Ambulatory Surgical Center Quality Reporting Program

Support Contractor

Pieces of the Puzzle: Understanding Quality Data Codes

Presentation

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Pam Harris: Hello, and welcome to the Ambulatory Surgical Center Quality Reporting Program webinar. 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 there 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 1 began the submission period for the web-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. ASC-9, as you are aware, the denominator criteria for ASC-9 was changed from 50 years and older to 75 years of age. The QualityNet tool has not yet been updated to reflect this change. This has been added to the Known Issues on QualityNet. You will still abstract

under the new specification guidelines of 50 to 75, just realize that this is not a specific option when you are entering your data.

Please be sure to keep your QualityNet and your NHSN password active by logging into your account on a regular basis. If you do not routinely access these accounts, they can become locked, and after one year, the credentials for 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 this slide. For problems with your NHSN account, please contact the NHSN directly at the email address you see here.

On April 27th, we will be presenting the second part of this webinar. In Part Two, we will be focusing on troubleshooting, sample claims, and when things go wrong. On May 25th, we will be presenting a webinar which will discuss data as it relates to this program and how it could be used to improve quality within your facility.

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. By having 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. Now, let me introduce our speaker.

I'm 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. So, let me hand it off to Karen.

Karen VanBourgondien: Thank you, Pam. Hello, everyone. I appreciate your joining us today. The presentation today is part one in a two-part series on the Quality Data Codes, QDCs. We will talk about these in quite a bit of depth and run by some examples of claims. I want to review these often troublesome measures and talk about them to ensure your success in the ASC Program. In Part Two, we will go into more depth and further discussion, and we

will discuss areas of trouble and how to optimize your compliance with these measures, so be sure to join us next month for Part Two.

Let's take a step back and talk about some background. The rise of the ASCs and the advantages they provide to patients and to the healthcare system in general have contributed to better quality, reduced cost, and more effective practices. CMS responded to leading organizations within the ASC community to request the method by which ASCs could report data reflecting the excellent care they provide.

In 2012, the ASC Program was implemented by CMS to promote the high quality of care patients receive in the ASC setting. The initial set of measures, including the Quality Data Code measures ASC-1 through ASC-5, were provided by the ASC Quality Collaboration and instituted by CMS.

CMS believes all consumers of healthcare should be able to make informed decisions regarding their healthcare choices. As such, the ASC Program was established to collect data reflected by the specific outcomes and processes for the purpose of public reporting. The overarching focus of the ASC Program is to present better care, smarter spending, and healthier people. CMS has put forth effort to ensure that the requirements of the ASC Program work together to support these goals. Performance transparency allows consumers to make smarter healthcare decisions and is an essential element of this program.

Along with your current and prospective patients, you now have the ability to compare your performance against other facilities. Comparison of similar facilities against each other, as well as against state and national performance, supports the informed consumer and advises providers by prompting quality improvement initiatives. Additionally, it provides the ASC community standardized care processes, where real improvements can be made and measured.

The ASC Program can be broken into two major components. Reporting of claims-based measures and reporting of web-based measures. These program requirements will only apply to facilities that have 240 or more Medicare claims per year. Program requirements will apply to facilities that have been open for at least four months prior to January 1 of the reported year. Failure to meet program requirements may result in up to a two percent reduction in your annual payment update, or APU.

There are two different components of the claims-based measures for this program. ASC-1 through ASC-5 are submitted to the warehouse through the QDCs, or G-Codes, that your facility populates on your CMS Form-

1500. You must report Quality Data Codes on a minimum of 50 percent of your claims in order to meet that program requirement.

The data for the other claims-based measure, which is ASC-12, are determined by billed CPT Codes and are automatically pulled from paid Medicare Fee-for-Service claims. You do not have to do anything for this measure, as that information is pulled directly from your processed claims. The web-based measures ASC-6, 7, 9, 10, and 11 – but remember, 11 is voluntary – are reported annually via the QualityNet online submission tool, while the web-based measure ASC-8 is reported through the NHSN/CDC online submission tool.

Here is a visual depiction of the pieces of the program that we just discussed. The claims-based measures are represented in both blue and purple. Now, they are both referred to as claims-based measures, but ASC-12 is the Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. And this data is automatically pulled from Medicare Fee-for-Service claims billed with CPT Codes that match this measure.

The measures ASC-1 through ASC-5 are measures where data are submitted via Quality Data Codes. You will notice that the web-based measures are also divided. The red-colored box with the measures ASC-6, 7, 9, 10, and 11, are the measures that are reported via the QualityNet online submission tool.

ASC-8 is reported separately in the CDC/NHSN online submission tool. Diligent reporting of each of these pieces will ensure your success with this program, and will prevent any reduction in your APU.

So, let's talk about the main focus of today's webinar, the Quality Data Codes. The Quality Data Codes are specialized, non-reimbursed CPT Codes that provide information about ASC performance and patient outcome. The QDCs, or G-Codes, were implemented by CMS to track the rate of occurrence of adverse outcomes within the ASC environment to better determine the relevance of these issues. So, for every Medicare Part B Fee-for-Service, Medicare Railroad Retirement Board, and Medicare Secondary Payer Claim that is submitted for payment, you must provide the corresponding G-Codes. This is how you provide valuable data on your facility's outcomes and processes.

So, these are the five measures. ASC-1 through ASC-5, that are addressed by placing G-Codes on every CMS Form-1500 claim, paper or electronic, that is submitted to CMS for payment. You will have a minimum of two QDCs and a maximum of five for each claim. These measures address

patient outcomes by tracking and collecting data on known events that occur in the ASC setting.

The measures include ASC-1, Patient Burns; ASC-2, Patient Falls; ASC-3, which are Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, or Wrong Implant. For simplicity, in this webinar I'm going to refer to the element of ASC-3 as Wrong Events. And finally, ASC-4, Hospital Transfer/Admission. ASC-5 additionally tracks the process associated with the timing of prophylactic antibiotics. Tracking of these events gives ASCs an opportunity to increase their awareness of preventable events to ultimately improve their processes.

So, here's the diagram showing how the five ASC measures are inter-related. ASC-1 to ASC-4 are related measures in that they look at patient outcomes. This allows us to group them together. ASC-5, on the other hand, is a facility process measure. So, it is reported as a separate entry. For this reason, we're going to pull ASC-5 out for the moment and set it aside, while we take a little bit closer look at the ASC-1 through 4 measures.

So, for each of the four measures, ASC-1 to ASC-4, there are two assigned G-Codes. The first one of which indicates the event occurred. The second one indicates the event did not occur. There is also a third G-Code option available to be used to report that your patient did not experience any events. The single G-Code G8907 can be used if no events occurred.

Let's look at these codes a little more closely. So, starting with ASC-1 at the bottom left of your screen and moving clockwise, you can see that each measure has its corresponding two G-Codes – the first indicating the event occurred, and the second indicates the event did not occur.

To clarify this, let's look at ASC-1. The G-Code G8908 would be chosen if your patient received a burn while in your facility. On the other hand, if your patient did not receive a burn, you will choose G8909. So, let's assume that your patient came in for his procedure, an inguinal hernia repair, and he moved through your facility experiencing no events, going home safe and sound. How would that be reported?

In this case, you would be able to report all your good work with a single G-Code, G8907, representing no events occurred. Good work. G8907 would be the G-Code you report on your CMS Form-1500. This is for ASC-1 through ASC-4. But you still need to look at one more piece before this pie is complete.

So now, we're going to go look at ASC-5. There it is. Remember, this measure looks at a process in your ASC environment. In particular, this

measure wants to know about the timing of prophylactic IV antibiotics. ASC-5 gives you three G-Code options, and you must report one of those codes on your CMS billing form to complete the required reporting for the QDC measures. Remember, you need to have QDCs on at least 50 percent of your claims in order to meet the reporting requirements for this program. So, let's take a little closer look at these ASC-5 G-Codes.

These three G-Codes represent IV antibiotic timing. Now, essentially, CMS wants to know, for those patients who are ordered an antibiotic, did they receive it on time, or was it given late? If your patient was ordered a prophylactic antibiotic, you need to look at the first two options.

G8916 is "Patient with preoperative order for IV antibiotic surgical site infection prophylaxis – antibiotic initiated on time." G8917 is "Patient with preoperative order for IV antibiotic surgical site infection prophylaxis – antibiotic **not** initiated on time." If your patient did not have an order for a preoperative antibiotic, you would then choose the third option, G8918.

Now, let's put the pieces together. So, we have already determined that for ASC-1 through 4, our patient experienced no events in your wonderful ASC. As a result, they are assigned the aggregate code for the four "no events" codes, which was G8907. Now, we see that your patient was ordered a pre-op antibiotic and received it on time. Awesome. That gets the code G8916. This gives us the minimum of two G-Codes to report on your claim. So now, we have all the pieces of the puzzle, and we are ready to report.

Let's take some of this information and put it into practical use and discuss the claim form itself. This is the CMS Form-1500, which is used to send in your Medicare claims for payment. Let's just touch on the elements of this form that, if done incorrectly, will put you at risk for failing your minimum requirement of reporting QDCs. Complete the form as you would normally, paying particular attention to the following highlighted areas, and these areas are demonstrated here on the slide.

Field 21A – This is at the very top left. This is where you populate your ICD-10 codes. Field 24B – In order to receive credit for your QDCs, this field, a place of service, must be 24. This identifies your facility as an ASC. Field 24D – In this field, you will place the billable CPT Code and your G-Code. All G-Codes and at least one CPT Code must be populated on every claim.

Now, I want to stop here for a minute, and I want you to notice the position of the codes here on this slide. The CPT Code must be above the Quality Data Codes. Field 24E – Your diagnosis, ICD-10 pointer code,

needs to be placed here next to its corresponding CPT Code. If there is no diagnosis pointer in Box 24E, the claim will be rejected by the MAC. Field 24F – Place the CPT associated charge and either zero, or if your billing system cannot accept the zero charge, then a one cent charge can be applied. This is a crucial step to make sure that these codes are accepted into the warehouse. Field 24J – The rendering provider must be the facility NPI, not the physician's NPI. Your ASC will not be given credit for those G-Codes if you put the wrong NPI in there.

So now, let's take a look at the patient who had the successful hernia repair with no events and an on-time antibiotic. So, this is what your bill would look like for the patient described on the previous slide. Yours may look a little different if you're using an electronic form, but the important information I have highlighted should appear on both electronic and paper claims. At the top left, "A" indicates ICD-10 CM K40.20 for bilateral inguinal hernia. You see here the date of service, the place of service – you are an ASC, so remember that's a 24 – the CPT Code for inguinal hernia repair, the diagnosis pointer code indicated by "1," and a nominal charge. Also note the two G-Codes that are populated on this form. G8907 represents ASC-1 through 4, and the G8916 represents that on-time antibiotic from ASC-5. Both of these codes are assigned a diagnosis pointer code and a charge. You can see all of that information demonstrated here on this slide.

To summarize the information we just covered, you have at least two G-Codes on each claim form. So, if all goes well for ASC-1 through ASC-4, you can use the G8907, and then you would choose an appropriate code for the ASC-5 measure. Please attach a charge, either zero or one cent, for appropriate acceptance into the warehouse. If you use one cent, the patient would not be responsible for this charge.

We covered so much already, and now that you have a good foundation, we're going to talk just a little bit about if things do not go so perfectly.

So, let's get started. Here are the G-Code groups again that we have already discussed. You can see here I have some of the codes outlined. I am identifying a patient who experienced a fall. So, patient falls are tracked by the measure ASC-2. Seen here on the top left, light blue box, this patient now has the code G8910, as this patient experienced a fall.

Now that we have an event from one of the four outcomes measures, ASC-1 through ASC-4, we are no longer going to be able to use that aggregate code of G8907. Instead, you will use the individual codes to report on each of the ASC-1 through ASC-4 measures.

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Now, we see here the four identified codes from each of the measures based on the patient that fell. We now have ASC-2, Patient Fall, in the light blue box, which represents the code that the patient experienced a fall. The other codes seen here represent no event for that measure. So, since there was an event, we cannot use that G8907 code. We have to answer all of the measures separately. All of the codes we would use in this scenario are seen here on this slide, and would be placed on that CMS Form-1500 claim.

So, let's clarify this just a bit. Remember this slide? Now, instead of the two G-Codes we saw prior, we have four. The three no event codes plus the fall code. All those codes are there in that light blue circle at the top of the slide. So, if we move down to the green circle, this patient was not ordered a pre-op IV antibiotic. So, we have been given the code G8918 to indicate this. The result of this encounter, demonstrated here in the large orange circle, will be a reporting requirement of five G-Codes on the claim. Let's look at this claim.

This is what the claim would look like, with the five G-Codes indicating an event occurred. In this case, the code G8909 indicating the patient did not experience a burn, code G8910 indicating that the patient experienced a fall, G8913 indicating the patient did not have a wrong event, G8915 indicating the patient was not transferred, and G8918 for ASC-5, indicating an antibiotic was not ordered. We would still fill out the rest of the claim, as we discussed prior, but more G-Codes are applied in this scenario.

In summary, for this event you will have the five G-Codes, and each of those codes would have a charge associated with it. Now, before we move on, let me introduce the term EOB, which is Explanation of Benefits. The Remittance Advice, or RA, reflects a billed charge. When you apply the charge next to the G-Code, if you applied a zero charge, your RA will display a code of N620. If you applied a one cent charge, you will receive a code of N572.

So, let's move into the next part of this presentation and just briefly review some things you can keep in mind to ensure your success in this program. Let's just answer a few questions. Things do happen. Let's go through some of the more common issues we see that result in ASC failures with regard to reporting Quality Data Codes.

What do you do if the codes are not being captured, but you are absolutely sure you reported them? Well, there are a few things. Check with your biller or your billing system to make sure that the forms are being correctly filled out, particularly with regard to multi-claims. Make sure these codes are transferring on each claim. Be sure you are notified of any

system changes or software updates. When this occurs, your system presets may have defaulted the place of service back to 11, which is a physician facility and will be rejected, or it could be any number of errors that may occur. So, again, follow up to ensure adequate reporting.

What are some other things that can be missing to cause issues with the reporting of your codes? Well, often when a claim has more than one CPT Code to bill, the G-Codes are placed on the first claim but not on any subsequent ones. This is a big issue with regards to the claims that have an event. These claims end up having five lines occupied by G-Codes, and only one left for the billable CPT Code.

If you place the G-Codes on one form without a billable CPT Code, this form will be rejected, and your codes will not make it into the warehouse. Confirm that the second G-Code is not on the seventh or fourteenth line item. These two line items split from the original claim into separate claims. Let's look at the next slide so that you can have a better idea of what we're talking about with regards to split claims.

So, this slide states that each form submitted must have at least one billable CPT Code and all the corresponding G-Codes, which will be either two or five for the patient and that encounter. Remember, we have talked about that you will have a minimum of two QDCs and a maximum of five.

Pay particular attention to line 7 and line 14, as they will split the claim. You must add G-Codes to that page as well. A G-Code should not be entered on the 7 or 14 line items. Again, the seventh and fourteenth line items split from the original claim into separate claims. If you have a split claim at the MAC and the QDCs are on one claim by themselves without a billable procedure code, the ASC will not receive credit for submission of the G-Codes. Please remember, a claim submitted without G-Codes will not be counted towards your total claims and will affect your required 50 percent submission.

We talked about the terms here on this slide previously, but it warrants some further discussion, as it is so important, and these things can be so helpful in monitoring your compliance with the reporting of these measures. As I mentioned previously, be sure to check with the source first. It's the easiest way to identify and fix any problems. Always check your EOB statement closely and refer to the remittance advice codes. An EOB is a statement sent by the insurance company explaining what medical treatments and services were paid. Remember, we said that G-Codes are non-billable CPT Codes that have to be reported with an associated nominal charge, either zero or one cent. The EOB will include the Remittance Advice, or RA, which is a notice of the payments

processed. If you used a zero charge, the remark code will display as N620. If you used a one cent charge, the remark code will display as N572. Check with your clearinghouse to ensure it is receiving the codes and that it is transmitting to the MAC.

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. Why wait to be notified that you're failing when you can proactively run your Claims Detail Report and your Provider Participation Report right from the QualityNet Portal. A preview report is sent prior to the facility's data being displayed publicly. You will be notified when the preview report is available for your review. These reports are great resources to help you in identifying your reporting issues and for preventing future ones. Let's take a closer look at the Claims Detail Reports so you know what all this is about.

The ASC Claims Detail Report identifies claims in final action status in the data warehouse. This is an example of the Claims Detail Report. Of course, all the PHI has been removed. On this report starting from the left, you will have the HIC Number, a claim receipt date, the date of service and the QDC codes entered, the patient's name, date of birth, and claim control number. That last number is an internal QualityNet number. This report is one avenue to check on the volume of QDCs that your facility has submitted. Remember that a facility must submit QDCs on at least 50 percent of their claims to meet the program requirement for that element. This report is updated monthly.

The Provider Participation Report displays a summary of the data submissions required for the payment year and your facility's performance. This is your facility's data that have been accepted into the warehouse. This slide represents a sample of the Provider Participation Report, as indicated by the title indicated by number 1. This report can be run through the QualityNet Secure Portal and updates monthly. As indicted by number 2, here you can see the total number of claims with QDCs, the actual total claims, and data completeness, which is essentially the percent of QDCs your facility has submitted. You will want to keep your eye on this report, as with changes to your system, staff, or other inputting factors, your rate could easily drop below the required threshold.

Also, please note at that number 2, that for ASC-8, this report will not reflect if your facility has completed the ASC-8 measure. You can see here by the ASC-8 measure, it says, "No." QualityNet is working to resolve this in future updates, but for right now, your NHSN data will not show as reported on this QualityNet report.

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You can see that this form provides some really helpful information for you about how well your facility is performing and should be used as an ongoing assessment of reporting status. There are a lot of resources available to you. Please go to our website, qualityreportingcenter.com. There's a huge amount of tools and information there. We also recently presented a webinar on all the tools available, and you can find them under the **Archived Events** tab on this website. That particular webinar was given on February 24.

We have covered a lot of information. Again, please join us next month for a continuation of this information, as we will go into greater detail on this subject and some troubleshooting problems. In a nutshell, to meet program requirements, you must have a compliance of at least 50 percent in the reporting of ASC-1 through ASC-5. Be proactive and consistent in reviewing and monitoring your own compliance.

That's all for me right now. I hope you join us next month. I'm going to hand it back over to Pam. Pam, back to you.

Pam Harris: Thank you, Karen. We now have time to go over some questions. Karen: "If an incorrect QDC Code was entered by mistake, is there a point that it can be corrected once submitted?"

Karen VanBourgondien: That's a great question, Pam. The answer to that is if this is noticed prior to a claim being adjudicated, a corrected claim can be submitted. Once a claim has been paid or adjudicated, a corrected claim cannot be re-submitted for a QDC correction only. Once a claim is adjudicated, all replicated claims will be rejected as a duplicate claim. If you do have any further questions beyond that, feel free to call us at our call center at 866-800-8756.

I have a question here, Pam. "Our facility did a very low count of Medicare cases. Are we required to report data, and do we have to apply G-Codes?" I'll go ahead and take that. If your facility has less than 240 Medicare claims for the previous year, you would not be required to participate in the program. But year-to-year this can change, so we always recommend to go ahead and submit QDCs in case you do go over that limit.

If you are required to report, then yes, you would put in the G-Codes on each Medicare claim, submit it for payment, and then you would also have to report on your web-based measures as well.

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Pam Harris: Let's see. Here's one, Karen. "I'm new to reporting. Is all the data needed for reporting automatically captured by the sending the actual claim?"

Karen VanBourgondien: There are two components to the ASC Program: submission of claims-based measure information and submission of web-based measure information, and we did go over that. So, ASC-1 through ASC-5: those are claims-based, and those refer to the Quality Data Codes. That's what you're going to put on your claim form. ASC-12 is also a claims-based measure, but remember, that information is extracted automatically from paid Medicare claims. You also have to report your web-based measures, and those are ASC-6, 7, 9, 10, and 11. They are submitted through the QualityNet online submission tool. And ASC-8 is reported to the NHSN/CDC on their online submission tool. So, a suggestion would be to read the "ASCQR Program Guide for New Facilities" [Editor's note: It can be accessed under the title "Successful Reporting in the ASCQR Program."]. You can find this document on our website, qualityreportingcenter.com. If you just click on "ASC," you'll be able to find that document. It's also under the **Videos, Resources, and Tools** tab.

Pam, here's a question that I'm going to – I'm going to give you because we get this all the time. "Is ASC-11 still voluntary?"

Pam Harris: And that is a yes. ASC-11 is still a voluntary measure. Please be advised that if you do report data, it will be publicly displayed on Hospital Compare.

"Why did my NHSN reporting not carry over to QualityNet? I have the data, and it was submitted correctly, but my report from QualityNet does not recognize this." Karen?

Karen VanBourgondien: Sure, I can take that. The NHSN data does not cross over onto QualityNet. Again, QualityNet is looking to resolve this in the future, but right now, that information does not show up on QualityNet. There are a couple of resources you can refer to. One, you can email NHSN directly. Also on our website, qualityreportingcenter.com, we have what we call a Status Listing Lookup Tool.

If you go to the ASC tab, a menu will open to your right, and you can just click on **Status Listing Lookup Tool**. Please be advised to always look at the date above that. It will say "Updated as of such and such date." So, if it said "Date as of Monday" and you reported your data on Tuesday, then it's not going to reflect that. So, be aware of the update information that is on that website.

Here's another question that we get quite often. "Where can I find the Specifications Manuals?" And I'll go ahead and take that. You can find all versions of the Specifications Manual on the qualitynet.org website. Just click on the gray **Ambulatory Surgical Centers** tab, it's at the top, and a drop-down box will appear, and you'll just click on the **Specifications Manual**. And the page will open, and you will be able to select whatever version of the manual that you want to look at.

I think, Pam, we have time for one more question. "If we have no events during an encounter, do we still have to apply an ASC-5 code?"

Pam Harris: Yes. If you have determined that for ASC-1 through 4 that the patient experienced no events, you would use the code G8907. Then you would apply one of the three codes that relate to ASC-5. Remember, you have to have a minimum of two QDCs on each claim.

All right. And maybe we've got time for one more. "What are some ways to make sure that my ASC is on track with submitting the required amount of Quality Data Codes on our claims?" And I can go ahead and take that. One way is to read your Claims Detail Report. This report is available on QualityNet's Secure Portal, and it is updated on a monthly basis.

Remember, this report will allow the facility to check on the volume of your QDCs that have been submitted by the facility. Another report that can be run is the Provider Participation Report. And this report will kind of give you a summary of the data submissions required for that payment year and your facility's performance. These were the two reports discussed during our presentation.

All right. Karen, that's all the time we have. I appreciate it. Now, I'm going to turn it back over to our host for the instructions on our CE process.

Matt McDonough: Thank you. Today's webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally accredited nursing provider. And as such, all nurses must report their own credits to their boards using our national provider number. That number is 16578, and is listed here on this slide.

This concludes our program for today. We hope you've heard useful information that will help you in your reporting for this Quality Reporting Program. Thank you again and enjoy the rest of your day.