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

**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

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

2014

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

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

2015

**More reporting requirements expected**

 toolkit sponsored by: ASCA, GIN, McKesson
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.
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.
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.

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<table>
<thead>
<tr>
<th>Measure</th>
<th>Reporting Period</th>
<th>Payments Affected Beginning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Burn</td>
<td>Begins October 1, 2012</td>
<td>2014</td>
</tr>
<tr>
<td>2. Patient Fall</td>
<td>Begins October 1, 2012</td>
<td>2014</td>
</tr>
<tr>
<td>3. Wrong Site/Side/Patient/Procedure/Implant</td>
<td>Begins October 1, 2012</td>
<td>2014</td>
</tr>
<tr>
<td>4. Hospital Admission/Transfer</td>
<td>Begins October 1, 2012</td>
<td>2014</td>
</tr>
<tr>
<td>6. Safe Surgery Checklist Use in 2012</td>
<td>July 1 thru August 15, 2013 (measures use 1/1/12–12/31/12)</td>
<td>2015</td>
</tr>
<tr>
<td>7. 2012 Volume of Certain Procedures</td>
<td>July 1 thru August 15, 2013 (measures use 1/1/12–12/31/12)</td>
<td>2015</td>
</tr>
</tbody>
</table>
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.
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

¹These 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

<table>
<thead>
<tr>
<th>First Critical Point</th>
<th>Second Critical Point</th>
<th>Third Critical Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>prior to administering anesthesia</td>
<td>prior to skin incision</td>
<td>during closure of incision and prior to patient leaving the operating room</td>
</tr>
<tr>
<td>▶ Verbal confirmation of patient identity</td>
<td>▶ Confirm surgical team members and roles</td>
<td>▶ Confirm the procedure</td>
</tr>
<tr>
<td>▶ Mark surgical site</td>
<td>▶ Confirm patient identity, procedure and surgical incision site</td>
<td>▶ Complete count of surgical instruments and accessories</td>
</tr>
<tr>
<td>▶ Check anesthesia machine/medication</td>
<td>▶ Administration of antibiotic prophylaxis within 60 minutes before incision</td>
<td>▶ Identify key patient concerns for recovery and management of the patient</td>
</tr>
<tr>
<td>▶ Assessment of allergies, airway and aspiration risk</td>
<td>▶ Communication among surgical team members of anticipated critical events</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▶ Display of essential imaging as appropriate</td>
<td></td>
</tr>
</tbody>
</table>
HOW TO COMPLETE A
CMS-1500 CLAIM FORM

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.
associated with running a full-service acute care facility. Since the first physician-led facility was opened in 1970, ASCs have provided patients with a highly specialized, lower-priced alternative to hospitals. ASCs have transformed the outpatient surgical care, including diagnostic and preventive health care procedures. ASCs have added considerable value to the US economy, with a 2009 total nationwide economic impact of $90 billion, including 250,000 jobs, $4.3 billion in wages and salaries, and $10 billion in tax revenue. ASCs also add considerable value to the US economy, with a 2009 total nationwide economic impact of $90 billion, including 250,000 jobs, $4.3 billion in wages and salaries, and $10 billion in tax revenue. ASCs perform more than 60 percent of all Medicare colonoscopies, contributing to a decade-long decrease in colorectal cancer mortality. There are more than 5,300 Medicare-certified ASCs across all 50 states, with more than 1,000 facilities owned in the last decade.

Innovative Practices

ASCs make valuable contributions to the evolution and improvement of health care by advancing innovations in anesthesia practice, new devices and surgical techniques. All ASCs are subject to rigorous oversight and independent inspections to assess each center’s level of compliance with federal government standards and demonstrate continual quality improvement. State-specific licensure is required by most states for ASCs to operate (e.g., ongoing inspection and reporting). Approximately 68 percent of the industry obtains additional accreditation from several leading organizations, including The Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC). ASCs that treat Medicare beneficiaries must meet federal government standards and demonstrate continual quality improvement.

2012 WINTER CODING SEMINAR

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Wynn Las Vegas Hotel

- Receive CMS updates and a summation of the final rule as it pertains to reimbursements for ASCs.
- Learn everything you need to know about the CPT 2013 changes, rationales and applications.
- Obtain valuable coding tips to ensure accurate coding and reimbursements.

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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.
- Join us for a wide variety of educational opportunities, the largest Exhibit Hall of the year and networking opportunities with your colleagues from around the country.

Learn more at ascassociation.org/ASCA2013
Including more than $5.8 billion in tax payments. Additionally, ASCs employ the equivalent of about 117,700 full-time equivalent as their procedure. Today, ASCs provide a patient-focused experience in an atmosphere removed from the distractions of hospital environments. This benefit is recognized by patients and insurers, including Medicare and Medicaid, in the form of lower health care spending and co-payments.

Since the first physician-led facility was opened in 1970, ASCs have provided patients with a highly specialized, lower-priced alternative to hospitals. ASCs focus on outpatient surgical and diagnostic procedures, with ASC patients reporting a 92 percent satisfaction rate.

As essential Medicare providers of surgical and cancer screening services, ASCs perform more than 40 percent of all Medicare colonoscopies, contributing to a decade-long decrease in colorectal cancer mortality. As a result, procedures in ASCs are not often delayed or rescheduled due to staffing issues or competing demands for operating room space from emergency cases. Additionally, physicians can personally guide patients through surgery and recovery, which leads to lower rates of infection and reduced length of stay.

ASCs make valuable contributions to the evolution and improvement of health care by advancing innovations in anesthesia practice, new devices and surgical techniques. For example, the industry has led the development of minimally invasive procedures and the advancement of anesthetic technology to replace the intraocular lens. This procedure is now commonly used nearly one million times each year.

ASCs are modern health care facilities focused on providing same-day surgical care, including diagnostic and preventive health care procedures. ASCs have transformed the outpatient surgical experience for millions of Americans by offering a convenient, personalized, lower-priced alternative to hospitals.

ASCs that treat Medicare beneficiaries must meet federal government standards and demonstrate continual compliance with Medicare’s standards. State-specific licensure is required by most states for ASCs to operate (e.g., ongoing inspection and reporting). Approximately 68 percent of the industry obtains additional accreditation from several leading organizations, including The Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC).

Learn more at ascassociation.org/Webinars