Ambulatory Surgical Center Quality Reporting Program

Support Contractor

Pieces of the Puzzle: Understanding Quality Data Codes

Questions & Answers

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Question: If ASC-9 does not apply to your specialty and your denominator and numerator are going to both be zero, will it let you do that measure?

Answer: Yes. If this is a measure you do not provide service for, then you should enter "zero" when entering your data in the QualityNet Secure Portal.

Question: For ASC-9, with ages 50-75, is this for data collected during 2016? Or were we supposed to collect data for 2015 at ages 50+ until October 2015 and then change to 50-75?

Answer: This change in the age of the patient will go in effect with the patients with encounter dates starting January 1, 2016, not the encounters you are currently reporting.

Question: For ASC-7, do we need to wait for the CPT/ICD codes? If so, will you notify us when they are determined?

Answer: For the reporting of ASC-7 using 2015 data, the surgical procedure codes are listed in Specifications Manual 4.1. This is the data currently being reported into QualityNet with a submission deadline of August 15, 2016.

Question: Should we wait until the ASC-9 tool is updated before we report on this?

Answer: No, this is not for the current reporting period. That change refers to encounters starting January 2016. You will not report *that* data until next year.

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Question: For ASC 1-5, did she say we must submit at least 50% of claims?

Answer: In order to meet the program requirements for this program, you must report QDCs on a minimum of 50 percent of the claims submitted to Medicare for payment.

Question: Please forgive me if you answer this later in the presentation. I realize ASC-12 is going to be automatically pulled, but I was wondering if there will be partial reports – for example, quarterly throughout 2016 – so we can monitor our performance before final scores are determined. We have tried to write monitoring reports, but because we do not have access to hospital admission data, we are not able to project.

Answer: At this time there are no plans for partial reports or frequent reports for ASC-12. For more information regarding ASC-12 and contact information for the measure writers, you can visit: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228775182443.

Question: We have been marking only G8907 and G8918. Are we supposed to be checking all the "no" sites? I am a little confused.

Answer: If the patient had no adverse events for ASC-1 through ASC-4, then you would apply the code G8907. If they did experience an event, you would report the code that corresponds to the event. To report for ASC-5, you would apply G8918 if there was no preoperative order for IV antibiotic surgical site infection prophylaxis. If the patient did have an order for antibiotics, you would report the code that correlates to that. Details can be found in the Specifications Manual and can be accessed on QualityNet. You can use this link: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772475754

Question: When appropriate, can you address if the G-Code for transfer is used if a patient is transferred to the hospital before a procedure for a condition they arrived with (ex: arrhythmia), and if this should count as a transfer?

Answer: Once the patient has completed registration upon entry into the facility and transfers to an acute care facility, this event would be reported as a transfer utilizing G8914. To clarify, there must be a CMS-1500 Form with a billable charge to apply the QDC. You cannot submit a QDC only.

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Question: If a patient received antibiotics after the procedure, however there was no pre-op order in place, is it correct to report the G8918 for no pre-op order?

Answer: That is correct. If the patient did not have a pre-op order for antibiotics in place, apply G8918.

Question: What do we do for patients that do not have a prophylactic IV antibiotic such as a cataract surgery patient? Do you report G8918?

Answer: Correct. G8918 is the code for Patient without preoperative order for IV antibiotic surgical site infections (SSI) prophylaxis.

Question: Does the gastroenterology lab have to report antibiotic usage since it is not for incisional infection?

Answer: Antibiotic orders for prevention of infections other than surgical site infections, such as bacterial endocarditis, are excluded from the denominator or excluded from the measure.

Question: Will there be a recording of this webinar?

Answer: Yes, the recording and transcripts will be posted at: http://www.qualityreportingcenter.com/asc/events/.

Question: Our MAC EOB shows "N246, this non-payable code is for required reporting only" and "N620 Alert: this procedure code is for quality reporting/informational purposes only" when we report 0.01 charge amount for G-Codes.

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

Question: Will those of us on the call today be automatically registered for the next webinar on April 27th?

Answer: No, you will still have to register for that event. The registration link is released one to two weeks prior to the event.

Question: I report the G-codes with a .01 charge, and the remit code is N620....is this correct?

Answer: Yes, this code indicates that the QDC is being accepted for quality purposes.

Question: On what date was the G8907 code supposed to be stopped? Are facilities required to go back and make changes to the G-Codes they have submitted with that G8907 code?

Answer: QDC 8907 has not been stopped; it continues to be applied to the claim when the patient does not have any adverse event during the encounter. No corrections are required.

Question: It was mentioned that the SAMS grid card expires if not used. I did not know this. How do I know if it has expired, and if so, what do I do? I received my card October 2014 and last used it July 2015.

Answer: Trying logging into your account. If you have difficulty, you will need to contact the NHSN help desk via email at: NHSN@cdc.gov . You may be able to request a password reset. You will be deleted from the NHSN system and have to re-register after 12 months of inactivity.

Question: Do Medicare commercial plans need quality G-codes?

Answer: If you are referencing Managed Care plans, the answer is "no." Only Medicare Fee-for-Service facility-level claims are included for purposes of this program. This would be Medicare Part B Fee-for-Service Claims, including for Medicare Railroad Retirement Board beneficiaries and Medicare Secondary Payer claims.

Question: How does the public access the reporting information?

Answer: Data reported by the facility will be posted to the Hospital Compare website for the public to access at this link: https://www.medicare.gov/hospitalcompare/search.html.

Question: If I am not sure how many claims we have submitted during the previous year, would I find the total under the Claims Detail Report?

Answer: The Claims Detail Report will provide a total claims count, or you can also look at the Provider Participation Report, and it will show you the annual claims count as well as other information. Should you have questions, contact the ASCQR Program at 866-800-8656.

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Question: Please confirm that ASC-9 will change from over 50 to from 50 to 75 only.

Answer: All changes to the ASC Program go through the rule writing process. For complete information, please read the 2016 Final Rule at: https://www.federalregister.gov/articles/search?conditions%5Bterm%5D=80+FR+70526&commit=Go. You may also obtain this information in the Specifications Manual which details measure information for this program.

Question: If the patient has 2 procedures, for example, colon and pan, and an ASC-1 – 4 event occurs, do the codes have to be reported for both procedures?

Answer: You will bill both procedures and all applicable QDCs per encounter. All QDCs for an encounter must be reported on the same claim for the same beneficiary for the same date of service. Should a claim require more than one CMS Form-1500, such as the seventh or fourteenth line-item, these line-items will automatically go onto another claim. So each claim must contain a billable line-item charge and the appropriate QDC in order to receive appropriate credit for the ASC Program requirement.