Ambulatory Surgical Center Quality Reporting Program

Support Contractor

Staying the Course: Sailing Toward Quality Reporting Success

Presentation Transcript

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Karen VanBourgondien**:** Good afternoon everyone. Welcome to the Ambulatory Surgical Center Quality Reporting Program Webinar. Thank you for joining us today. My name is Karen VanBourgondien, an Education Coordinator for the ASC Program. If you have not yet downloaded today's hand-outs, you can get them from our website at qualityreportingcenter.com. Just click on today's event and you should be able to download those hand-outs. They are also attached to your ReadyTalk invite that you received for this webinar. Today's speaker is Laurie Ciannamea, a Project Coordinator with the ASC Program. Laurie has an extensive background in healthcare, and has been with this program since its inception.

Before we get started today, let me just make a couple of announcements. When you are using the question and answer tool, please remember to not submit any PII, which is Personally Identifiable Information, or PHI, Protected Health Information. On that platform, we can't accept that type of information, and if you enter a question with that type of information it will automatically be deleted and we won't be able to respond to your question. So, examples of PII and PHI are patients' names, HIC numbers, medical record numbers, or any other unique identifying number code or characteristics. So just keep that in mind.

Please join us on April 26, we will be discussing tools and resources that are available to you to optimise your reporting for this program. Any

additional information regarding program updates or educational opportunities will be sent via ListServe. If you're not signed up for ListServe, it's an automatic email service. We highly recommend that you sign up for that and you can do on the homepage of QualityNet.

The learning objectives of this program are listed here on this slide. This program is being recorded, and 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 on our website at 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 that's located on the left side of your screen, and one of our subject matter experts will respond. And we hope that by having live chat we can respond and accommodate your questions in a timely manner. So, without any further delay, let me turn things over to our speaker, Laurie Ciannamea, Laurie?

Laurie Ciannamea: Thanks, Karen. Hello, everyone, we're so glad you were able to join us for today's webinar. To begin today's presentation; let's briefly touch on what's required in order to meet the requirements of the Ambulatory Surgery Centre Quality Reporting Program, or ASCQR.

This slide displays a direct quote from the Code of Federal Regulations or CFR, in which CMS defines the claims threshold that mandates a facility to participate or be subject to a 2% reduction in annual payment update. Okay, that's fine but, you ask, what does that really mean? By way of an answer, let me give you an example: a facility had 200 claims in 2015, affecting payment year 2017. Because they fell below the 240 case threshold in 2015, they would not be required to report 2016 encounter data in 2017, which would impact payment year 2018. It is the facility's responsibility to monitor claims volume to ensure that they report data if they exceed the 240-case threshold for any given payment year.

ASC-12 is an outcome measure that calculates a facility level rate of risk-standardised, all-cause, unplanned hospital visits within seven days of an outpatient colonoscopy, among Medicare Fee-for-Service patients aged 65 and older. Data collection begins with claims submitted in 2016 to affect payment determination beginning 2018. The data, which is facility specific, is being collected by CMS directly from the facility's Medicare Fee-for-Service claims. This means that the facility does not need to extract data or submit any data separately from its claims. No additional action is required by the facility to meet this measure.

Let's continue by discussing the five measures, as listed on this slide, that the facility reports on its claims using Quality Data Codes or QDCs. Later on, we'll discuss QDCs in greater detail. Using QDCs, the facility describes the patient's experience at the ASC and whether or not the patient experienced any adverse events from measures ASC-1 to ASC-4. For ASC-5, the QDC defines whether or not there was an order for Prophylactic IV Antibiotic and whether or not it was administered timely.

To be compliant with program requirements, facilities must report QDCs on at least 50% of the claims submitted to Medicare for payment in a given calendar year. So, we've talked about using QDCs to report on ASC-1 through ASC-5, but what are QDCs anyway? Let me try to explain. Quality Data Codes are specialised, non-reimbursed CPT codes that provide information about ASC performance and patient outcomes. QDCs are reported via Medicare Fee-for-Service claims, either primary or secondary, and including Medicare Railroad claims. They are not reported on Medicare Advantage, HMO Replacement, or any commercial care claim. They are non-payable procedure codes. The Quality Data Codes, 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 corresponding G-codes. This is how you provide valuable data on your facility's outcomes and processes.

Now, let me share a few helpful hints to help you ensure that your QDCs are accepted and that you receive credit for reporting. Each Medicare Fee-for-Service claim, primary or secondary, submitted for payment should have a minimum of two and a maximum of five QDCs applied to the claim upon submission. If there is only one QDC on the claim, for example, you will not get credit for QDC reporting on that particular claim. There is no means by which to add or change QDCs once the claim has been processed for payment. So, be sure that they are correctly entered on the claim when you initially submit it to CMS.

Each page of the claim should have at least one billable charge and the QDCs on it. So, if the claim has numerous procedure codes, and rolls onto multiple pages, be certain to include the QDCs on each page. Similarly, if a claim requires more than one Form CMS-1500 version 02/12, such as the 7th or 13th line item, these line items will automatically go onto another claim to which QDCs must be added. Also, you do not want to submit the

QDCs alone without a billable charge or they will not be accepted. The billable charges have to be above the QDCs or they will not be recognised.

It's important that your facility's NPI, and not the physicians, appear on the claim in position 24-J.

So, this is the CMS Form-1500, which is used to send in your Medicare claims for payment, whether on paper, or electronically. Let's just touch on some elements of this form that, if done incorrectly, will put you at risk for failing the minimum requirement of reported QDCs. Complete the form as you would normally, paying particular attention to the following highlighted areas: field 21-A, this is where you populate your ICD-10 codes, the letter adjacent will be your diagnosis pointer; field 24-B, in order to receive credit for your QDCs, this field, the place of service, must be 24, which identifies your facility as an ASC; in field 24-D, you will place the billable CPT codes, and your G-codes. All G-codes, and at least one CPT code, must be populated on every claim, every page.

Notice the position of the codes here on the slide; the CPT code must be above the QDC codes. Field 24-E, 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 24-E, the claim will be rejected by the MAC. Field 24-F, place the CPT associated charge here at either zero, or if a billing system cannot accept a 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 24-J, Rendering Provider must be the facility's NPI, not the physicians NPI. Your ASC will not get any credit for those G-codes if you put the wrong NPI in this field. If you need further clarification about QDCs, there are two excellent webinars on the qualityreportingcenter.com, from March and April of 2016 that you can find under the **Archived Events** tab.

There are currently five measures that are entered using the CMS web-based tool. These measures are answered only one time each year. In order to report these measures, the user must have access to the QualityNet Secure Portal and be assigned a data entry role. Note that ASC-11 is a voluntary measure at this time. A facility may choose to report the measure, in which case the data will be subject to public reporting, but the facility can also decline to report data without facing any negative financial impact.

Data on these measures is collected based on encounters for a full calendar year. The data is then submitted at any time between January 1 and August 15 of the year following. You should note that with the 2017 Final Rule, the submission deadline of August 15 will be moving up to May 15, beginning in 2018, when you enter your data for the year 2017.

ASC-8 is also reported via an online tool but it is reported via the National Healthcare Safety Network, or, NHSN, which is part of the Centers for Disease Control and Prevention, the CDC. This measure is not reported via QualityNet. The NHSN platform is unrelated to QualityNet, and in fact, the two platforms do not even speak to one another. In order to be able to enter the ASC measure data for your facility, you will have to go through a separate registration process with the NHSN. Becoming an authorized user with the NHSN is a multi-step process, and we encourage you to begin well in advance of the submission deadline if you are a new user so that you do to miss the submission deadline while waiting for your credentials. The data collection period for this measure mirrors the current flu season, October 1 through March 31. The data submission period for this measure is also different than the measures submitted on the QualityNet website. For this measure, the data can be reported at any time between October 1, 2016 and May 15, 2017.

Now that we've discussed what's required, let's talk about how you can keep your quality reporting on course. One of the best ways for facilities to stay in the know about the program is to join ASCQR ListServe, which is comparable to a large email distribution. It's our way, as the program support contractor, to share news and information about the program with participating facilities. While we won't inundate you with emails, the ListServe is how we keep facilities in the loop with program updates, and remind them about important dates and deadlines to keep their reporting on track.

On the QualityNet homepage, follow the link to join ListServe by double clicking where it says 'Sign-up for Notifications and Discussions', as circled here in red. The ListServe registration page will display. Enter your user information, including your name and your email address, enter a password of your choosing but be sure to follow the legend provided or your password will not be accepted. Once you've entered your user information, select the ASC Program as the one you will want to receive notifications from. Then, scroll down to the very bottom of the page and click on 'Submit'. You will receive a response stating that you have successfully joined the ListServe. Subscribing is just as easy as that.

Next, let's review how to run reports on QualityNet that will help you track your progress. Before we start to talk about how to run reports on the QualityNet website, let me clarify an assumption that I have made for the purpose of this presentation. I'm assuming you have access to, and know how to, sign into the QualityNet Secure Portal. If you need assistance with signing in, I would encourage you to view the video, *Entering Web-Based Measures*, available on the qualityreportingcenter.com website. Later in this presentation we will discuss the website in more detail, and I will again point out the video that I just referred to.

All right, now that you've signed into QualityNet you have arrived at the homepage. Hover your mouse over the **My Reports** tab and a dropdown box will display, double click on '**Run Reports**.' Once again, click on '**Run Reports'**, the *Selection Page* will display. In the dropdown box, under the *Report Program* heading, select '**ASCQR**'. Under the *Report Category* heading select **'Ambulatory Surgical Center Reports – Feedback'**, and then click on '**View Reports'**. Once you've clicked on that **View Reports** button, you will see the list of reports; that list is what you see here on the slide next to the arrow. For this example, select '**ASC Claims Detail Report'** by double clicking on it. Next, you will enter the parameters for the report you want to run. The state is which your facility is located will show, along with the name of your ASC. Enter the start and end dates of the period for which you would like to view claims data, then click on **'Submit'** at the bottom of the page. That will take you onto the next page where you'll be able to find the report.

Now that you've run the report, you'll want to find it. On this screen select '**Search Reports'**. A list of all the reports that you have run in the past 30 days, if any, will be displayed. When the report is complete and ready for viewing, a green check mark will show in the *Status Column*, to the far left of the *Date Requested Column* and the *Report Name*. To open the report, click on the magnifying glass on the right of the report name in the *Action Column.* That will allow you to review the report, print it, or save it, whatever works best for your needs. Again, the report will only be accessible for 30 days from the date it is run, so be sure to save it if you will need to access it again later.

Okay, so now that you have the report open, let's talk about what information the report is providing. The Claims Detail Report, or CDR, is a reflection of the billings submitted by your facility to Medicare for payment. It includes all of the claims your facility submitted during the

timeframe you specified in the report parameters that we discussed earlier. Each line provides details about an individual claim, including the Patients Medicare Health Insurance Claim Number, or, HIC Number, the date it was received by Medicare, the Date of Service, the Quality Codes that appeared on the claim, the patient's last and first name, date of birth and the Claims Control Number, which is system generated.

This report is a valuable tool that you could use for auditing purposes, which we'll talk more about momentarily, when used in conjunction with the Remittance Advice that you receive from Medicare. Also, this report allows you to see, at a glance, what QDCs are being billed most frequently by your facility, or if there are gaps where QDCs were either absent from the claim or were not accepted into the warehouse. And that's important because if a claim goes into the warehouse without its QDCs, whether they were left off the claim or they didn't make it into the warehouse for another reason, your facility is not getting credit for reporting those QDCs. And remember, facilities have to maintain a 50% yearly QDC submission rate in order to receive full annual payment updates.

If there are claims appearing on the Claims Detail Report without QDCs, you will want to look to see what happened that the QDCs did not make it into the warehouse. First, be certain that the QDCs — again, that's a minimum of two and a maximum of five QDCs per claim — were on each page of the claim when it was submitted. Next, you should check with your billing software vendor to make sure that they are able to process zero charge line items, such as the QDCs. We have also received reports that some clearinghouses have stripped QDCs off claims. So, be sure that your clearinghouse is receiving and transmitting the QDCs when you send the claim onto the Medicare Administrative Contractor, or MAC, for processing. And, finally, verify that the MAC is transmitting the QDCs along with the claims into the warehouse.

Remember this screen? Well, from here we're going to run the Participation Report next to the red arrow, using the same steps we used earlier. On this screen, enter the Payment Year that you want to review, and then click on **Submit** at the bottom of the page. You can retrieve this report using the same steps that we discussed earlier when we ran the Claims Detail Report. The Participation Report is a wealth of information that you will want to look at each quarter to make sure your facility is meeting its reporting goals. In the upper-left corner, you will see the state in which the facility is located, the NPI, the name of the facility and the city. Below that, you will see the total number of claims with QDCs that have been accepted into the warehouse, so far, for this Payment Year, the total Claims Volume, the QDC Reporting Rates for the Payment Year and

that the CMS reporting threshold is 50%. To the right, you will see that this facility has an active Security Administrator, and is a participating facility. Next, you will see a list of the Web-Based Measures and the reporting status for each.

Below the division line, you will see each of the Claims-Based Measures ASC-1 through ASC-4. The numerator for ASC-1 through ASC-4 is the number of times each measure was reported. For example, if a patient burn had been reported, the number "1" would appear in the numerator column next to that measure. The denominator is the total number of claims submitted in that particular quarter. The measure value, using that same example, is the number of times per 1,000 cases that a burn is reported. It is calculated as the numerator divided by the denominator, times 1,000 cases. For ASC-5, the denominator is the number of claims on which you have indicated that there was an order for prophylactic antibiotic. The numerator is the amount of times the antibiotic was administered on time. The measure value is calculated as the numerator, divided by the denominator.

Next, let's review more reports that are sent via the Secure File Transfer, through QualityNet, that will help you to track your progress.

When the report has been uploaded to your Secure File Exchange Mailbox, you will receive an email notifying you that it has been received. Log into the QualityNet Secure Portal, and at the top of the screen you will see the Secure File Transfer icon, which I have circled here in red.

When your mailbox opens, you will see an email and an attachment. In this example, the Preview Report. To open the message, click on the report title. From there you can print the report, or save it, whatever is your preference.

The preview report is really a "heads-up" report that allows ASCs to preview the data that will be publically reported on the Hospital Compare website. It is a comparative report that is updated once a year, and uploaded to your Secure File Exchange Mailbox. The report shows how your facility's rate compared to the national and state rates for measures ASC-1 through ASC-5. It also shows you how the data reported via the online tools compares to the state and national data for each measure.

There are two footnotes in the legend at the bottom that explain when the data submitted was insufficient to report, number one, and when the data was not reported for a measure, number five. Look at ASC-8, -9, -10, and -11 on the far right side of the report. You will note that there is a

footnote showing for each measure. That is because there was no data entered for any of these measures.

There are two additional, important points to remember about the Preview Report. First, there is no means by which to correct the data shown here. Once the data is in and the warehouse has locked down at the end of the submission period, it cannot be changed or corrected, and that is what will be publically reported. Second, this report is only available to you for a short review period of about 30 days. After that, the Preview Report is taken down and further review is not possible.

This slide shows a portion of the Claims Detail Report for ASC-12 that is being sent to you by the Support Contractor specific to this measure. It is important that I point out to you that while this report has the same name as the QualityNet report, they are two very different reports. This report is related only to one measure, ASC-12, and it is generated from a separate source. This particular report, on this slide, contains available claims data with dates of service from January 1, 2016 to August 31, 2016. Final measure calculations will use claims data with dates of service from January 1, 2016 through December 31, 2016. The final calculations will be performed, after claims within the measurement period have reached three months of maturity, and the measure rates will be publicly reported no earlier than December 2017. You can access more information on the QualityNet website, under the Measures tab in the drop-down menu for ASC.

The Mid-Year Report is a status report that provides a snapshot of your facility's QDC submission rate as compared with other facilities of similar size, and specialty on a state and national level. Page one of the report shows your facility's unique quality reporting information. It displays the facility's NPI, the state, and CMS region in which it is located and its specialty. Next, it shows the number of claims the facility has submitted as of the run date of the report, the number of claims on which QDCs were reported and the reporting percentage, that's followed by the QDC submission rate of the previous year. You'll note that, as of the run date, the facility had not yet submitted its measures via the QualityNet Web-Based Tool, nor has it reported the Influenza Vaccination Measure via and NHSN Web-Based Tool.

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Page two of the report has three different series of graphs. The top one shows how a facility's QDC reporting rate compares on a state and national level, from quarter three of 2015 through quarter two of 2016. You will know, that as of the run date, the facility had no quarter two claims submitted, no data to report. The next series of graphs displays the national aggregate reporting rates by facility size or claims volume. To the left are the smaller volume facilities, then mid-size, followed by facilities with 300 or more claims per year. The final series of graphs displays the national aggregate reporting rates by facility specialty.

Page three provides a visual of QDC reporting rates, first by the county in which this particular facility is located, and then on a national scale. The last page of the report looks at how the facility's claim submissions compares with the national reporting rate per 1,000 claims. The data is broken down by quarter. So, what does it tell us? Let's look at quarter three, 2015 data. For measures ASC-1 through ASC-4, the facility had 56 claims and none of those claims had any adverse events reported. So, the reporting rate per 1,000 claims is zero, which is good news. The National Rate per 1,000 claims varies by measure, which indicates that some facilities have reported negative patient experiences during that particular quarter.

For ASC-5, the facility has 41 claims that had an order for prophylactic antibiotics. Their rate per 1,000 claims is 1,000, which means that, in all 41 cases, the patient received an antibiotic in a timely manner. Again, on the national level, the reporting rate is slightly lower than 1,000 meaning that there had been instances reported, in that quarter, where the antibiotic was not administered on time. The last table on the report displays the national rates per 1,000 claims by specialty for each of the included reporting quarters.

There are lots more tools available for you to use in your efforts to stay on course. Let's talk about what's on the qualityreportingcenter.com website that may be helpful to you. Qualityreportingcenter.com is the support contractor's website, and it is loaded with information and tools and resources you can use to make sure you're on track. So, let's take a look. Start by clicking on the 'ASC' tab and the menu of selections will be displayed. Under the ASC-101 tab, you'll find several short educational videos that may be helpful to those who are new the program as well as to those needing a quick refresher. Also, on the page, as you scroll down, you will find several guides that are designed specifically for those just getting started with the ASCQR Program. If you recall, I spoke earlier in the presentation about the short video about entering measures via the

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QualityNet Wed-Based Tool. That video, as you can see on this slide, is found on this page.

Under the 'Upcoming Events' tab, next to the blue arrow, you will find news about the webinars that the support contractor will be presenting in the future. You can follow the link provided to register for a webinar of interest to you and you will also find the slide deck for the webinar when it is posted to this page; approximately one week to ten days in advance of the actual presentation. The 'Archived Events' tab, next to the red arrow, located just beneath 'Upcoming Events', will take you to a full listing of previously presented webinars. There, you will find the recorded version of the presentation, including the questions and the answer portion, as well as the written transcript of the presentation. All of the presentations that have been made since the very beginning of the ASCQR Program are archived for you to review at your convenience.

On the Tools and Resources page, you will find an assortment of links to program and measure resources and tools. You will also find resources from CMS and various professional associations. There's a wealth of information available from this page that will help keep you on target to successful quality reporting.

Qualit-e-Quips are easy to read and easy to understand biweekly newsletters that are emailed to members on the ListServe distribution list. These newsletters share updates for information about a single topic. They're intended to provide the reader with essential information in a quick and easy format. On this page, you will find all of the *Qualit-e-Quips* that have been sent since we began to publish them in 2015.

We talked about the program requirements we use to track your progress and ensure that your quality reporting remains on course. But, inevitably, there are sand bars along the way that you all need to avoid in order to make it to port. So, let's take a few minutes to talk about three of the most common obstacles to success that facilities may face.

One of the most important steps that you can take to keep your facility on track is to monitor your QDC submissions. You want to be sure you stay on top of it, making sure the QDCs are finding their way into the warehouse, and that the facility is being credited for reporting. When you receive Remittance Advice (RA) from Medicare, take some time to carefully review it. Make sure that the RA shows at least one billable charge, and a minimum of two/maximum of five QDCs for each claim. The facility's NPI, not the physician's, should show, and the place of service code should be 24. Finally, look for a remark code of N620 or

N572, the former remark code indicates a zero charge amount was entered next to the QDC, the latter indicates that a one cent charge was applied.

Billing software systems and electronic health records are sometimes changed, sometimes updated. Either way, you'll need to be sure that, whenever a change occurs with the system used by your facility, it can correctly process the QDCs you are submitting on your claims. That's especially true when it comes to processing the zero charge line items, such as QDCs. It is the facility's responsibility to make sure that system glitches don't prevent the QDCs from finding their way from your hand to the warehouse. Please stay on top of any changes made to your software.

CMS has taken the stance that the facility is responsible to have someone available at all times who has the ability to enter data, retrieve reports and such via QualityNet. Don't fall short due to staffing changes. Make sure that the facility has at least two active Security Administrators at all times so that there is always a primary and a secondary user available to report data. The same thing applies to NHSN. Be sure that you have two users on board who have an active NHSN account at all times. Once a person has a Security Administrator, or an NHSN role assigned, it's easy to keep it active by simply logging into the account every 60 days.

Another way to make sure that you have successfully entered your data is by using our *LookUp Tool* located on our website at qualityreportingcenter.com. You will hover your cursor over the ASC tab, and click on the *LookUp Tool*, a page will open that will allow you to check the status of your Web-Based Measures. If there's a 'yes' beside the measure, then the system has the measure reported, if there's a 'no', this would mean that the measure is not in the system as reported. Please, always look at the date above where you will enter either your NPI or CCN that will tell you the date that this information was last updated.

You can also see that there is a Claims Detail Report located on the QualityNet Secure Portal, if you receive the response 'yes', then your facility has a Claim Detail Report for the ASC-12 measure. Likewise, if you receive the response 'no', your facility either does not have — excuse me, your facility does not have that report. You can also find your CCN number on this page. If you know your NPI but you don't know your facility's CCN, you can enter the NPI, and this tool will provide you with the CCN. We highly encourage you to use these tools; this gives you the ability to stay on top of things and to watch your own performance making sure that you are meeting the program requirements and keeping yourself in the loop, about your own self-sufficiency. CMS wants ASCs to be successful and provide transparency of ASC quality to the public. Today

we've covered the program measures and participation in the ASC program. We've talked about reports that are available to you, and some helpful tools. At the end of the day, CMS wants you to be successful in reporting and your dedication to quality. Here's to a successful journey.

Well, that about does it from me today, I hope you've found this information helpful. With that, I'll turn things back to Karen.

Karen VanBourgondien: Thank you, Laurie, for all that great information. Just a reminder, to everybody, if for some reason your question did not get answered in the chat box, please know that all questions and all answers are posted on our website, qualityreportingcenter.com, along with the word-for-word transcript of the presentation that is usually posted within a couple of weeks. So, that's all the time we have today, we really appreciate you joining us today. I'm going to turn things back over to our host to discuss the CE process. Thanks again everybody and have a great day.