Quality reporting for ASCs is off to a good start

Starting October 1, 2012, the Centers for Medicare and Medicaid Services (CMS) began requiring quality reports on Medicare claim forms from ambulatory surgery centers (ASCs). From all indications, complications were few, and ASCs already are using the new statistics to gain insight into operational trends.

Ultimately, the self-reports of patient safety measures will be publicly available and used to determine a portion of Medicare payments starting in 2014.

Initial reports indicate ASCs using computerized information systems find adopting the new G codes easier, and while ASC employees are adapting quickly, some Medicare representatives need to be more familiar with the process. (G codes are alphanumeric codes that indicate the presence or absence of an event such as a patient burn.)

Sharing best practices

“So far, things are going well,” reports Jan Allison, RN, CHSP, director of quality and accreditation at Surgical Care Affiliates (SCA) based in Birmingham, Alabama. SCA’s 140 surgery centers are comparing notes on the most efficient ways to implement the program, she adds.

“We have shared best practices, such as communication between billing and administration and even risk management.”

To aid communication and to document compliance, SCA designed a template for a form that is attached to each patient chart, listing the measures with a space for checking off the codes that apply.

“The nurse providing the last level of care [before discharge] fills out the form,” Allison explains. “The administrator or risk manager reviews the form and signs off before sending it on to billing. So, if an event happens, they are assured of being aware for appropriate followup.”

Medicare auditors keeping track

Some ASCs have found that Medicare auditors, especially those from outside contractors, are underreporting compliance with the 50% requirement. This may be because auditors check only paid claims for the presence of G codes, and these may represent only a small proportion of submitted claims.

One facility received an auditor letter citing it for not meeting the requirement. The letter states in part, “Your facility’s QDC [quality data code] use status is calculated from your Medicare FFS [fee for service] claims from October 1, 2012 to the present (the letter is dated November 12, 2012).” The letter also notes that calculations were based “on the available claims that have been processed,” meaning claims submitted but not yet paid during the last quarter were not counted, and little more than a month’s worth of paid claims were counted.

“Our reports say we entered a G code event in every case,” the ASC’s billing manager says. “They looked at only a small population.”

Until Medicare provides clarification, ASCs should be aware that auditors may
challenge their compliance. The number of paid claims in the early months of the program may not be enough to represent at least half of all claims submitted.

According to the Medicare audit letter, 79% of ASCs have met the minimum reporting requirement of 50% of procedures, and 33% are using G codes on all of their claims.

**Cooperation is key**

Since the quality reporting program was proposed, ASCs and their organizations have been working with CMS and accrediting bodies to iron out questions and implement suggestions.

The latest development is an addendum to version 1.0a of the Ambulatory Surgical Center Quality Reporting Program Specifications Manual. In response to early reports by ASCs that codes were not always recognized by claim systems when Medicare was a secondary payer, the updated version 1.0b extends the reporting date for Medicare secondary payer patients to January 1, 2013.

The October starting date itself was a compromise; CMS originally asked for reports starting January 1, 2012, on 7 quality measures. The agency later changed that requirement to October 1, 2012, for 5 measures, with another 4 to be added later. Under the Medicare outpatient payment rule, failure to meet reporting deadlines for at least 50% of the measures could result in lower reimbursement.

During a video conference in September 2012, Anita Bhatia, PhD, showed ASC managers the new claim form and how to code the various quality measures. Dr Bhatia is program lead for the CMS ASC quality reporting program.

The data will be made available to the public, she told them, but the format has not yet been determined. It will likely be on a website.
Reporting timeline
CMS released a revised timeline for quality reporting, including the delayed start date for secondary payer reports.

The initial 5 measures are patient burn, patient fall, wrong site, hospital transfer, and IV antibiotic timing.

On July 1, 2013, ASCs must begin reporting the sixth measure, use of a safe surgery checklist for all patients, and the seventh, annual procedure volume. However, they must report these measures retroactively; the July report will be for 2012.

Reports for the sixth and seventh measures will be reported on the CMS-sponsored QualityNet web site (www.qualitynet.org).

The eighth measure, vaccination of staff against influenza, will be reported starting October 1, 2014, using the National Health Care Safety Network.

Reports based on procedures performed between October 1 and December 31, 2012, will affect payment updates for 2014. The payments will depend on whether an ASC reported using the CMS codes, not on whether the ASC actually complied with the protocols. There are no current requirements for validation of the reports, Dr Bhatia noted.

Training and technology
At Lakeview Surgery Center in West Des Moines, Iowa, electronic medical record software was upgraded to accept the 12 G codes representing all possible alternatives. Then business office and clinical staff received training separately. According to clinical director Rikki Knight, MHA, RN, 100% of the codes have been accepted, and the system has not created extra work.

Discharge nurses are responsible for making the quality reports.

“That seems to be going fine with no problems and has become a part of our routine,” Knight says. “We feel it is simple and causes no extra work on either our business office or clinical staff.”

Shortly after implementation, a hospital transfer occurred, providing a real-time test of the system.

“Everything pulled correctly,” Knight says.

Useful data
Long before the quality reporting program took effect, the ASC division of the national hospital company HCA Healthcare was already collecting clinical data and began planning early for addition of the G codes.

“Because we have so many centers, we’ve been collecting that data and reporting for quite some time,” regional division vice president David Roy says of HCA’s internal quality program.

One thing they have learned is that deep vein thrombosis (DVT) occurs more frequently in the region surrounding Denver than the national average, possibly because of the higher altitude.

“DVT was identified as an issue to work on,” Roy says. “We’re now investigating more deeply.”

Tracking transfers
Baycare Health System in Clearwater, Florida, trained business and clinical staff together. “They already worked together well,” says ambulatory surgery director Nancy Burden, MS, RN, CAPA, CFAN.

As Baycare’s 4 ASCs began recording the quality measures, Burden’s staff no-
noticed an anomaly in the rate of hospital transfers. Using available national data, Burden and her staff compared Baycare’s transfer rate, as reported to CMS, with nationwide rates. “Our facilities have been consistently higher than the rest of the country.”

Further analysis revealed the reason: Baycare ASCs are especially likely to examine patients on the day of surgery for any conditions not evident at the time of scheduling.

Any sign of elevated risk is a signal to move the procedure to a hospital. Most of Baycare’s transfers turned out to occur before rather than after surgery and to be precautionary rather than due to complications.

“Such a precaution is good for the patient,” Burden says.

Sharing responsibility
Orthopaedic Surgery Center in Concord, New Hampshire, assigns OR nurses to document IV antibiotic administration. The postanesthesia care unit (PACU) nurses are responsible for documenting any other events or hospital transfers.

“To comply with this regulation and to make it easy, I placed a bright green sheet in every patient record,” director Donna Quinn, BSN, MBA, RN, CPAN, CAPA, says. After nurses complete the form, they give it to the director, who uses it to complete a daily form generated by the billing service.

The billing service’s software generates a daily report identifying the Medicare patients, along with a list of G codes. The report completed by the director then provides the information needed to generate the appropriate codes for the Medicare claim.

“It has become part of the routine,” Quinn says. “The staff knows it needs to be done and is being compliant.” She notes, however, that documentation would be easier if all departments had integrated computer systems.

“It may be an easy process for facilities that are completely electronic,” she says, “but being paper and electronic still requires manual intervention.”

—Paula DeJohn