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CMS expert offers advice on ASC quality reporting

With the early issuance of quality reporting codes for Medicare, both ambulatory surgery centers (ASC) and the Centers for Medicare and Medicaid Services (CMS) have a chance to develop expertise in their use and to resolve any technical problems before the mandatory start date of October 1, 2012.

And that is what is happening.

For example, some early-adopting ASCs have seen their Medicare claim forms returned because a processor's system didn't recognize the new codes.

CMS is investigating. "Let me find out what's going on," Anita Bahtia, PhD, told a group of ASC administrators on hearing of the problem. Meanwhile, she assured them, they will be paid if they resubmit the claims but leave out the new codes, called G-codes, for now.

Dr Bahtia, whose specialty is public health, is program leader for quality reporting at CMS.

"The point of starting early is to practice," she reminded the group in a presentation to the Ambulatory Surgery Center Association (ASCA) annual conference in May 2012 in Dallas.

'They listened'

Outgoing ASCA president David Shapiro, MD, praised Dr Bahtia and CMS for working closely with the industry to craft a coding system that would reflect accurately ASC practices without placing undue administrative hardship on surgery centers.

"They really listened to us," Dr Shapiro says. "They told us what their issues were, and we told them what ours were." Among the issues were the need to use limited staff resources effectively and the need for training and access to CMS for information.

The new codes are the product of close collaboration between the industry and CMS regulators. CMS adopted most of the measures and criteria developed by the ASC Quality Collaboration (ASC QC), a consortium of ASCs, professional associations, and accrediting organizations.

The quality measures the codes will reflect are:

- patient burns
- patient falls
- wrong-site surgery
- hospital transfers
- timing of prophylactic antibiotics.

The National Quality Forum, a national standards organization, endorsed the measures before they were submitted to CMS and will continue to review and update them as needed.

CMS issued the new codes on April 1, 2012, and ASCs were invited to start using them immediately. After October 1, 2012, ASCs that fail to use the new codes for at least half of the 5 measures will be penalized in 2014 with a 2% reduction in that

ASC-reported data shows a good record on quality

It is unlikely that there will be any surprises after ambulatory surgery centers (ASC) start reporting quality measures. For the initial 5 measures that CMS will start collecting in October 2012, a recent study shows ASCs have a good record, and it's getting better.

During the 4th quarter of 2011, data provided by 1,309 ASCs indicate their patient-fall rate is 0.126 per 1,000 admissions, down from 0.156 in the 1st quarter of 2011.

Patient burns declined even more sharply for this group, to 0.017 per 1,000 admissions from 0.035 in the 1st quarter.

The ASC Quality Collaboration (ASC QC) issues quarterly reports based on voluntary reporting by participating ASCs. In the current report, every state was represented except Vermont.

For the other measures, results in the 4th quarter compared with the 1st quarter were as follows:

- Hospital transfer: 1:04 per 1,000 admissions, down from 1:194
- Wrong site: 0.045 per 1,000 admissions, up from 0.03
- IV antibiotic timing: 98% on time, up from 97%.

A 6th measure, appropriate surgical site hair removal, was included in the survey. ASC QC recommended it, but the Centers for Medicare and Medicaid Services (CMS) did not adopt it. The survey responses showed 99% of participants used appropriate methods, up from 98%.

According to ASC QC executive director Donna Slosburg, RN, the results are made public and may be helpful to patients considering outpatient surgery.

"These data and the accompanying information do not present all there is to know about the quality of ASCs," Slosburg notes. "Patients are encouraged to discuss these quality indicators with their local ASC staff and their physicians."

year's payment update. CMS provides additional details on its web site at www.cms.gov.

To keep implementation simple, there is no need to register to participate, though ASCs will need to have their claim systems modified to accept the new codes.

"If you submit codes, CMS considers you to be participating," Dr Bahtia says. However, CMS is considering a process to let ASCs formally withdraw from the program.

"There are no performance thresholds," she adds. Reporting "yes" or "no" on each measure is sufficient. There are 12 G-codes in all, covering various circumstances related to the 5 measures.

To assist in communication, CMS sponsors the QualityNet web site (www.qualitynet.org), which includes a secure question-and-answer feature.

"Use QualityNet," she advises, rather than the many other Internet resources available: "You will get answers much faster."

On April 30, 2012, CMS released the Ambulatory Surgical Center Quality Reporting Specifications Manual, Version 1.0. ASC QC offers an implementation guide on its web site, www.ascquality.org.

ASCA is offering help to its members via a series of webinars and discussion groups.

Why the focus on quality?

"It's something you all have been doing forever," Dr Shapiro told the ASCA administrators, regarding the focus on quality. Documenting that effort is something else: "It costs money, it takes time."

The recent focus on defining and measuring quality will benefit ASCs in several

ways, he says. Pursuing quality "motivates people to excel and increases the likelihood of desired outcomes."

In addition, it will provide a marketing tool for ASCs by demonstrating with statistics the level of quality their patients enjoy.

"With no mandate [for reporting quality], regulators and Congress had the impression that ASCs did not measure quality," Dr Shapiro says. "It was not the case; it was just that there was no mandate."

In any case, he notes, state accreditation requirements are beginning to include quality reporting with increasing frequency. From a business perspective, quality measurement is a management tool that helps in planning, improvement priorities, recruitment, and attracting investors.

"This is the bright side of the CMS mandate," he says.

Looking to the future

The first 5 quality measures will be reported on Medicare claim forms starting in October. The codes reported for procedures performed between October 1, 2012, and December 31, 2012, will affect the payment updates for 2014.

Dr Bahtia stresses that payments will be based on whether the ASC reports or not—not on whether the ASC complies with the quality criteria.

The 6th quality measure, use of a safe-surgery check list, and 7th measure, the volume of selected procedures, will become reportable July 1, 2013, through August 15, 2013, but those reports will be based on performance this year—from January 1, 2012, to December 31, 2012.

Rather than using claim forms, ASCs will enter data on a CMS-assigned website. Failure to report these measures will result in lowered payments in 2015.

The 8th measure, vaccination of staff against influenza, takes effect October 1, 2014, through March 31, 2015. During that period, ASCs must report vaccination rates using the National Health Care Safety Network administered by the Centers for Disease Control and Prevention.

Dr Bahtia says she is beginning to develop criteria to be used in adoption of value-based purchasing (otherwise known as "pay for performance") for ASCs. In March 2012, the Medicare Payment Advisory Commission (MedPAC) recommended that ASCs begin participating by 2016. ❖

—Paula DeJohn

Have a question on the OR revenue cycle?

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