The New CMS Quality Reporting System

What a Center Needs To Do

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ASC Quality Data Reporting

- New ASC Quality Reporting Program beginning with the CY 2014 payment determination, with data collection beginning in CY 2012 for certain measures
- ASCs that don't submit quality measure data will incur up to a 2.0% reduction to any annual increase provided under the payment system for such year
- Several mechanisms of reporting
- Staggered implementation of required measures
- Many unresolved issues remain

Final Rule Quality Reporting

ASC Quality Reporting
The new ASC quality reporting program is by far the most significant element of the proposed regulation.

Effective Date. The proposed rule would have required ASCs to commence reporting on January 1, 2012. **The final rule defers the date for the submission of quality date until October 1, 2012.**

Quality Measures and Timeline

Effective October 1, 2012 (and for the 2014 payment determination), ASCs will be required to report on: *patient burns; patient falls in the ASC; wrong site, wrong side, wrong patient, wrong procedure, wrong implant; hospital transfer/admission; and prophylactic IV antibiotic timing*. (CMS deleted the measures for *hair removal* and *selection of prophylactic antibiotic.*

In 2013 (and for the 2015 payment determination), ASCs will additionally report on *safe surgical checklist use* and *ASC facility volume for selected surgical procedures.*

In 2014, in addition to potential measures in specialty areas, CMS will add *influenza vaccination coverage among healthcare personnel.*

Reporting Methods

ASCs will be required to use different methods to report the required information. The first five measures will be reported by using codes added to claims, while the safe surgery check list and the surgery volume measures will be reported via the internet and the influenza vaccination measure will be collected via the CDC's National Health Safety Network. ASCs that fail to report data on the five quality measures will have their 2014 rates reduced by 2.0%.

Quality Data Code Mechanics

Beginning October 1, 2012, ASCs must begin including on the CMS-1500 claim form for services the quality data codes for the 5 measures selected by CMS for the initial year of the reporting program.

At this time, CMS can only receive this information when submitted on Medicare claims.

The CPT Category II or HCPCS Level II G codes to describe the quality measures were announced by Medicare in the 2nd quarter of 2012.

Quality Data Codes

Quality Data Codes developed by CMS as "G-codes"

Intended for use in transmission of quality data with billing submissions

"Quality data codes" to be placed on Part B claims submitted by ASCs for Medicare fee-for-service patients beginning October 1, 2012.

CMS developed QDCs for each proposed claims-based quality measure

After the G-codes were released by Medicare, ASCs were authorized to begin using these codes on April 1 on a trial basis

Quality Reporting G-Codes

G8907 Applies to all four outcome measures

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

Quality Reporting G-Codes

G8908 Burn
G8909 No burn
G8910 Fall
G8911 No fall
G8912 Wrong site
G8913 No wrong site
G8914 Transfer/admission
G8915 No transfer/admission

Quality Reporting G-Codes

G8916 Patient ***with*** preoperative order for IV antibiotic surgical site infection prophylaxis, antibiotic initiated on time

G8917 Patient ***with*** preoperative order for IV antibiotic surgical site infection prophylaxis, antibiotic ***not*** initiated on time

G8918 Patient ***without*** preopertive order for IV antibiotic surgical site infection proplaxis

Quality Data Code Mechanics

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QualityNet

- Established by the Centers for Medicare & Medicaid Services (CMS), QualityNet provides healthcare quality improvement news, resources and data reporting tools and applications used by healthcare providers and others.
- QualityNet is the only CMS-approved website for secure communications and healthcare quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, end stage renal disease (ESRD) networks and facilities, and data vendors.
- http://qualitynet.org/
- ASC Registration not available until 2013

Quality Net Mechanics

CMS will begin collecting information on certain quality measures in 2013 through their QualityNet website.

Centers will have to create an account on the website, and log in during specific periods in 2013 to attest to whether they had a safe surgery checklist in use during Calendar Year (CY) 2012.

This is also where centers will report information for the surgical volume measure that collects information on the all patient volume of specific ranges of HCPCS.

The National Healthcare Safety Network (NHSN)

- The National Healthcare Safety Network (NHSN) is a secure, internet-based surveillance system that integrates and expands legacy patient and healthcare personnel safety surveillance systems managed by the Division of Healthcare Quality Promotion (DHQP) at CDC. NHSN also includes a new component for hospitals to monitor adverse reactions and incidents associated with receipt of blood and blood products. Enrollment is open to all types of healthcare facilities in the United States, including acute care hospitals, long term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long term care facilities. For more information, click on the topics below.
- http://www.cdc.gov/nhsn/

Initial ASC Quality Measures

ASCs will be required to report on only 5 measures instead of seven for the 2014 payment determination (reporting to begin October 1, 2012).

ASC-1: Patient Burn
ASC-2: Patient Fall
ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4: Hospital Transfer/Admission
ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing

The would be 6th and 7th (Antibiotic selection and Hair Removal) have been pushed back.

Patient Burn

Intent To capture the number of admissions (patients) who experience a burn prior to discharge

Numerator/Denominator Numerator: Ambulatory Surgery Center (ASC) admissions experiencing a burn prior to discharge Denominator: All ASC admissions

Inclusions/Exclusions Numerator Inclusions: ASC admissions experiencing a burn prior to discharge Numerator Exclusions: None Denominator Inclusions: All ASC admissions Denominator Exclusions: None

Data Sources ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.

Data Element 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, (e.g. warming devices, prep solutions, electrosurgical unit or laser)

Patient Fall in the ASC

Intent To capture the number of admissions (patients) who experience a fall within the ASC

Numerator/Denominator Numerator: Ambulatory Surgery Center (ASC) admissions experiencing a fall within the confines of the ASC Denominator: All ASC admissions

Inclusions/Exclusions Numerator Inclusion: ASC admissions experiencing a fall within the confines of the ASC Numerator Exclusion: ASC admissions experiencing a fall outside the ASC Denominator Inclusion: All ASC admissions Denominator Exclusion: ASC admissions experiencing a fall outside the ASC

Data Sources ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.

Data Element 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. (National Center for Patient Safety)

Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Intent To capture any ASC admissions (patients) who experience a wrong site, side, patient, procedure or implant

Numerator/Denominator Numerator: All Ambulatory Surgery Center (ASC) admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant Denominator: All ASC admissions

Inclusions/Exclusions Numerator Inclusions: All ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant Numerator Exclusions: None Denominator Inclusions: All ASC admissions Denominator Exclusions: None

Data Sources ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.

Data Element Definitions

Admission: completion of registration upon entry into the facility

Wrong: not in accordance with intended site, side, patient, procedure or implant

Hospital Transfer/Admission

Intent To capture any ASC admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC
Numerator/Denominator Numerator: Ambulatory Surgery Center (ASC) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC Denominator: All ASC admissions
Inclusions/Exclusions Numerator Inclusions: ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC Numerator Exclusions: None Denominator Inclusions: All ASC admissions Denominator Exclusions: None

Data Sources ASC medical records, incident/occurrence reports and variance reports are potential data sources

Data Element 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 ASC

Prophylactic IV Antibiotic Timing

Intent To capture whether antibiotics given for prevention of surgical site infection were administered on time

Numerator/Denominator Numerator: Number of Ambulatory Surgery Center (ASC) admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection, who received the prophylactic antibiotic on time Denominator: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection **I**

Inclusions/Exclusions Numerator Exclusions: None Denominator 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

Data Sources ASC medical records, as well as medication administration records, and variance reports may serve as data sources. Clinical logs designed to capture information relevant to prophylactic IV antibiotic administration are also potential sources.

Prophylactic IV Antibiotic Timing

Data Element Definitions

Admission: completion of registration upon entry into the facility

Antibiotic administered on time: Antibiotic infusion is 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. Timing starts at the time antibiotic infusion is initiated.

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

Structural Measures

Volume Data for Selected Procedures
Safe Surgical Checklist Use

Facility level (all payer) data
Retrospective data covering CY 2012 (Jan-Dec)
Reporting Period July 1 – August 15, 2013
Affects Payment Year Determination 2015
Reported via Quality Net

ASC Facility Volume Data on Selected Procedures

GI HCPCS Codes: 40000 through 49999, G0104, G0105,G0121,C9716, C9724, C9725, 0170T

Eye HCPCS Codes: 65000 through 68999, 0186, 0124T, 0099T, 0017T, 0016T, 0123T, 0100T, 0176T, 0177T, 0186T, 0190T, 0191T, 0192T, 76510, 0099T

Nervous System HCPCS Codes: 61000 through 64999, G0260, 0027T, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0062T

Musculoskeletal HCPCS Codes: 20000 through 29999, 0101T, 0102T, 0062T, 0200T, 0201T

Skin HCPCS Codes: 10000 through 19999, G0247, 0046T, 0268T, G0127, C9726, C9727

Genitourinary HCPCS Codes: 50000 through 58999, 0193T, 58805

ASC Facility Volume Data on Selected Procedures

Examples

GI: Laparoscopy, Bariatric Surgery, Endoscopy
Eye: Cataract Removal with Insertion IOL, Nasolacrimal Duct Probe
Nervous System: Epidural or Intrathecal Drug Pump, Laminectomy
Musculoskeletal: Drainage of Finger Abscess, Ankle Arthroscopy, Rotator Cuff Repair
Skin: Wound Debridement, Mastectomy, Mohs Surgery
Genitourinary: Cystoscopy, Transurethral Resection of Prostate

Use of Safe Surgical Checklist

- The measure would assess whether the ASC uses a safe surgery checklist in general, and would not require an ASC to report whether it uses a checklist in connection with any individual procedures.
- The proposed safe surgery checklist measure assesses the adoption of a best practice for surgical care that is broadly accepted and in widespread use among affected parties
- This measure in the ASC Quality Reporting Program is consistent with CMS's goal to align measures across settings because the same measure will be incorporated into the Hospital OQR Program for CY 2014 payment determination
- CMS notes that this provides alignment with initiatives of other organizations, such as American College of Surgeons' Nora Institute for Patient Safety, the American Society of Anesthesiologists, TJC, the National Association for Healthcare Quality and the AORN
- ASC would report whether their facility employed a safe surgery checklist that covered each of the three critical perioperative periods for the entire calendar year of 2012 during the 45-day window from July 1 through August 15, 2013

CMS's Examples of "Safe Surgery Practices"

- Verbal confirmation of patient identity
- Marking of the surgical site
- Check anesthesia machine/medication
- Assessment of allergies, airway and aspiration risk
- Confirmation of surgical team members and roles
- Confirmation of patient identity, procedure, and surgical incision site
- Confirmation of count of surgical instruments and accessories

Current CMS Quality Reporting Program

Measure	Reporting Period	Payments Affected	Reporting Method
Patient Burn	October 1, 2012	2014	G Codes
Patient Fall	October 1, 2012	2014	G Codes
Wrong Site, Patient, Procedure, etc.	October 1, 2012	2014	G Codes
Hospital Transfer/ Admission	October 1, 2012	2014	G Codes
Prophylactic IV Antibiotic Timing	October 1, 2012	2014	G Codes
Safe Surgery Checklist Use in 2012	July 1-Aug 15 2013	2015	Quality Net
Volume of Selected Procedures 2012	July 1-Aug 15 2013	2015	Quality Net
Influenza Vaccination Rate	Oct 1, 2014-Mar 31, 2015	2016	NHSN

Payment Penalty Explained

A center that does not successfully report data to the Medicare program will have their payments reduced by 2 percent in 2014.

CMS will identify centers by their CMS Certification Number (CCN) – formerly called the Medicare Provider Number.

If a center does not submit quality data beginning October 1, 2012, CMS will reduce the 2014 ASC conversion factor for that center by 2%, so all claims will be paid at a lower rate.

For example, if the conversion factor for the year was $40.00, a non-reporting ASC would start with a base rate of $39.2. That new 'starting point' would then be multiplied by the relative weight for each service and adjusted by the wage index to arrive at the price for an individual center.

Additional Quality Reporting Info from the IPPS* Rule (April 24, 2012)

The completeness threshold is set at 50%

ASCs will be considered successful reporters and get their full payment if 50% of the relevant claims contain the quality data codes. This threshold will be increased in future years. Page 931.

In keeping with other reporting programs CMS will not seek to validate what is reported through record review or other means. Page 932.

There is a process for an extension in extraordinary circumstances. Page 933.

The reconsideration process is based on the ones the hospital uses now. Page 935.

There are limited details on how the public reporting will work, which is something ASCA will comment on.

*Inpatient Prospective Payment Systems

IPPS Rule Quality Reporting

The use of quality data codes on an ASC's claims will indicate that a facility is participating in the quality reporting program. No additional action by the ASC is required.

Any ASC that is a Medicare-participating facility as of January 1, 2012, will need to begin reporting October 1, 2012, to be eligible for the full Medicare payment update in 2014. Those that are designated as open by October 1, 2012, will need to begin reporting January 1, 2013. Although CMS has not clearly indicated how this schedule will affect ASCs that open in the future, ASCs that open by October of a given year could reasonably expect to be required to begin reporting on January 1 of the subsequent year. ASCA will seek clarification on this point.

The proposal sets a completeness threshold of 50%, which means that ASCs will be considered successful reporters and will not face financial penalties if 50% of their Medicare claims contain quality data codes. This threshold will increase in future years as ASCs become more experienced with the new quality reporting system.

CMS will not seek to validate what ASCs report through record review or any other means beyond the usual claims validation process Medicare contractors conduct.

If an ASC believes that CMS has erred in determining that the ASC has failed to adequately report data, that ASC will have access to the same reconsideration process available to hospitals.

ASCs that are unable to report quality data due to extraordinary circumstances will be able to avail themselves of an extension/waiver process.

IPPS Rule Quality Reporting

While CMS noted that it is "proposing that any and all quality measure data submitted by [an] ASC" could be made public, the agency did not specify what data it will use for public reporting. ASCA has and will continue to advocate for CMS to begin by posting on their web site those ASCs participating in the program as facilities gain familiarity with reporting. This transition would then be followed by CMS posting each facility's performance on the measures as they do for hospitals and home health agencies.

ASCs will be required to designate an individual to serve as the Center's QualityNet administrator. This person will serve as a point of contact between the ASC and the QualityNet web site. ASCs will use this site to report data on their use of a safe surgery checklist and the surgical volume they manage beginning in the summer of 2013. ASCs will need to have a QualityNet administrator in place by that time. CMS cautions that ASCs should allow two weeks to complete the process of registering a QualityNet administrator with CMS.

CMS Release of Quality Reporting Manual

In April of 2012, the Centers for Medicare & Medicaid Services (CMS) released its manual for the ASC quality reporting program .

The manual provides detailed information on how ASCs will be reporting quality data to CMS.

Full Title:

CMS Ambulatory Surgical Center Quality Reporting Program
Quality Measures Specifications Manual
Version 1.0

Of note, the manual indicates that ASCs that used a safe surgery checklist based on accepted standards of practice at any time during 2012 can answer "yes" when they report whether they used a safe surgery checklist during the year.

Previously, CMS had indicated that ASCs would be able to answer "yes" only if they had a safe surgery checklist in place on January 1, 2012. This change will allow more ASCs to be able to report that they used a checklist in 2012.

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Take Home Messages

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