Medlearn Matters
Information for Medicare Providers

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Note: This article was revised on December 29, 2005 since the Centers for Medicare & Medicaid Services revised the related CR4183. The number of measures that will initially be used in the PVRP has been changed to 16 measures. The transmittal number and related CR release date (see above) were also changed.

Physician Voluntary Reporting Program (PVRP) Using Quality G-Codes

Provider Types Affected

Physicians and other health care providers who bill Medicare

Provider Action Needed

This article provides information about the Centers for Medicare & Medicaid Services' (CMS) Physician Voluntary Reporting Program (PVRP). It will assist physicians in understanding this new voluntary reporting program and the use of G-codes to report data about the quality of care provided to Medicare beneficiaries.

Background

As part of its overall quality improvement efforts, CMS is launching the Physician Voluntary Reporting Program (PVRP). This new program builds on Medicare's comprehensive efforts to substantially improve the health and function of our beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered.

Under the voluntary reporting program, physicians who choose to participate will help capture data about the quality of care provided to Medicare beneficiaries, in order to identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care. Voluntary reporting of quality data through the PVRP will begin in January 2006.

National Consensus Measures and Indicators

To this end, CMS has begun the process of developing a comprehensive set of national consensus measures and indicators that will allow physicians to more efficiently report quality information on the health services provided to Medicare beneficiaries.

CMS has identified 36 evidence-based clinically valid measures that have been part of the guidelines endorsed by physicians and the medical specialty societies and are the result of extensive input and feedback from physicians and other quality care experts.

However, after announcing the PVRP on October 28, 2005, suggestions have been made by several physician organizations to identify a starter set in order to lessen the potential reporting burden for physicians and better align the PVRP with other quality measurement activities affecting physicians.

CMS has decided to adopt the suggestion of a smaller core starter set of PVRP measures. The core set consists of 16 measures, which will significantly reduce the number of measures applicable to any individual physician practice specialty. Additionally, we have selected primary care measures based on measures that are National Quality Forum (NQF) endorsed, part of the Ambulatory Care Quality Alliance (AQA) starter set, and that will be used by the Quality Improvement Organization (QIO) programs for physician quality improvement in its eighth Scope of Work (8th SOW). Despite the smaller starter set of 16 measures, the PVRP maintains its same scope of coverage for physician specialties.

Confidential reports available to physicians will be limited to the 16 core starter set. Physicians may report clinical data on the remaining 20 measures, but will not receive summarizing reports.

Moreover, CMS is developing the underlying infrastructure so that the reporting of these measures on existing physician claims could begin as soon as January 1, 2006.

Data Collection Through the Administrative Claims System

The usual source of the clinical data for quality measures is retrospective chart abstraction, but data collection through chart abstraction can be quite burdensome. Additionally, while electronic health records may ultimately greatly facilitate clinical data reporting, they do not, at present, provide a widespread means for physicians to report clinical data.

Therefore, to avoid the necessity for chart abstraction, CMS will start the process of collecting quality information on services provided to the Medicare population by using the administrative claims system.

G-Codes

Specifically, CMS has defined a set of HCPCS codes (termed G-codes) to report data for the calculation of the quality measures. These new codes will supplement the usual claims data with clinical data that can be used to measure the quality of services rendered to beneficiaries.

CMS currently has 16 sets of specialty measures. Additional measures to cover a broader set of specialties will be developed over the next few payment cycles. Each measure has a defined numerator (the appropriate G-code) and a denominator (specifically defined according to the appropriate services or condition). The reporting rate is calculated as a percentage for each of the 16 measures.

You can use G-codes when all of the following circumstances are met:

- The G-code reported on the claim relates to a covered diagnosis, covered treatment(s), or covered preventive service(s) that are applicable to the beneficiary.
- The G-code is directly relevant to the specific service(s) provided to the beneficiary by the practitioner reported on the claim.
- The G-code represents medically necessary and appropriate medical practice under the circumstances.
- The basis for the G-code is documented in the beneficiary medical record.

Important Points for Physicians

- When applicable, the G-code should be reported in addition to CPT and ICD-9 codes required for appropriate claims coding.
- They do not substitute for CPT and ICD-9 codes requirements for payment.
- They are not associated with a separate fee, and will not be individually compensated.
- G-codes are always billed in conjunction with a service and are never billed independently.
- The G-codes should be reported with a submitted charge of zero ($0.00). (G-codes will not appear on the Medicare Physician Fee Schedule Data Base (MPFSDB) because there are no relative value units (RVUs) or amounts for these codes.)
- They are not specialty specific. Therefore, a medical specialty may report G-codes classified under other specialties. However, it is anticipated that the reporting of certain G-codes will be predominated by certain specialties.
- The failure to provide a G-code will not result in denial of a claim that would otherwise be approved, and thus submission of a G-code is voluntary.

Although reporting is voluntary, CMS is encouraging physicians to submit G codes when applicable. The PVRP's objective is to provide CMS with data that it can use to calculate quality measures. Therefore, CMS will calculate the reporting rate for physicians who participate in the program, and will provide them with feedback information in an effort to assist them in improving their data accuracy and reporting rate.

Additional Information

The specific quality measures related to the G-codes in this initial program launch are reflected in the table at the end of this article.

You can find more information about the physician voluntary reporting program and quality G-Codes by going to http://www.cms.hhs.gov/Transmittals/downloads/R35DEMO.pdf on the CMS website.

Appendices accompanying CR4183 contain the specific G-Codes and their descriptors as they relate to the developed quality measures reflected in the above table. The transmittal will list both the 36 proposed measures and the 16 measures which will be used initially in the PVRP.

Finally, if you have any questions, please contact your Medicare carrier at their toll-free number, which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS website.

Physician Voluntary Reporting Program
G-Codes and Descriptions for Clinical Measures

Measure	G-Code/Descriptions
Aspirin at arrival for acute myocardial infarction	G8006: Acute myocardial infarction: patient documented to have received aspirin at arrival measure G8007: Acute myocardial infarction: patient not documented to have received aspirin at arrival G8008: Clinician documented that acute myocardial infarction patient was not an eligible candidate to receive aspirin at arrival
Beta blocker at time of arrival for acute myocardial infarction	G8009: Acute myocardial infarction: patient documented to have received beta-blocker at arrival G8010: Acute myocardial infarction: patient not documented to have received beta-blocker at arrival G8011: Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure
Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus	G8016: Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as less than or equal to 9% G8015: Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as greater than 9% G8017: Clinician documented that diabetic patient was not eligible candidate for hemoglobin A1c measure G8018: Clinician has not provided care for the diabetic patient for the required time for hemoglobin A1c measure (6 months)
Low-density lipoprotein control in patient with Type I or Type II diabetes mellitus	G8020: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as less than 100 mg/dl G8019: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as greater than or equal to 100 mg/dl G8021: Clinician documented that diabetic patient was not an eligible candidate for low-density lipoprotein measure G8022: Clinician has not provided care for the diabetic patient for the required time for low-density lipoprotein measure (12 months)
High blood pressure control in patient with Type I or Type II diabetes mellitus	G8024: Diabetic patient with most recent blood pressure (within the last 6 months) documented less than 140 systolic and less than 80 diastolic G8023: Diabetic patient with most recent blood pressure (within the last 6 months) documented as equal to or greater than 140 systolic or equal to or greater than 80 mmHg diastolic G8025: Clinician documented that the diabetic patient was not an eligible candidate for blood pressure measure G8026: Clinician has not provided care for the diabetic patient for the required time for blood pressure measure (within the last 6 months)
Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction	G8027: Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on either angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy G8028: Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on either angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy G8029: Clinician documented that heart failure patient was not an eligible candidate for either angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy measure
Beta-blocker therapy for patient with prior myocardial infarction	G8033: Prior myocardial infarction – coronary artery disease patient documented to be on beta-blocker therapy G8034: Prior myocardial infarction – coronary artery disease patient not documented to be on beta-blocker therapy G8035: Clinician documented that prior myocardial infarction – coronary artery disease patient was not an eligible candidate for beta-blocker therapy measure
Assessment of elderly patients for falls	G8055: Patient documented for the assessment for falls within last 12 months G8054: Patient not documented for the assessment for falls within last 12 months G8056: Clinician documented that patient was not an eligible candidate for the falls assessment measure within the last 12 months

Measure	G-Code/Descriptions
Dialysis dose in end stage renal disease patient	G8075: End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2) G8076: End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2) G8077: Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure
Hematocrit level in end stage renal disease patient	G8078: End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11) G8079: End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11) G8080: Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure
Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis	G8081: End-stage renal disease patient requiring hemodialysis vascular access documented to have received autogenous AV fistula G8082: End-stage renal disease patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula
Antidepressant medication during acute phase for patient diagnosed with new episode of major depression	G8126: Patient documented as being treated with antidepressant medication during the entire 12 week acute treatment phase G8127: Patient not documented as being treated with antidepressant medication during the entire 12 week acute treatment phase G8128: Clinician documented that patient was not an eligible candidate for antidepressant medication during the entire 12 week acute treatment phase measure
Antibiotic prophylaxis in surgical patient	G8152: Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) G8153: Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) G8154: Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure
Thromboembolism prophylaxis in surgical patient	G8155: Patient with documented receipt of thromboembolism prophylaxis G8156: Patient without documented receipt of thromboembolism prophylaxis G8157: Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure
Use of internal mammary artery in coronary artery bypass graft surgery	G8158: Patient documented to have received coronary artery bypass graft with use of internal mammary artery G8159: Patient documented to have received coronary artery bypass graft without use of internal mammary artery G8160: Clinician documented that patient was not an eligible candidate for coronary artery bypass graft with use of internal mammary artery measure
Pre-operative beta blocker for patient with isolated coronary artery bypass graft	G8161: Patient with isolated coronary artery bypass graft documented to have received pre-operative beta-blockade G8162: Patient with isolated coronary artery bypass graft not documented to have received pre-operative beta-blockade G8163: Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for pre-operative beta-blockade measure