

Bundled Payments for Care Improvement (BPCI) Advanced MY4 (2021) Quality Measures Frequently Asked Questions (FAQ)

This document provides questions and responses for a number of BPCI Advanced Model Year 4 (MY4) topics. Additionally, Quality Measure Fact Sheets are available on the [BPCI Advanced website](#).

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Quality Measure Sets in BPCI Advanced

Q1: What is new in quality measurement for BPCI Advanced in MY4?

A1: Starting in MY4, CMS will offer an Alternate Quality Measures Set. The new Alternate Quality Measures Set includes up to three Clinical Episode-specific measures derived from a combination of quality data codes (QDCs), Hospital Inpatient Quality Reporting (IQR) Program, claims, and registry data sources. CMS developed the Alternate Quality Measures Set with extensive input from stakeholders, including professional health associations, clinical data registries and clinicians. CMS added this new set of measures to allow BPCI Advanced Participants to have more choice on how the quality of care is measured in the Model. Starting with MY4, Participants will have the option to select either the Administrative Quality Measures Set or the Alternate Quality Measures Set for each of the Clinical Episodes in which they participate.

Q2: Where can I find more details about the Alternate and Administrative Quality Measures Sets for MY4?

A2: CMS created a set of [Quality Measure Fact Sheets](#) that provide detailed technical guidance to Participants about the rationale for selecting each of these Quality Measures, the Clinical Episodes to which they may apply, measure specifications, how the numerator and denominator are to be calculated for each measure, and how data is submitted to CMS. CMS also created a [BPCI Advanced Clinical Episodes and Quality Measure Correlation Table](#), which identifies each MY4 Clinical Episode with its corresponding Medicare Severity–Diagnosis–Related Groups (MS-DRGs), Healthcare Common

Procedure Coding System (HCPCS) codes, or International Statistical Classifications of Diseases (ICD) 9th or 10th revision, and aligned Administrative/Alternate Quality Measures. Other supporting documents will be shared with all Participants and posted to the [BPCI Advanced website](#) as they become available.

Q3: Can we choose some quality measures from the Administrative and some from the Alternate Quality Measure Sets?

A3: BPCI Advanced Participants must select *either* the Administrative or Alternate Quality Measure Set for *each* Clinical Episode. However, Participants do not need to select the same Quality Measure Set across all of their Clinical Episodes. For example, if a Participant is participating in five Clinical Episodes, the Participant can select the Alternate Quality Measure Set for three of the Clinical Episodes and the Administrative Quality Measure Set for two of the Clinical Episodes.

Q4: We are a Convener. Do all of our Episode Initiators need to participate in the same Quality Measure Set (within a Clinical Episode or across Clinical Episodes)?

A4: No, each Episode Initiator can select either the Administrative or the Alternate Quality Measures Set for each Clinical Episode that they have selected.

Submitting Quality Measure Data in BPCI Advanced

Q5: Do I need to be a registry member to submit quality data for certain Clinical Episodes? Is this different if I am an acute care hospital or physician group practice?

A5: Yes, Participants will need to be, or become, members of the relevant registry, or multiple registries, if they select Alternate Quality Measures that are reported by registries. However, Participants do not need to be a registry member to submit quality measures through the Administrative Quality Measures Set. All measures in the Administrative Quality Measures Set and some measures in the Alternate Quality Measures Set are calculated using claims data or QDCs submitted through claims. Please see the [BPCI Advanced Clinical Episodes and Quality Measures Correlation Table](#) or the [Alternate Quality Measure Fact Sheets](#) to determine which registry or registries are reporting data for specific quality measures in the Alternate Quality Measures Set.

Q6: How do we submit data for registry measures in the Alternate Quality Measures Set?

A6: Each registry collecting data for BPCI Advanced has its own data collection procedures and timelines. General data submission guidance is included in each [Alternate Quality Measure Fact Sheet](#).

Q7: For some Quality Measures, it looks like the data are captured via a QDC or a registry. How do we know which submission method applies?

A7: The BPCI Advanced Alternate Quality Measures Set includes two measures that can be submitted using either QDCs or a registry:

- Patient-Centered Surgical Risk Assessment (Quality Payment Program (QPP) #358)
- Preventive Care & Screening: Tobacco Use (NQF #0028)

The data submission method for these measures depends on which Clinical Episodes a Participant selected. Please refer to the [BPCI Advanced Clinical Episodes and Quality Measure Correlation Table](#) document to determine which data submission method applies to each Quality Measure for a specific Clinical Episode.

Quality Measure Scoring and Performance Data in BPCI Advanced

Q8: Can you confirm the baseline and Performance Periods for the Alternate Quality Measure Set that will be used in the Composite Quality Score (CQS)?

A8: MY4's Performance Period covers calendar year 2021. The Alternate Quality Measures collected using registries and from the Hospital IQR Program will be baselined against 2020, and the Alternate Quality Measures collected using QDCs will be baselined against 2021 given that there is no earlier data for these measures.

Quality measures that are also in the Administrative Quality Measures Set have the following baselines:

- Advance Care Plan (NQF #0326): July-December 2019 for MY1&2 Participants, and Calendar Year 2020 for MY3 Participants
- All-Cause Readmissions (NQF #1789): Calendar Year 2018 for MY1&2 Participants, and Calendar Year 2019 for MY3 Participants
- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA): NQF #1550 Calendar Year 2018 for MY1&2 Participants, and Calendar Year 2019 for MY3 Participants

Q9: Will Clinical Episodes have their own Quality Score? Will volume affect the impact of performance on the overall CQS?

A9: Yes, a Quality Score will be calculated for each individual Clinical Episode. For Episode Initiators (EIs) that participate in multiple Clinical Episodes, the Quality Scores for each Clinical Episode will be combined into a CQS at the EI level, and weighted by the respective Clinical Episode volumes. The CQS is then converted into a percentage and applied to the Net Positive Total Reconciliation Amount or Net Negative Total Reconciliation Amount, as applicable, to produce the Adjusted Total Positive or Negative Reconciliation amount. All applicable measures carry equal weight when calculating the Quality Score

for each Clinical Episode. Quality Scores for individual Clinical Episodes are weighted by Clinical Episode volume when Quality Scores from multiple Clinical Episodes are combined into a CQS at the EI level.

Q10: During reconciliation periods, will Participants receive quality measure performance data specific to individual physicians?

A10: No. Quality measure performance data will be provided at the EI level.

Quality Data Codes (QDCs)

Q11: What is a QDC?

A11: Health care providers use non-billable Quality-Data Codes (QDCs) to collect and submit quality data through Medicare Part B Claims. Health care provider billing departments use non-billable QDCs for performance management, quality reporting, and additional data, to capture information without having any impact on payment. Healthcare professionals sometimes refer to QDCs as G codes, Current Procedural Terminology (CPT¹) II codes, or Level II HCPCS codes. Health care providers can use QDCs to enrich their medical claims data. More information on QDCs can be found on the [2019 Merit-based Incentive Payment System \(MIPS\) Quality Performance Category: Medicare Part B Claims Data Submission Fact Sheet](#).

Q12: What does a QDC look like on a claim?

A12: QDC are non-payable codes. When you attach a QDC to a claim, you must include a \$0.00 line item charge for the QDC. Health care providers and/or billing departments attach QDCs on a payable claim (on a CMS-1500 or UB04 form), specifically the claim for the visit when the action happened. Some billing software will not accept a code without a charge. If your billing software will not accept a code without a charge, attach a \$0.01 line-item charge for the QDC to mitigate these software limitations. This \$0.01 is a technicality, and when these claims arrive at the Medicare Administrative Contractor (MAC) for processing, the MAC automatically erases the \$0.01. More information on QDCs can be found on the [2019 Merit-based Incentive Payment System \(MIPS\) Quality Performance Category: Medicare Part B Claims Data Submission Fact Sheet](#).

¹ CPT® is a registered trademark of the American Medical Association (AMA).
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Q13: How must health care providers report a QDC on a claim?

A13: Health care providers must report QDCs:

- On the claim(s) with the denominator billing code(s) that represent(s) the eligible Medicare Part B Physician Fee Schedule (PFS) encounter
- For the same beneficiary
- For the same date of service
- By the same clinician who performed the covered service, applying the appropriate encounter codes (International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), CPT Category I, or HCPCS codes). CMS uses these codes to identify the measure's denominator
- On a UB-04 or a CMS 1500 form

Health care providers must also make sure that the claim has a total positive payable amount. CMS has provided further guidance on how to report a QDC on the [2019 Merit-based Incentive Payment System \(MIPS\) Quality Performance Category: Medicare Part B Claims Data Submission Fact Sheet](#).

Q14: Can health care providers add a QDC after submission of a claim?

Q14: Health care providers cannot add QDCs after they have submitted a claim. Claims may only be resubmitted if a material change impacting payment is involved. Since QDCs are non-payable codes, MACs will not allow health care providers to retroactively correct or add them to the claim after submission or processing. More information on QDCs can be found on the [2019 Merit-based Incentive Payment System \(MIPS\) Quality Performance Category: Medicare Part B Claims Data Submission Fact Sheet](#).

Q15: Can health care providers submit a QDC as the only line on a claim?

Q15: Health care providers cannot submit a QDC as the only line(s) on a claim. Health care providers and billing departments can only add QDCs to payable claims; the claim itself must have a total positive value. The \$0.01 that may accompany a QDC does not count as a reimbursable service. Therefore, health care providers must submit QDCs with an accompanying payable line, e.g., a CPT code for an office visit. If a claim only contains codes for non-payable services, the health care provider cannot submit a QDC with that claim. In short, health care providers cannot file a claim that only consists of one or more QDCs. To ensure the MAC processes the QDC correctly, CMS advises health care providers to add the QDC to the claim relevant to the measure. More information on QDCs can be found on the [2019 Merit-based Incentive Payment System \(MIPS\) Quality Performance Category: Medicare Part B Claims Data Submission Fact Sheet](#).

Q16: What happens if a MAC denies the claim?

Q16: If a MAC denies a claim, the health care provider generally cannot resubmit the claim; she or he must appeal it. If the appeal is successful, then the MAC will reverse and pay the claim, and the QDC submitted with the original claim will still be there. If the MAC rejects the claim back to the health care provider, and the health care provider fixes the issue and resubmits, the health care provider should ensure the appropriate QDC is on the claim. More information on QDCs can be found on the [2019](#)

Q17: If a health care provider did not bill the Advance Care Plan (ACP) or Perioperative Cephalosporin QDCs with the first inpatient claim, can the health care provider add them on the post-op follow-up visit?

Q17: Health care providers should not bill the ACP or perioperative cephalosporin QDCs on a postoperative follow up visit. This is because health care providers bill postoperative visit using the CPT code 99024 – “Postoperative follow-up visit, normally included in the surgical package, to indicate that the physician performed an evaluation and management service during a postoperative period for a reason(s) related to the original procedure.” CPT code 99024 has a zero-dollar amount associated with it. Per the explanation above, coding 99024 with a QDC will result in a zero-dollar claim and the MAC will not accept the QDC.

Q18: Who can bill the 99497 and 99498 codes for ACP in BPCI Advanced?

Q18: Any Medicare-enrolled health care provider can submit Qualifying CPT or CPT II codes, including physicians, advance practice nurses, and physician assistants, regardless of the healthcare provider's participation in the Model. Billing departments can include ACP discussions held by other members of the health care team if they are held “incident to” the services of a billing practitioner, including a minimum of direct supervision. This could include a registered nurse (RN) or licensed social worker, assuming they meet supervision requirements. In settings in which “incident to” does not apply (such as an inpatient setting), only physicians and non-physician health care providers (including nurse practitioners, physician assistants, and clinical nurse specialists), are qualified to perform and report ACP discussions.

Q19: Will the ACP Quality Measure accept both QDCs and CPT codes?

Q19: The ACP Quality Measure is informed by both QDCs and CPT codes. Participants can document the ACP using the following CPT codes or combinations of codes:

- (1) 99497;
- (2) 99497 and 99498;
- (3) 1123F; or
- (4) 1124F.

Participants that submit CPT codes 99497/99498 do not need to include the CPT II 1123F or 1124F codes to receive credit for this measure. Participants using the CPT II codes must include these codes on a claim with a billable service.

Q20: What is the lookback period for the Perioperative Care: Selection of Prophylactic Antibiotic - First or Second Generation Cephalosporin (NQF #0268) Quality Measure?

Q20: CMS has determined that the lookback period will start one day prior to the first day of the anchor stay or anchor procedure and end when the anchor stay or anchor procedure ends. For example, if the first day of an anchor stay occurs on July 1st and the beneficiary is discharged on July 3rd, then CMS will scan that BPCI Advanced Beneficiary’s Medicare claims for dates of service between June 30th to July 3rd for the G9197 or G9196 codes.

Resources

Resource	Website Address
Quality Measure Fact Sheets	https://innovation.cms.gov/innovation-models/bpci-advanced/quality-measures-fact-sheets
Clinical Episode to Quality Measure Correlation Table	https://innovation.cms.gov/innovation-models/bpci-advanced/quality-measures-fact-sheets
Quality Methodology Webcast Slides	https://innovation.cms.gov/files/slides/bpciadvanced-wc-jan2020qualmethodology-slides.pdf
2019 Merit-based Incentive Payment System (MIPS) Quality Performance Category: Medicare Part B Claims Data Submission Fact Sheet	https://qpp-cm-prod-content.s3.amazonaws.com/uploads/444/2019%20Claims%20Data%20Submission%20Fact%20Sheet.pdf