Quality Reporting

# Quality Reporting Codes

## Tracking Performance for Quality Improvement

This section provides an overview of the coding methodologies that are required to track performance for the Clinical Integration/ ACO program metrics from practices that do not use an EHR.

**Quality-Data Codes (QDCs)**

QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified CPT Category II codes and/or G-codes that describe the quality action required by a measure's numerator.

**Practices will be using CPT II Codes and HCPCS G codes to report compliance with the MSSP measures.**

Healthcare Common Procedure Coding System (HCPCS), often pronounced by its acronym as "hick picks", is a collection of standardized codes that represent medical procedures, supplies, products and services. The codes are used to ensure that the healthcare claims are processed by Medicare and other insurers in an orderly and consistent manner. The Healthcare Portability and Protection Act of 1996 (HIPPA) mandated that all healthcare claims be reported using HCPCS.

**HCPCS is divided into two subsystems, Level I and Level II.**

<table>
<tr>
<td rowspan="3">HCPCS Level I consists of the Current Procedural Terminology (CPT) codes.</td>
<td rowspan="3">CPT<br>(Current Procedural Terminology)<br><br>The CPT system is maintained and copyrighted by the American Medical Association (AMA). ◆ CPT is currently identified by the CMS as Level 1 of the HCPCS. ◆ CPT system is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures provided by healthcare providers such as physician, nurse practitioners and physician assistants. ◆ Each CPT code is numeric and has five digits. ◆ Has 3 categories, detailed on right</td>
<td>CPT Category I<br>Includes procedures that are consistent with contemporary medical practice and are widely performed. ◆ Category I codes are the five-digit numeric codes included in the main body of CPT. ◆ Category I is the section that coders usually identify with when talking about CPT.</td>
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<tr>
<td>CPT Category II Codes<br>Supplementary tracking codes used for performance measurement. ◆ Facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care. ◆ CPT II codes are alpha-numeric containing five characters, with four digits followed by an alphabetical fifth character, the letter 'F'. ◆ These are optional codes used to facilitate data collection and are never used as substitutes for the standard Category I CPT codes. ◆ Use of Category II codes for performance measurement can decrease the need for record abstraction and chart review when measuring the quality of patient care. ◆ CPT II codes are not modified or updated during the reporting period and remain valid for the entire program year as published in the measure specifications manuals.</td>
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<tr>
<td>CPT Category III<br>Temporary codes for emerging technology, services and procedures. They are used to report new technology, services or procedures that do not currently have a CPT code assigned</td>
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<tr>
<td>HCPCS Level II codes</td>
<td colspan="2">Level II of the HCPCS is a standardized coding system primarily represents items and supplies and non-physician services not covered by the AMA's CPT-4 codes. ◆ HCPCS is established and maintained by the Centers for Medicare and Medicaid Services (CMS) ◆ Level II codes are alpha-numeric and are composed of a single letter in the range A to V, followed by 4 digits. ◆ The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT but for which there are no CPT codes. G codes are used for quality reporting. ◆ Only Level II codes are referred to as HCPCS. HCPCS Level II is the section that coders usually identify with when referring to the HCPCS codes.</td>
</tr>
</table>

CPT II codes

HCPCS G codes

**Determining which codes to use:**
When both a CPT and a HCPCS Level II code have virtually identical narratives for a procedure or service, use the CPT code. If, however, the narratives are *not* identical, use the HCPCS Level II code. For more on Code Sets:
http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/TransactionCodeSetsStands/CodeSets.html
http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCS_Coding_Questions.html

Some measures require more than one quality action and therefore, have more than one CPT Category II code (G-code) or a combination associated with them.

**The CPT Category II code, which supplies the numerator, must be reported on the same claim form as the payment ICD-9 and CPT Category I codes, which supply the measure's denominator.**

**Multiple CPT Category II codes can be reported on the same claim, as long as the corresponding denominator codes are also included as line items for that claim.**

Quality-data codes can relay information such as:

- ✓ **The measure requirement was met;**
- ✓ **The measure requirement was not met due to documented allowable performance exclusions (i.e., using performance exclusion modifiers)**; and
- ✓ **The measure requirement was not met and the reason is not documented in the medical record (i.e. using the 8P reporting modifier).**

Individual the quality-data codes can be associated with more than one measure. In order to determine which quality-data codes and modifiers to report as a line item on a claim, you will need to understand the measures that you have selected to report.

Based on CMS specifications, this guide will help you:

- Identify eligible cases based on ICD-9-CM and CPT Category I codes;
- Choose the correct quality-data codes to report;
- Know when to use "exclusion" modifiers (i.e., 1P, 2P, and 3P); and
- Know when to use a reporting modifier (i.e., 8P).

## Use of CPT II Modifiers

- ★ CPT II modifiers are unique to CPT II codes and may be used to report measures by appending the appropriate modifier to a CPT II code as specified for a given measure.
- ★ Use of the modifiers is unique to CPT II codes and may not be used with other types of CPT codes.
- ★ Use of modifiers is guided by the measure's coding instructions.
- ★ Reporting for some measures may require that you append a modifier to a CPT Category II code. CPT Category II modifiers serve to exclude patients from a given measure's denominator **when the measure's specification permits their use**, **and may only be reported with CPT II codes**. They cannot be used with G-codes.
- ★ Coding instructions included in the *Specifications* document indicate when a modifier is required.

There are two kinds of CPT II Modifiers:
**Exclusion modifiers** and the **8P reporting modifier**.

## Exclusion Modifiers

- ★ Exclusion modifiers may be appended to a CPT II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record.
- ★ Some measures do not allow performance exclusions.
- ★ Reasons for appending a performance measure exclusion modifier fall into one of three categories:
- ★ **Performance measure exclusion modifiers fall into one of three categories:**

**1P - Medical Reasons:** e.g., Contraindicated (patient allergic history, potential adverse drug interaction, other)

**2P - Patient Reasons:** Includes: Patient declined; other patient reasons

**3P - System Reasons:** Includes: Resources to perform the services not available; insurance coverage/payor-related limitations; other reasons attributable to health care delivery system

## Performance Measure Reporting Modifier

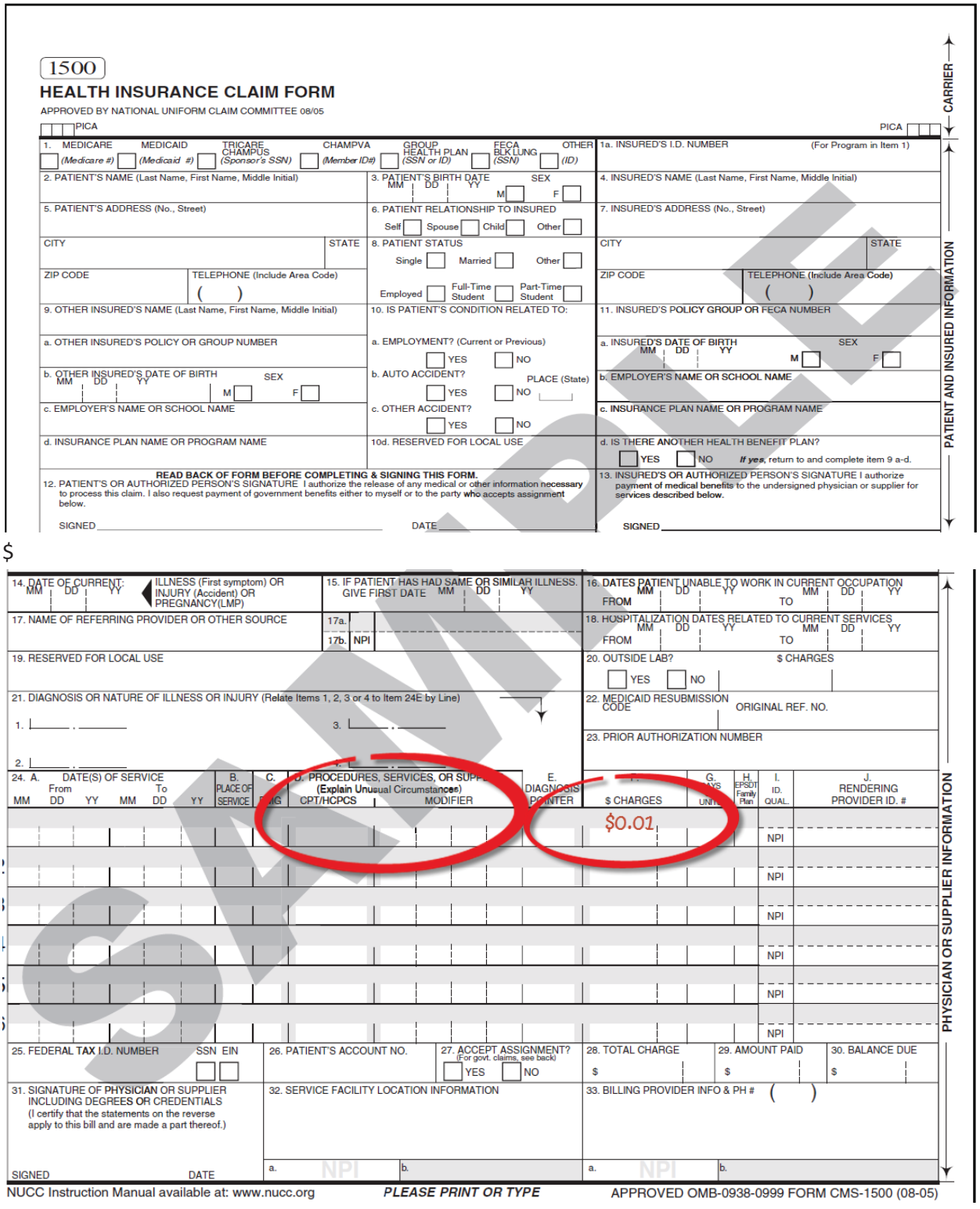
**Performance Measure Reporting Modifiers** facilitates reporting a case when the patient is eligible but an action described in a measure is not performed and the reason is not specified or documented.

**8P - action not performed, reason not otherwise specified**

- ★ Use of the 8P reporting modifier indicates that the patient is eligible for the measure. However, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers.
- ★ The 8P reporting modifier facilitates reporting an eligible case on a given measure when the quality action does not apply to a specific encounter.
- ★ The eligible professionals can use the 8P modifier to receive credit for satisfactory reporting but will not receive credit for performance.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5640.pdf

# CMS-1500 Claim Form Sample



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

CARRIER

PATIENT AND INSURED INFORMATION

$

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | $0.01 | | | NPI | |
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25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)



☞ Quality data code line items (CPT II codes) must be submitted with a charge of zero dollars ($0.00). If your system does not allow a $0.00 line item charge, use a small amount such as $0.01.