GIQuIC: A PQRS Qualified Clinical Data Registry

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Meaningful Measurement of GI Practice

Purpose

This presentation provides information about the Physician Quality Reporting System (PQRS) participation option in Qualified Clinical Data Registries (QCDRs) for the 2015 program year, specifically the approved GIQuIc QCDR.
Meaningful Measurement of GI Practice

Objectives

- Discuss PQRS reporting and the QCDR option
- Discuss PQRS requirements relative to reporting via the GIQuIc QCDR
- Discuss the initial steps required to utilize GIQuIc as a QCDR for your 2015 PQRS reporting
PQRS is a reporting program that uses negative payment adjustments to promote reporting of quality information by eligible providers and group practices.
Eligible providers that do not satisfactorily report or satisfactorily participate in PQRS will be subject to a payment adjustment.

<table>
<thead>
<tr>
<th>PQRS Program Year</th>
<th>PQRS Payment Adjustment Period</th>
<th>Negative Adjustment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>2017</td>
<td>- 2.0%*</td>
</tr>
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</table>

* Applies to all of the eligible provider’s or group practice’s Medicare Part B Physician Fee schedule (PFS) covered professional services under PFS during the payment adjustment period.
PQRS Participation via “registry”

- Qualified PQRS Registry
  - Individual eligible provider reporting
  - Group Practice Reporting Option (GPRO)
  - Includes PQRS measures and measure groups
- Qualified Clinical Data Registry (QCDR)
  - Individual eligible provider reporting only
  - Can include PQRS or non-PQRS measures (or both)
PQRS Participation via QCDR

- Criteria to avoid the 2017 PQRS payment adjustment
  - Report at least 9 individual measures, of which at least 2 must be outcome measures, covering at least 3 National Quality Strategy (NQS) domains for 50% or more of applicable patients of each eligible provider (12 months)
    - If the QCDR does not have 2 outcome measures, then the QCDR must have and report at least 1 outcome measure and 1 of the following other types of measure: 1 resource use, OR patient experience of care, OR efficiency/appropriate use, OR patient safety measure.
The Value-based Payment Modifier (VM) assesses both quality of care furnished and the cost of that care under the MPFS.

The VM is an adjustment made on a per claim basis to Medicare payments for items and services furnished under the MPFS.

- High-quality and/or low-cost groups can qualify for upward adjustments
- Low-quality and/or high-cost groups and groups that fail to satisfactorily report PQRS are subject to downward adjustments
The VM is applied at the TIN level and applies to all physicians billing under that TIN.

<table>
<thead>
<tr>
<th>Value-based Payment Modifier</th>
<th>All physicians in groups with 2+ EPs and physicians who are solo practitioners</th>
<th>Mandatory Quality-Tiering for PQRS reporters:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Groups with 2-9 EPs and solo practitioners: Upward or neutral VM adjustment only based on quality-tiering (+0.0% to +2.0x of MPFS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Groups with 10+ EPs: Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Groups and solo practitioners receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-PQRS reporters:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Groups with 2-9 EPs and solo practitioners: automatic -2.0% of MPFS downward adjustment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Groups with 10+ EPs: Automatic -4.0% of MPFS downward adjustment</td>
</tr>
</tbody>
</table>

2015 Qualified Clinical Data Registry Reporting presentation by Daniel Green, MD FACOG, Medical Officer CMS, February 25, 2015.
Value-based Payment Modifier

For CY 2017 VM payment adjustment, physician solo practitioners and physician groups with 2+ EPs

PQRS Reporters – 3 types
1a. Group reporters – Register for GPRO Web Interface, Registry, or EHR AND meet the criteria to avoid the 2017 PQRS payment adjustment OR
1b. Individual reporters in the group – at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment.
2. Physician Solo practitioners - Report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment.

Mandatory Quality-Tiering Calculation

Groups with 2-9 EPs and solo practitioners
- Upward or neutral VM adjustment based on quality-tiering (+0.0% to +2.0x of MPFS)

Groups with 10+ EPs
- Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)

Non-PQRS Reporters
Do not register for GPRO Web Interface, registry, or EHR or 50% EP threshold OR do not avoid the 2017 PQRS payment adjustment

-2.0% (for groups with 2-9 EPs and solo practitioners)
-4.0% (for groups with 10+ EPs) (Automatic VM downward adjustment)

Note: The VM payment adjustments are separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.
Physician Compare

- Encourage consumers to make informed choices
- Incentivize physicians to maximize performance
2015 QCDR measures are available for public reporting on Physician Compare

- Individual eligible provider-level
- PQRS and nonPQRS measures
- No first year measures
GIQuIC and the EHR Incentive Program

- GIQuIC participation *does not* satisfy the electronic clinical quality measure (eCQM) reporting component of the EHR Incentive Program

- GIQuIC participation may assist in satisfying Stage 2 MU Menu Objective Measure #6
  - Successful ongoing submission of specific case information from Certified Electronic Health Record Technology (CEHRT) to a specialized registry for the entire EHR reporting period
ACG and ASGE Advocating for Alignment

- The measures that make up the eCQM reporting component of meaningful use (MU) for the EHR Incentive Program are not specific to gastroenterology.

- The ASC Quality Reporting Program submission process is via CMS’ QualityNet website. An option to report to this program via a registry does not currently exist.
GIQuIC: A Quality Improvement Registry

We created GIQuIC based on a belief that the scientific measurement of the quality of endoscopic procedures will provide valid and reliable comparative information to participating physicians and facilities to support their quality improvement initiatives.

~ Irving M. Pike, MD, FACG, FASGE
President, GI Quality Improvement Consortium
February 23, 2010
Criteria to avoid the 2017 PQRS payment adjustment

<table>
<thead>
<tr>
<th>Requirement</th>
<th>GIQuIC QCDR</th>
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</thead>
<tbody>
<tr>
<td>Report at least 9 individual measures</td>
<td>The GIQuIC QCDR has 13 individual measures from which to choose</td>
</tr>
<tr>
<td>At least 2 must be outcome measures</td>
<td>The GIQuIC QCDR has 4 outcome measures with those 13</td>
</tr>
<tr>
<td>Covering at least 3 National Quality Strategy (NQS) domains</td>
<td>The 13 GIQuIC QCDR measures cover 4 NQS domains</td>
</tr>
<tr>
<td>For 50% or more of applicable patients of each eligible provider (12 months)</td>
<td>To participate in GIQuIC a provider must upload 100% of colonoscopy cases done at the participating site(s)</td>
</tr>
</tbody>
</table>
PQRS Participation via the GIQuIC QCDR

giquic.gi.org/pqrs.asp

GIQuIC
Enhancing patient care. Providing real-time peer-based performance evaluation. Setting the standard in quality improvement initiatives.

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Physician Quality Reporting System (PQRS)
Meaningful Use

Physician Quality Reporting System (PQRS)

CMS Approves GIQuIC as a PQRS Qualified Clinical Data Registry
Learn how you can successfully participate in PQRS submitting GI-specific measures

We are pleased to announce that the GIQuIC Registry has again been approved as a Qualified Clinical Data Registry (QCDR) for reporting to the Physician Quality Reporting System (PQRS) for the 2015 reporting year. The QCDR reporting mechanism is a dynamic reporting option that allows providers to report on measures that are meaningful to their specialty practice and foster improvement in the quality of care provided to patients.

Since 2010, GIQuIC has grown in value as a clinical benchmarking tool for gastroenterology practices, surpassing 1 million colonoscopy cases in October 2014. In April 2014, CMS approved GIQuIC as a QCDR for the 2014 PQRS reporting year, facilitating endoscopists’ documentation of compliance with quality measures. Over 600 GIQuIC participants elected to utilize the GIQuIC QCDR for their 2014 PQRS reporting.

For the 2015 reporting year, eligible providers who satisfactorily participate in PQRS will avoid the 2017 payment adjustment of negative 2.0%, an adjustment that will be compounded further by the value-based payment modifier up to an additional negative 4.0% depending upon group size.

To see the detailed specifications of the clinical quality measures on which the GIQuIC QCDR will report for PY2015 please click here.
PQRS Participation via the GIQuIC QCDR

GI Quality Improvement Consortium, Ltd. (GIQuIC)

2015 QCDR Non-PQRS Measure Specifications

Following is an overview of the clinical quality measures in GIQuIC that can be reported to CMS for the Physician Quality Report System (PQRS) via GIQuIC’s status as a qualified clinical data registry (QCDR) for the 2015 program year. Additional detail for each measure follows on the subsequent pages.

Reporting via a QCDR for program year 2015, to avoid the negative 2% payment adjustment in calendar year 2017 a provider must successfully report at least 9 individual measures, of which at least 2 must be outcome measures, covering at least 3 National Quality Strategy (NQS) domains for 50% or more of the eligible provider’s applicable patients.

Note: Standard measures with a 0 percent performance rate will not count.

<table>
<thead>
<tr>
<th>GIQuIC QCDR #</th>
<th>Title</th>
<th>Type</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adenoma Detection Rate</td>
<td>Outcome</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>2</td>
<td>Adequacy of bowel preparation</td>
<td>Process</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>3</td>
<td>Photodocumentation of the cecum (also known as cecal intubation rate)</td>
<td>Process</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td></td>
<td>– All Colonoscopies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Photodocumentation of the cecum (also known as cecal intubation rate)</td>
<td>Process</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td></td>
<td>– Screening Colonoscopies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Incidence of perforation*</td>
<td>Outcome</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>6</td>
<td>Appropriate follow-up interval for normal colonoscopy in average risk</td>
<td>Process</td>
<td>Communication and Care Coordination</td>
</tr>
<tr>
<td></td>
<td>patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Age appropriate screening*</td>
<td>Outcome</td>
<td>Efficiency and Cost Reduction</td>
</tr>
<tr>
<td>9</td>
<td>Documentation of history and physical rate - Colonoscopy</td>
<td>Process</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>10</td>
<td>Appropriate management of anticoagulation in the peri-procedural period</td>
<td>Process</td>
<td>Communication and Care Coordination</td>
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<tr>
<td></td>
<td>rate – EGD</td>
<td></td>
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<tr>
<td>11</td>
<td>Helicobacter pylori (H. pylori) status rate</td>
<td>Process</td>
<td>Communication and Care Coordination</td>
</tr>
<tr>
<td>12</td>
<td>Appropriate indication for colonoscopy</td>
<td>Process</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>14</td>
<td>Repeat screening colonoscopy recommended within one year due to</td>
<td>Outcome</td>
<td>Efficiency and Cost Reduction</td>
</tr>
<tr>
<td></td>
<td>inadequate bowel preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Appropriate follow-up interval of 3 years recommended based on</td>
<td>Process</td>
<td>Communication and Care Coordination</td>
</tr>
<tr>
<td></td>
<td>pathology findings from screening colonoscopy in average-risk patients</td>
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*indicates an inverse measure in which a lower performance rate (closer to zero versus 100) is better.
Effective Clinical Care

- Adenoma Detection Rate [Outcome]
  - Percentage of patients age 50 and over undergoing screening colonoscopy with a finding of at least one adenomatous polyp

- Adequacy of Bowel Preparation [Process]
  - Percentage of colonoscopies with a bowel preparation documented as adequate or better
Effective Clinical Care

- Photodocumentation of the cecum, which is also known as cecal intubation rate – All Colonoscopies [Process]
  - Percentage of colonoscopies into the cecum including photodocumentation of one or more of the cecal landmarks (ileocecal valve, appendiceal orifice, or terminal ileum)
Effective Clinical Care

- Photodocumentation of the cecum, which is also known as cecal intubation rate – Screening Colonoscopies [Process]
  - Percentage of screening colonoscopies into the cecum including photodocumentation of one or more of the cecal landmarks (ileocecal valve, appendiceal orifice, or terminal ileum)
Effective Clinical Care

- Documentation of history and physical rate – Colonoscopy [Process]
  - Percentage of colonoscopies with history and physical documented

- Appropriate indication for colonoscopy [Process]
  - Percentage of colonoscopy procedures performed for an indication that is included in a published standard list of appropriate indications and the indication is documented
Patient Safety

- Incidence of Perforation [Outcome]
  - Percentage of total patients experiencing a perforation during colonoscopy, recognized immediately (before the patient leaves the facility)
Communication and Care Coordination

- Appropriate follow-up interval for normal colonoscopy in average-risk patients [Process]
  - Percentage of average-risk patients aged 50 to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report
Communication and Care Coordination

- Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients [Process]
  - Percentage of average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas, Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component), Sessile serrated polyp ≥ 10 mm OR sessile serrate polyp with dysplasia OR traditional serrated adenoma who had a recommended follow-up interval of 3 years for repeat colonoscopy
Communication and Care Coordination

- Appropriate management of anticoagulation in the peri-procedural period rate – EGD [Process]
  - Percentage of patients undergoing an EGD on an anti-platelet agent or an anticoagulation who leave the endoscopy unit with instructions for management of this medication
Communication and Care Coordination

- *Heliobacter pylori (H. pylori)* status rate

[Process]
- Percentage of patients undergoing an EGD with a duodenal or gastric ulcer whose *H. pylori* status is unknown who have a plan documented for assessing *H. pylori* status
Efficiency and Cost Reduction

- Repeat screening colonoscopy recommended within one year due to inadequate bowel preparation [Outcome]
  - Percentage of patients with an inadequate bowel preparation who received a recommendation for a repeat screening colonoscopy of one year or less

- Age appropriate screening colonoscopy [Outcome]
  - Percentage of patients aged 85 years or older undergoing screening colonoscopy
Submit your provider consent/agreement by September 15, 2015

The eligible provider must include the NPI/TIN combination under which s/he bills for professional services

- **NPI**
  - The individual NPI can be found in form field 24-J of the CMS-1500 claim form.

- **TIN**
  - The TIN can be found in form field 25 of the CMS-1500 claim form.
The “Mechanics” of Using GIQuIC as a QCDR

- Continue to submit all case data to GIQuIC as normal
- Run your measure reports – at least 4X prior to end of December 2015
  - Reminder: The GIQuIC registry Home Page includes User Guides and training recordings. Additionally, live training sessions are held monthly.
- Respond to data validation requests promptly
GIQuIC QCDR Timeline

- **September 15, 2015:** Consent forms must be signed by each provider
- **Mid January 2016:** All data from 2015 must be entered into the GIQuIC registry
- **Mid February 2016:** Providers attest to accuracy of data GIQuIC will be submitting on their behalf
- **Mid March 2016:** GIQuIC submits quality measure data on behalf of providers to CMS for PQRS reporting
Additional Questions

- **QualityNet Help Desk**
  866-288-8912 (TTY 877-715-6222)
  7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@hcqis.org
  You will be asked to provide basic information such as name, practice, address, phone, and e-mail

- **GIQuIC/ACG**
  - **Laurie Parker**, GIQuIC Executive Director
  - lparker@gi.org or info@giquic.org

- **GIQuIC/ASGE**
  - **Eden Essex**, ASGE Asst. Director Quality & Health Policy
eessex@asge.org