



Ambulatory Surgical Center Quality Reporting Program

Support Contractor

More Pieces of the Puzzle: Troubleshooting Quality Data Codes (QDCs)

Presentation

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Pam Harris: Hello, and welcome to the Ambulatory Surgical Center Quality Reporting Program websiteinar. Thank you for joining us today. My name is Pam Harris, a project coordinator for the ASCQR Program. If you have not yet downloaded today's handouts you can get them from our website at www.qualityreportingcenter.com. Go to the Events banner on the right side of the page, and click on today's event. There will be a link that will allow you to access and print the handouts for today's webinar. Additionally, these slides were attached to the ReadyTalk reminder email. It is on the right side of that reminder. As you can see, we are live streaming in lieu of using only phone lines. However, phone lines are available should you need them.

Before we begin today's program, I would like to highlight some important dates and announcements. January 1st began the submission period for the website-based measures that are entered through QualityNet. The submission deadline is August 15, 2016. ASC-8 is entered through the NHSN website and has a submission deadline of May 15, 2016, for this current flu season. Please be sure to keep your QualityNet and your NHSN passwords active by logging into your accounts on a regular basis. If you do not routinely access these accounts, they can become lost and after one year the credentials for

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your SAMS card and QualityNet account expire, requiring you to start the application process all over again.

The easiest way to avoid these issues is to log in every 60 days. If you have any problems with your log-in capabilities on QualityNet, please call their help desk directly at the number you see here on the slide. For problems with your NHSN account, please contact the NHSN directly at the email address you see here.

On May the 25th we will be presenting a webinar on reviewing data and using the data for quality improvement. Notifications of upcoming events and program information and updates will be sent via ListServe by the support contract.

The learning objectives for this program are listed here on the slide. This program is being recorded. A transcript of today's presentation, including the questions and answers received in the chat box, and the audio portion of today's program will be posted at www.qualityreportingcenter.com at a later date.

During the presentation, as stated earlier, if you have a question, please put that question in the chat box located on the left side of the screen. One of our subject matter experts will respond. Again, by having a live chat, we hope to accommodate your questions timely and have real time feedback. Some of the questions that are entered during the presentation will be shared at the end of the presentation.

I am pleased to introduce today's speaker, Karen VanBourgondien. Karen is the Education Coordinator for the ASC and OQR Programs. She has diverse clinical experience in data abstraction, quality improvement, and education.
Karen...

Karen

VanBourgondien: Thanks, Pam. Hello, everyone. I really appreciate you joining us today. The presentation today is part two in a two-part series on Quality Data Codes. We're going to talk quite a bit about these often troublesome measures. We are going to go into some sample scenarios, and we're going to highlight some

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problem areas to help illustrate some of the problems that people have, and troubleshoot and figure out together how to solve these problems.

Last month we went into a lot of detail about Quality Data Codes, or QDCs, also known as G-codes. QDC is the acronym, but they are also known as G-codes, as I just said. So for the sake of this webinar, we are going to kind of use them interchangeably, but know that they do all mean the same. Today we're going to change our focus in that we're going to discuss more of the problems with QDCs and troubleshooting. We're going to discuss the remittance advice and explanation of benefits. We're going to present some problem claims, how you could keep tabs on your progress, and some resources that are available to assist you with your success in the reporting for this program.

If you attended last month's webinar, then you remember that we went into great detail regarding the program requirements for the ASCQR Program. We will again touch on a couple of important points. If your facility bills 240 or more patients annually for Medicare, you should be participating in this program. Now, if you find yourself in a position where you are under that but you may hit that 240 threshold or go over, we highly recommend that you go ahead and apply QDCs. Better to be safe.

In order to meet the requirements, you should be applying QDCs on a minimum of 50 percent of your claims. Remember, you will have to have at least two G-codes if everything goes well, and a maximum of five if you do have an event for that patient encounter. For those of you that have 240 or more Medicare claims annually, you should be applying these QDCs and reporting your website-based measures. As this presentation is related to QDCs, we are going to keep our focus there.

The issue we spoke of regarding 240 Medicare claims or more can be confusing, so we have a visual depiction of that program requirement. To review, let's say that in the year 2016 your facility has 240 or more Medicare claims. You would then be required to apply G-codes on at least 50 percent of your Medicare claims for the year 2017. This would also be the year that you would use as encounter dates for the collection of data for your web-based

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measures. The data is what you would actually report on in the following year – 2018 – and this will affect your 2019 APU. The gist of this is if your facility is close to 240 or you project to be, it is safer to just go ahead and report your QDCs. Let's get back to the point, QDCs.

We talked about the EOB and the RA on our last webinar. Here we can review a bit and elaborate when we need to. Let's start building on what we learned about QDCs from last month's webinar. When you're looking at the RA, EOB there is information you can gather from this. On this slide we are going to discuss the remittance advice or RA and some tips to ensure you are staying on track. A correct RA reflects a billed charge and a minimum of two QDCs or G-codes or a maximum of five QDCs. We just discussed this on the previous slide. We did go into quite a bit of detail on this in last month's webinar. If you did miss that or you need to review, please go to our website, qualityreportingcenter.com, under the Archived Events tab for that review.

Now the G-codes will split into separate claims when one of the G-codes is entered on the seventh or 14th line of that claim. A billed charge must be affiliated with the correct number of G-codes on each claim in order to receive credit for this component of the program requirement. So let's take a look at a few sample RAs.

This is a sample RA for when things are going right and all of your hard work has crossed over successfully. You can see here in the highlighted areas that there are G-codes and the correct place of service, or POS. So let's discuss things that I have circled here. On the far left, you see the code N620. Now remember, this is the code that will display when you use a "zero" charge associated with the QDC.

Moving to the right under the place of service column, you will see a 24. You should have that 24 there, as that is what associates your facility as an ASC as opposed to, say, an 11 which would identify your facility as a physician's office. Here on the last column to the right that is circled are the codes. We have here a CPT code with 2 QDCs. The billable CPT code is on the top with the QDCs underneath. Perfect. Now, let's move on to when things are not so perfect.

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In this example we have the appropriate place of service – and you remember that that is 24 – and there is a CPT code but no G-codes. Oh boy. In this instance, no G-codes were applied on the claim. Once the claim has been paid, you cannot correct this. You cannot generate a claim for the sole purpose of adding G-codes. This is another reason why you should be diligent in keeping track of your compliance. So let's talk about what you can do if your RA shows this situation: the billed charge and no G-codes.

Hmm, so what do we do in this situation? If the RA is showing a billed charge but no QDCs, there are a few things you can do to check things out. Check to ensure that the billable charge and the G-codes were billed on the same claim form for the same date of service at the same time. Check to ensure your software is transmitting the G-codes with a “zero” charge amount. Some software programs require at least a \$0.1 charge for transmission.

If you use a zero charge, the remark code will display at N620. Remember we saw that on the previous sample slide. If you used a one cent charge, the remark code will be N572. You can check with your clearinghouse to ensure it is receiving the G-codes and it is transmitting the G-codes to the MAC for CMS. You can also check with the MAC to confirm the codes came through on the same claim and to verify how the MAC processed them. Now, the advice: if you do go this avenue, then you will need the claim number and transmittal batch number in order for the MAC to research this matter.

All right then, so let's take a look at another scenario.

To put this into perspective, imagine this is what you are looking at when examining your RA EOB. I have circled here the two G-codes, but there is no billed procedure code. What do we do? Well, let's discuss this situation.

If the RA shows only G-codes, this could indicate the claims were split at the carrier. We've talked about split claims a few times now. We will follow the same steps that we just discussed a moment ago on the previous slide but look at a few more suggestions. If the MAC notifies you that the claim was split at the carrier because the facility's NPI is not listed in box 24-J, check to see if the NPI is missing from that box. You will also want to confirm that the

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second G-code is not on the seventh or 14th line item. As we've talked about, those line items will split from the original claims onto separate claims.

Let's look at some situations and see if we can work them out together. We all know things don't always go according to plan. We can look at some example patients and try to figure out what the course of action should be.

This patient is entering an ASC for an upper stomach intestinal scope for biopsy. She has recurring UTIs and has an antibiotic ordered for that. The question is, would we include this patient and count it for the reporting of ASC-5? That's a good question. Let's talk about the answer.

In this scenario the antibiotic the patient has ordered is not for the prevention of surgical site infections, or SSI. You can see the denominator criteria for ASC-5 here on this slide. You will also note that in the Specifications Manual an exclusion for the denominator is a pre-op order for antibiotic for prevention of infections other than surgical site infections and ASC admissions with a pre-op order for prophylactic antibiotic not administered via the IV route.

You will still use the code G-8918 to report for the measure ASC-5. This code is to be reported for patients with no indication for or no order for an IV antibiotic prophylaxis for SSI. This does not place the case with this code in the denominator, but it is necessary for calculating the completeness of reporting. Now, what does this scenario look like when it's billed?

Our patient here has a billable procedure code and the two G-codes. For ASC-1 through ASC-4, the code G-8907 is used because this patient had no adverse event, meaning no burn, no fall, no wrong event, and no transfer. The code G-8918 is used with regard to ASC-5, as this patient did not have an IV antibiotic or for SSI. So let's take a look at another scenario.

Our patient in scenario two is a patient that had two procedures done, and the patient had a fall while in the ASC. The question is: do we place QDCs for each procedure? Well now, this sounds complicated. Let's find out what should we do in this circumstance.

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The short answer is yes. If you have an event, you know right there you will be reporting five QDCs, so you have those five QDCs plus the billable procedure code. Remember, as we said multiple times, should a claim require more than one form 1500, such as with the use of the seventh line item, these line items will automatically go on to another claim. Each claim must contain a billable line item charge and appropriate QDCs. Remember in our earlier scenario when the RA showed only QDCs? Well, we want to avoid that. Now let's take a look at what this scenario should look like on the billing form.

We have everything filled out as it should be. There is a billable procedure code and the QDCs for this scenario in which the patient experienced a fall. Now again, because the patient experienced an event, we cannot use that G-8907 code. We now have to provide a code for each measure, ASC-1 through 4, and then, of course, we still have to report for ASC-5. So in short, we will have those five QDCs which are displayed here on this slide.

So here we have the first procedure, the patient had with the five QDCs. Okay? So where did the other procedure go? Good question. Let's take a look.

Because this claim will need more than one 1500 form, that second procedure code will fall onto line item 7. You can't have a procedure code with no QDCs, and you can't have QDCs with no billable items. So here, as we see, the second procedure is billed with those same appropriate QDCs after. Again, make sure you're keeping track of your compliance. Now, on that note, we talked last month about how to check on your own performance. We received additional inquiries with regard to the issue, so we're going to take a few minutes to review some areas that you can use to monitor yourself.

Outside of your facility there are several other avenues where you can look into your own performance. These tools help you become an active participant in your facility's success. We had talked already quite a bit about your EOB and your RA. There are other options that will allow you to check your performance. You can proactively run your Claims Detail Report and your Provider Participation Report from the secure side of the QualityNet Portal. These reports are great resources to help guide you in identifying your

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reporting issues and from preventing future ones. These two reports provide various information as they relate to the program and your facility's individual performance. The preview report will give you a sneak peek on what will display publicly for your facility. Now, last month we discussed the Claims Detail Report and Provider Participation Report in some detail, so if you need to review or you did not see part one of this series, you can review them on our website. Just know that you have accessed information that will ensure your compliance with the program requirements. For those of you that do not know how to run these reports, I'm going to very briefly show you where to go on QualityNet.

Once you log in to the secure side of QualityNet, this is what you will see. Look at the area I have circled here in red. To run a report, you will click on the down arrow button next to My Report. Then this drop-down box you will see here on this slide will appear. You will then click on **Run Reports**.

This screen will display next, and you're again going to click on **Run Reports** which I have circled here on this slide. This will be the next screen. Under Report Program to the left, you will choose **ASCQR** circled here in red. This may be the only option you have depending on your access rights. To run a Claims Detail Report or a Provider Participation Report, under the Report Category you will choose **Ambulatory Surgical Center Report- Feedback** from the drop-down option. You will then click that **View Reports** button to the right. That will allow you to choose the report that you want to run.

We have covered this extensively in other webinars. If you feel you need further assistance with this, please review some of the previous webinars. If you would like someone to walk you through this for the first time, please feel free to call our call center. Anyone that answers will be glad to walk you through this process.

On the support contractor's website, www.qualityreportingcenter.com, there are a lot of additional resources to assist you with your success.

On this slide you can see the website, qualityreportingcenter.com. We just did a webinar in February that spoke to resources available for the success of the

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reporting of this program. If you are not aware of things that are available, please go back and view that webinar on this particular site. It goes into quite a bit of detail. I would like to also let you know that we have some short tutorial videos on that site as well. The library does continue to grow, so check back from time to time and see what's new. But for now, the issue is Quality Data Codes specifically, so we will point out that there are resources on this site to assist you in your knowledge and understanding of the QDCs. If you're not familiar with this site, I'm going to show you where to find these things. So let's say you just put in your browser, www.qualityreportingcenter.com.

This is the homepage that you will land on. By placing your cursor on the ASC box, a menu opens to your right, and you can see that here on this slide. For the purposes of our discussion, we will choose the **Videos, Resources, and Tools** navigation, circled here in red.

The next page you will land on, you will then scroll down that page until you see the Measure Resources section. I placed red arrows on the documents that refer to QDCs. However, there are numerous other tools listed here on other topics that will also help you. Again, we add to this often, and we try to provide as much assistance as we can. For that reason, when you access this site, you may see additional topics that are not seen on this screenshot here today. There's a lot of information on this site, so please take the time to look around.

Again, we've covered a lot of information. To recap some of the main topics, please make sure your QDCs are crossing over. We want you to get credit for all the great work that you do. You have a minimum of a 50 percent threshold on the reporting of QDCs. To make sure that you are obtaining that minimum percentage, run the reports we talked about; keep track of your own performance; optimize all of the tools and resources available to you. We only covered a few of the resources available that are on qualityreportingcenter.com as they relate to QDCs. There are a lot more.

In addition to resources discussed in this webinar there are also numerous other resources available on QDCs and the CMS 1500 form. That's all I have

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for you today. I really hope we were able to clarify the questions that you may have had and contributed to your further understanding of the reporting of QDCs. Pam, back to you.

Pam Harris: Thank you Karen. That was great information. I think we now have time to go over some questions, and I've picked out a few. Karen – this one came in, it says: “We have been using only the two codes, G8907 and G8918. Are we supposed to be checking all the sites? I am a little confused.”

Karen

VanBourgondien: That is a good question, and Pam, as you know, we do get variations of that same question. So let me back up and try to respond and clarify some things with regard to that.

If a patient had no adverse events for ASC-1 through ASC-4, then you can use that aggregate code G8907. If they did experience an event, say they fell, they had a burn or they had a wrong event or they were transferred, then you can't use that G8907 code. You then have to report the code that correlates to the event that occurred. So you would not be able to use that G8907. You would have to answer yes or no to each measure for ASC-1 through ASC-4.

Then we still have to report for ASC-5. So you could apply G8918 if there was no pre-operative order for IV antibiotic surgical site infection prophylaxis. If the patient did have an order for antibiotics, you would have to report the code that correlates to that. We did talk a little bit about that in one of the scenarios during the webinar, so you may – if you're still confused, you can review that, and by all means, you can certainly call our call center.

Pam, I see one here. “If a patient received antibiotics after the procedure, however, there was no pre-operative order in place, is it correct to report the G8918 for no pre-op order?” Can you take that, Pam?

Pam Harris: Sure, Karen. Yes, that is correct. If the patient did not have a pre-op order for antibiotics in place, you apply the G8918. The fact that there were antibiotics given to the patient during or after the procedure is a separate issue.

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And Karen, I've got one. "Does the gastroenterology lab have to report antibiotic usage since it is not for incisional infection?"

Karen

VanBourgondien: This is kind of along the same lines, so there is some confusion here.

Antibiotic orders for prevention of infections other than surgical site infections, such as maybe bacterial endocarditis, those are excluded from the denominator, excluded from the measure, and again, we did discuss this during the webinar. So, you are still going to use that G8918 code because the antibiotic ordered was not for prevention of SSI.

Let's see, Pam. "For ASC-7, do we need to wait for the CPT-ICD codes? If so, will you notify us when they are determined?" I can go ahead and speak to that. For the reporting of ASC-7 using 2015 data, the surgical procedure codes are listed in Specifications Manual version 4.1. This is the data currently being reported on QualityNet with a submission deadline of August 15, 2016.

Pam, here is another question: "Our MAC EOB shows N246 and 'this non-payable code is for required reporting only,' that's what it says, and an N620 alert, 'this procedure code is for quality reporting informational purposes only' when we report a \$0.1 charge amount for G-codes." That's a good question. Pam?

Pam Harris: Thanks. Please check your Claims Detail Report located on QualityNet to ensure that you are receiving appropriate credit for reporting the G-codes. It sounds as if the N246 is the remark code by the MAC for your – that your state utilizes. Again, check your Claims Detail Report. Should you have questions, follow up with the ASCQR Program.

And Karen here's another question: "Do Medicare commercial plans need quality G-codes?"

Karen

VanBourgondien: If you are referencing managed care plans, the answer is no. Only Medicare Fee-for-Service facility-level claims are included for the purposes of this program. So this would be Medicare Part B Fee-for-Service claims and that

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would include Medicare Railroad Retirement Board beneficiaries and Medicare Secondary Payer.

Oh here's a different question here, Pam. "I did not know that my SAMS Grid card expires if not used. How do I know if it has expired, and if so, what do I do? I received my card last year around October, and the last time I used it was June of last year." You want to go ahead and answer that, Pam?

Pam Harris: Sure. Try logging in to your account. If it – if you have difficulties and it says that you that you are locked out, you will need to contact the NHSN help desk, and you can do that. You can send an email to nhsn@cdc.gov. You may be able to request a password reset. If your SAMS card has expired, then you will be deleted from the NHSN system, and you will have to re-register after 12 months of inactivity. So try that first, and then email NHSN.

Karen, I think we've got time for one more question and that would be that they're confused about the Provider Participation Report and the Claims Detail Report. What is the difference?

Karen

VanBourgondien: That's a really good question. Both reports are very important. They do give you slightly different information. We did go into a little bit more detail last month, so I would recommend going back and looking at last month's webinar so you can have a visual. But in short, a Claims Detail Report will give you every QDC itemized that is reported. The PPR is set up a little bit differently; it provides you a little bit more information. It does tell your total compliance, your total denominator and numerator for all of the ASC-1 through 5 measures, and tells you if you have an active SA.

So there's a lot of little differences, and again, please go back and review the webinar. By all means you can give us a call at our call center at 866-800-8756. We'll be happy to show step-by-step over the phone, guide you through how to run these reports. You can run the reports yourself, and then we can look at them together and help you to understand what you're looking for and looking at if you need that kind of help.

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Also, let me mention that on qualityreportingcenter.com, if you need any assistance with regard to understanding QDCs, there are multiple tools on that site to help guide you through the reporting of these measures ASC-1 through 5. This information is in addition to what is in the Specifications Manual, and it should help you to be successful in the reporting of these measures for this program.

And as always, as we stated, if you need any other help, please contact our call center, and that number is 866-800-8756. So I hope that today, Pam, that we were able to answer some questions. We try to speak to the most common questions that we're coming in. Again, if you need other help, call our call center, review our webinars that are on our website, and I think that's about all the time we have.

Pam Harris: Well, thanks Karen, I do appreciate it. Now, I think that's all the time we have for today. Thanks again.

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