into percentiles. Sets of comparable patients are combined for all peer group physicians and are ranked from lowest to highest percentile. If the sample size is adequate, we apply the Wilcoxon rank-sum test to determine the statistical significance of the physician’s rank sum compared with their peer group’s rank sum at the 75th percentile performance rate.

The cost efficiency criteria are met for physicians with a lower population cost result. The cost efficiency criteria are also met for physicians with an average population cost result who also have a lower episode cost result. A description of episode cost methodology is explained in the next section.

Episode Cost Measurement

Episode cost measurement compares a physician’s observed costs for episodes of care to a peer group’s costs for similar episodes of care, with adjustments for the patient’s severity of illness and the physician’s case mix. An episode of care is a grouping of services provided to an individual patient within a given time period surrounding a given illness (or group of similar illnesses).

Episodes include all services delivered to a patient, including those of other physicians or clinicians and related to a specific procedure or treatment of a condition. Episodes include dollars paid to the physician for direct services as well as facility costs and ancillary services which the software logic determined were related (e.g., medications, diagnostic tests). Using software, we categorize episodes as Episode Treatment Groups® (ETG®) or Procedure Episode Groups® (PEG®). Physicians’ costs must be statistically significantly lower than the peer group’s physicians at the 75th percentile performance for all physicians (measured in the same specialty for the same types of episodes in the same geographic area) in order to meet the episode cost measurement criteria. Complete ETG episodes are attributed to the physician who was responsible for at least 30 percent of the total costs. The responsible physician must be in a Premium-evaluated specialty that typically manages the care of patients for a given type of episode.

For surgeries and certain other procedures among cardiologists, ob-gyns, orthopaedic surgeons, and spine surgeons, we assess cost efficiency through analysis of procedural episodes constructed by PEG. This process aggregates paid claims into procedure-based episodes of care. The unit price of each discrete clinical service, the choice of diagnostic or therapeutic modality, facility costs, and the volume and mix of services used in the episode influence the cost of an episode of care.
UnitedHealth Premium Physician Designation Program Summary Methodology

Summary – Cost Efficiency

The cost efficiency evaluation process is described in the flowchart on this page.

For population cost measurement, patients are attributed to no more than one eligible physician within each specialty category. An annualized risk-adjusted cost record is created for a patient within each specialty category. The physician's annualized risk-adjusted patients' costs are organized into sets of patients from other physicians according to the same types of patients.

For episode cost measurement, ETG and PEG software generate episodes of care and allow for case-mix and severity adjustments. Episode costs are attributed to a single responsible physician. The physician's actual costs are organized into sets of costs from other physicians according to the same types of cases and severity levels.

For both episode cost and population cost measurement, the physician's costs within each set are evaluated against their peer group's costs by ordering the costs from lowest to highest cost. The costs are converted into percentiles to allow comparison across different types of cases or patients. Then the outliers are removed. Sets of comparable costs for all peer group physicians are combined and ranked from lowest to highest percentile. If the sample size is adequate, the Wilcoxon rank-sum test is applied to determine the statistical significance of the individual physician's ranks compared with their peer group's expected rank. An overall cost efficiency outcome is assigned based on the population cost/episode cost process.
Important notes about the UnitedHealth Premium Physician Designation Program

The information from the Premium physician designation program is not an endorsement of a particular physician or health care professional’s suitability for the health care needs of any particular member. UnitedHealthcare does not practice medicine nor provide health care services. Physicians are solely responsible for medical judgments and treatments supplied. The quality and/or cost efficiency designation of a physician does not guarantee the quality of health care services members will receive from a doctor and does not guarantee the outcome of any health care services members will receive.

Likewise, the fact that a physician may not be designated by this program does not mean that the physician does not provide quality health care services. All physicians in the UnitedHealthcare Network have met certain minimum credentialing requirements. Regardless of whether a physician has received a designation, members have access to all physicians in the UnitedHealthcare Network, as further described under the member’s benefit plan.

The assessment result “Not Enough Data to Assess” is not an indicator of the total number of patients treated by the physician or the number of procedures performed by the physician. Rather, it reflects the statistical requirements of the Premium designation program, which includes only health plan claims associated with specific program measures and relevant to the physician’s designated specialty. In some cases, there may not be enough data to complete the analytic process from a statistical standpoint.

UnitedHealthcare informs members that designations are intended only as a guide when choosing a physician and should not be the sole factor in selecting a physician. As with all programs that evaluate performance based on analysis of a sample, there is a risk of error. There is a risk of error in the claims data used in the evaluation, the calculations used in the evaluation, and the way the program determined that an individual physician was responsible for the treatment of the patient’s condition. Physicians have the opportunity to review this data and submit a reconsideration request. UnitedHealthcare uses statistical testing to compare a physician’s results to expected or normative results. There is a risk of error in statistical tests when applied to the data and a result based on statistical testing is not a guarantee of correct inference or classification. We inform members that it is important that they consider many factors and information from as many sources as possible when selecting a physician. We also inform our members that they may wish to discuss designations with a physician before choosing him or her, or confer with their current physician for advice on selecting other physicians.

The information contained in this Summary Methodology is subject to change.
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<thead>
<tr>
<th>Specialty and Condition/Procedure for Quality Measurement</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>Acute Bronchitis, Acute Sinusitis, Asthma, Diabetes, Hypertension, Pharyngitis, Pneumonia, Rheumatoid Arthritis, Upper Respiratory Infection</td>
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<tr>
<td>Cardiology</td>
<td>Acute Myocardial Infarction (AMI), Atrial Fibrillation, Cerebral Vascular Accident &amp; Transient Cerebral Ischemia (Stroke), Congestive Heart Failure, Coronary Artery Bypass Graft, Coronary Artery Catheterization (Diagnostic), Coronary Artery Catheterization (PCTA), Coronary Artery Catheterization with Drug Stent, Coronary Artery Catheterization with Non-Drug Stent, Coronary Artery Disease, Diabetes, Hyperlipidemia, Hypertension, Implantable Device Defibrillator, Implantable Device Pacemaker, Invasive Therapeutic Electrophysiology (Ablation), Ischemic Vascular Disease, Pneumonia, Rheumatoid Arthritis</td>
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<td>Ear, Nose and Throat</td>
<td>Acute Bronchitis, Acute Otitis Externa, Acute Sinusitis, Adenoidectomy, Laryngoscopy with Treatment, Migraine Headache, Myringotomy, Nasal Ablation, Nasal Endoscopy with Treatment, Nasal Vestibule Repair, Pharyngitis, Septoplasty, Tonsillectomy, Tonsillectomy and Adenoidectomy, Turbinate Excision, Tympanic Membrane Repair, Tympanoplasty, Tympanostomy, Upper Respiratory Infection</td>
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<tr>
<td>Endocrinology</td>
<td>Chronic Kidney Disease, Coronary Artery Disease, Diabetes, Hyperlipidemia, Hypertension, Ischemic Vascular Disease, Migraine Headache, Osteoporosis Management, Pregnancy Management</td>
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<td>Family Medicine</td>
<td>Acquired Immune Deficiency Syndrome (AIDS/HIV), Acute Bronchitis, Acute Myocardial Infarction (AMI), Acute Otitis Externa, Acute Sinusitis, Asthma, Atrial Fibrillation, Attention Deficit Hyperactivity Disorder (ADHD), Back Pain, BMI Assessment, Breast Cancer - Part I, Breast Cancer Screening, Cerebral Vascular Accident &amp; Transient Cerebral Ischemia (Stroke), Cervical Cancer Screening, Chlamydia Screening, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Colon Cancer, Colorectal Cancer Screening, Congestive Heart Failure, Coronary Artery Disease, Depression, Diabetes, Epilepsy, Glaucoma Screening, Hepatitis C, Hypertension, Immunizations for Adolescents, Inflammatory Bowel Disease, Ischemic Vascular Disease, Mental Illness, Migraine Headache, Multiple Sclerosis, Osteoporosis Management, Pharyngitis, Pneumonia, Pneumonia Vaccination, Pregnancy Management, Prostate Cancer, Rheumatoid Arthritis, Sickle Cell Anemia, Upper Respiratory Infection, Well-Child Visits</td>
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<td>Gastroenterology</td>
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<td>General Surgery</td>
<td>Appendectomy, Breast Cancer - Part I, Cerebral Vascular Accident &amp; Transient Cerebral Ischemia (Stroke), Colon Cancer, Cholecystectomy, Diagnostic Colonoscopy, Incisional or Ventral Hernia Repair, Inflammatory Bowel Disease, Inguinal Hemia Repair, Lower Gastrointestinal Endoscopy with Treatment, Lower Gastrointestinal Removal, Prostate Cancer, Umbilical Hemia Repair</td>
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<td>Internal Medicine</td>
<td>Acquired Immune Deficiency Syndrome (AIDS/HIV), Acute Bronchitis, Acute Myocardial Infarction (AMI), Acute Sinusitis, Alcohol and Other Drug Dependence Treatment, Asthma, Atrial Fibrillation, Back Pain, BMI Assessment, Breast Cancer - Part I, Breast Cancer Screening, Cerebral Vascular Accident &amp; Transient Cerebral Ischemia (Stroke), Cervical Cancer Screening, Chlamydia Screening, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Colon Cancer, Colorectal Cancer Screening, Congestive Heart Failure, Coronary Artery Disease, Depression, Diabetes, Epilepsy, Glaucoma Screening, Hepatitis C, Hyperlipidemia, Hypertension, Immunization for Adolescents, Inflammatory Bowel Disease, Influenza Vaccination, Ischemic Vascular Disease, Mental Illness, Migraine Headache, Multiple Sclerosis, Osteoporosis Management, Pharyngitis, Pneumonia, Pneumonia Vaccination, Prostate Cancer, Rheumatoid Arthritis, Sickle Cell Anemia, Upper Respiratory Infection, Weight Assessment and Counseling, Well-Child Visits</td>
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<thead>
<tr>
<th>Specialty</th>
<th>Condition/Procedure for Measurement</th>
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<tr>
<td>Nephrology</td>
<td>Chronic Kidney Disease, Coronary Artery Disease, Diabetes, Hyperlipidemia, Hypertension, Ischemic Vascular Disease</td>
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<td>Neurology</td>
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<td>Neurosurgery, Orthopaedics and Spine</td>
<td>Achilles Tendon Repair, Ankle Ligament Repair, Arthrodesis (Midfoot), Arthroscopic Decompression (Shoulder), Arthroscopic Removal of Foreign Body/Debridement (Shoulder), Arthroscopic Repair Rotator Cuff, Arthroscopic Repair - Slap Shoulder, Arthroscopy of Ankle with Major Repair, Arthroscopy of the Hip, Bunionectomy, Carpel Tunnel Release - Arthroscopic, Carpel Tunnel Release (Open), Cervical Spine Fusion, Cervical Spine Fusion with Hardware Insertion, Cervical Spine Laminectomy, Decompression (Herniated Disc/Lumbar Back), Fusion (Lumbar Back), Fusion (Lumbar Back) with Hardware Insertion, Hammer Toe Repair, Hip Replacement, Hip Replacement Revision, Knee Arthroscopy with Cruciate Ligament Repair, Knee Arthroscopy with Meniscectomy, Knee Replacement Surgery, Knee Replacement Surgery Revision, Lumbar Spine Revision, Other Knee Arthroscopy with Treatment, Rotator Cuff Repair, Shoulder Arthroscopy with Claviculectomy Tenodesis or Capsulorrhaphy, Shoulder Arthroscopy with Synovectomy or Lysis Adhesions, Vertebral Corpectomy</td>
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<td>Obstetrics and Gynecology</td>
<td>Acquired Immune Deficiency Syndrome (AIDS/HIV), Acute Bronchitis, BMI Assessment, Breast Cancer - Part I, Breast Cancer Screening, Cautery of Cervix, Cervical Cancer Screening, Chlamydia Screening, Colorectal Cancer Screening, Conization of Cervix, Depression, Diabetes, Endometrial Ablation, Endometrial Ablation with Hysterectomy, Epilepsy, Excision of Fibroid Tumor(s) of Uterus, Excision of Ovary/Ovarian Duct, Hyperlipidemia, Hypertension, Hysteroscopy with Treatment, Incision and Drainage of Bartholin’s Gland Abscess, Inflammatory Bowel Disease, Influenza Vaccination, Laparoscopic Total Hysterectomy, Lysis and Adhesion of Ovary/Ovarian Duct, Migraine Headache, Osteoporosis Management, Ovary/Ovarian Duct Removal, Pneumonia Vaccination, Pregnancy Management, Rheumatoid Arthritis, Stress Incontinence Repair, Supracervical Hysterectomy, Total Abdominal Hysterectomy, Vaginal Hysterectomy, Weight Assessment and Counseling</td>
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<td>Pediatrics</td>
<td>Acute Sinusitis, Alcohol and Other Drug Dependence Treatment, Asthma, Attention Deficit Hyperactivity Disorder (ADHD), BMI Assessment, Chlamydia Screening, Chronic Kidney Disease, Depression, Diabetes, Epilepsy, Immunization for Adolescents, Immunizations for Adolescents, Influenza Vaccination, Migraine Headache, Pharyngitis, Sickle Cell Anemia, Upper Respiratory Infection, Weight Assessment and Counseling, Well-Child Visits</td>
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<td>Rheumatology</td>
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<td>Urology</td>
<td>Chronic Kidney Disease, Cystourethrocopys with Treatment, Laser Coagulation, Lithotripsy, Prostate Cancer, Stress Incontinence Repair, Transurethral Destruction of Prostate Tissue, Transurethral Resection of Bladder Neck</td>
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