Implementation guide for registry-based reporting for the Hepatitis C (HCV) Measures Group
Overview of PQRS\textsuperscript{1,2}

What is Medicare’s PQRS?

The Physician Quality Reporting System (PQRS) is Medicare’s “pay for performance” program for physicians and other eligible professionals (EPs). PQRS is now a requirement for all physicians treating Medicare patients, and is now part of value-based payment under Medicare’s new Value-Based Payment Modifier reimbursement program. In 2015, PQRS and Value-Based Payment requirements apply to all physicians.

Why is PQRS Important?

EPs who report the Hepatitis C (HCV) Measures Group must report through a CMS-qualified registry.

Requirements for Registry Reporting: 12 months

For registry-based submissions, a participating EP must report on all applicable measures within the HCV Measures Group or other selected measures group for a sample of at least 20 patients, a majority of whom (11) must be Medicare Part B FFS patients seen during the entire reporting period (Jan. 1 through Dec. 31, 2015), who meet the measures group patient sample criteria.

Measures groups containing a measure with a 0 percent performance rate will not be counted as satisfactorily reporting the measures group.

Patient Sample Criteria for the HCV Measures Group are patients aged 18 years and older with a specific diagnosis of chronic Hepatitis C accompanied by a specific patient encounter.

How do I report PQRS data for Medicare patients?

Physicians in groups of fewer than 10 EPs who do not successfully report PQRS measures for 2015 will be subject to a payment adjustment of \(-2.0\)% applied to all of the EP’s covered professional services under the Medicare Physician Fee Schedule. The payment adjustment will apply in 2017.

Physicians in groups of 10 EPs or more who do not successfully report PQRS measures in 2015 will be subject to a payment adjustment of \(-4.0\)%.

**Measures Group**

Hepatitis C Measures Group patients aged 18 years and older with a specific diagnosis of HCV (diagnosis codes below) and accompanied by a specific patient encounter.

**Note:** The following diagnosis codes indicate chronic hepatitis C (HCV):

- **ICD-9-CM** (for use 1/1/2015–9/30/2015)
  - 070.54
- **ICD-10-CM** (for use 10/1/2015–12/31/2015)
  - B18.2

**Note:** Measure #401 must include a diagnosis code indicating cirrhosis:

- **ICD-9-CM** (for use 1/1/2015–9/30/2015)
  - 571.2, 571.5
- **ICD-10-CM** (for use 10/1/2015–12/31/2015)
  - K70.30, K70.31, K74.60, K74.69

**CPT Patient Encounter Codes**

- 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99406, 99407

*Report a numerator option on all applicable measures within the HCV Measures Group for each patient within the EP’s patient sample.*
The 2015 PQRS Measures Group for Hepatitis C¹²

Measures Developed by: The American Medical Association Physician Consortium for Performance Improvement (AMA-PCPI), Centers for Medicare and Medicaid Services Quality Incentive Plan (CMS/QIP), American Gastroenterological Association (AGA), and American Association for the Study of Liver Diseases (AASLD)

ICD-9-CM Diagnosis Code for Hepatitis C
070.54:
(for use 1/1/2015–9/30/2015)

G8545:
I intend to report the Hepatitis C Measures Group (registry reporting). Code indicates intent to report the HCV Measures Group.

Note: Per CMS, it is not necessary to submit the measures group–specific intent G-code for registry-based submissions. However, the measures group–specific intent G-code has been created for registry-only measures groups for use by registries that utilize claims data.

*Numerator Description*

Measure 84
**Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment**
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who started antiviral treatment within the 12 month reporting period for whom quantitative hepatitis C virus (HCV) ribonucleic acid (RNA) testing was performed within 12 months prior to initiation of antiviral treatment.

Measure 85
**Hepatitis C: HCV Genotype Testing Prior to Treatment**
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who started antiviral treatment within the 12 month reporting period for whom hepatitis C virus (HCV) genotype testing was performed within 12 months prior to initiation of antiviral treatment.

Measure 87*
**Hepatitis C: Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Testing Between 4-12 Weeks After Initiation of Treatment**
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative hepatitis C virus (HCV) ribonucleic acid (RNA) testing was performed between 4-12 weeks after the initiation of antiviral treatment.

Measure 130†
**Documentation of Current Medications in the Medical Record**
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbs, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.

Measure 183
**Hepatitis C: Hepatitis A Vaccination**
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who have received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A.

Measure 226†
**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**
Percentage of patients 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

Measure 390
**Discussion and Shared Decision Making Surrounding Treatment Options**
Percentage of patients aged 18 years and older with a diagnosis of hepatitis C with whom a physician or other qualified healthcare professional reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient. To meet the measure, there must be documentation in the patient record of a discussion between the physician or other qualified healthcare professional and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward treatment.

Measure 401
**Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis:**
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) at least once within the 12 month reporting period.

See AGA copyright information regarding the Hepatitis C Measures Group on page 8.

¹Measure #87 only needs to be reported if initiation of antiviral treatment took place before October of the measurement year (12 weeks before the end of the measurement period).
²Measures 130 and 226 have been designated as “cross-cutting” measures that can also be reported as quality metrics for Medicare ACOs (accountable care organizations), Meaningful Use Stage 2, and as individual measures that can be reported via claims, Group Practice Reporting Option (GPRO), registry, and certified electronic health records. EPs or group practices that treat at least one Medicare patient in a face-to-face encounter must report on at least one cross-cutting PQRS measure.

All PQRS Measures Groups contain at least one cross-cutting measure.
Reporting Options\textsuperscript{1,2}

**Hepatitis C (HCV) Measures Group reporting options with CMS Qualified Registry\textsuperscript{2}:**

- Report on at least 20 unique patients who meet HCV Measures Group criteria.
- Registry reporting sample in 2015 requires a majority (11) of Medicare Part B FFS patients. Others can be commercial or Medicare Advantage patients.
- The 20-patient sample must be reported by each individual physician or EP submitting billing for Medicare reimbursed services.

**How do I enroll in a registry?**

EPs should compare registries on individual costs and services, data needs, and success rates. Generally, quality data codes (QDCs) or group-specific intent G-codes are not needed for registry submissions, but may be required by some. Ask registries for references from other physician practices in your specialty area to confirm their data submission history.

AGA offers a registry for members through CE City (PQRS Wizard), a CMS-approved registry that provides reporting support for all PQRS Measures Groups, including Hepatitis C.

Information about how the DHRP relates to demonstrating quality through the AGA, including the Roadmap to the Future of GI, is available at: \url{http://www.gastro.org/practice/roadmap-to-the-future-of-gi}.

For more information, contact the AGA Institute at \url{www.gastro.org/dhrp} or 301-654-2055.

What is a value-based payment modifier (VBPM)?

Under the Affordable Care Act (ACA), Medicare established a value-based payment modifier that provides differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule.

This differential payment will be based on:

1. Quality of care provided to Medicare patients through performance of PQRS measures.
2. Cost of care provided during the performance period (calendar year).

In 2015, VBPM reimbursement will apply to physicians in groups of 100 or more based on their 2013 quality and cost performance. For groups of 100 or more, 2015 payment will be adjusted upward, downward or remain neutral.

In 2016, the VBPM will apply to physicians in groups of 10 or more based on their 2014 reporting of PQRS measures and cost of care. Payment in 2016 for these physicians in groups of 10 to 99 will be adjusted upward or remain neutral.

Starting in 2015, all physicians will be evaluated on their performance of quality measures and cost of care, with VBPM payment applied to all in 2017.

How can physicians prepare for the value-based payment modifier?

In late 2014, CMS distributed Quality Resource and Use Reports (QRURs) and Physician Feedback Reports to all physicians. These reports contain performance on the quality and cost measures used to calculate the VBPM and additional information to help physicians coordinate care and improve quality.

Physicians can contact CMS for information and resources via www.cms.gov, the CMS PQRS QualityNet Help Desk at 866-288-8912 or qnetsupport@hcqis.org, and AGA and other physician associations.

2013 QRURs are now available through IACS (Individuals Authorized to Access CMS Services) accounts for those groups and physicians who are reporting quality metrics through Group Practice Reporting Options (GPROs).

Physicians and groups that are reporting as individuals also can access their physician feedback report via www.qualitynet.org/pqrs > Communication Support Page > Create NPI Level Report Requests. The report will be sent within one to three business days. A request must be submitted for each individual physician with each individual’s National Provider Identifier (NPI) number.

How is the value-based payment modifier calculated?

Successful reporting of PQRS measures in 2015 is necessary to avoid an automatic financial adjustment of –2.0% (0-9 EPs) or –4.0% (10+ EPs) applied to all Medicare in-office billable services in 2017.

If PQRS is successfully reported, a composite score based on PQRS performance and total per capita costs per physician for Medicare Part A (hospital) and Medicare Part B (physician services, including ancillary services) will be calculated to determine final payment in 2017. Medicare payments under Part D for drug expenses are not included.

Value-based payment modifier scores are based on standardized performance comparing each evaluated physician or group of physicians with a national mean score, adjusted for specialty composition and patient risk.
Value Modifier (VM) and the Physician Quality Reporting System (PQRS)

Note: While successful PQRS reporting is necessary for the potential to reach the best possible VM score and avoid an automatic payment adjustment, the VM score, including cost and quality measures, may result in a lower or no incentive payment if physician Medicare costs are high and/or quality reporting results are low.

For 2015 reporting and 2017 payment
Groups of physicians with 2+ eligible professionals (EPs) and solo practitioners

PQRS reporters
Report through registries, meet 50% threshold, use EHRs or self-nominate for GPRO Web interface, and avoid the 2017 payment adjustment under PQRS

Mandatory quality tiering calculation

Groups of 2-9 physicians and solo practitioners
Upward or neutral adjustment based on quality tiering (+0.0% to +2.0%)

Groups of physicians with 10+ EPs
Upward, neutral, or downward adjustment based on quality tiering (–4.0% to +4.0%)

Non-PQRS reporters
Do not use registries or meet 50% threshold, use EHRs or self-nominate for GPRO Web interface, and do not avoid the 2017 payment adjustment under PQRS

–2.0% (downward adjustment) for groups with 2-9 EPs and solo practitioners

–4.0% (downward adjustment) for groups with 10+ EPs

Note: Non-PQRS reporters receive an automatic value modifier downward adjustment.
Quality tiering for physicians groups of two to nine and solo practitioners will result in an upward or neutral impact in 2017— if groups report PQRS successfully in 2015.

Physicians in groups of less than 10 who do not report PQRS successfully in 2015 receive an automatic downward adjustment of –2%.

Future reimbursement could be reduced for high-cost providers, even if PQRS is reported successfully.

Physicians who do not report PQRS successfully in 2015 receive an automatic downward adjustment of –4%.

What does CMS advise physicians to do in 2015?

- Decide how to participate in PQRS in 2015 as soon as possible.
- Groups can report PQRS Measures as:
  - Individual physicians
    - At least 50 percent of the group must report PQRS successfully.
    - Physicians reporting as individuals may report different PQRS Measures Groups within their group. For example, some physicians may report the HCV Measures Groups, while others in the group could report a different Measures Group, such as Hepatitis C.
    - PQRS Measures Groups, such as the HCV Measures Group, may be reported by individual physicians in a group practice via a CMS-qualified registry.
    - AGA’s CMS-qualified registry option is CE City PQRS Wizard.
  - Group Practice Reporting Option (GPRO)
    - GPROs cannot report Measures Groups.
    - All physicians in a GPRO must report the same set of individual measures.
    - Physicians who report via the GPRO typically focus on primary care quality measures, although there are two individual measures for hepatitis C (HCV):
      - Measure #400: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk—National Quality Strategy Domain: Community/Population Health
      - Measure #387: Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users
Questions?

For questions about PQRS, contact the CMS PQRS QualityNet Help Desk at 866-288-8912, 7 a.m. to 7 p.m. CT or email: qnetsupport@hcqis.org

Additional tips for successful reporting

For more information and CMS advice on how to successfully implement PQRS and report on the Hepatitis C (HCV) Measures Group, see the 2015 Physician Quality Reporting System Measures Groups Specifications Manual and Getting Started with 2015 PQRS Reporting of Measures Groups at:

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

Medicare has a list of approved registries you may access at:


For more information:

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisandPayment.html

www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

References:


5. Value-Based Payment Modifier. Centers for Medicare & Medicaid Services website.


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