Medicare's Quality Reporting Program

Preparing GI ASCs for October 2012

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Presenters

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Mr. Chapman is a past president of the Medical Group Management Association's (MGMA) Gastroenterology Administrators Assembly. He represents the ASGE on the Board of Directors of the Accreditation Association for Ambulatory Health Care (AAAHC) where he currently is the chair of the Standards and Survey Process Committee. He is a trained and active surveyor specializing in surveying endoscopic ASCs.

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Agenda

- Basic overview of ASC Quality Reporting Program
- Program updates in the IPPS proposed rule
- General overview of measures required to be reported for the 2014, 2015, and 2016 payment determinations
- Update to measure details and coding specifications
- Submitting quality measures
- Ways to prepare

Introduction & Background

- **Medicare ASC Quality Reporting Program**: CY2012 Medicare Hospital Outpatient Prospective Payment System (OPPS)/ ASC Payment final rule as well as the CY2013 Inpatient/Long Term Care Hospital Prospective Payment System (IPPS) Proposed Rule.

- Beginning **Oct. 1, 2012**, ASCs will be required to report five quality measures on Medicare claims forms.
  - Patient Burn
  - Patient Fall
  - Wrong site, side, patient, procedure, implant
  - Hospital admission/transfer
  - Prophylactic IV antibiotic timing

- ASCs that fail to successfully report these measures will face a 2% reduction in facility fee reimbursement in 2014.

- Pay for Reporting Only: No performance thresholds.

- Payment reduction application to begin with CY 2014 payment.

- ASCs will be required to report additional quality measures in 2013 and 2014.

Why is ASC reporting important?

ASCs not reporting quality data in 2012 will have payments reduced by 2% in 2014.

(Conversion Factor – 2%) x Relative Weight= Payment Rate

($50 –2%) = $49 x 100 = $490 instead of $500

CMS & ASC Quality Reporting

- ASC Specifications Manual: April 2012
  - Measure information, data transmission guidelines, etc.
- Quality Data Codes: April 2012 ASC Change Request
  - For use beginning April 1, 2012
- Medicare Learning Network Special Edition planned
- Inpatient\Long Term Care Hospital PPS Payment Rule
  - Proposed April 2012; Final Rule August 2012
- Outpatient\ASC PPS Proposed Rule
  - Proposed July 2012; Final Rule November 2012

Inpatient/Long Term Care Hospital PPS Payment Rule

Proposed Program Administration

- CMS is proposing that once an ASC submits quality measure data, it would be considered as participating in the ASC Quality Reporting Program.
- CMS is proposing to make any and all quality measure data submitted to the ASC publicly available, except for years in which the ASC is withdrawn from the program.
- ASCs must have a QualityNet administrator to submit data for the July 1- Aug. 15, 2013 reporting period for the 2015 payment determination.

Inpatient/Long Term Care Hospital PPS Payment Rule

Proposals Regarding Form, Manner, and Timing for Claims-Based Measures for CYs 2014 and 2015 Payment Determination

- Claims for services furnished between Oct. 1, 2012 and Dec. 31, 2012 would have to be paid by April 30, 2013 to be included in the data used for the 2014 payment determination.
- In order to avoid the payment adjustment, ASCs will need to report the quality data measures on at least 50 percent of claims that meet the measure specifications.
- Threshold will increase in future years.

Inpatient/Long Term Care Hospital PPS Payment Rule

Proposed Program Validation of Claims-Based and Structural Measures

- Not proposing to validate claims-based measures and structural measures.

Proposed Extraordinary Circumstances Extension or Waiver for the CY 2014 Payment Determination and Subsequent Payment Determination Years

- CMS is proposing to adopt a process for an extension or waiver for ASCs submitting information for meeting program requirements similar to the process adopted for the HOPD.

Inpatient/Long Term Care Hospital PPS Payment Rule

Reconsideration and Appeals Process

- Process will be modeled after the Hospital Inpatient and Outpatient Quality Reporting Programs. A request would need to be submitted by March 17 of the affected payment year.
- CMS intends to complete any reconsideration reviews and communicate the results of these determinations within 90 days following the deadline for submitting requests for reconsideration.
- Appeals process for the ASC Quality Reporting Program reconsideration decisions will be issued in future rulemaking.

Measure Summary

Measure	Reporting Period	Payments Affected
1. Patient Burn	Begins Oct 1, 2012	2014
2. Patient Fall	Begins Oct 1, 2012	2014
3. Wrong Site, Side, Patient, Procedure, Implant	Begins Oct 1, 2012	2014
4. Hospital Admission/Transfer	Begins Oct 1, 2012	2014
5. Prophylactic IV Antibiotic Timing	Begins Oct 1, 2012	2014
6. Safe Surgery Check List Use	July 1 thru Aug 15, 2013 (for 1/1/12-12/31/12)	2015
7. Volume of Selected Procedures	July 1 thru Aug 15, 2013 (for 1/1/12-12/31/12)	2015
8.Influenza Vaccination Coverage Among Health Care Workers	Oct 1, 2014 thru Mar 31, 2015	2016

Measurement Development

- CMS selects measures that reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities.
- NQF
- ASC Quality Collaboration

Reporting Mechanisms

- **Claims Based Reporting – Quality Data Codes**
  - Patient Burn
  - Patient Fall
  - Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
  - Hospital Admission/Transfer
  - Prophylactic IV Antibiotic Timing

- **Reporting via Quality Net**
  - Safe Surgery Check List Use
  - ASC Facility Volume Data on Selected ASC Surgical Procedures

- **Reporting Via CDC's National Health Care Safety Network (NHSN)**
  - Influenza Vaccination Coverage Among Health Care Workers
  - NHSN measure data collection details to be proposed

Administrative Issues

- Participation Status
  - For initial year, ASCs deemed participating if they submit QDCs on claims
- QualityNet accounts
  - Sign-up available January 2013
  - Required for entry of structural measure data
  - NOT required currently
- Reports and Report Access
- Available January 2013
- QualityNet account required for access

Quality Data Codes (QDCs)

- CPT Category II codes or Level II G-codes
- Codes for presence *or* absence of event
- 12 QDCs for the 5 claims-based measures

QDC G8907

- A QDC has been established to report that the patient did **not** experience the events for four of the five claims-based outcome measures. If this code is used, none of the other QDCs should be used for these four measures.

- **G8907**: Patient documented **not** to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility.

- **Note**: For surgical patients with an order for prophylactic antibiotics, information on the fifth measure, Prophylactic IV Antibiotic Timing, will be reported separately. If the patient received the prophylactic antibiotic on time and did not experience any of the events (a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility), the code listed above (G8907) would be used **in addition to** G8916.

Details of Measures

Patient Burn

- Denominator: All Medicare ASC admissions
- Numerator: Medicare ASCs admissions experiencing a burn prior to discharge
- Numerator QDC Options for Reporting:
  - **G8908**: Patient documented to have received a burn prior to discharge.
  - **G8909**: Patient documented not to have received a burn prior to discharge.
  - **G8907**: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility.
  - **Note**: If using code G8908 or G8909, do not use code G8907.
- Key definitions:
  - Admission: completion of registration upon entry into the facility
  - Burn: Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical or radiation (for example, warming devices, prep solutions, and electrosurgical unit or laser)
  - Discharge: occurs when the patient leaves the confines of the ASC.
- Measurement begins Oct. 1, 2012 DOS for Medicare patients
- Report using QDCs on Medicare claims for DOS on or after Oct. 1, 2012

Details of Measures

Patient Fall

- Denominator: All Medicare ASC admissions
- Numerator: Medicare ASCs admissions experiencing a fall within the confines of the ASC
- Numerator QDC Options for Reporting:
  - **G8910:** Patient documented to have experienced a fall within the ASC.
  - **G8911:** Patient documented **not** to have experienced a fall within the ASC.
  - **G8907:** Patient documented **not** to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility.
  - **Note**: If using code G8910 or G8911, do **not** use code G8907.
- Key definitions:
  - Admission: completion of registration upon entry into the facility
  - Fall: a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions
- Measurement begins Oct. 1, 2012 DOS for Medicare patients
- Report using QDCs on Medicare claims for DOS on or after Oct. 1, 2012

Details of Measures

Wrong Site, Side, Patient, Procedure, Implant

- Denominator: All Medicare ASC admissions
- Numerator: All Medicare ASCs admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant
- Numerator QDC Options for Reporting:
  - **G8912:** Patient documented to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event.
  - **G8913:** Patient documented not to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event.
  - **G8907**: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility.
  - **Note:** If using code G8912 or G8913, do not use code G8907.
- Key definitions:
  - Admission: completion of registration upon entry into the facility
  - Wrong: not in accordance with intended site, side, patient, procedure or implant
- Measurement begins Oct. 1, 2012 DOS for Medicare patients
- Report using QDCs on Medicare claims for DOS on or after Oct. 1, 2012

Details of Measures

Hospital Transfer/Admission

- Denominator: All Medicare ASC admissions
- Numerator: ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASCs.
- Numerator QDC Options for Reporting:
  - **G8914:** Patient documented to have experienced a hospital transfer or hospital admission upon discharge from ASC.
  - **G8915**: Patient documented not to have experienced a hospital transfer or hospital admission upon discharge from ASC.
  - **G8907**: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility.
  - **Note**: If using code G8914 or G8915, do not use code G8907.
- Key definitions:
  - Admission: completion of registration upon entry into the facility
  - Hospital Transfer/Admission: any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room.
  - Discharge: occurs when the patient leaves the confines of the ASCs.
- Measurement begins Oct. 1, 2012 DOS for Medicare patients
- Report using QDCs on Medicare claims for DOS on or after Oct. 1, 2012

Details of Measures

Prophylactic IV Antibiotic Timing

- Denominator: All Medicare ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection
  - Exclusions: ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of infections other than surgical site infections (e.g. bacterial endocarditis); ASC admissions with a preoperative order for a prophylactic antibiotic not administered by the intravenous route.

- Numerator: Number of Medicare ASC admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection who received the prophylactic antibiotic on time

- Numerator QDC Options for Reporting:
  - G8916: Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time.
  - G8917: Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time.
  - G8918: Patient without preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis.

Details of Measures

Prophylactic IV Antibiotic Timing

- **Note:** The QDC of G8907 can be used if the patient did not experience any of the events for the four outcome measures (a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility); this code would be used plus one of the codes above for the prophylactic antibiotic timing measure for complete reporting of the 5 claims-based measures.

- **Key definitions:**
  - On time: antibiotic infusion initiated within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g. introduction of endoscope, insertion of needle, inflation of tourniquet), or two hours prior if vancomycin or fluoroquinolones are administered
  - Prophylactic antibiotic: an antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of this measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin and Vancomycin

- Measurement begins Oct. 1, 2012 DOS for Medicare patients
- Report using QDCs on Medicare claims for DOS on or after Oct. 1, 2012

Details of Measures

Safe Surgery Checklist Use

- Intent: Assess whether an ASC uses a safe surgery checklist
- May employ any checklist as long as it addresses effective communication and safe surgery practices in each of three peri-operative periods: prior to administering anesthesia, prior to incision, and prior to the patient leaving the operating room
- Applies to all ASCs, including GI endoscopy centers
- Measure must be in use anytime between **Jan. 1, 2012-Dec. 31, 2012** to report "yes"
- Report "Yes" or "No" for the entire calendar year on the QualityNet web site July 1-Aug. 15, 2013

Details of Measures

Safe Surgery Checklist Resources

- GI Societies
  - Gastroenterology Safe Surgery Checklist for ASCs: http://www.gastro.org/practice/quality-initiatives/GI_Safe_Surg_Checklist.pdf
- World Health Organization (WHO)
  - http://www.who.int/patientsafety/safesurgery/ss_checklist/en/
- SafeSurg.org
  - For a modifiable template: http://www.safesurg.org/template-checklist.html
  - For examples, including for endoscopy centers: http://www.safesurg.org/modified-checklists.html
- AORN (combines WHO checklist and JC universal protocol)
  - http://www.aorn.org/PracticeResources/ToolKits/CorrectSiteSurgeryToolKit/Comprehensivechecklist/

Details of Measures

ASC Volume of Selected Procedures

- Intent: Measure all patient volume of procedures performed in various categories by aggregate.
- Measurement period **Jan. 1, 2012–Dec. 31, 2012**
- Report volumes for entire 2012 calendar year on the QualityNet web site July 1–Aug. 15, 2013

Gastrointestinal	GI endoscopy procedures	43239,43235, 43248, 43249, 43251, 44361, 45330, 45331, 45378, 45380, 45381, 45383, 45384, 45385
	Swallowing tube (esophagus)	43450
	Hernia report	49505
	GI Screening procedures	G0105, G0121

Details of Measures

Influenza Vaccination Coverage among Healthcare Personnel (HCP)

- Intent: assess the percentage of HCP immunized for influenza during the flu season
- CDC in the process of revising measure specifications
- Definitions pending, but appears HCP will include:
  - Staff on facility payroll
  - Licensed independent practitioners, e.g., physicians, advance practice nurses and physician assistants
  - Student trainees and adult volunteers
- Measurement begins with immunizations for the flu season in fall of 2014
- Report to CDC's NHSN Oct. 1, 2014–March 31, 2015

The Challenge for Software Vendors (… and us)

Timing from Final Rule ➔ Wide Scale Rollout

- **The Problem:** In a "perfect world" scenario software vendors would have 18 months from the publication of the Final Rule to the effective date of the requirements. On a razor's edge they can do it in nine.

- **Requirements:**
  - The actual programmatic solution may involve the shortest time requirement of any of the steps.
  - Evaluation of process flow and where the new item "fits" within the program so that it is not obtrusive to the user.
  - Develop additional user interface components and test for usability.
  - Develop training materials and include in the overall training manual/methods for the software.
  - Work with related software companies as required to develop and test interface requirements.
  - Fold the changes in the overall software and along with training materials push out to beta sites.
  - Continue in a live production environment until "bugs" are worked out and materials are approved.
  - Include in a software update and roll out to all users.
  - Provide education materials and make account reps available to answer questions.

Be Aware of the Required Handoffs
(… and be prepared to manage them)

Each Handoff is a Potential Point of Failure

- **The Challenge**: In an electronic health record environment there are three to four handoffs as one component transfers data to the next. Awareness of each is critical and creating an awareness of where your vendors stand in the development and testing process is a critical management requirement.

- **Typical Handoffs**:
  - Each measure MUST be clearly documented in the patient medical record.
  - The EHR component must handoff (👍👎) the appropriate G-code to the billing component.
  - Some practices may deploy separate EHR and PMS requiring an additional handoff (👍👎) .
  - Typically the PMS will build a charge batch and handoff (👍👎) the data to a Clearing House.
  - The Clearing House will then handoff (👍👎) the batch to a Medicare Fiscal Intermediary (FIs).
  - Each handoff (👍👎) must be tested and verified PRIOR to October 1, 2012.
  - Your vendors MUST be aware of the requirement and MUST be working toward a timely solution.
  - Be aware that for some practice based EHRs the ASC component could be a lower priority.
  - The time to speak with your vendors is today.

Some of the Work is already done (… although not without pain)

ePrescribing and the 5010 has prepared the way

- **The New Norm:** ASC Quality Measure reporting involves methodology that until just a few years ago would have been impossible.

- **How Firm the Foundation:**
  - The ePrescribing process paved the way for the reporting of a zero dollar G- code which at the time was a common edit performed on Medicare claims resulting in a denial of the claim.
  - All EHR and PMS software as well as Clearing House formats and Medicare FIs should now be capable of accepting a zero dollar G-code without and error flag.
  - The 4010 electronic format allowed for the transmittal of only eight codes.
  - The 5010 electronic format provides for the transmittal of significant additional data including the expansion of the number of codes allowed within a single claim.
  - IMPORTANT – Review on-going 5010 error reports to identify any problems associated with the acceptance of G-codes of any kind.

Have a Plan B
(… and C and perhaps D)

Include ASC Measure Reporting in Your Contingency Plans

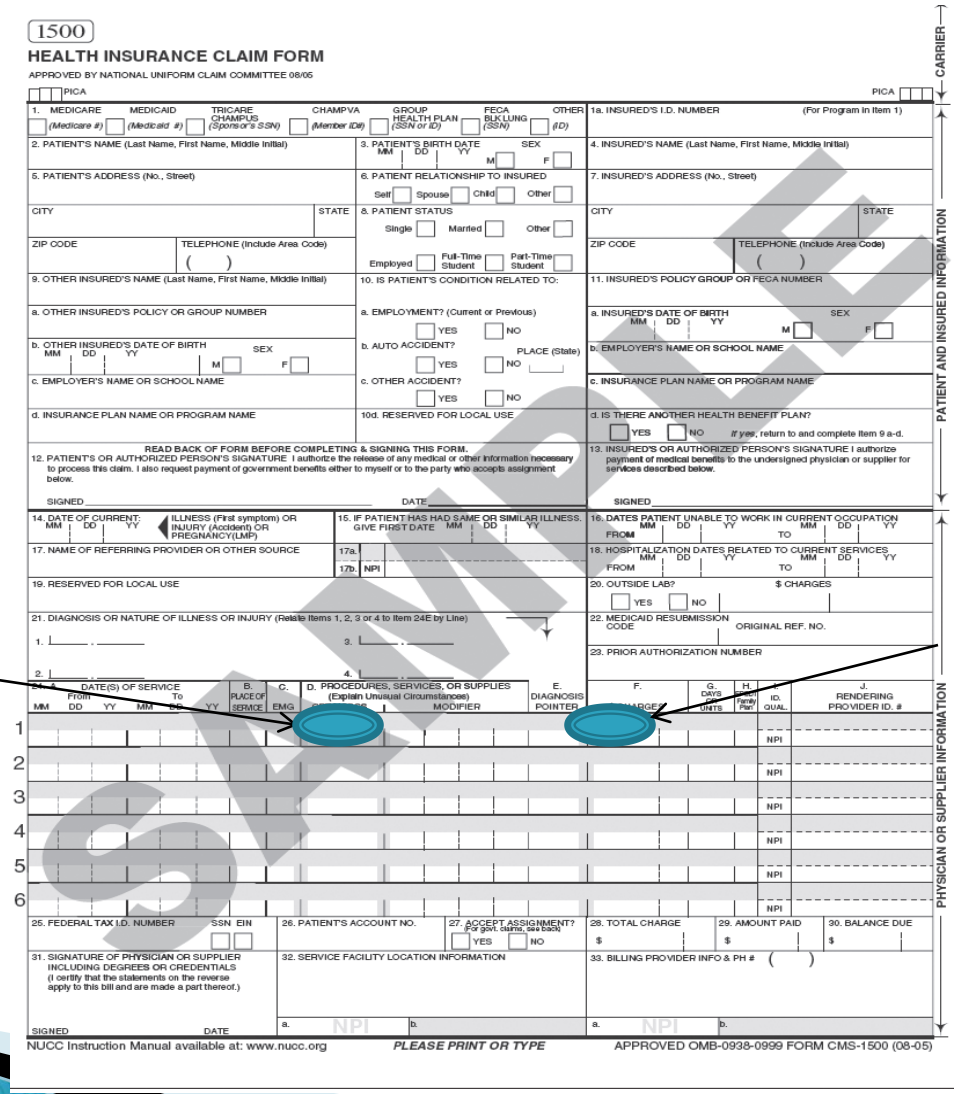
- **The Ball Drops October 1, 2012**: Regardless of software vendor performance the requirement is the requirement.

- **Develop and Test Contingency Plans**:
  - Practices with EHRs typically have a "paper protocol" for use during power outages or other disaster situations. Make sure to include forms or other means to capture and document the requirements of the ASC Quality Measure program.
  - If your software vendor is not ready on October 1, 2012 be prepared to document the measure result for each patient on paper in such a way that it can later be incorporated into the electronic medical record.
  - Be prepared to train your clinical staff on contingency plans and the importance of compliance.
  - The most critical handoff (👍👎) is between the Clearing House and the Medicare FIs.
  - Explore and test methods to edit pre-Clearing House billing batches to include the appropriate G-codes should any of the handoffs (👍👎) fail.
  - Review in detail any billing batches created for dates of service on or after October 1for correct reporting until errors and rejections are eliminated.

How to Submit Quality Reporting Information via Claims

Enter the QDC corresponding to the services provided in the box 24D.

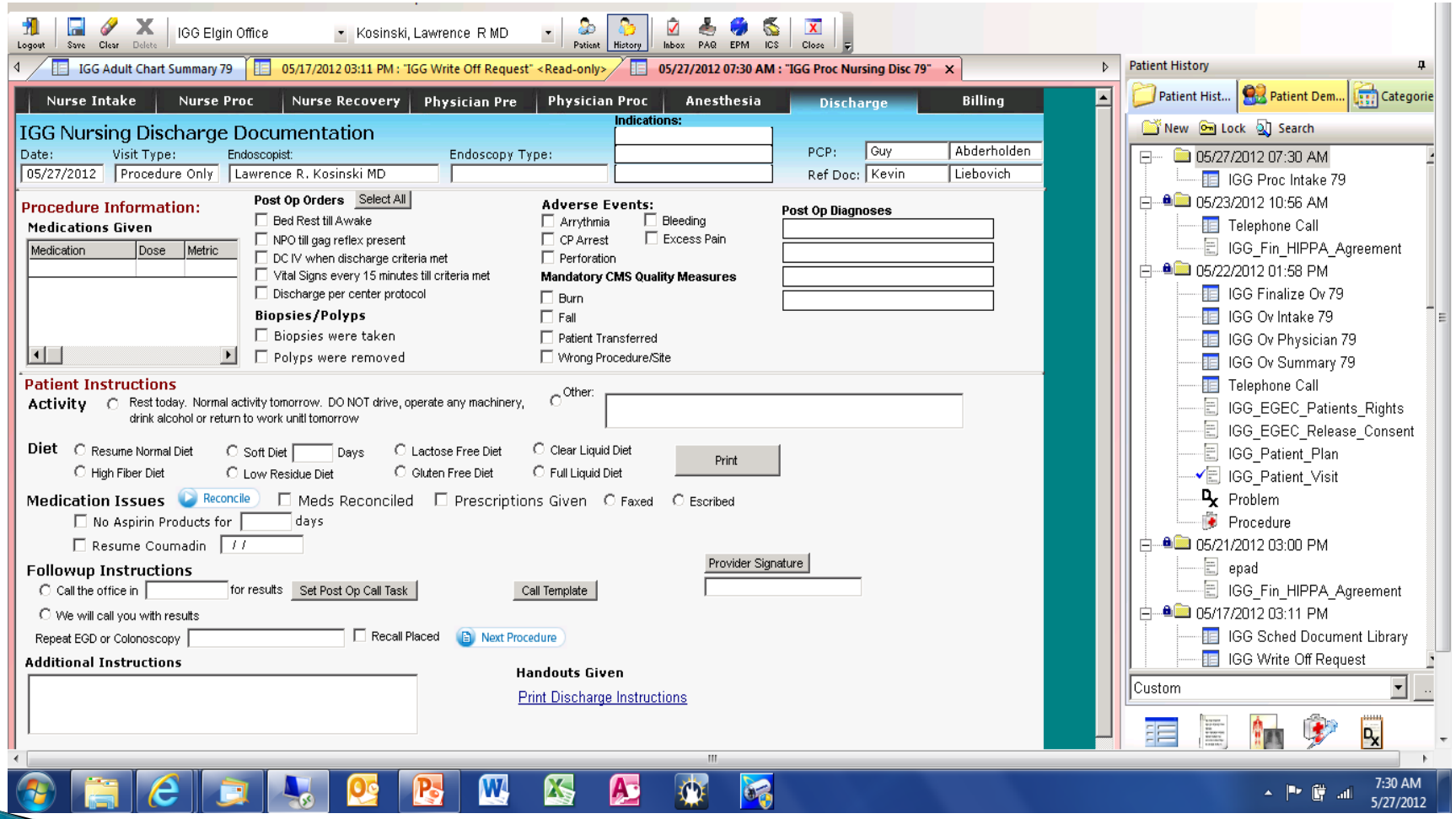
Enter the charge in the box 24F. Do not use a dollar sign or decimal point.



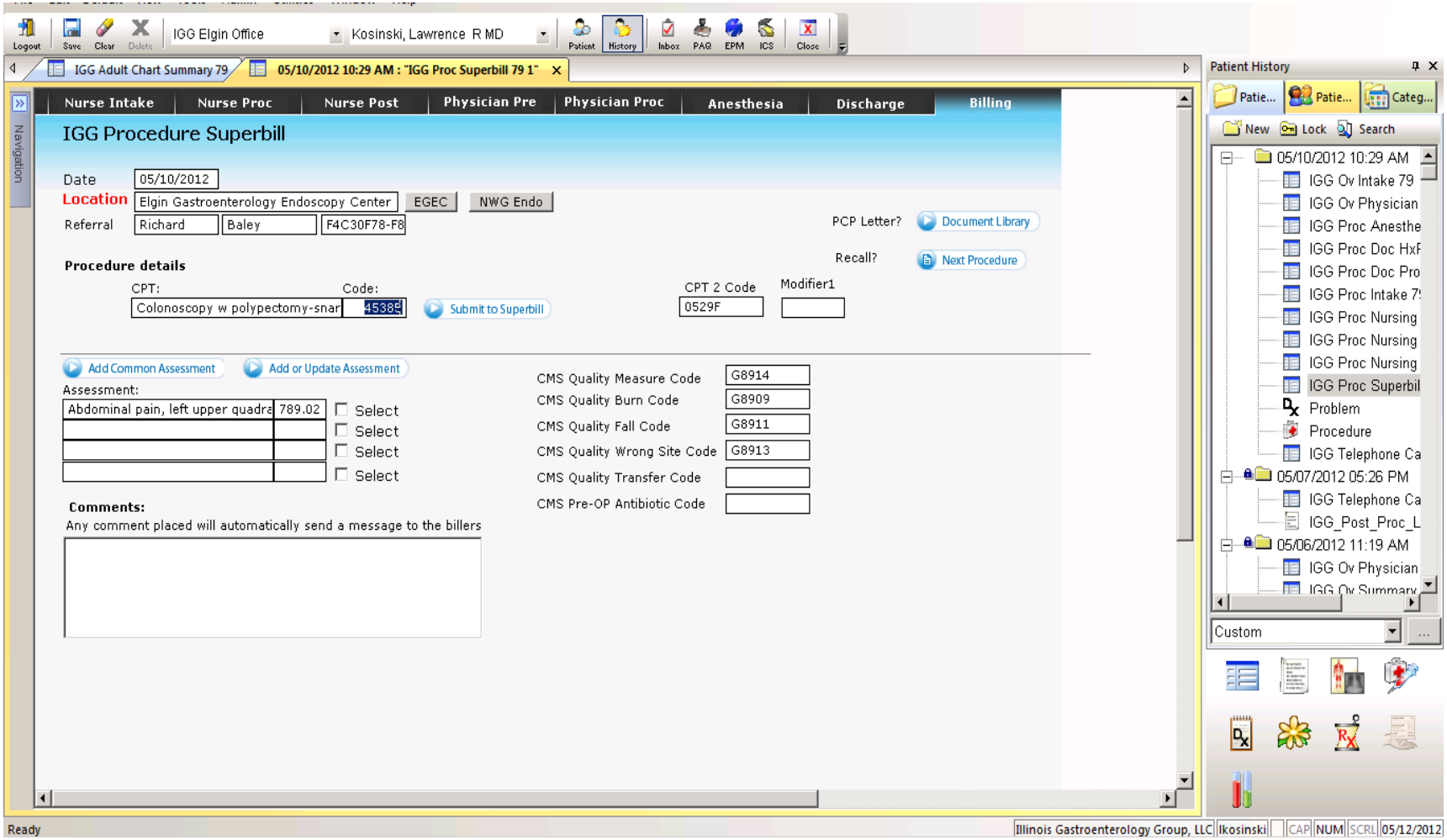
Submitting Quality Reporting Information via EHR

- Coding is required on every procedure
  - Even if no quality issue occurred
  - A default code can be created in the PM System
  - Coding by exception is most reasonable
- The reporting should be seamlessly integrated into the workflow
- Clinical reporting in the ASC EMR should automatically trigger the appropriate G Code in the Practice Management System

Seamless Integration



Digital Superbill



Ways to Prepare

- Designate a point person
- Review measure specifications
- Process for recording occurrences
- Begin conversation with IT provider
- Start submitting quality reporting information now
- Be aware! January 1, 2012 volume data collection and Safe Surgery Checklist
- Look for future ACG, AGA, ASGE webinars

Questions?

Additional Questions

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