

**MEDICARE QUALITY CODES  
AND THEIR IMPACT ON PHYSICIANS**

**A Critical New Support Function for IPAs and PHOs**

**White Paper**

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**December, 2005**

## ABSTRACT

### Medicare Quality Codes: How ICLOPS Helps IPA and PHO Physicians “Meet the Grade”

Measuring quality medical services has become a heavy interest of government and private payers for the past two years. First emerging as patient safety issues in Leapfrog and Medicare demonstration projects for hospital services, employer coalitions and insurance companies are rushing to calculate quality ‘scores’ as a way of identifying cost-effective physicians. Pay-for-performance reimbursement plans and consumer-directed health plans, both of which depend on assessing and distributing information on clinical performance, are the latest wave of quality-based health care financing.

The problem is that methods of measuring physician performance have been highly variable, with no common standard or data collection techniques. That situation is about to change. Medicare is about to begin a set of data collection efforts, called G-Codes, that will change quality measurement – and physician reimbursement – forever, and this will spark rapid adoption of the system by private payers. Physicians who don’t have the means to track their own clinical results will be losers, literally, of patient volume and revenues.

There is an opportunity in this potential crisis, and it can benefit physicians. Independent Practice Associations (IPAs) and Physician Hospital Organizations (PHOs) are well-positioned to help their physicians measure quality effectively, track patient care from one physician to the next (and into hospital services), and defend physicians against unfair external rankings. These organizations have the governing structure and history that can be modified to collectively collect data and anticipate, not just respond to, quality scores by Medicare and private payers..

ICLOPS helps IPAs and PHOs meet these objectives. ICLOPS collects and aggregates data, measures performance against standards, and implements point-of-service tools for physicians and patients to meet standards of care. ICLOPS’ analyses proactively inform physicians about issues before the payers generate punitive financial action, and they support IPA negotiation of fee-for-service performance-based contracts.

This paper presents information on Medicare quality codes and their impact on physicians. It explains how IPAs can help member physician practices meet and demonstrate higher standards of quality, without any system changes or new work for member physicians. ICLOPS enables IPAs to face the challenge of measuring clinical performance in multiple independent practices with different practice environments, clinical styles, and information systems.

ICLOPS is a company that analyzes physician practice data to manage quality with targeted communications to patients and prompts for physician visits. The communications increase revenue, quality, and patient retention for physician practices by ensuring better follow-up care, especially for chronic disease patients; improve patient management of their health; and increase patient satisfaction with physician services.

## G-Codes: Potential Impact on Physicians

G-Codes were introduced by CMS (Centers for Medicare and Medicaid Services) in November, 2005. They are part of the Level II Healthcare Common Procedure Coding System (HCPCS), used to identify products, services, and procedures not included in the Level I CPT-4 codes maintained by the AMA.

The G-Codes are part of CMS' Physician Voluntary Reporting Program (PVRP) to begin on January 1, 2006. Medicare has identified 36 initial measures for the program, with codes to be submitted like CPT codes on Medicare claims. There is no fee attached; however, they have been designated as central to Medicare's pay-for-performance program.

Examples of some of the initial set of G-Codes are:

G-Code Area	G-Code	Description
Aspirin at arrival for acute myocardial infarction	<b>G8006:</b>	Acute myocardial infarction: patient documented to have received aspirin at arrival
	<b>G8007:</b>	Acute myocardial infarction: patient not documented to have received aspirin at arrival
	<b>G8008:</b>	Clinician documented that acute myocardial infarction patient was not an eligible candidate to receive aspirin at arrival measure
Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus	<b>G8016:</b>	Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as less than or equal to 9%
	<b>G8015:</b>	Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as greater than 9%
	<b>G8017:</b>	Clinician documented that diabetic patient was not eligible candidate for hemoglobin A1c measure
	<b>G8018:</b>	Clinician has not provided care for the diabetic patient for the required time for hemoglobin A1c measure (6 months)
High blood pressure control in patient with Type I or II diabetes mellitus	<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
	<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
	<b>G8025:</b>	Clinician documented that the diabetic patient was not an eligible candidate for blood pressure measure
	<b>G8026:</b>	Clinician has not provided care for the diabetic patient for the required time for blood measure (within the last 6 months)

G-Codes are a further development of AMA Category II Codes, but the AMA was not prepared for their movement into the CMS reimbursement arena. The AMA had been working to obtain approval of some of these codes from different specialty societies, and has taken a position that pay-for-performance programs should be “rewarding” (“providing fair and equitable program incentives”) for physicians. The adoption of the G-codes has transpired in the face of likely decreases in Medicare payments to physicians for next year. Medicare is taking the approach that any pay-for-performance program must be budget neutral, which by definition will reward some physicians while decreasing reimbursement for others.

CMS says that the G-Codes are an interim step until electronic submission from EHRs/EMRs replaces this process. This position could change, however, because the administrative burden of obtaining, modeling, and analyzing data dumps from diverse EMR systems will slow CMS adoption of this mechanism of data collection. It is more likely that pay-for-performance plans will actually begin with payment for submission of quality audit codes, and further codify their status and utility.

## Transition of Medicare G-Codes into Private Pay-for-Performance

Like the last major fundamental reimbursement methodology adopted by Medicare, the physician Resource Based Relative Value Scale (RBRVS), private payers will be quick to collect and use data from the G-Codes. Data input will move from voluntary to mandatory, and from zero impact on reimbursement to a major component of reimbursement.

Many efforts for improving quality have focused on encouraging physicians to adopt electronic medical records (EMR) so that they ultimately have the ability to track patient services and transfer clinical information to other physicians. With G-Codes, we see the first adoption of data for sole use by a payer. G-Codes will provide payers with more detailed clinical information. This will allow more meaningful comparisons between physicians; however, without the ability to collect and adjust G Code responses, the results of analysis will be incomplete and potentially misleading.

In this scenario, failure of physicians to prepare for or manage G-Codes will be serious in terms of reduced reimbursement or relegation to lower tier networks (causing loss of patients).

Under pay-for-performance (P4P), a great concern of physicians is that they will be measured on outcomes of very disparate groups of patients. It will be critical for physician organizations to measure the characteristics of the registry population for factors that will strongly influence outcomes. This serves to identify how difficult management may be and handicap the performance of the physician so there is a more level playing field. These characteristics include age, comorbidities, disease complications, habits, health beliefs, social support, physique, emotional state, and visit and therapeutic adherence.

Why should physicians be concerned with the quick adoption of G-Codes and their likely incorporation into pay-for-performance plans? The fairness of G-Codes, while laudable efforts to begin clinical data collection and measure quality, create two main issues:

- **Most physician offices have no ability to evaluate and defend their G-Code results, nor the quality “scores” that will result.**

G-Codes alone cannot accurately represent physician quality. In order to adjust the codes to patient populations or individual patient circumstances, additional codes or modifiers will be

needed. For example, when a G-Code is submitted for a diabetic patient whose most recent Hemoglobin A1C within the last 6 months was greater than 9% whose prior value was also greater than 9%, the patient is poorly controlled. Is the poor lab value a result of the patient's nonadherence to standards of visit frequencies for diabetics, lack of physician communication and/or testing, or other factors? Without the ability to evaluate that information as well, the patient's continuing poor condition should not be attributed to physician quality issues.

Additionally, many outcomes measures are influenced heavily by patient behaviors, not just the quality of care provided by the physician. A comparison to the airline industry is often used to admonish quality processes in the healthcare industry. It should be noted that no airline would ever allow their airplanes to be serviced and maintained inexpertly and then be held responsible for the planes' performance and safety.

- **Changes are necessary in some of the underlying physician charge capture processes so that codes can be supplied.**

A number of the initial G-Codes are for in-hospital care, which is not reflected in most office charts. It will be necessary for physicians to alter current processes for services rendered in non-office settings. This is not bad, but it will require coordination between physicians and hospitals or point-of-care collection tools for physicians that, in the current environment (with physicians practicing in multiple institutions), are not always feasible.

## **Support for Physician Quality Measurement – A Critical Job for IPAs and PHOs**

Physician practices are not well equipped to manage quality efforts. They have neither the infrastructure to accomplishing this, nor the time and resources to do it. There are also disincentives in the G-Codes that could influence physicians to incorrectly report patient data or to avoid responsibility for patients with poor clinical conditions.

IPAs and PHOs have potential to help physicians in quality measurement. They are the only entities organized to work with private practices on a market level, and they have the necessary governance and quality review infrastructure from their origins in managing capitated or other negotiated contracts. They also have the mechanisms for enrolling and credentialing physicians in a way that is consistent with local payer requirements.

Working with IPAs and PHOs may be of value to CMS. CMS will not be able to interact with physicians in a manner comparable to an IPA, and working through physician networks committed to quality will enhance CMS – and other payers’ – quality efforts. Payers should expect IPAs to provide disease management that is now being outsourced. With the right tools this should be doable for IPAs, who should receive comparable compensation for these services.

There are also advantages to physicians for IPAs and PHOs taking on these functions. Outcomes measures are more fairly deployed when the payer deals with a physician organization such as an IPA/PHO, as a larger number of patients will be part of the analysis.

For these reasons, IPAs and PHOs have the perfect opportunity to help physicians prepare and manage G-Codes by providing critical functions in the quality arena. The role of IPAs will be to provide administrative support and infrastructure to practices, particularly in meeting quality measurements, report cards, and influencing market share. IPAs can provide a supportive system for primary care physicians to comprehensively manage the chronic diseases in their practices. This may occur through provision of nutritional counseling, supporting group visits, and behavioral support (goal setting) for selected patient populations.

In order to adequately address quality initiatives, the IPA or PHO must incorporate a number of new functions that will substantially alter the organization and relationships with its physicians. These are the key ingredients to those functions:

1. IPAs should aggregate and compare data across practices. Physicians need to be able to see how they “stack up” in these measurements by a supportive organization, so that they may react and improve. The IPA should analyze the characteristics of poorly controlled patients, institute quality initiatives, and measure the results.

Sophisticated analysis of the data will be necessary. Measuring quality with G Codes makes the most sense for primary care physicians and medical sub-specialists. For surgeons, these codes often reflect hospital processes, e.g., the G Codes for antibiotic prophylaxis prior to surgery. For surgeons, an analysis of complication rates, adjusted for patients with similar pre-operative states (e.g. co-morbid conditions, immunosuppression) will be necessary, as well as a number of other comparisons.

Analyses of these types require large numbers of patients. Single specialty IPAs (especially those representing a surgical specialty) have the aggregated number of patients to benchmark outcomes, as their aggregated data will be a unique resource. These IPAs may also provide enhancement in the quality of care to patients in unexpected ways. For example, orthopedists may take a lead in assessing patients for osteoporosis, or for a falls prevention program for elderly patients who have suffered a fracture (e.g. Colles’).

2. IPAs should be the arbiter of attribution disputes both within the IPA, and between the IPAs and payers. The issue of “attribution” of physician care will be of great importance in the entire quality measurement process. Physicians will be reluctant to submit a G-Code reflecting a poor outcome, and the poorly controlled patient may appear to a physician as a “hot potato”. The primary care physician may refer a poorly controlled diabetic to an endocrinologist to deflect responsibility for the care of that patient to the endocrinologist, rather than take responsibility for results. This process could also occur in the opposite direction, with endocrinologists providing “consultations” on poorly controlled diabetics and quickly redirecting the patient back to the referring physician. IPAs can oversee the disease registry and assume responsibility for

submitting codes to the physician for completion in order to avoid these patient quality issues, using data to identify patients by condition.

Ensuring that patients are correctly attributed to physicians in the IPA will require tracking patient adherence to standards of visit frequency. This is essential for physician buy-in. If the patient is not returning to the office for management (as expected by the physician) and is poorly controlled, the physician understandably won't wish to be graded on that patient's disease control.

In the process of evaluating attribution of patients, a number of patients will be found who have no one managing their care. This may occur for a variety of reasons, but a strong effort should be made to get these patients under a physician's care. Letters from IPA physicians welcoming these patients will assist in this population-based quality effort. The combined involvement of the physician organization and payer will be needed to bring these patients under effective long-term care.

3. IPAs should engage patients and collect additional patient information to support quality efforts. Some non-compliant patients will feel more comfortable with physicians who don't push or challenge them on such behaviors as smoking, weight loss, and physical activity. Consumers and employers understand and prefer outcome measures to patient satisfaction in measuring quality. This is why quality efforts must actively involve patients and be visible to them.

Organized communications to patients within different disease registries and or age/gender populations will be essential if process measures assume a greater component of any quality effort. Outcomes are dictated to a great degree by the patient's involvement and self-management of his/her disease state.

If physicians take the added step of contacting (in writing) their patients with chronic diseases and providing guidelines of expected care, this will help in attributing patient care to particular physicians. If the patient doesn't follow up with the physician as requested, then that patient would be dropped from the report card denominator for the physician. This information is of value to payers, and ultimately to employers, as a means of focusing on this population to determine which provider is managing the condition

4. IPAs should use point-of-service methods to increase quality and ensure the collection of quality data, by central distribution of prompts containing quality codes. Prompts and reminders are important tools to assist physicians in addressing care that may be overlooked or missed. Without prompts in the chart at the point of service delivery, it will be difficult for physicians to remember to input the G-Codes necessary to capture the quality data for Medicare and other payers.
5. IPAs and PHOs should coordinate the collection of hospital data or develop tools that will help physicians complete G-Codes in all patient care settings. Many of the G-Codes apply to clinical services or outcomes that are actually delivered in the inpatient setting and are tied to admissions. IPAs and PHOs have the means of integrating this data in ways that private physicians cannot, and doing so will benefit their constituent physicians by demonstrating additional quality “points”. This service is one of the unique contributions that an IPA or PHO can make to its physician membership.

## ICLOPS: Creating an Immediate Foundation for IPA and PHO Quality Efforts

ICLOPS helps IPAs and PHOs to manage clinical quality in member physician practices using a 3-part system. This includes the analysis of data from physician practices, communications to patients, and point-of-care prompts for physicians. ICLOPS requires little effort from practices and no extra system costs, removing barriers to participation in IPA or PHO projects.

All of the functions required for assisting IPAs with quality management and G-Codes are built into ICLOPS services. Key aspects of ICLOPS' services for IPAs and PHOs include:

- Data aggregation and analysis. ICLOPS extracts and aggregates practice data from physician practice management systems for analysis. By the identification of patients by condition, age, gender, and history, ICLOPS is able to generate analyses that compare results by physicians. G-Codes are collected in the process, allowing ICLOPS to evaluate not only physician use of the codes but to analyze all the components of quality that payers will be able to see. There is no need for interfaces or for physicians to change systems to participate, and physicians can adopt an EMR at their own speed without affecting results.

ICLOPS' sophisticated analyses make it possible to contest results of external rankings with payers. Stratification of patient risk as well as the production of additional analyses is essential to fair treatment by payers.

- Determination of attribution of patients to physicians. When all IPA practices participate, ICLOPS performs analyses that track patients from one provider to another. ICLOPS can evaluate patient services to determine the most appropriate "home" for the patient, and identify patients who have need of a central provider of care.
- Engaging patients in care and collection of additional data from patients. Patient communications are a standard feature of ICLOPS services. ICLOPS creates letters under the physician's electronic signatures that incorporate practice letterhead, and are customized to patient names, gender, diagnoses, and status. These are sent to patients to convey standards of care and to request that the patient come into the office for certain tests and services. The ICLOPS communication package also includes requests that patients provide information on

issues they have with medical adherence, such as not understanding the value of the treatment or problems in accessing it. Patients who believe their physicians take the trouble to write them have increased satisfaction and higher adherence to treatment plans.

- Use of point-of-service prompts are always included in ICLOPS projects. These prompts are check-offs for physicians during the visit, and quality audit codes are incorporated to these prompts (such as G-codes). This allows for the capture of more relevant information. The prompts are customized and vary over time; they are tied to the patient's condition and quality initiatives of the IPA. The prompts are placed in the patients' charts along with patient communications, as a result of ICLOPS analyses, and serve as triggers for physicians to submit the quality codes.
- Collection of hospital data. ICLOPS can incorporate hospital data in much the same way that it includes data from various physician systems. In this way it is possible to track care delivered by physicians in hospital settings.

## **Summary: A Case for IPAs and PHOs in Managing Physician Quality Data**

IPAs and PHOs have an obligation to help physicians address emerging patient and quality issues. These organizations provide a structure for supporting physicians in tackling the considerable technical and analytical functions involved in measuring and demonstrating quality. These functions cannot be absorbed by practices, and without the support of IPAs and PHOs, practicing physicians will be virtually helpless in defending their reputations or in managing the quality of care they deliver.

Unfortunately, IPAs and PHOs have been slow to transition from the management of capitated business or simple negotiation of contracts with payers to more substantial initiatives, because of traditional dues structures. However, there is a strong case for these physician networks to head in this direction.

- A shift in health care plans offered by employers and payers is demanding the selective contracting of physicians based on quality and data.. IPAs and PHOs which cannot develop this capability will become obsolete for their membership.
- Competition for patients along quality tiers will ultimately result from many of the data collection efforts and quality initiatives now being developed by payers. Maintaining the business will require more sophistication than in the past, especially in data analysis, to defending the grades received from outside parties.
- Movement to quantify quality will only increase over time. As in other industries, physicians will be forced to demonstrate that they produce results. It makes sense for IPAs and PHOs to embrace the task early and help physicians before the G-Code capture becomes mandatory.
- Given Medicare's budget-neutral approach and the certainty that other payers will take a similar stance, IPAs and PHOs need to act to avoid further decline in revenues for their physician members.