Ambulatory Surgery Center Association

QUALITY REPORTING TOOLKIT

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QUALITY DATA G-CODES

Corresponding Quality Measure	G-code
If no adverse events occurred, report the following:	
All four adverse events **did not** occur	**G8907**
If one or more adverse events occurred, report four of the following:	
Patient burn	**G8908**
Patient burn **did not** occur	**G8909**
Patient fall in ASC facility	**G8910**
Patient fall in ASC facility **did not** occur	**G8911**
Wrong site/side/patient/ procedure/implant	**G8912**
Wrong site/side/patient/ procedure/implant **did not** occur	**G8913**
Hospital transfer/admission	**G8914**
Hospital transfer/admission **did not** occur	**G8915**
Always report one of the following:	
Prophylactic IV antibiotic initiated **on time**	**G8916**
Prophylactic IV antibiotic not initiated on time	**G8917**
Patient without preoperative order for prophylactic IV antibiotic	**G8918**

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QUALITY REPORTING TIMELINE

2012

Before October 1:
Trial period for quality G-code reporting

October 1:
Quality G-code reporting begins; 50% of Medicare claims must contain G-codes

For all patients, use a safe surgery checklist at any time during the year and track surgical volume from Jan 1 to Dec 31 to report in 2013

October 1 – December 31:
Include G-codes only on claims where Medicare is the primary payer

2013

January 1:
Begin to include G-codes on claims where Medicare is either the primary or secondary payer

March:
Register for the QualityNet site at *qualitynet.org*

July 1 – August 15:
Report 2012 use of safe surgery checklist and total 2012 surgical volume on the QualityNet site

2014

Influenza Vaccination Coverage among Health Care Professionals added to quality reporting measures

2015

More reporting requirements expected

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Important Dates for Medicare's New Quality Reporting Program

Until October 1, 2012, when the quality reporting requirement takes effect, ASCs can use the new quality data G-codes on a test basis to ensure that the process is running smoothly. ASCs that experience any problems should alert ASCA so that it can work with the Centers for Medicare & Medicaid Services (CMS) to fix the problems on a systemic level.

October 1, 2012:

ASCs will be required to start reporting quality data G-codes on five measures (four adverse events and the timing of prophylactic IV antibiotic administration) or face future Medicare payment reductions. ASCs will include the G-code corresponding to the Medicare patient's experience under the procedure code(s) in box 24 D of the CMS-1500 claim form.

The number of G-codes reported on the claim form will always be either two or five:

- One G-code that corresponds to the patient's experience with IV antibiotic prophylaxis will be reported on all claims.
- An additional G-code, G-8907, will be reported if the patient does not experience any of the four specific adverse events (patient burn, patient fall, wrong site/side/patient/procedure/implant and hospital transfer/admission).
- An additional four G-codes, each corresponding to one of the four specific adverse events, will be reported if the patient does experience one or more of the adverse events.

  For a detailed list of the quality data G-codes, visit *ascassociation.org/Gcodes*.

October 1 – December 31, 2012:

ASCs will be considered successful reporters and not face future financial penalties if 50 percent of their Medicare claims contain quality data codes. (This percentage may increase in future years.) In addition, ASCs should include the G-codes only on claims where Medicare is the primary payer.

January 1, 2013:

ASCs should begin placing the G-codes on claims where Medicare is either the primary or secondary payer. ASCs can now register to use CMS's QualityNet site, *qualitynet.org*. Because these accounts will be deactivated after 120 days of inactivity, ASCA suggests that ASCs wait until March 2013 to register.

July 1 – August 15, 2013:

ASCs will be required to go to *qualitynet.org* and report their total surgical care volume for selected groups of procedures and whether they used a safe surgery checklist at any time between January 1, 2012, and December 31, 2012. No particular checklist is required. For a list of sample safe surgery checklists, visit *ascassociation.org/QualityReporting*.

2014:

One additional measure, Influenza Vaccination Coverage Among Health Care Personnel, is slated to be added to the list of quality reporting measures.

2015 & Beyond:

More requirements are expected to be added.

Ambulatory Surgery Center Association

QUALITY REPORTING

FREQUENTLY ASKED QUESTIONS

The Centers for Medicare & Medicaid Services (CMS) recently announced details of its new quality reporting program for ASCs, which will begin in 2012. Under the program, ASCs that fail to report required information will face a 2% reduction in their Medicare payments. This document provides answers to some frequently asked questions about the program. To view more frequently asked questions, visit *ascassociation.org/QualityReporting*. ASCA members with additional questions can contact ASCA's Member Services Team at *asc@ascassociation.org* or 703.836.8808 for answers.

CMS has indicated that it will continue to publish more answers to questions about Medicare's quality reporting program in regular updates of the program's specifications manual. Updated versions of the manual will be available on ASCA's web site at *ascassociation.org/QualityReporting*.

1. What measures will we be required to report? When will we be required to report them?

As of October 1, 2012, ASCs will be required to report data on the following five quality measures:

1. Patient Burn
2. Patient Fall
3. Wrong Site/Side/Patient/Procedure/Implant
4. Hospital Admission/Transfer
5. Prophylactic IV Antibiotic Timing

2013 will usher in the addition of two more measures:

1. Safe Surgery Checklist Use in 2012
2. 2012 Volume of Certain Procedures

While ASCs won't be required to report information on these last two measures until 2013, at that time, they will be expected to report data based on activities conducted in 2012. This means that an ASC should ensure that it is using a safe surgery checklist and has a system in place to capture surgical volume data on January 1, 2012. ASCs that want to avoid financial penalties will need to report whether or not they were using a safe surgery checklist at any time between January 1, 2012, and December 31, 2012. If a high percentage of ASCs report that they did not use a safe surgery checklist in 2012, CMS's public reporting of that information could generate negative news stories and concerns among patients and providers.

In 2014, one additional measure, Influenza Vaccination Coverage Among Health Care Personnel, is slated to be added to the list of quality reporting measures. This measure assesses the percentage of health care personnel (HCP) who have been immunized for influenza during the flu season.

Each year, CMS will evaluate the list of measures, adding new measures and, potentially, retiring existing ones. CMS will select measures that reflect consensus among affected parties and, to the extent feasible, will include measures set forth by one or more national consensus-building entities. The chart that follows provides a summary of the measures ASCs will be required to report initially, and their performance and reporting dates.

Measure	Reporting Period	Payments Affected Beginning
1. Patient Burn	Begins October 1, 2012	2014
2. Patient Fall	Begins October 1, 2012	2014
3. Wrong Site/Side/Patient/ Procedure/Implant	Begins October 1, 2012	2014
4. Hospital Admission/Transfer	Begins October 1, 2012	2014
5. Prophylactic IV Antibiotic Timing	Begins October 1, 2012	2014
6. Safe Surgery Checklist Use in 2012	July 1 thru August 15, 2013 (measures use 1/1/12–12/31/12)	2015
7. 2012 Volume of Certain Procedures	July 1 thru August 15, 2013 (measures use 1/1/12–12/31/12)	2015
8. Influenza Vaccination Coverage Among Health Care Personnel	October 1, 2014, thru March 31, 2015	2016

2. How will the 2% penalty be calculated and applied?

An ASC that does not successfully report data to the Medicare program by the specified 2012 deadlines will have its payments reduced by 2% in 2014. CMS will identify ASCs by their CMS Certification Number (CCN), which was formerly called the Medicare Provider Number. Beginning October 1, 2012, at least 50% of Medicare claims must contain quality data G-codes. If a facility fails to meet that requirement, CMS will reduce the 2014 ASC conversion factor for that center by 2%, causing all of the ASC's Medicare claims to be paid at a lower rate. For example, if the conversion factor for the year is $40.00, a non-reporting ASC would start with a base rate of $39.20. 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 reimbursement Medicare will provide to that ASC.

Failure to report in subsequent years will affect future years' payments to the same extent. For example, an ASC that fails to report in 2013 will receive reduced payments in 2015. The penalties, however, will not be cumulative. An ASC that fails to report in 2012 but successfully reports in 2013 will receive the full payment update in 2015.

3. My ASC is run by a management company. Can the corporate office report my facility's data for me?

Generally, no. Beginning on October 1, 2012, ASCs must use quality data G-codes that Medicare released in 2012 to report the five measures that CMS selected for the initial year of the reporting program. ASCs will need to include these codes on the CMS-1500 claim forms they submit to Medicare. At this time, CMS can receive this information only when it is submitted on Medicare claims.

CMS will begin collecting information on certain quality measures in 2013 through its QualityNet web site (*qualitynet.org*). (Note that the web site is not yet able to accept ASC registrations.) ASCs will have to create an account on the web site and log in during specified periods of time in 2013 (see the chart included in the response to Question #1 above) to report whether or not they had a safe surgery checklist in use during Calendar Year 2012. Beginning in 2013, ASCs will also need to use this site to report the surgical volumes for specific procedures performed in 2012 on all patients (Medicare and non-Medicare). This information could be reported by an individual who is located either in a center or at a corporate headquarters as long as the ASC has authorized that person to file the report using the center's unique access code.

4. Will Medicare evaluate our ASC's performance based only on whether we report the data as required, or do we have to achieve certain results? In other words, will CMS penalize us if we fail to meet certain benchmarks?

For now, if you report the required data (for example, whether or not you used a safe surgery checklist any time during 2012) you will be in compliance with the ASC Quality Reporting Program and receive the full annual update to your payments. The program does not currently base payments on your performance on the quality measures.

ASCs should be aware that CMS will make these data reports available to the public. The public may form a negative perception of ASCs that do not report data or that report poor performance on the quality measures, so centers are encouraged to focus not only on reporting successfully, but also on achieving high levels of performance on each measure.

5. Do we have to report data for Medicare patients only or for all patients?

This answer depends on the reporting measure. The first five measures in the chart included in Question #1 will need to be reported using the G-codes that Medicare has provided. Your ASC will need to report these measures only for Medicare Part B fee-for-service beneficiaries (including Railroad Retirement Board). For example, no data would be submitted for a Medicare beneficiary who is enrolled in a Medicare Advantage plan. Beginning January 1, 2013, your ASC will also need to report these measures on claims where Medicare is the secondary payer.

Beginning in 2013, however, ASCs will be required to report their total—Medicare and non-Medicare—2012 surgical volume for certain specified procedures.

The other two measures that have been announced—Safe Surgery Checklist Use and Influenza Vaccination Coverage Among Health Care Personnel—are not patient-specific. They apply to the general operation of the ASC.

6. Do we report data on claims for Medicare beneficiaries if they are for non-covered services?

No. When a Medicare beneficiary has a service that is not covered by Medicare, you would not report quality data on the claim submitted for this service.

7. Should an ASC report a charge or leave the charge field blank when reporting a G-code on a claim?

G-codes must be entered on the CMS-1500 claim form and have an associated charge in order to be accepted into the CMS warehouse. These codes will populate fields 24 D and 24 F on the claim form.

- The submitted charge field cannot be blank.
- The line-item charge should be the numeral “0” (zero). Please note that dollar signs ($) or decimal points are not accepted.
- If a system does not allow a zero line-item charge, a nominal amount can be substituted; the beneficiary is not liable for this nominal amount.
- Entire claims with a zero charge will be rejected. The total charge for the claim cannot be zero.
- When a zero charge or a nominal amount is submitted to the carrier or contractor, payment for the amount included in the ASC quality data G-code line is denied and tracked.

8. Will my ASC receive a Remittance Advice (RA) associated with a claim that contains a G-code line-item?

ASCs will receive an RA for a claim on which the G-code is reported. The RA will include a standard remark code (N365) and a message confirming that the G-code passed into the National Claims History (NCH) file. N365 reads as follows: “This procedure code is not payable. It is for reporting/information purposes only.” The N365 remark code does not indicate whether the G-code is accurate for that claim or for the measure being reported.[1]

ASCs should keep track of all cases that they report using a G-code so that they can verify the G-codes that their ASC reported against the RA notice sent by their Medicare Administrative Contractor (MAC). Each G-code line-item will be listed with the N365 denial remark code.

ASCs should note that the submission of a non-zero charge amount for G-codes may complicate secondary payers’ processing of the claims. ASCs are not allowed to collect any monies from beneficiaries for charges submitted for the G-codes.

9. We forgot to put the G-codes on a claim. Can we resubmit the claim with the proper G-codes attached?

Claims may not be resubmitted for the sole purpose of adding or correcting G-codes.[1]

10. We submitted a claim that was denied, but the error has been corrected and we plan to resubmit the claim. Do we include the G-codes again?

If a denied claim is subsequently corrected through the appeals process involving the carrier/Medicare Administrative Contractors, G-codes should also be included on the resubmitted claim in accordance with the instructions in the measure specifications.[1]

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[1]These answers are based on guidance issued by CMS for the Physician Quality Reporting System (PQRS) program. While we anticipate that the agency will apply similar guidance to the ASC Quality Reporting Program (QRP), CMS could apply different standards. These FAQs will be updated when final guidance is issued by CMS.

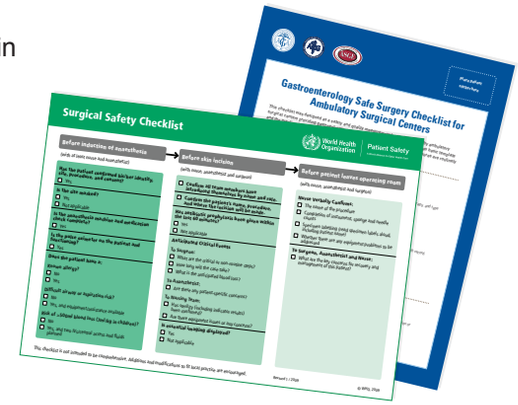
REPORTING USE OF A

SAFE SURGERY CHECKLIST

In 2013, ASCs will be required to go to the CMS QualityNet web site between July 1 and August 15 and report whether they used a safe surgery checklist at any time between January 1, 2012, and December 31, 2012, for all patients, not just those covered by Medicare.

ASCs are required to report safe surgery practices during each of the three critical perioperative periods. CMS provides the examples below. Because CMS is not dictating that ASCs use a particular checklist, ASCs are free to select a checklist (or multiple checklists) that meets their individual needs.

It is also important to note that, although CMS uses the name safe "surgery" checklist, the measure applies to all ASC procedures, including those that are generally considered to be diagnostic and pain management procedures (e.g., certain endoscopies and injections for controlling pain).



Several organizations, including the World Health Organization and the Association of periOperative Registered Nurses (AORN), have developed boiler plate checklists that can be adjusted to suit the needs of a particular ASC. To view and download several of these sample checklists, visit *ascassociation.org/QualityReporting*.

CMS's Examples of Safe Surgery Practices

First Critical Point	Second Critical Point	Third Critical Point
prior to administering anesthesia	prior to skin incision	during closure of incision and prior to patient leaving the operating room
▸ Verbal confirmation of patient identity ▸ Mark surgical site ▸ Check anesthesia machine/ medication ▸ Assessment of allergies, airway and aspiration risk	▸ Confirm surgical team members and roles ▸ Confirm patient identity, procedure and surgical incision site ▸ Administration of antibiotic prophylaxis within 60 minutes before incision ▸ Communication among surgical team members of anticipated critical events ▸ Display of essential imaging as appropriate	▸ Confirm the procedure ▸ Complete count of surgical instruments and accessories ▸ Identify key patient concerns for recovery and management of the patient

CMS ASC Quality Reporting Program Quality Measures Specification Manual Version 1.0a

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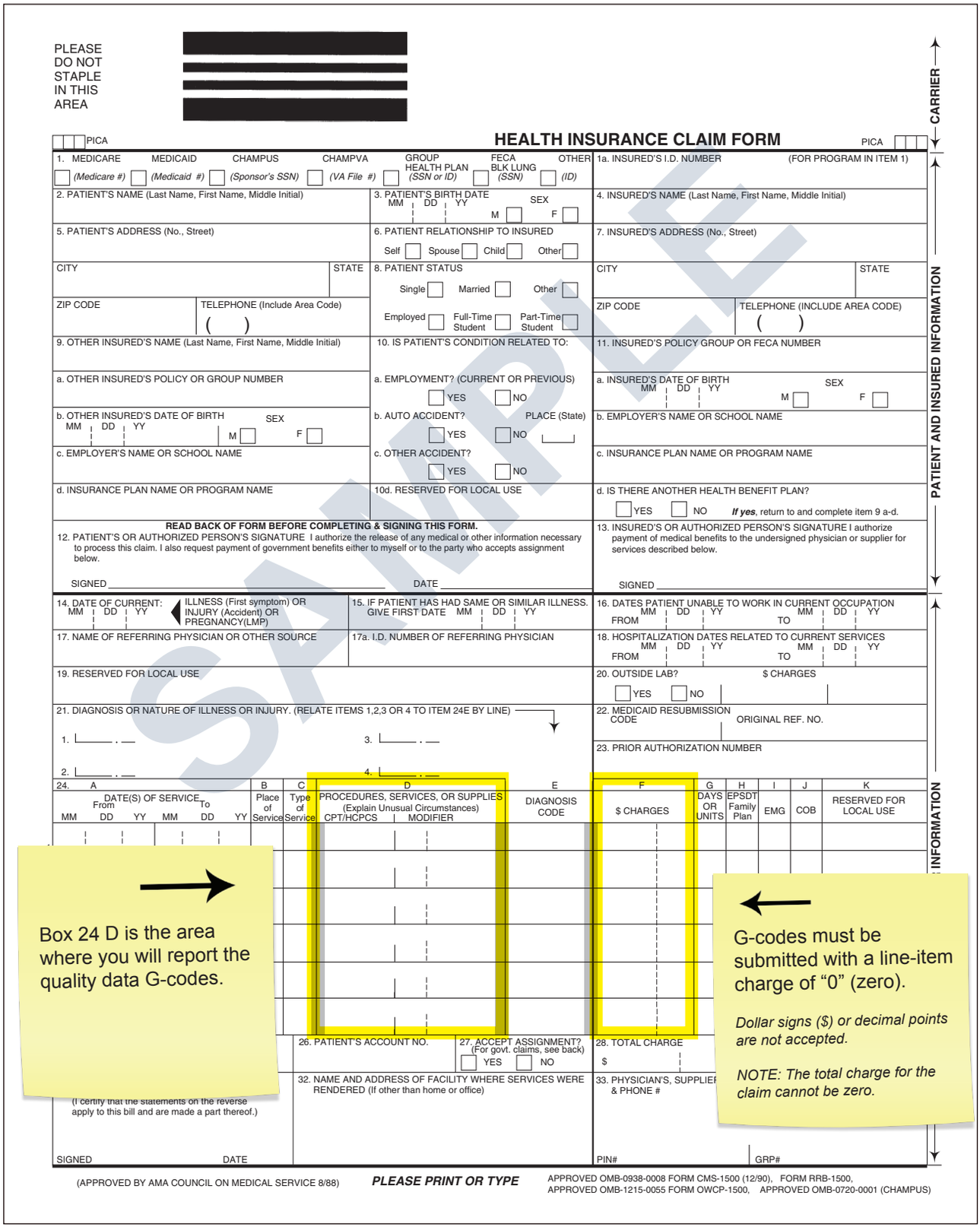
HOW TO COMPLETE A

CMS-1500 CLAIM FORM



PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

INFORMATION

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER & PHONE #

SIGNED DATE

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Box 24 D is the area where you will report the quality data G-codes.

G-codes must be submitted with a line-item charge of "0" (zero).

Dollar signs ($) or decimal points are not accepted.

NOTE: The total charge for the claim cannot be zero.

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- Obtain valuable coding tips to ensure accurate coding and reimbursements.

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Surgical Notes

Register now at ascassociation.org/Coding

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BOSTON: APRIL 17–20

- ASCA's annual meeting will be held in Boston at the Hynes Convention Center, April 17–20, 2013.
- ASCA 2013 promises to be the largest and most comprehensive industry event of the year, with an anticipated attendance of more than 2,500 attendees.
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Learn more at ascassociation.org/ASCA2013

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ASCA 2012 Webinar Series

Upcoming Webinars

FREE: Quality Measure Reporting
Tuesday, September 11, 1:00 pm ET
Donna Slosburg, BSN LHRM CASC, *Executive Director, ASC Quality Collaboration* and Gina Throneberry, MBA RN CNOR ONC CASC, *Director of Education & Clinical Affairs, ASCA*

Please note, continuing education credits are not provided.

Tough Coding Issues for Pain Management
Tuesday, September 18, 1:00 pm ET
Lisa Rock, *President,* Tamara Wagner (BS, CPC), *Vice President, Coding,* and Jessica Edmiston (BS, CPC, CASCC), *Manager, Coding, National Medical Billing Services*

An ASC's Guide to Evaluating Anesthesia Support and Secrets About Your Anesthesia Partnership You Should Know
Tuesday, October 9, 1:00 pm ET
Speaker: TBD

Documentation Deficiencies that Impact Reimbursement for ASCs
Tuesday, November 13, 1:00 pm ET
Stephanie Ellis, RN, CPC, *Ellis Medical Consulting, Inc.*

Preparing for 2013—Medicare's Final Rule
Tuesday, December 18, 1:00 pm ET
Jonathan Beal, ASCA

Recorded Webinars

Personnel Challenges that Tax ASCs
Tuesday, August 28, 1:00 pm ET
Ann Geier MS RN CNOR CASC, *Sr. Vice President of Operations, Ambulatory Surgical Centers of America*

Preparing for 2013—Medicare's Proposed Rule
Tuesday, August 14, 1:00 pm ET
Jonathan Beal and Marian Lowe, *ASCA Health Care Policy Consultants*

10 Best Practices for 2012 ASC Payer Contracting Negotiations
Tuesday, July 31, 1:00 pm ET
Susan Charkin, MPH, *President, Healthcents*

Targeted Solutions Tool™: Reducing Risk. Reducing Wrong Site Surgery.
Tuesday, July 10
Melody Dickerson, RN, MSN, Master Black Belt, *The Joint Commission*

Revisiting Your Surgery Center's Infection Control Plan—An Annual "Checkup" for Ensuring Regulatory and Accreditation Survey Compliance
Tuesday, June 26
Lee Anne Blackwell, RN, BSN, EMBA, CNOR, *Group Director Clinical Services, Team UP, Surgical Care Affiliates*

FREE: Quality Measure Reporting in 2012
Tuesday, June 5
Donna Slosburg, BSN LHRM CASC, *Executive Director, ASC Quality Collaboration* and Gina Throneberry, MBA RN CNOR ONC CASC, *Director of Education & Clinical Affairs, ASCA*

Please note, continuing education credits are not provided.

Analyzing Your Revenue Cycle
Tuesday, May 22
Lisa Rock, *President, National Medical Billing Services*

Learn more at ascassociation.org/Webinars