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

Keywords

MM4183, CR4183, TransmittalR35DEMO, physician, voluntary, reporting, program, PVRP, G-Codes

Provider Types Affected

Physicians and other health care providers who bill Medicare

Key Points

- The effective date of instruction is January 1, 2006.
- The implementation date is January 3, 2006.
- The new Physician Voluntary Reporting Program (PVRP) builds on Medicare's comprehensive efforts to substantially improve the health and function of beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered.
- Under the PVRP, 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.
- CMS has adopted a core starter set of 16 PVRP measures based on those that are National Quality Forum (NQF) endorsed, part of the Ambulatory Care Quality Alliance (AQA) starter set, and used by the Quality Improvement Organization (QIO) programs for physician quality improvement in its eighth Scope of Work (8th SOW).
- 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.
- Each quality 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.

- Providers 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 Regarding G-codes

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

Important Links

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4183.pdf>

<http://www.cms.hhs.gov/Transmittals/downloads/R35DEMO.pdf>