April F:

The Quality Insights QPP support center team welcomes you to today's webinar. How to Report MIPS Quality Measures in 2020 Using Medicare Part B Claims. My name is April Faulkner and I would like to take a moment to review a few items before we begin the presentation.

April F:

All participants entered today's webinar in a listen only mode. Should you have a question during today's presentation, please type it into the Q&A box at the bottom right of your screen. We will address questions at the end of the presentation as time permits. If we do not have time to answer every question, we will provide a follow up Q&A email to all attendees with the information. Today's webinar is being recorded. The recording, along with the slide deck and a transcript of the webinar, will be posted on the Quality Insights QPP support center website within the next few days. These resources can be found on the archive events webpage. I have posted a link to that webpage in the chat box.

April F:

At this time, I would like to introduce our presenters. Joining us today are two members of the Quality Insights QPP Support Center Team. Joe Pinto and Marvin Nichols. I will turn over the presentation to them to get us started.

Marvin N.:

Thank you April and good afternoon everyone. Our team has prepared a wonderful webinar today that is full of great information and resources that will assist you in submitting quality data by claims. But first lets go over the learning objectives.

Marvin N.:

First learning objective is to provide an overview of the 2020 MIPS Quality category. We will identify quality measures that can be reported using Medicare Part B claims. We'll identify applicable patients. We will demonstrate how to report codes on claims and we will describe how to trach successful submissions.

Marvin N.:

Next slide deck please.

Marvin N.:

But first let’s do an overview of the quality category for 2020. Next slide.

Marvin N.:

As a refresher, the minimum MIPS score to avoid a penalty has increased to 45 points. So, that means that the payment adjustments have increased as well to plus or minus nine percent. So, in essence, if you score less than 45 points, you could receive a penalty of up to nine percent. Slide please.

Marvin N.:

Quality category has the highest weight of the four categories and should be reported to achieve the highest possible MIPS score. So Quality is worth 45, Promote Interoperability is worth 25, Improvement Activities are worth 15%, and the cost is worth 15%.

Marvin N.:

If the Promote Interoperability category is reweighted to zero, Quality category weight increases to 70%. Next slide.

Marvin N.:

The Quality category is worth 45% of your total MIPS score. The performance period is the full calendar year. The maximum points for the Quality category for clinicians and small practices is 60 points. And clinicians in smalls practices must submit at least one quality measure will receive six additional points that will be added to your Quality category score. Next slide please.

Marvin N.:

So your reporting requirements is to report six quality measures or one specialty measure set. If greater than six measures are reported, CMS will score your six top measures. You have to report at least one outcome or high priority measure and bonus points are earned if additional outcome or high priority measures are reported. You have to report at least 20 cases for each measure and report at least 70% of measure eligible cases. If less than 70% are reported, the measures will be worth three points for clinicians in small practices that, that's clinicians with 15 clinicians or below and is zero points for clinicians in larger practices. Next slide please.

Marvin N.:

There are two options that are available for individuals and groups. You can log into the portal and upload your quality data file, or submit directly, or have a third party intermediary submit the directly on your behalf. Additional options available to clinicians in small practices, is to submit quality measures via Medicare Part B claims. Additional options available to groups of greater than 25 clinicians, is to submit a specific set of quality measures using the CMS web interface. Next slide.

Marvin N.:

Measures can be submitted using more than one method to help you improve your quality score. If the same measures are submitted using multiple methods, the one with the highest numbers of points will be scored. Next slide.

Marvin N.:

So you can receive additional quality bonus points in the Quality category and those bonus points are: two points for each outcome or patient experience measure, one point for each high-priority measure, one point for each measure submitted using end to end electronic reporting, and six points for clinicians in small practices who submit data for at least one quality measure.

Marvin N.:

The first step is to ensure your eligibility. You can confirm your small practice status by visiting the QPP portal and checking your eligibility and then in that section you will see a special stance and it will have if you are determined to be a small practice.

Marvin N.:

Clinicians in small practices who do not have an EHR can earn points in the quality category by reporting via claims. Facility-based clinicians in small practices can submit quality measures using claims, even if some clinicians in their group use an EHR. Just a reminder, only Medicare patients are included when you're reporting quality measures via claims.

Marvin N.:

Step 2, so select the claims measures. There are 55 measures available in 2020 that can be reported. This includes five outcome measures and 27 high-priority measures. More than half can be reported by primary care clinicians and other measures are used for specialties. We have a link here that shows all 55 measures that can be downloaded from the PDF that was sent to you prior to this webinar.

Marvin N.:

These are the 14 measures that you can earn up to 10 points. You can earn up to seven points for 30 measures. These are some of them and the next page is the rest of them. As you can see on the left hand side, we have it broken down to the possible physician or possible specialty that can report the measure. So you can go back and review it at your leisure. Next.

Marvin N.:

We also have a list of measures that can earn up to three points, but there's potential of earning more than three points with these measure if a benchmark can be established after the 2020 data is submitted.

Marvin N.:

Select measures that are applicable to your practice so you can improve performance rates and increase your MIPS score. Most claim measures only need to be recorded once during the calendar year. With an exception of the documentation of current meds, that needs to be reported every visit. If you have difficulty finding measures that apply to your Medicare patients, you can review the codes that you frequently bill. Also, as you can see from that list that was just previously shown, there are only a few that are worth 10 points, so in order to receive the max, you are going to have to be strategic about the quality measures that you pick to perform.

Marvin N.:

You can use the 2020 Medicare Part B claims measures specifications and supporting documents as a resource. So what you would do is just open the folder called 2020 Medicare Part B claims supporting documents and from there open up the 2020 claims single source excel file.

Marvin N.:

This is an example of the single source document. As you can see it has four different tabs, you have the cover tab, the instructions tabs, codes tab, and the release notes tab. What you would do is identify your E&M management codes that you frequently bill to Medicare and click on the down arrow in the Code column D as illustrated. Once the arrow is selected, a drop down menu will appear. You will enter the code you would like to search for in the empty field and then select the okay button.

Marvin N.:

Column A will identify the quality measures that are related to the code that you entered. So in this example, the code that was selected was 99291 and then you will see the list of quality measure ID codes. See number one, number is diabetes, but you can use the 2020 Medicare Part B claims measure resource to identify the name of the measure that corresponds to the measure ID.

Marvin N.:

TO undo your search and enter anther code, you simply just click the arrow that is filtered and select clear filter from code.

Marvin N.:

Step three, identify Medicare patients for each measure. Each measure has a specific criteria that identify which patients are applicable to that measure. Criteria can be based off of age, gender, or specific medical diagnosis such as diabetes or hypertension. Measure eligible patients are documented in a denominator section of the measure specifications sheet. Each measure has its own specifications sheet based on the method in which the quality measure will be submitted. For claims reporting, you must use the resources 2020 Medicare Part B claims measure specification and supporting documents.

Marvin N.:

Here's an example of how to find the denominator. Look at the specifications sheet and look at the heading of the denominator and it spells out what are the patients that fit the denominator for this particular quality measure. In this example, for 113 colorectal cancer screening, that would be any patients 50-75 years of age with a visit upon the measurement period.

Joe P.:

Okay, thank you Marvin. And that will bring us to step number four in the process. This is the create new office workflow step. First of all, it's to begin with staff education. When we do say staff education, we are referring to all the office staff and that does include the billers, about the necessity to report quality measures in order to for your practice and clinicians to avoid the Medicare penalty and also more importantly, to improve patient care. You should provide a copy of the specification sheets to everyone in the practice so that they can see which Medicare patients are applicable to each measure, noting how often the measure has to be reported in 2020. Also, very important that if your practice does use an external billing company, we do advise that you make sure that they also receive the educational materials.

Joe P.:

First off as establishing a process to identify patens and if possible use billing software in order to flag claims every time that the combination of codes in the denominator is billed. You should create a formal process and document the policy to ensure that all denominator eligible patients are captured. This will also ensure staff that they know that they have to add certain billing codes to those claims before the claim is submitted to Medicare. Next slide.

Joe P.:

Step five is assigning codes to the eligible patients. As far as assigning the codes, adding codes to the claims to receive credit for reporting a quality measure, you must add a special code or a set of codes to the claim before it is submitted to Medicare. Now the code identifies which measure is reported and whether or not the clinician took appropriate action to improve the patient's health and also if the patient should be excluded from the measure, or if the patient should not be included at all due to special certain circumstances. Next slide.

Joe P.:

There is also the codes used for claims reporting and they are called Quality Data Codes or better known as the QDCs. QDCs include the CPT category two codes, that include with or without the modifiers and or the HCPCS G-codes. We've included at the bottom of the screen, for you to take a look at, a couple of examples of common QDC codes. The 0518F, including the appropriate modifiers. Also, the 0528F, with the appropriate modifiers. And the 3288F and 1100F code, along with the modifiers. Next slide.

Joe P.:

What do the QDCs represent? Well QDCs identify whether the measure performance was A: met, meaning that appropriate care was given and documented, B: not met, meaning that appropriate care was not given or not documented for that particular patient encounter, C: an exclusion, meaning that a circumstance when the patient should be removed from the denominator, and D: and exception, meaning that a patient falls in to the denominator but meets a circumstance defined in the measure specification that allows the patient to be removed from the denominator. Next slide.

Joe P.:

Where can you find QDCs? Well, they're located in each measure specification. Once again, we're going to show you, as Marvin did earlier, the measure specs for ID 113, that is for colorectal cancer screening. You can see that on the screen shot on the right of your screen, we've also included some of the codes that would be relevant for this particular measure. The 3017F code, meaning that the measure was met. The 3017F with the AP modifier, indicating that the measure was not met. Also, the three exclusion codes, which are the G-codes: 9710, 9711, and 9901. Next slide.

Joe P.:

There are also a number of different QDC resources available. One that we do want to point out to you is one that Quality Insights has developed. It's a resource that lists the QDCs for 17 of the most commonly reported claims measures. That particular tool that you can utilize in our resource section is

entitled the 2020 QDC Worksheet for Reporting Quality Measures Using Medicare Part B Claims. Now this resource can be customized to only include the quality measures that your practice will report in 2020 and it's very simple to use. All you need to do is select the most appropriate QDC that corresponds with the action taken during the encounter. Next slide.

Joe P.:

Next slide you'll see that there is a screenshot of the Quality Data Code Worksheet, that includes the 17 claims measure that was previously mentioned. We have the measures listed for you along with the identification number that is assigned to that quality measure and the page in which you can find the measure specifications for the measure. Next slide.

Joe P.:

As far as using the QDC Worksheet, all you need to do is print a worksheet for every Medicare patient that falls into the denominator each day and write their name, date, clinician that is applicable to that patient at the top of the form. Ask the clinician or the assigned staff to check the box for the most appropriate QDC at the end of the office visit or day, however that fits into your specific workflow. Then given the completed QDC worksheet to your biller so that the QDC code or set of codes can be added to the claim prior to submission. Next slide.

Joe P.:

We have a couple of examples of measure examples of what you can find on the QDC Worksheet. The two that we've selected are the high blood pressure screening and follow up measure that is ID number 317. As well as the pneumococcal vaccination measure, ID number 111. You'll see on your screen that we've included the reporting frequency for the measure, the denominator in terms of the age in which it's appropriate for those patients, as well as the tracking information, does the code in 620 appear on the RA or BOB. And we're going to be talking about that particular code coming up shortly. In addition to that, you have the G-codes and when they would be applicable to that particular measure. Next slide.

Joe P.:

So step number six is completing the documentation on the claim. This is very, very important. To complete the claim form and receive credit, the Medicare Part B claim can be submitted either electronically or via the CMS-1500 claim form. All you need to do is enter the appropriate QDC in the QDC field and that would be line-item number 24d on form. And then an entry in the line-item charge field is also required. So, what you would need to do is enter either a zero dollar amount or a one cent dollar amount in the line-item charge to every claim that has a QDC. Next slide.

Joe P.:

As for submitting claims, the last day to submit a claim with a QDC for 2020 is determined by the Medicare Part B administrative contractor, more commonly known as the MAC. For the states of Delaware, New Jersey, and Pennsylvania, the MACs in those particular states are Noridian Healthcare Solutions and NovitasS. And for those of you in the state of West Virginia, your MACs are Palmetto GBA and CGS Administrators. Keep in mind that all claims must be processed no later than that 60 days after the end of the performance year. Next slide.

Joe P.:

Step seven is talking about tracking claims with a QDC. We strongly urge you to implement a tracking process. It's very important for you to track the claims with a QDC to ensure that you receive credit for reporting each quality measure because as you know for 2020 there is a 70% data completeness requirement to earn the maximum quality score. The one resource that we like to bring up is the 2020 Quality Measure Tracking Sheet for claims reporting. You can see a screenshot on your slide right now. This form can be used for tracking a lot of information for the Medicare Part B claims. You would enter the date of the office visit, the patient's name, the quality measure ID, any of the QDCs that are submitted for that particular measure including the date that the claim was submitted, and then for follow up purposes dating the RA or EOB received and whether or not the N620 code appears. Next slide.

Joe P.:

Next up is checking your remittance advice, the RA codes. When you do successfully submit a valid QDC, the RA or EOB, and EOB is your explanation of benefits, they will list the CARC code. CARC is the acronym for Claims Adjust Reason Code and that would be number 246. There is also the RARC, that is the Remittance Advice Remark Code, N620. And Group Code CO or PR, now CO is the acronym for Contractual Obligation, PR stands for Patient Responsibility. For code N620, it tells you that the QDC or QDCs, in terms of multiple, are valid for MIPS reporting and QDC line-item was billed and thus the claim will be used to calculate quality reporting. If the N620 code appears, then when you bill the 00 line-item, be insured of that. Also, CO 246 N620 will appear when you bill for a one cent in the line-item, which once again is line-item 24d on the claim form. One note to make you aware of, code N620 does not guarantee that the QDC was correct or that the reporting thresholds were met. Next slide.

Joe P.:

It's also very important for you to follow up when the N620 code does not appear. You need to check to see if the QDC and line-item charge were on the same claim and were billed together. If you use billing software, you should check to see if it is transmitting the QDC with a zero or that one cent charge in line-item 24d. Also, check with your MAC to ensure that the codes came through on the same claim and ask how they process that claim. Also, finally in the process, you should check with your clearing house to ensure if they received the QDCs and that it is transmitting those QDCs to the appropriate MAC in your state. Next slide.

Joe P.:

So, what do you do if you have denied claims? If your MAC denies payment for all billable services on a claim, the QDCs will not count towards the quality measure or be included in final MIPS analysis. If you correct a denied claim, however, and it gets paid through and adjustment, reopening or the appeals process with an accurate code that corresponds to a measure's denominator, then you can include the QDCs on the corrected claim. Next slide.

Joe P.:

As for resubmitting claims, claims cannot be resubmitted to the MAC for the sole purpose of just adding or correcting a QDC. However, claims can be resubmitted to correct and or add the line-item charge associated with the QDC just as long as the QDC was present on the original claim. Next slide.

Joe P.:

So next up we are going to talk about the summary and the resources, just to summarize everything that we discussed today and the informational session. Step number one, select the measures applicable to your Medicare population. Step number two, identify Medicare patients eligible for each quality measure. Step three in the process, make sure to add the QDCs on the claims that reflect the action taken during the encounter. Step four, enter the line-item charge. Make sure, this is very, very important, either the zero dollar amount of the one cent charge on the claim in line-item 24d. Step five is to submit the claim. And the all-important step six, track the claims with the QDCs by checking those remittance advice codes. Next slide.

Joe P.:

We also want to make a point to remind you that the quality measure data that is submitted for calendar year 2020, will not be available for you to view on the QPP portal until at least January 2021. So, if you're looking to follow up on the information from your claims to see where you are in the process, you will not be able to access the information until it is posted on the portal beginning a year from now, in January 2021. So just keep that in mind. Next slide.

Joe P.:

Finally, we just want to bring up some important information in terms of the resources for the claims reporting. I mentioned earlier about the various resources. There are a multitude available for you. Quality Insights does have a list of these four individual resources for the 2020 MIPS reporting year available in our resources library. You can just click on the link in the handouts that were provided to you. Also, CMS has an additional listing or resources as well, through the QPP website. You can check their resources in addition to the ones that are available through Quality Insights. That pretty much concludes the informational portion of today's webinar so I'll hand things back over to April for the questions and answers session.

April F:

All right, thanks so much. At this time we will move into that Q&A portion of the session. If you have any questions for our team please type them in the Q&A box at the bottom right of your screen. If you have already submitted a question, we will go ahead and address it now.

April F:

First question: Will Medicare as secondary and Palmetto claims count as eligible patients? And in parentheses they have Palmetto for railroad Medicare.

Marvin N.:

I'll take that one. So Medicare is going to look at your Medicare Part B claims. If you're charging on the Medicare Part B then it's going to look at those patients. If it's not charged on the Medicare Part B, then it's not going to be a part of the regiment set. Yes.

April F:

Okay. Let's see, we do have another question, again if you have questions-

Marvin N.:

I'm sorry. If he needs anymore follow up he can reach out to one of us and we can go into that in further detail.

April F:

Okay. And now this is kind of a two part I'm going to read. Can you clarify the reporting requirements of 20 patients minimum based on 70% percent of your patients? They went on to explain if CMS does the calculations based on claims processed, what opportunity does the provider have to calculate 70%?

Marvin N.:

I'll take that one as well. And I see that our colleague, Lisa, has given him some excellent information so I won't repeat what she says to him. What I will say is Joe went over that we have a tracking system, a tracking system resources, that's available through Quality Insights that will help you keep track of your patients and hopefully, by using that document plus whatever internal tracking mechanisms that you're using, that you will know that you are meeting that data completeness rate of 70%.

April F:

Okay. Another question has come in. Will there ever be a set of quality measures for pain management?

Joe P.:

That's a good question. I wish that we had a definitive answer for that particular question. That is based on how CMS is going to operate from one year to another. There are measures that are added every and removed the MIPS program each year. As we go along, and I would assume that because pain management is one of the newer specialties that are approved for MIPS reporting that they will be adding as we go along, so we're pretty much in the dark on that as well as the practices are in terms of when certain measures will be added to the program and made available.

April F:

Okay, and here's a question for me. When and where will these slides be available? If you look in the chat box on your screen, scrolling up to the top, I do have in there a link where the slide deck recording and printed transcript will be posted. The slide deck will be there within the next day. So it's on the QPPsupport.org website under the archived events page.

April F:

Now we're going to go back to the team. Is it possible to use a registry for the first six months of data mined and the claims base for the second six months of data submission

Marvin N.:

Hi, this is Marvin again. So, no, and the reason why I say no, and anyone can chime in from the team if I am given incorrect information, but my understanding is that when you submit quality measures for a whole year... Now you can submit any [inaudible 00:32:34] but that method still has to be completed in the whole year. And what I mean by that, is if you're going to do via registry, you have to use the registry for the whole year. If you're going to submit via claims, you have to submit the whole year. If you're going to use the EHR, you're going to have to submit the whole year. Hopefully someone will say yay or nay if I'm on the right track of that question.

April F:

And in the meantime, another question came in. What are the options for resubmitting the code if not submitted on the initial visit claim?

Joe P.:

I can take that one April. Basically you're going to want to check with the MAC that is operating in the state that you are practicing in for some guidelines on the resubmission for the claims that would include the codes. And remember, I did mention earlier during the informational part of it, that resubmissions for the claims cannot be done through the MAC for the sole purpose of just adding or correcting your QDC, so you can actually resubmit correct or add the line-item charge associated with QDC, as long as you did have the QDC already on the original claim. But definitely check with the MAC in your individual state for some clarification on that.

April F:

Okay.

Marvin N.:

And April, I want to go back to the question before, to Patricia's question. When I say no, what I mean by no, is that you won't get full credit. So if you submit six months' worth of data to QPP, you're not going to have the data completeness rate so therefore, your small practice, you're only going to receive three points for each quality measure. Yes, you may be able to submit but, no you're not going to get your full credit or worth of data, so that's what I mean by no. I just wanted to clarify that.

April F:

Okay, and another one. Are the quality measures pretty much the same as they were last year?

Marvin N.:

So the quality measures have changed a bit. We have resources at Quality Insights that has identified the new quality measures and we've identified the ones that have been removed. If they are not on the

list of resources that are available with this document, if you reach out to us we can identify the measures that you have in question.

April F:

Okay. Isn't there a code you submit on a claim that signals to Medicare that you are reporting measures on claims?

Marvin N.:

Yes, it is, and Joe went over that on his portion of the presentation. Those were the QDC codes. When you submit your claim and you submit your claim with your procedure codes and your CPT codes, you're also going to put that QDC code in there and the QDC code lets Medicare know that, "Hey, we want this code to be submitted with this quality measure. We want this patient's information to be submitted with this quality measure." When Joe was explaining what those QDC codes were, that's the code that you will submit with the claim.

April F:

Okay, so someone is asking: So there is no longer a single code as there was with PQRS?

Marvin N.:

Each measure has their own list of codes. So there is not one single code.

Joe P.:

Right. You basically need to look at the measure specifications for the measure that you are submitting the claim for. It will indicate which of the codes and the G-codes and the modifiers that are applicable for that particular measure.

April F:

Okay, this next question comes from a provider that does not have the capacity to generate reports. He says I also go to 10 nursing homes, all of which have different EHRs in which I document care. I use a billing company for all billing. Where do I begin? I did not see many quality measures specific for psychiatry.

Marvin N.:

Just reach out to us... You're a special case. We've run into certain clinicians that actually are in the same position that you are. We would have to work with you one on one to determine what's best to get your data basically. Reach out to us and one of the practice transformation specialist will have a one on one with you.

April F:

Okay. Another question came in. We are a small practice, to submit via claims, we would need to begin next January 2021, to receive full credit? Is that correct?

Marvin N.:

Sorry, can you say the questions again, I'm sorry.

April F:

No problem. They said they're a small practice. They're wondering if they... To submit via claims, would they need to begin next January, of 2021, to receive full credit?

Marvin N.:

For... Oh okay, actually another one of our colleagues is going to reach out to you. Rebecca is going to reach out to you because, that's a little...

April F:

Specialized?

Marvin N.:

Yeah, a little specialized, yeah you can say that.

April F:

Okay, here's another one. Can I submit measures that fall in the PCP category, possible reporting physician, if I am a specialist?

Marvin N.:

So the short answer is you can submit any quality measure you would like, and if it fits your practice, and if it's applicable to your practice, you can submit any of them. The reason why the specialists measures were created was to... You can submit quality measures for anything. You don't have to be a specialist to submit a particular quality measure. [inaudible 00:40:46]

Joe P.:

Yeah, and just one addition to what Marvin is saying on that as well. What you need to do is to check the listing of the measures for the 2020 performance year on the QPP website to ensure that the measures that you intend to submit via claims data method, reporting method, are eligible to be submitting via the claims reporting method because some measures can only be submitted electronically and others are eligible for you to select via claims. If the measures specifies that it cannot be submitted via claims, then if you are utilizing the claims reporting method, then you wouldn't be able to select that measure and get credit for it.

April F:

Okay, any other questions? Oh, I do see another question. Can you still report via both claims and registry?

Marvin N.:

Absolutely. The beauty of the submission method is if you submit any method, CMS is going to take your top six. So, if you submit via claims, if you submit via registry, if you submit via EHR, CMS is going to look at top six and give you top six scores.

April F:

Okay, I see no further questions, but I did put up on the screen our contact information so if more questions arise people can feel free to reach out to us and we'd be happy to answer them. I want to thank everyone for joining us today and just a quick reminder, when you close out of today's session, you will automatically be directed to a very brief evaluation. Please take a moment to complete it. We greatly appreciate feedback and comments. Please note that the next edition of QPP live will be held on Thursday, February 20th at 9:30AM. I have posted a registration link in the chat box, we hope you can join us. Thanks again for joining us today and have a great rest of the day. The session has now concluded.

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