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QUALITY REPORTING: Improve Communication Between Clinical And Admin Sides--Or Lose Out

It's not too early to start figuring out how to capture quality data

While your physicians are noting whether or not they provided aspirin to patients as suggested by quality guidelines, you might want to save some aspirin for yourself. Medicare's quality reporting project is likely to give you a major headache as you struggle to understand its complexities in time for the July 1 start date.

-This program is going to be arcane and difficult to implement,- says **Barbara McAneny**, a physician with **New Mexico Oncology** in Albuquerque. But with reimbursement cuts, her practice can't afford to pass up another 1.5 percent in reimbursement.

The basics: You don't have to register for the program. You choose which quality measures you-re going to start reporting on, and just start reporting them.

Important: When you-ve reported a particular quality measure once, Medicare will expect you to keep reporting on it at least 80 percent of the time where it applies.

Reporting on quality measures correctly will mean working on communication between your clinical staff and your administrative people, CMS officials warned.

Step 1: First, you-ll have to identify which patients and visits qualify for the quality reporting.

Step 2: Then, your physician **must** document in the medical record whether he or she followed a particular quality guideline. CMS won't tell you how, or where, this documentation should appear. You could use a checkbox or an area on your encounter form.

Step 3: After that, you have to translate that quality information over to your claims submission process, so you can submit the correct code, stating whether or not the physician followed the quality guideline. (Whether the answer is yes or no, you get credit for reporting.)

The biggest hurdle will be prodding software vendors to update systems to handle this program, McAneny predicts. She's reluctant to spend the money on upgrades before she knows whether the program will be permanent.

More details: CMS officials also revealed specifics about the quality-reporting program:

- You don't have to be a Medicare participating physician to participate in the program.

- CMS will post detailed instructions about how to report the 74 measures on the Web long before the July 1 deadline.

- When you use the -G- codes (or Category II codes in some cases) to report on the quality measures, you must record a charge of $0.00 with those codes.

- You must report the quality codes on the same claim as the payment codes for that service.

- The analysis of whether you reach the 80-percent requirement for the measures you report will be based on each

individual provider's NPI. So if some of the physicians in a group practice are more diligent about reporting quality info than others, they have a better chance of receiving bonuses.

But Medicare will pay the 1.5 percent bonus based on the pro-vider's Tax ID number, which may be a group practice.

- If a provider only reports on one or two measures per claim, Medicare will have -some sort of validation- to make sure only one or two measures applied, CMS officials said.

- You won't be able to take CMS through any kind of administrative review, or federal court, over its decisions in this program. But there will be a process for you to appeal payment amounts.

- Providers will receive -feedback reports- that may help them improve their practices.

- You-ll have a -reporting modifier- to let the carriers know whether or not you thought a particular quality measure applied in this case. You-ll only report some measures, such as whether the doctor tested a diabetic patient's hemoglobin A1C, once per year. After that, you just need to note that the doctor already performed that test.

- If two physicians from different specialties are both caring for the same patient, they can both report the same quality measure for that patient.

- You can start reporting quality measures any time after July 1. But CMS will judge whether you reported quality measures for 80 percent of your claims based on a July 1 start date. So the later you start, the less your chances of getting the bonus.