Laurie Fink: Good afternoon, and welcome to today's webinar, Reporting Quality Measures Using Medicare Part B Claims. My name is Laurie Fink, and I'm a communications specialist with Quality Insights. I will serve as the host for today's session. For those listening to the recorded webcast, welcome, and thanks so much for watching. We will get started with the presentation in just a few moments, but first I'd like to go over a few housekeeping items.

Laurie Fink: All participants enter today's webinar in a listen only mode, should you have a question during today's presentation we ask that you please type it into the Q&A box in the bottom right of your screen. We will address all questions at the end of the presentation as time permits. If we do not have time to get to every question, we will make sure to provide you with answers via email after the discussion.

Laurie Fink: Today's webinar is being recorded. The recording along with a tri-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 archived events page. A link to this webpage can be found in the chat box.

Laurie Fink: Joining us today to talk about the 2019 MIPS Promoting Interoperability Category are three members of the Quality Insights QPP Support Center team, including Marvin Nichols, Roxanne Fletcher, and Kathy Wild. Without further ado I will hand over the presentation to Marvin to kick things off. Marvin?

Marvin Nichols: Thank you, Laurie. Today our learning objectives will be to define what the 2019 MIPS Quality Category requirements are. To identify quality measures that can be reported using claims. To identify who can submit quality measures via claims, and to demonstrate how to select measures, and how to report measures, and finally to describe how to track successful submissions. Next slide.

Marvin Nichols: What I would like to do first is to go over the 2019 Quality Categories. For 2019, you need to reach a neutral threshold of 30 points in order to achieve the neutral threshold. The 45% weight of the Quality Category is the highest of all weighted categories. Next slide, please.

Marvin Nichols: Here, we have the data for the category weights, so as I just mentioned the quality category is 45%, plus promoting interoperability category, which is 25%, and the improvement activities, which is 15%, and the cost category is 15%, as well, totally a 100%. Now, if you're promoting an interoperability category, reweighted to zero, the quality category will then increase to 70% leaving the improvement activities at 15%, and your cost category at 15%. Next slide, please.

Marvin Nichols: The performance period for the quality category is full calendar year, from January 1st, 2019 to December 31st, 2019. You must report at least six quality measures, or a specific measure set. One measure must be an outcome, or a high priority measure. If you report more than six measures, CMS will score the six measures with the highest performance rates. Bonus points are also earned if additional outcome, or a high priority measures are reported. Quality measures can be reported by clinicians in small practices even if the practice does not have an electronic health record.

Marvin Nichols: There are two different ways to report. You can report via individual, or you can report by group. The data submission options are direct submission, log in, and upload, Medicare Part B Claims, and CMS web interface, if you have groups with 25 or more clinicians. Please note that quality measures cannot be reported by attestation, which is the manual data entry. Next slide, please.

Marvin Nichols: New reporting option in 2019. Measures can be submitted using more than one method. If the same measure is submitted using multiple methods, the one with the highest number of points will be scored. Next. Roxanne, who can report quality measures using the Medicare Part B claims?

Roxanne Fletcher: Sorry about that. I was on mute. I apologize. That's a question I do get asked quite a bit about. Medicare Part B claim submission. In 2019, reporting quality measures using claims is only available to clinicians in small practice, and again a small practice is made up of 15 or fewer clinicians billing under the same group TIN. You can check your status, whether you're with a small practice designation by entering in your NPI in the QPP Participation Look-up tool.

Roxanne Fletcher: We are providing the link on the slide that you'll be receiving, but the other place that you can always go is go to qpp.cms.gov. That will take you out there, and you'll see a tab that says, MIPS, you click on that, and you'll see on the left hand side it says, look up your NPI to see if you've got your participation. Here, we'll show you what you're looking at clinician levels, small practice desk, especially at a small practice desk, so it has clinician level and practice level. Next slide, please.

Roxanne Fletcher: Who can benefit from reporting from claims? This is usually done by practices that do not have an electronic health record system. They can earn points in the quality category to increase their total MIPS score. As Marvin stated a few minutes ago, you must have a score of 30 points to avoid the 7% penalty in 2021. Previously, we could get away with reporting an improvement activity, but that is not enough for this year. We do encourage you to listen up, and if you haven't submitted a claim yet, get ready to get that then in place. The facility based clinicians in small practices can submit quality measures using claims, even if some their clinicians in their group use an EHR. Okay. Like,

Marvin had stated before you can submit quality measures more than one way. Next slide.

Marvin Nichols: Great. That's great, Rox. Thank you. There are over 250 quality measures. How can a clinician, or a clinicians practice know, which ones that are reported via claims?

Roxanne Fletcher: Let's look at that. I'll take that on. For claims support reporting, there's 64 quality measures. We've generously, again, on the slides given you these resources that you can link to. The quality resources has their own list of measures, and this link will take you to our list of the approved Medicare Part B Claims measures.

Roxanne Fletcher: Then, CMS has a zip file of all 64 claims. Where is that? That's located, this link, so let me explain, this link can be found, again, at that qpp.cms.gov website. You click on that MIPS tab, again, and you go down, and on the left hand side it will say, review, explore measures and activities. Once you click on that, you'll go about mid page, and you'll see this document right here, 2019 Medicare Part B Claims Measure Specifications and Supporting Documents. Next page.

Roxanne Fletcher: Here, and in a few minutes I'll kind of explain this a little bit greater, but there are 18 measures with 10 point maximum. This is the most that you can get for quality measure is the 10 points. These items here, these 18 is the ones that you can earn these 10 points for. The next two slides we'll see there's 33 measures that have a maximum of seven points. Basically, what's happened here, there's a benchmark, and they've been capped out, topped off as you cannot earn more than seven points for them.

Roxanne Fletcher: Then, we have a small group of measures, the next page that are topped out at core, three. What this is, quality measures with an asterisk have the possibility of earning more than three points, if a benchmark can be established using the 2019 data. What's great is if you print out these three slides, these four slides, you can kind of use that as a guide to see, one, what they are, and I think they may indicate if they're a high priority or process. The next page.

Marvin Nichols: Thanks again, Roxanne. I'm a group of clinicians, that they want to be the best, they want to be high performers, what are some of the best practices that you can suggest to give them a maximum quality category score?

Roxanne Fletcher: All right. Let's go over that. Of course, CMS recommends that you report six measures to get the best possible quality score, highest score. One of them being an outcome or a high priority measure. Like I said, that previous list that we looked at, if you look at them, you can select them and see, which one would be an outcome or high priority measure. Then, the best thing to do is try

to select measures that are applicable to your practice. If you select them of course it's easier to meet that mark of reporting for them. The special note here, only Medicare patients will be captured when you report via claims.

Roxanne Fletcher: When you're looking at, for instance, current medications, review of current medications, that would basically cover your total patient population. But, for the purpose of quality measures for those who are submitting claims, we're only going to be looking at Medicare patients, so the only ones that will be captured. When we get further down the list here, you'll see that with the denominator you're going to when you go to specifications it will tell us what the requirements are for each measure. Again, you're only reporting on Medicare patients. Let's see what we have next.

Roxanne Fletcher: Measure reporting requirements. This is to increase your chance of receiving the maximum number of points, and you must meet these three requirements. One is case minimum. We do recommend that you report data for a minimum of 20 cases per measure. That you report data for at least 60% of the Medicare patients included in each measure, and that you select measures that have a benchmark. Again, as we have seen previously those with a benchmark have higher point value.

Roxanne Fletcher: Then, I wanted to review number one again, report data on a minimum of 20 cases. You're thinking, oh, God, six measures, 20 cases, that's like a 120, not necessarily, and let me specify what I'm saying. If you have somebody that's coming in, and you're doing a full risk assessment, you're also maybe reviewing their current medications, so basically that one person can count for the two different measures, so kind of keep that in mind, don't feel overwhelmed, we're going to give you some tools a little bit later in the presentation on how to manage this. Next slide.

Roxanne Fletcher: Benchmarks. I have a lot of practices that say, "What the heck is a benchmark?" It's the process of comparing your performance with an external standards. CMS does this benchmarking to assign points to each measure. They are based on the performance of those who reported the measure two years earlier. Measures with benchmarks are worth up to 10 points, unless they are topped out and capped, in which case they are worth up to seven points. Here we provided a link that will give you access to look at the whole list of the topped out quality measures. Again, the list that we looked at earlier we saw, which ones were worth 10 and, which ones had been topped to cap at seven points. Next.

Roxanne Fletcher: Measures without a benchmark. If a measure cannot be reliably scored, benchmark meaning greater than or equals 20 cases, and then greater than or equal to 60% of eligible cases the maximum score is reduced to the following. If

you're a small practice, you do get little extra bonuses there by you get three points for a measure without a benchmark. Then, if you are with a bigger practice, a large practice, which is made up of 16 or more clinicians, then you're only earning one point. Again, we have a link here that will take you to the 2019 quality benchmarks. Next slide...

Marvin Nichols: How can my practice pick out the best quality measures that are applicable to my practice?

Roxanne Fletcher: Let's take a look at that, Marvin. Let's see. It says one of the best things to do is check codes for common diagnoses. A lot of times what I'm asking, talking with a practice about this I'll say, "What codes are you using? What diagnosis do you use the most frequently?" There is a resource, and it's called the 2019 Claims Single Source, and we're going to provide some information in a few minutes on what that looks like, and kind of guide you through that.

Roxanne Fletcher: Another place is to locate it, it's a folder called, Medicaid Part B Claims Spec Supporting Documents. You can download this. Again, that's at that qpp.cms.gov website. You go out to that, and you again click on the MIPS tab that's on exploring measures, and it will take you here, and you'll see this document, and when you click on that document it will give you the different measures that are available.

Roxanne Fletcher: If we go to the next page, let's go into a little bit more to this claim single source. When you go out there, you'll see this page, it'll have your cover, your instructions, your codes, and your release notes. For the purpose of this, we want to concentrate on the codes. Next slide.

Roxanne Fletcher: To search by code, first you're going to identify your most commonly billed HCPCS or E/M codes in your practice. Then, you're going to click on the down arrow in the code column D. Right here. Then, the next slide. Then, once the arrow is selected a drop down menu will appear. Then, you can enter your code in the empty field, and select the okay button. Then, from there it's going to bring up the results. Then, the results shows measures that include the specified codes, so you can see there's more than one measure, and you're thinking, how do I find the measure ID? We're going to get to that. All right. Next slide. To undo your search and enter in another code, click the arrow that is filtered and select clear, and for your filter from the code. Okay? You can do that, and search another one.

Marvin Nichols: Great, Rox. Do I have to report for all my Medicare patients? Do I report for some Medicare patients? Do I report for all my patient population? Explain that to me, please.

Roxanne Fletcher: Okay. I'll be happy to do that, Marvin. A measure specification, so to identify denominator eligibility cases. This again, that I was referring to is finding out what the specs are particularly for that measure. After selecting measures, review the specification for each measure.

Roxanne Fletcher: Again, that sweet spot is that 2019 Medicare Part B Claims Measure Specifications and Supporting Docs. Then, you're going to measure or list it separately in a QPP resource library based on the method in which the quality measure will be submitted. When you go to this, you're going to, there's a little search area where you can actually search different measures yourself, but you want to make sure that you're selecting the 2019 Medicare Part B Claim. Next.

Roxanne Fletcher: A measure specification provides a detailed description of the measure's data elements, such as the measure types, the numerator, denominator, codes, et cetera. You're going to pay attention to the denominator criteria to see, which patients qualify for each measure, and they'll give you age, gender, this ICD-10 codes, the HCPCS codes, that type of thing is all going to be included in this specification. Next page.

Roxanne Fletcher: Here's an example. One of the first questions I get, what's the ID? The ID number that you're looking for is where it says quality ID 113. I know in the past with meaningful use a lot of it was the NQF numbers that we were looking for, but here when we go to search the specification we're looking at this quality ID number, is what we're searching for. Kind of gives us, and it states here, because we done a search by Medicare Part B, yes, the collection type is for the Medicare Part B Claims. This is a process.

Roxanne Fletcher: It's a process, and it gives me a description of percentage of patients within an age group that appropriate screening for colorectal cancer, in this case. It kind of breaks down what the instructions are and measure submission types, the denominator, here we're looking at the denominator. You can see what your CPT, or HCT codes are that you must have listed in order to submit your quality measures. There's a couple of different steps. One, you have to make sure that you have one of these codes in there, and then you also have to have a numerator code. Next page.

Marvin Nichols: Thank you, Rox. Thank you so much.

Roxanne Fletcher: You're welcome.

Marvin Nichols: I want to bring Kathy into this conversation. Kathy, I have a question for you. If I'm a practice, how can I get organized to ensure that I'm capturing all the patients and to ensure that my performance rate is correct?

Kathy Wild: All right. Hello, Marvin and audience. First of all, we want to remind you that we're available to help you, so please call us. So far, we've thrown out at you a lot of links to resources, and they're on the QPP website, we have developed some, but what I'm going to do now is try to walk you through it to show you exactly what has to be done. There is education involved, and there's creating a new office workflow.

Kathy Wild: The one thing you do after you select your measures is you've got to make sure that you have a process in place, so that all your denominator eligible patients are accurately identified on the claim. I'm going to give you an example. If you pick the measure for depression, you want to make sure that all the people that have a diagnosis of depression are identified, and you know that you're going to go ahead and do that quality measure for that.

Kathy Wild: The same would be true if they had a diagnosis of hyper tension, or diabetes. Then, one thing that I love that Rox pointed out is that what you can do with some of these prevention measures, prevention care and screening, is that you can actually collect data from multiple measures on the same patient. I'm just going to give you an example of some of those measures that might be applicable to the same person during the same office visit.

Kathy Wild: If you decide to do influenza immunization, pneumococcal. If you want to do the tobacco use screening, or the BMI screening that is something that if you collect those data on those five measures, you would have that patient, and get credit for all of them. That's the one thing you want to do is just make sure that everyone in your practice knows, which measure you're going to do, including your billers, they have to know that, so that they know that, okay, we have to focus on what's going to be done, and make sure we provide that, and do that measure, so that we get credit for doing it.

Kathy Wild: The measure specs that Roxanne just showed you a minute ago are like the Bible. Once you go ahead and select the measures in your practice that you're going to report, print those off, and share them with everybody during a staff meeting, so they kind of see them kind of explain what's going on. This is how I get credit, so it would just help everyone go ahead and get your quality score higher. Next slide, please.

Kathy Wild: Okay. Another thing to do is use billing software. If you are able, and you have billing software available, that's going to be able to assist you with the claim's submission process a lot, because then you could set the software up to go ahead and flag those claims for those denominator eligible cases. Like, we said, you would use the spec, flag those codes in there, and then that would show you that, oh, I have this patient today that would be applicable for this quality measure. That would be very helpful. It will also ensure that your staff know

that they have to add this certain billing codes that I'll go over in a minute, before the final claim is submitted. Next slide, please.

Marvin Nichols: Thanks, Kathy. That was an excellent example of how clinical workflows should work in a practice. Let's just say, my staff knows the clinical workflow now, and we're billing correctly, how do I know if Medicare is receiving the claims that I'm reporting?

Kathy Wild: Okay. Next slide, please. Of course, because we're dealing with claim forms, we are also going to deal with codes, so CMS created what's called Quality Data Codes, and we often refer them to QDC's. They actually identify, which measure you are reporting for MIPS, so attaching these, when CMS sees them they'll know, which quality measure, oh, I see this code therefore I know you're capturing data for the BMI measure, or the tobacco measure. Just so you know, the QDC's are codes that you're probably familiar with. They involve CPT category II codes, with or without modifiers and then there's also called the HCPCS G-codes, which I think everyone has experience with. Next slide, please.

Kathy Wild: What exactly do QDC's represent? They know the code is specific to whether the measure performance criteria was met, or not met. For example, if you're assessing someone for tobacco smoking, one of the first things you do on it is ask them if they are a smoker, or not, so if you've identified that patient as being eligible for that measure, and you ask that question, you will get credit, so you would put a specific code down. If you don't ask that question during the office visit, therefore you would have to put a different code down that says, no, I did not ask them, therefore I don't get credit for this measure.

Kathy Wild: In addition to the codes for meeting the measure or not meeting, there's codes that have to do with exclusions and exceptions. I kind of get them confused. Luckily on the specification menu sheet they go ahead and they'll specify that for you, but just to briefly describe them, so the exclusions describe a circumstance when the patient should be removed from the denominator.

Kathy Wild: An example for that, would be breast cancer screening, if you're doing that measure. Someone with a bilateral mastectomy they can go ahead and be excluded from that. Also, if you've got patients that is receiving hospice services, a lot of the preventative care and screening measures they would be excluded from, such as pneumococcal vaccination, colorectal screening, things like that.

Kathy Wild: Then, we have the exceptions, they occur when a patient falls into the denominator, but there's special circumstances in the measures that allow these patients to also be removed from the denominator. I'll give you an exception of that. For the flu vaccination, if there is a reason, if you never ask the patient about it, then that would be not met, however, if you've asked the

patient, and there are reasons why it was not given, you can specify that, and then therefore that patient would be excluded from the denominator, too.

Kathy Wild: Some examples for the flu vaccination would be the patient, the doctor documents in the medical record that the patient is allergic to the vaccine, or there's some other medical reason why he could not receive it, or the patient just declined it. Will it completely remove that patient from the denominator, or it could be the vaccine, you don't have it available in your office at that date. Just so you know that you did ask that question, but this is the reason why it wasn't done. Next screen, please.

Kathy Wild: Where do I find these QDC's? They are in that measure specification sheet. Basically, like I said, they are kind of, there's usually at least two. One, for a performance met. One, for a performance not met. Then, if there's an exclusion or exception those are also included. What you would want to do is go ahead and pick that code that specifies with what action was performed during that patient encounter?

Kathy Wild: Just again, I want to remind you that everything should be documented in the medical record, so that when the biller goes to see, which QDC code to attach to the claim, they can go ahead, and look in the medical record, and say, "Yes, for this patient, for the tobacco smoking cessation that they were asked the question never smoke," or whatever, so that they would know to pick yes, I met this measure. As you see, if they are in the denominator then the choices are yes or no, and those are the exclusion, the exception patients, they're not included when they go to analyze your data. Next slide, please.

Kathy Wild: Here's an example, I'm going to stick with the colorectal cancer screening, which is one of the claims measures. Roxanne, showed you part of this specification, what I highlighted here is where the actual QDC codes are. For this one, as I stated, if a patient is receiving hospice services then they would be completely eliminated from looking at this measure. What you would do in that case is put that code down, G9710, that tells CMS that this patient is excluded from the denominator. Another reason is if you don't do the screening, but you have some other medical reason, and once again that's going to be based on what that physician, clinician states in the medical record during that encounter.

Kathy Wild: Now, if the measure is met, that colorectal cancer screening results are documented and reviewed in the chart, then that means you met the measure, then you can go ahead and add that CPT23017F code on the claim form. That means you met the measure, and you would get credit towards your quality measure performance rate. Now, however, if the performance is not met, if the results were not documented or reviewed, then you would go ahead and have

to put this other code in, and that tells them that you have to count this patient in your performance rate, but that the measure is not met. Next slide.

Kathy Wild: What I am going to do here is, this is we are really pleased that we finally have this worksheet ready for you. What we did is we took the top 17 claims measures, there's 64 of them, the ones that aren't really very specific to a certain condition, and we created a worksheet, and included all of those QDC codes, we included the, let me see, hold on, the other important things, like the reporting timeframe, and things like that for you.

Kathy Wild: We put it together in a sheet where you can print it, it's four pages, if you double side it, it's only two, staple that together, and then for every patient you see where you know you're going to be doing a quality measure, attach that with your chart, so that it can be easily, someone could circle it while the encounter is going on, and then the biller would have all that information readily available, they wouldn't have to look at the specification manual, because the codes are right there in front of them.

Kathy Wild: We think you'll find this very, very handy. Once again, it will tell you the maximum core available, the frequency, and remember for some of these measures you only have to report on a patient one time for the calendar year, and then some of the measures are once every office visit, and that varies on what exactly you're measuring. There are a couple that are even more specific than that, such as the flu vaccination, I'm sorry, is only applicable once during the flu season, so it would be like September to March.

Kathy Wild: Anyways, all of that is readily available, and has the denominator on there, so that you know if we're doing depression the patient has to be over 12. If we're doing screening for high blood pressure, the patient has to be over 18, so it's something that we think you'll find very handy. In addition to having the link for it here, it's also on our Quality Insights website. Next slide, please.

Kathy Wild: This is just a screenshot of what our QDC worksheet looks like, and this is just the very top of page one. What we've got here is a place for you to write the patient name, the date of the office visit, who the clinician is that seen the patient. Then, the first box at the left gives you those 17 commonly billed claims measures. Then, the box at the right is just an example of the screening for high blood pressure measure. Then, once again, there is your score frequency denominator, and all the codes. Next slide.

Marvin Nichols: Great information, Kathy. What if I'm a practice on this webinar, and I've identified my quality measures in the accompanied Quality Data Codes, where do I document this code on the claims, and more importantly when do I document the QDC code on a claim?

Kathy Wild: All right. I'm going to see if I can answer that for you. These QDC's, these codes, get attached right onto the claim. Remember, it's important for you to try to attach one to everybody that's in that denominator, which ever population you're looking at for that measure, you're going to try to do it.

Kathy Wild: Now, CMS knows that everyone's going to miss some, so therefore they have set the goal for 2019 for data completeness is 60%. What that means is for 60% of the patients you've seen, during the reporting year they want to see data on that. Now, the good thing is everybody that can report using claims has to be in a small practice, because that's all it's eligible for.

Kathy Wild: Even if you don't report 60%, even if you don't report 20 cases, you will still receive three points for each quality measure submitted via claim. I'm going to repeat that again. Even if you haven't started, and you report one patient for six different measures, you're going to get six measures times three points each, 18 quality points just for reporting on one patient each.

Kathy Wild: Additionally, I don't have this here, but there's what's called a small practice bonus, so you're going to get another six points added to your quality numerator, so you would have 18 plus six, you'd have 24 quality points just by doing one patient for one measure. Now, we don't encourage that, I mean, but it's the bare minimum to help you get through this, so that you're not totally overwhelmed. Next slide.

Kathy Wild: Marvin, you had asked where do you document it? Most of you are using the CMS-1500 claim form, so the field to write the QDC is actually item 24d, and then just note that if you're in a critical access hospital method II, and you use claims, also, you can also go ahead, and you're in a small practice, you can submit QDC's, but it would be on your 1450 claim form. Next slide.

Kathy Wild: The deadline. The reporting deadline for this year, we know is December 31st, however, because claims you always have extra time to submit claims, the claims have to be processed, and not submitted, I'm saying the word, processed, no later than 60 days after the end of the performance year. Therefore, what we're suggesting is that you go ahead and contact your Medicare Part B administrative contractor, also referred to as MAC, and I've got a list of who they are, and the state where you practice, contact them, and ask them that specific question, when's the last day I have to submit a 2019 claim with a QDC, so I can get credit for MIPS.

Kathy Wild: They will tell you. Once again, they need time to process the claim, so you have to give them some time, so it might be in February, is what I'm thinking, it probably won't be March 31st, which is the end of the actual MIPS reporting.

They're going to need it to have time to process it, so just so you know that. Next slide.

Marvin Nichols: Thanks, Kathy. Is there any other information a practice would need to document on the claim, beside the Quality Data Codes?

Kathy Wild: Actually, there is Marvin. If you submit a QDC, but you don't submit and write down a line item charge, guess what? You won't get credit. This is the other requirement. It's very simple, and once you remember the simple fact then you'll just remember to do both hand in hand. Number one, submit the QDC.

Kathy Wild: Number two, you have to put an entry in that line item charge box on the claim form. You can either put zero cents in there, or if you have billing software, or if you prefer you can put the one cent code down, because some billing software won't accept it if you just put zero in there, but just remember you have to have that line item charge down, so put the two when you do the QDC, make sure you do that, too. That will make sure, hopefully, that everything gets processed correctly, and then it will be identified as a quality measure for MIPS. Next slide.

Marvin Nichols: Thanks, Kathy. How can I be sure that Medicare knows that I'm reporting MIPS quality measures on any of my claims?

Kathy Wild: That's a great question. What we suggest you do is for each of the measures that you're going to report, you create a tracking spreadsheet, and you keep track of all the denominator eligible cases you report. Okay? Then, what you want to do is also record the QDC codes you wrote down, and the measures, and then that way you can verify if they were actually submitted, and tracked by looking at the Remittance Advice codes, an explanation of benefit codes.

Kathy Wild: I'm going to go through that in a minute. But, that is one way to do it, so make that first spreadsheet with the cases you report, include your QDC's, and then you've got that, and then you could add a call in to see if you're getting these codes back, of the RA codes.

Kathy Wild: If you receive a Claim Adjustment Reason Code, also called a CARC, then you know that QDC was successfully submitted, so that's what you're looking out for, so rather than just when you get the EOB's look at them, it's good to just have a spreadsheet to see how many of them you get back. The CARC 246 code is simply saying, "This non-payable code is for reporting only," but they acknowledge that you submitted those codes. Next slide, please.

Kathy Wild: To get into more detail. These are the codes that you really want to look for, so the code N620, it will be on your Remittance Advice, if you build the claim with a zero QDC line item. Then, they'll add CO 246 before that, if you billed the one

cent line item. It doesn't matter if you bill zero, or one cent, either way those both verify the fact that you've submitted a QDC and the line item, which are the two requirements. You'll notice that was billed, and the claim will be used to calculate your quality measures. But, just know that the code does not guarantee that your QDC was correct, or that you reporting thresholds were met, whether they are all counted or not, but it does guarantee they'll be looking at that. Next slide, please.

Marvin Nichols: Thanks again, Kathy. Now, as we know in any type of data entry, mistakes can happen, so what if the RA code does not show up on my Quality Data Code?

Kathy Wild: Okay. There's a couple things you can do to follow-up, so you're getting those RAs back, you're looking at your spreadsheet, checking them off. First, I would go ahead and make sure that you included the line item with the QDC on the same claim form for the same date of service at the same time. All of that is important. You got to make sure you do that when you submit that initial claim.

Kathy Wild: You could also, if you're using billing software, make sure it is transmitting the QDC with that line item charge code will either be zero or one cent. If it's leaving that off, remember then they're not going to go ahead and you're not going to get that RA, they're not recognizing it. If you've done both of those things, and you're not sure what's happening, go ahead and contact your MAC, make sure that the codes came through on the same claim, and verify how the MAC process those claims.

Kathy Wild: Say, I've been reporting QDC's, and line items, and I'm not getting the RA codes back, can we go over these? But, they would be the person that you would go to. Then, lastly if the MAC can't figure it out, then go with your clearinghouse to ensure it received the QDC, and that they're transmitting out those QDC codes to the MAC. As you can see there's a couple places where things possibly could go wrong, and that's why it's very important for you to keep track of them, so that you get credit. Remember, you want to earn the most quality points as you can, therefore, you want as many people in your numerator as possible. Next slide, please.

Kathy Wild: Okay. Denied claims. If your MAC, if you get a claim back, and your MAC denied payment for everything for that encounter, for everything on the claim, then CMS will not count the QDC's in the MIPS analysis, they just completely throw that one out, so then what you'd have to do on your spreadsheet is go ahead and remove them only because that whole encounter was denied. That's the policy. Next slide.

Marvin Nichols: Thanks, Kathy. Another question. Can I resubmit any claims to include a QDC? Basically, can I resubmit a claim only to add the Quality Data Code to it?

Kathy Wild: Right. The simple answer is, no. It would be nice, especially people that haven't submitted any claims codes, yet, to go back through whatever patients they've seen in 2019, but unfortunately CMS will not allow that. If you only want to add a QDC, so you get credit for MIPs, the answer is, no, you cannot resubmit it. But, you can certainly start moving forward.

Kathy Wild: Now, if you have a denied claim, it gets paid, it gets readjusted, and then the new code you realize does correspond to one of the measures that you're reporting, at that point you could add a QDC on the corrected claim. But, that's probably going to be very rare when that happens. The good thing is if you do submit a QDC, and it was on the original claim, but you did forget to add that line item, you can resubmit a claim to go ahead and add that, so they will give you credit for that. But, remember that QDC has to be there on the original claim.

Marvin Nichols: Okay. Kathy, what if I wanted to change a diagnoses on the claims code, or a claims form?

Kathy Wild: Sure. Okay. Let's talk about diagnoses a minute. On the CMS-1500 form, you can report up to 12 diagnosis. They are in item 21. Then, if you're doing this on the electronic claim form you can do it in the header. Now, only one diagnosis can be linked to each line item, but you can report all diagnosis on the base claim and they'll all be included in the Medicare Part B claims data analysis. Remember, I just want to stress again, that all coding and documentation rules apply to claims reporting, therefore, you have to make sure that whatever is being done the quality action for each measure is being documented by a clinician or a physician in that medical chart. Next slide, please.

Kathy Wild: For items containing Quality Data Codes, only one diagnosis from the base claim should be referenced in the diagnosis pointer field. To report a QDC for a measure that requires multiple diagnoses, you must enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Hopefully, someone in your billing department understands that. I have no experience working with claims, but I think that makes sense what they're saying, so you just have to make sure that's being done, also. Next slide.

Marvin Nichols: Thanks again, Kathy. What are the best practices for a clinician to be successful in the claims reporting?

Kathy Wild: Okay. Basically, what we did was we created, I just want to go over a little brief checklist. Once you select your quality measures, what are the main things you have to do? Make sure that whenever a patient meets that denominator, and that measure, and remember one patient can be in the denominator for

multiple measures, you want to attach the most appropriate QDC code that corresponds with the action taken during the encounter. Okay?

Kathy Wild: Then, you got to make sure you enter that line item charge, and you can either enter zero cents or one cent. Then, you would just go ahead and follow the normal coding process for the way you file the claims, now. Then, the last thing would be that big tracking mechanism, and that is to make sure you get credit. Okay? Once you get the mindset, and you establish that workflow in your practice, it really will be somewhat simple to do. Next slide.

Marvin Nichols: Thank you. One more question for you, Kathy. Is there a way that I can check my claim score on the QPP portal?

Kathy Wild: Sure. Unfortunately, it is not available yet for the data that's been submitted so far this year. What CMS has said is that when they open the QPP portal for 2019 data submissions on January 2nd, that at that time when you log into the portal using your HARP account log in credentials you'll be able to see the data that has been submitted via claims, so far.

Kathy Wild: Once again, you'll be able to see that beginning in January. As you continue to submit claims through the rest of the year, and they get processed, that data will change in the portal, so then we recommend that you go ahead and check that whole time until the submission period ends at the end of March, you should see your quality score changing based on the extra data that you're reporting. Next slide.

Kathy Wild: Lastly, we have developed some great resources to help you with claims reporting. We've got the links here. We've got them on our website, too. We hope and encourage you to use all of them, and of course call us for extra help. Next slide.

Marvin Nichols: Thank you, Kathy.

Laurie Fink: [crosstalk 00:49:31], Kathy.

Marvin Nichols: And thank you, Roxanne. Sorry, Laurie.

Laurie Fink: No. That's okay.

Marvin Nichols: No, you go ahead.

Laurie Fink: All right. Great. It looks like we have about 11 minutes left in this session, so we will go ahead and move into the Q&A portion of our presentation. If you have any questions for our team, we invite you to type them into the Q&A box on the

right of your screen, and if you have already submitted a question throughout the presentation it will be addressed now as time permits.

Laurie Fink: Our first question comes in from Christine. She asks, "Should this be done for Medicare Advantage Plans, too, or just straight Medicare?"

Kathy Wild: Great question. Does anyone know the answer on our team? I think it's just Medicare Part B [crosstalk 00:50:31].

Roxanne Fletcher: Yeah. This is Rox. Can you hear me. It would just be straight Medicare.

Kathy Wild: Right. Okay. Then, we agree.

Lisa: Lisa agrees, too.

Laurie Fink: Okay. Our next question asks, "How does CMS know, which patients are being reported for the measures I have selected?"

Kathy Wild: I can take that one. Once again, it's going to be identified by the QDC codes. Remember, the population for each measure can vary, some are based on age, some on specs, because you've got some breast cancer screening, and things like that for women on your diagnosis, such as hyper tension, or diabetes, and there's a whole bunch of other factors. Once the population is identified, it's done so by the measure specification code, so you would have that in your codes, and then as long as you attach the QDC codes, CMS would know that, that's one of the measures that are being reported.

Laurie Fink: All right. Thanks, Kathy. Next question is, "My physicians only see inpatients, and have closed our outpatient office, do the same QPP standards apply?"

Kathy Wild: All right. We're thinking about that one.

Roxanne Fletcher: Can you repeat the question, Laurie? I think what they're asking, so they're doing all inpatient.

Kathy Wild: Right.

Laurie Fink: Right.

Roxanne Fletcher: Closed their outpatient. The one thing I guess they need to check is their NPI lookup, because one thing we haven't mentioned here is when you do the NPI lookup it will list how they need to report for 2019. If they're reporting with an ACO, through a hospital, or if through your private practice, if they bill through

their private practice, they may need to report. Lisa, do you want to add anything to that? Kathy?

Lisa Sagwitz: Yeah. What I'm thinking is using the NPI number to check participation status on the QPP website, there are going to be special statuses listed, so Jean, take a look and see if your doctors are listed as hospital based. Hospital based means that at least 75% of their billing goes through a certain service code number to indicate that they're inpatients.

Lisa Sagwitz: If they're listed as hospital based, that provides you some changes in how your reporting would be. I would say reach out to us, make sure that we know what state you're in, and we have your phone number, or your email, and let's plan on having a call when we can review that individually with you, and give you the best direction.

Rabecca Dase: This is Rabecca. I just kind of want to add to what Lisa said about the special status. Something to consider as well depending where they do see their patients, they could also be what's called, facility based, that's another special status, which again would in fact change their reporting requirements and potentially offer flexibility, so definitely Quality Insights is going to be able to help you walk through all of your options for this.

Laurie Fink: All right. Thanks, everybody. Next question is, "Do we need to register first on the QPP website before reporting the QDC's on claims?"

Kathy Wild: This is Kathy. The answers, no. There's no registration for QPP reporting at all. You can just start attaching QDC codes to your claims starting today, tomorrow, whenever you want. Then, they will get processed. CMS has predetermined on annual basis, they predetermine who has to participate, and that's where we referred to that MPI Lookup Tool, so if you put it in there, they know who has to participate, they know who has to earn at least 30 points this year, and if you don't earn those 30 points, they will find you, and attach that negative 7% payment adjustment, if you don't have at least 30 points. To answer your question, quickly, no, you can just go ahead and start the claims reporting immediately.

Laurie Fink: All right. The next question is, "What is the caps for MIPS survey measure that can count as one of the six measures?"

Kathy Wild: I can take that one. That is something that you would have had to register the previous year, if you want to report that. CMS needs to know ahead of time, and so I think the deadline, if you had done that, if you were going to report it for 2019 you would have had to request or inform CMS before the end of 2018. Therefore, if you haven't done them, then you can't count that.

Kathy Wild: Basically, what it is, is its satisfaction kind of survey, but would be sent to the patients in your practice, there's specific questions, specific things that you have to do for that. We can go into in more detail. The other criteria for that is you have to have at least two clinicians in your practice to administer that. Therefore, it can't be a solo practitioner. Please reach out to us and we can go over that in more detail with you.

Laurie Fink: Okay. Another good question just rolled in, "If the doctor bills for 99213, am I able to add QDC codes for medication review, osteoarthritis, pain level, flu vaccine, and ammonia vaccine all on the same claim?"

Marvin Nichols: Hi. I'll take that one. If you can reach out to one of us, we can review each quality ID specification sheet and see if that CPT code is attached to those quality measures that you want to attach to your QDC to. You have to look to see if the procedure code fits into each quality ID in order to use those Quality Data Codes. If you can leave your information in the chat box, or in the Q&A, and one of our practice information specialists can reach out to you, and look at each individual specification sheet of all the ventures that you just said.

Kathy Wild: Go ahead, Lisa.

Lisa Sagwitz: I was going to give a plug for our new resource, the six page step by step guide to report quality measures using Medicare Part B Claims. I think that may be answered in there.

Kathy Wild: That's one of the resources that we have, the link provided, too. I was going to say that is a common code, and probably will be in most of the denominators for those measures. Then, you just have to see the other denominator criteria to see if the patient would fall under that, but once again we'd have to look at each measure to see if you could do that, but the answer is it could be possible.

Laurie Fink: All right. Thank you to everyone who joined us today. Just a quick reminder that when you close out of today's session you will be automatically directed to a very brief evaluation. We ask that you please take just a moment to complete it, and it helps us to develop future educational sessions that best meet your needs. Thanks, again, for joining us today. I hope you have a great rest of the day. This session is now concluded.

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