# Physician Voluntary Reporting Program: Medicare's Quality Measures Program Authorized for Incentive Payments in 2007



*by Bonnie S. Peters, CCS-P*

Traditionally, the payment system for physicians has been based on fee for service and did not include rewards or incentives for quality. However, as a result of evidence that shows significantly improved quality in hospitals when incentives are offered, the Centers for Medicare and Medicaid Services (CMS) decided to expand the reporting of quality measures into the physician sector.

In January 2006 CMS launched the Physician Voluntary Reporting Program (PVRP). The program is part of CMS's comprehensive initiative to improve the health and function of Medicare beneficiaries by preventing chronic disease complications, avoiding unnecessary hospitalizations, and improving the quality of care delivered.

Physician participation in the reporting of quality measures is essential to CMS's initiative because physicians are gatekeepers in the delivery of healthcare services. CMS indicated that physicians with higher quality performance will be paid more in the future. PVRP is designed to encourage physicians to begin voluntarily reporting clinical data relating to evidence-based quality measures to CMS.

With the program's introduction, physicians could report on up to 36 evidence-based quality measures. However, CMS decided to initially adopt a smaller core starter set of 16 measures to reduce the reporting burden. Physicians only received confidential feedback reports on the 16 core measures, even if they reported additional measures.

At the end of 2006, CMS announced a preliminary list of 45 total measures effective January 1, 2007, with an additional 21 measures expected to be effective subsequently. The core set decreased to 15 measures, including several modifications. (At press time, CMS still described the 2007 list as "preliminary." Updates are available at www.cms.hhs.gov/pvrp.)

## Core Starter Set Measures

The core starter set measures were developed by physicians working with AQA (formerly known as the Ambulatory Care Quality Alliance), the National Quality Forum, and the AMA Physician Consortium. The set includes measures for primary care and emergency medicine physicians, nephrologists, and surgeons. For 2007 several AMA-PCPI measures were substituted for measures of the same topic. As a result, 15 measures form the preliminary core set in 2007. They include:

- Aspirin at arrival for acute myocardial infarction
- Beta blocker at time of arrival for acute myocardial infarction
- Hemoglobin A1c control in patient with type I or type II diabetes mellitus
- Low density lipoprotein control in patient with type I or type II diabetes mellitus
- High blood pressure control in patient with type I or type II diabetes mellitus
- Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction
- Beta-blocker therapy for patient with prior myocardial infarction
- Screening for fall risk
- Dialysis dose in end-stage renal disease patient
- Hematocrit level in end-stage renal disease patient
- Antidepressant medication during acute phase for patient diagnosed with new episode of major depression
- Timing of antibiotic prophylaxis in surgical patient
- Venous thromboembolism prophylaxis (when indicated in all patients)

- Use of internal mammary artery in coronary artery bypass graft surgery
- Pre-operative beta-blocker for patient with isolated coronary artery bypass graft

## Reporting the Data: G Codes and CPT Category II Codes

CMS has developed a set of HCPCS codes to report these quality measures. Known as G codes, they are reported in addition to the usual claims data on the CMS 1500 claim form after a service has been performed. Each quality measure has a defined numerator and denominator. The numerator will be the appropriate G code or CPT category II code. The denominator will be defined according to the appropriate service or condition. CMS also provides instructions with each quality measure.

According to CMS, physicians should report G codes or CPT category II codes when the following conditions are met:

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

Performance measure exclusion modifiers were developed to be used with CPT category II codes as appropriate. These exclusion modifiers include:

- 1P for medical reasons
- 2P for patient reasons
- 3P for system seasons

Either a G code or a CPT code can be submitted individually, but physicians cannot submit both for the same service. G codes and CPT category II codes will not be considered a substitute for CPT and ICD-9-CM codes. In addition, these PVRP codes are for voluntary reporting only and are not associated with a separate fee. Thus, there is no additional reimbursement for reporting these codes.

Currently, CMS is collecting the data by using the administrative claims system instead of retrospective chart abstraction. CMS has assured physicians that failure to report these codes will not result in a denial of a claim. EHRs will improve the efficiency of clinical data reporting; however, most physicians are not yet using an EHR for clinical data collection in the office setting.

## A “Dear Doctor” Letter and Confidential Feedback Reports

In an effort to encourage participation, CMS issued a “Dear Doctor” letter outlining why physicians should participate in PVPR on a voluntary basis. CMS encouraged doctors to participate to learn about their performance prior to having payments attached to the reporting program; because of Congressional interest in incorporating pay-for-performance in future physician payment schedules; to ensure that claims processing and office software can support the codes used for reporting; and to give CMS feedback on what works and what doesn’t in the system.

CMS also announced that confidential feedback reports would be available to physicians in December 2006. The confidential feedback reports will reflect data submitted between April 1 and June 30, 2006, and will be calculated as a percentage for each quality measure.

## Physician Concerns

Not all physicians are embracing the PVRP initiative. Many physicians, practice administrators, and physician organizations have expressed concerns about the program. Their concerns include:

- Two types of measurements in PVRP, performance and outcomes. Outcomes are very controversial because physicians may not be able to control the patient's compliance. Thus, there is apprehension that physicians may discharge these noncompliant patients (some of the sickest patients) from their practice to improve outcome scores.
- Some surgeons expressed concerns regarding the prophylactic antibiotics that are to be given to the patient prior to surgery. Even though prophylactic antibiotics are routinely ordered, in some cases the antibiotic was not given to the patient prior to surgery.
- Conflicting information may be reported, especially when one physician places a patient on medication but another physician takes the patient off medication.
- Reporting performance measures requires additional staff time to process claims.
- Practices with EHRs may need to have their existing software modified, which would add additional costs to their overhead.
- Issues surrounding third-party payer recognition of G codes. For example, if Medicare is a secondary payer and a G code is submitted, the claim may be rejected because it does not conform to the private payer's guidelines.

## The First Step in Payment Incentives for 2007

CMS did not introduce PVRP as a pay-for-performance demonstration or set any expectations that it eventually would be transformed into one. However, many believed that Medicare would eventually adopt such a system. The private sector has seen numerous success stories with pay-for-performance, so it is a logical progression for Medicare to adopt it, also.

Although Medicare can implement PVRP, authorization for funding must come from legislation. Authorization came at the end of the year, when the president signed the Tax Relief and Health Care Act of 2006. In part, the act mandates a physician quality reporting system and authorizes a payment incentive. The incentive will be based on quality measures reported for care delivered between July 1 and December 31, 2007. Participation remains entirely voluntary.

PVRP adds yet another layer to coded medical record data. It is important that coders, administrators, and providers understand this initiative thoroughly in order to accurately submit their data if they choose to participate in the program. It will be equally important for physicians and the industry to participate in the development of the quality measurement system.

## Resources

Centers for Medicare and Medicaid Services (CMS). "Physician Voluntary Reporting Program." Available online at www.cms.hhs.gov/PVRP.

CMS. "Physician Voluntary Reporting Program (PVRP) Background and General Information." October 16, 2006. Available online at www.cms.hhs.gov/PVRP/Downloads/PVRPBackground.pdf.

CMS. "Physician Voluntary Reporting Program (PVRP) Using Quality G-Codes and CPT Category II Codes (CPT II Codes)." *MLN Matters*, April 3, 2006. Available online at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5036.pdf.

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