

Voluntary quality reporting program initiated for physicians

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On October 28, 2005, the Centers for Medicare & Medicaid Services (CMS) announced the launch of a physician voluntary reporting program (PVRP) as part of the agency's ongoing efforts to improve quality in health care. This article is intended to increase surgeons' understanding of the PVRP, including an overview of its purposes, means of implementation, and potential problems and benefits for participants.

Background

The development of the PVRP is CMS' most recent step toward implementing its quality initiative, first announced in November 2001 by Tommy Thompson, then-Secretary of the U.S. Department of Health and Human Services. The program began in April 2002 with the nursing home quality initiative, which set quality measures for those facilities that agreed to participate in a pilot project. The nursing home measures were applied nationally in November 2002. CMS then extended the quality initiative to home health agencies and hospitals in 2003. In 2004, the initiative was further expanded to include dialysis facilities that treat patients with end-stage renal disease and to primary care physicians. Hence, the PVRP is the first physician-centered quality improvement program from CMS available at the national level.

The PVRP allows physicians to report quality measures through the claims system. Participating physicians also may register to receive confidential feedback on their performance, including a comparison to regional, state, and national performance levels. The feedback reports are intended to allow physicians to gauge their success in identifying patients on whom to report data and in determining their quality performance for selected conditions.



The quality measures will be reported at the practice level through tax identification numbers. Although participation is not tied to payment at this time, it could easily be transformed into a pay-for-performance system. Therefore, physicians are advised to carefully monitor the program not only in terms of their own participation, but also with an eye on the relevance and effectiveness of the initial measures.

The measures

CMS originally released a set of 36 measures for reporting, but after additional physician input, CMS reduced the number of measures to 16. On December 27, a new starter set of quality measures was released. Of the 16 initial measures, only five are surgery-related, two of which are specific to coronary artery bypass graft surgery. The three remaining surgical measures are receipt of autogenous arteriovenous fistula in end-stage renal disease patients requiring hemodialysis, antibiotic prophylaxis in surgical patients, and thromboembolism prophylaxis in surgical patients.

Most of the PVRP measures center on primary care services, including control of diabetes mellitus, heart failure, and end-stage renal disease. Other areas addressed include depression and assessment of elderly patients for falls.

The five surgical measures in the PVRP examine processes rather than outcomes. The program does include outcome measures for primary care physicians, such as control of hemoglobin A1c (less than or equal to 9%), low-density lipoprotein (less than 100 mg/dl), and high blood pressure (less than 140 systolic and less than 80 diastolic) in patients with type 1 or type 2 diabetes. Because the program is not risk-adjusted, the number of outcome measures included is limited.

Reporting

The most common source of clinical data for quality measures is retrospective chart abstraction, but CMS found this method too burdensome for the initial phase of the program. The PVRP measures will be submitted using "procedure" codes, known as G-codes, to report clinical data through the claims processing system. G-codes are part of the Healthcare Common Procedure Coding System (HCPCS) and consist of an initial "G" fol-

lowed by four numbers. G-codes will be reported on the claim form in addition to the required Current Procedural Terminology (CPT)* code. It is important to understand that G-codes are not substitutes for CPT codes, are not associated with a separate fee, and are ineligible for compensation from CMS. The submission of G-codes is voluntary, and, therefore, claims will be paid regardless of whether a G-code is provided.

CMS considers the G-code system a temporary method of data collection until electronic clinical data submission becomes possible through electronic medical records. As health information technology becomes more widely available and accepted, risk-adjusted outcome measures can be implemented.

G-code measurements

Under the current system, each quality measure has multiple corresponding G-codes. The physician reports the G-code that represents the clinical service furnished. Each measure has a numerator, which is the G-code, and a denominator, which is the population being evaluated. An example of a PVRP measure is as follows:

Measure: Antibiotic prophylaxis in surgical patient

- *Numerator:*

- 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.

- *Denominator:*

- Specified CPT codes.

CMS has stated that physicians may select which measures they will report. At press time, the feedback report physicians will receive was still in draft form, but preliminary information suggested that for each measure, CMS will col-

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2005 American Medical Association. All rights reserved.

lect information on the number of patients with the relevant condition and patients with a G-code reported to generate a reporting rate, as well as the number of patients in the denominator and numerator to generate a performance rate.

Uses of the data

CMS has stated that information obtained through the PVRP will *not* be available to the public. However, physicians should bear in mind that this program is modeled on the hospital voluntary reporting project, which ultimately evolved into public reporting in the form of CMS' hospital compare program.

Selection of measures

CMS defines an effective measure for performance measurement, quality improvement, disease prevention, and public reporting as "valid, reliable, evidence-based, and relevant for consumers, clinicians, and purchasers."[†] Various physician and quality care organizations, including the National Quality Forum (NQF) and the Ambulatory Care Quality Alliance (AQA), endorsed segments of the initial 36 measures. The revised set of 16 measures is based on measures endorsed by the NQF and the AQA that will also be used by the Quality Improvement Organization (QIO) programs. Surgical specialties were not heavily involved in the development of the PVRP.

The revised set of measures includes improvements to the denominator of three surgical measures. The CPT codes in the denominators were redefined for receipt of autogenous arteriovenous fistula in end-stage renal disease patients requiring hemodialysis, use of internal mammary artery in coronary artery bypass graft surgery, and preoperative beta-blocker for patients with isolated coronary artery bypass graft. In addition, problematic surgical measures were removed from the initial set for further study.

The College and other physician groups are working with the Physician Consortium for Performance Improvement (PCPI), NQF, AQA, and CMS to develop measures that are relevant to surgical care. In 2006, the College and its partners will progress to developing surgical

measures, and the PCPI will begin studying and developing additional surgical measures with the College as their lead organization. The 20 measures that were removed from the initial set will be further defined, and new quality measures will be phased into the PVRP as they are developed and approved.

Problems and challenges

The PVRP instructions are incomplete, and the omissions could pose challenges to the submission of data. CMS has agreed to revise the instructions but has given no timetable for doing so. Sources of trouble that the physician community has called to the attention of CMS include the following:

- The instructions direct physicians to insert the procedure code as the first item on a claim and to follow it with the G-code on the next line without a corresponding charge. The instructions do not explain whether other fields on the line item should be included, such as the date of service or diagnosis code.
- The instructions are incomplete on whether the G-code can be reported on a claim that is separate from the one containing the CPT code for the primary procedure.
- Many of the surgery-related measures are written as hospital-related measures. For instance, the antibiotic prophylaxis measure states "patient documented to have received antibiotic prophylaxis..." rather than "documentation that physician ordered antibiotic prophylaxis..."
- The current instructions include a list of CPT codes for the surgery measures that are arbitrary, omitting many relevant procedures. CMS has promised to make the list more complete.
- The measure for receipt of an autogenous arteriovenous fistula in end-stage renal disease patients has a major flaw. Eligible patients are those who are already receiving dialysis. Because an autogenous arteriovenous fistula has to mature before use, patients will have documentation that they received both an autogenous arteriovenous fistula and some other form of venous access. The current G-codes do not account for this situation, and physicians would have to report two G-codes for one measure.

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[†]Centers for Medicare & Medicaid Services. *CMS Manual System: Pub 100-19 Demonstrations*. Washington, DC: U.S. Department of Health & Human Services; 2005.

Benefits of participation

Although the system is imperfect, reporting could benefit surgeons in several ways. First, data collected from physicians will provide Medicare with information on the quality of care that beneficiaries currently receive. Second, participating physicians can receive feedback on their performance and will have the opportunity to comment on how quality reporting could be streamlined and improved. Another advantage of participating is the opportunity to use the PVRP as a trial run. Many health policy experts believe that a mandatory physician reporting program or a pay-for-performance system is imminent.

Participating in the PVRP allows physicians to improve the ease and accuracy of data submission in a voluntary setting.

Interested physicians began reporting measures to CMS on January 3. New participants may begin submitting G-codes at any time. To receive feedback, however, physicians must register with their state's quality improvement organization. At press time, registration was scheduled to become available in February. Feedback may be available as early as July or August 2006.

For more information, including a full set of instructions and measures, visit *www.cms.hhs.gov/quality/pfqi*. Ω