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**Note:** This article was revised on June 20, 2006. Please note the special "Introduction" section that has been added to the article on this page. Also, CMS has released CR5036 and related MM5036, which announces that CPT II codes are available for certain measures.

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

### Provider Types Affected

Physicians and other health care providers who bill Medicare

### Introduction

In January of 2006, the Centers for Medicare & Medicaid Services (CMS) launched the Physician Voluntary Reporting Program (PVRP) with a core starter set of 16 measures. Collection of data on the 16 measures is currently underway.

CMS is now encouraging physicians to register their intent to participate in the PVRP through the secured link <http://www.qualitynet.org>. Physicians can continue to report on the PVRP measures regardless of whether they register their intent to participate or not. However, by registering their intent to participate, physicians will be able to receive confidential feedback on their reporting rate and performance rate for each measure that they reported on.

Registering the intent to participate is the first step to registering for the feedback report. In June, CMS will begin contacting the individuals responsible in each physician office for completing the registration for the feedback report. CMS will walk these individuals through finishing the confidential registration process. By registering the intent to participate now, physician offices not only have the benefit of receiving feedback reports on the PVRP measures, CMS will also help their office in June with completing the full registration for the feedback reports.

CMS is strongly encouraging physicians to register their intent to participate by April 1<sup>st</sup>. The physician feedback reports will first be available in December 2006 and is based on second quarter data, which will be collected from April 1<sup>st</sup> through June 30<sup>th</sup>. Although registration of intent will be welcome after April 1<sup>st</sup>, CMS strongly encourages physicians to register their intent to participate by April 1<sup>st</sup> so that feedback reports can be based on as much data collected in the second

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quarter as possible. Again, physicians can continue to submit data on PVRP measures whether they register their intent or not. However, registering the intent by April 1<sup>st</sup> will enable CMS to provide feedback reports based on the most information available for quarter 2.

Registration of intent to participate does not obligate a physician to participate as CMS understands that unpredictable future events may occur that would ultimately prevent one from actually participating. Also, physicians can submit data on the PVRP measures without registering their intent to participate.

To reiterate, CMS strongly encourages all physicians to register their intent to participate by April 1 so that:

- We can help physician offices in June with completing the full registration for the feedback reports;
- The physician's feedback reports available in December 2006 reflect the most information available for the second quarter, April 1<sup>st</sup> – June 30<sup>th</sup>; and
- Physician offices will be able to receive feedback reports on their reporting and performance rates for the PVRP measures for which information was submitted.

## Provider Action Needed

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This article provides information about the 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

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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

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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.

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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

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information in an effort to assist them in improving their data accuracy and reporting rate.

## Additional Information

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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.

**Please note that MM5036 has modified this table to include CPT II codes that can be used instead of the noted G-codes. Also note that either a G-code or a CPT II code, should be submitted, but never both.**

MLN article may be reviewed at

<http://www.cms.hhs.gov/MLnMattersArticles/downloads/MM5036.pdf> on the CMS website.

More information about PVRP and quality G-Codes and CPE can be found in CR5036 is available at

<http://www.cms.hhs.gov/Transmittals/downloads/R43DEMO.pdf> on the CMS website.

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/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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

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

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Measure	G-Code/Descriptions
Beta-blocker therapy for patient with prior myocardial infarction	<p><b>G8033:</b> Prior myocardial infarction – coronary artery disease patient documented to be on beta-blocker therapy</p> <p><b>G8034:</b> Prior myocardial infarction – coronary artery disease patient not documented to be on beta-blocker therapy</p> <p><b>G8035:</b> Clinician documented that prior myocardial infarction – coronary artery disease patient was not an eligible candidate for beta-blocker therapy measure</p>
Assessment of elderly patients for falls	<p><b>G8055:</b> Patient documented for the assessment for falls within last 12 months</p> <p><b>G8054:</b> Patient not documented for the assessment for falls within last 12 months</p> <p><b>G8056:</b> Clinician documented that patient was not an eligible candidate for the falls assessment measure within the last 12 months</p>
Dialysis dose in end stage renal disease patient	<p><b>G8075:</b> 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)</p> <p><b>G8076:</b> End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2)</p> <p><b>G8077:</b> Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure</p>
Hematocrit level in end stage renal disease patient	<p><b>G8078:</b> End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11)</p> <p><b>G8079:</b> End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11)</p> <p><b>G8080:</b> Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure</p>
Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis	<p><b>G8081:</b> End-stage renal disease patient requiring hemodialysis vascular access documented to have received autogenous AV fistula</p> <p><b>G8082:</b> End-stage renal disease patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula</p>
Antidepressant medication during acute phase for patient diagnosed with new episode of major depression	<p><b>G8126:</b> Patient documented as being treated with antidepressant medication during the entire 12 week acute treatment phase</p> <p><b>G8127:</b> Patient not documented as being treated with antidepressant medication during the entire 12 week acute treatment phase</p> <p><b>G8128:</b> Clinician documented that patient was not an eligible candidate for antidepressant medication during the entire 12 week acute treatment phase measure</p>
Antibiotic prophylaxis in surgical patient	<p><b>G8152:</b> Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)</p> <p><b>G8153:</b> Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)</p> <p><b>G8154:</b> Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure</p>
Thromboembolism prophylaxis in surgical patient	<p><b>G8155:</b> Patient with documented receipt of thromboembolism prophylaxis</p> <p><b>G8156:</b> Patient without documented receipt of thromboembolism prophylaxis</p> <p><b>G8157:</b> Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure</p>

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Measure	G-Code/Descriptions
<p><b>Use of internal mammary artery in coronary artery bypass graft surgery</b></p>	<p><b>G8158:</b> Patient documented to have received coronary artery bypass graft with use of internal mammary artery  <b>G8159:</b> Patient documented to have received coronary artery bypass graft without use of internal mammary artery  <b>G8160:</b> Clinician documented that patient was not an eligible candidate for coronary artery bypass graft with use of internal mammary artery measure</p>
<p><b>Pre-operative beta blocker for patient with isolated coronary artery bypass graft</b></p>	<p><b>G8161:</b> Patient with isolated coronary artery bypass graft documented to have received pre-operative beta-blockade  <b>G8162:</b> Patient with isolated coronary artery bypass graft not documented to have received pre-operative beta-blockade  <b>G8163:</b> Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for pre-operative beta-blockade measure</p>

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