Surgical Quality Care Program

Administrative (Clinic admin., HR, Billing, Scheduling and IT)

A pay-for-quality program developed by the Washington State Department of Labor & Industries in collaboration with provider experts to improve workers' outcomes while strengthening your clinic's ability to offer high quality surgical care.

SQC Program Participants' Manual (Administration)
May 2022

Contents

Overview

The Administrative version of the Surgical Quality Care (SQC) program participants' manual will explain the SQC program to your administrators, human resources, billing staff, scheduling staff and IT so they can each understand the program and their role in it. There will be occasions to reference supplemental documents, web resources as well as the Program Participants' Manual (Medical) to get a more complete understanding of the SQC program.

Chapter 1 – What the program is about

The SQC program is a pay-for-quality program that rewards musculoskeletal surgeons for their mastery of administrative best practices aimed at streamlining many of the tangles that make treating workers' compensation patients (workers) a burdensome process. Having the shared goal of patient recovery, your team works cooperatively with the Washington State Department of Labor and Industries (L&I). However, "your team" involves many facets, be it internal (i.e. surgeons, administration, PAs, MAs, schedulers, billing) or external (i.e. ancillary providers, claim managers, vocational services, Comagine, etc.). Read on to find out more!

Who may participate?

The SQC program is exclusively for musculoskeletal surgeon(s) who:

1) Are participants in L&I's Orthopedic and Neurological Surgeon Quality Project (Ortho/Neuro)
2) Are credentialed as an L&I provider, with an active L&I provider ID number
3) Regularly treat workers injured on the job, be it State Fund or Self-Insured
4) Have completed the SQC program's orientation
5) Meet the program's clinical entrance criteria for Medical Treatment Guidelines, Opioid Prescribing Guidelines, utilization review, and reoperation rate criteria. (This program holds the surgeon accountable for their physician assistants' (PA's) prescribing practices.)

Why participate?

Taking a step beyond our primary goal of cooperatively working towards patient recovery, participating surgeons are eligible to receive incentive pay. The higher the assigned adoption level, the greater their potential earnings. See the SQC Program Participants' Manual (Medical) for adoption level specifics.

Significance of an adoption level

There are four (4) adoption levels, each with a distinct payment level.

1. Low Adopter - pays out at approximately 10% of the maximum payment level.
2. Medium Adopter - pays out at approximately 50% of the maximum payment level.
3. High Adopter - pays out at approximately 65% of the maximum payment level.
4. Sustaining Adopter - pays 100% of the maximum payment level.

Chapter 2 – The Surgical Health Services Coordinator

To being with, your surgeons will be restricted to a Medium Adopter level without the support of a Surgical Health Services Coordinator (SHSC). The following section will address four (4) aspects of the Surgical Health Services Coordinator (SHSC): the origination of an SHSC, the envisioned role of an SHSC in your clinic, SHSC qualifications, and SHSC tools/resources.

Origination of an SHSC

The 2011 Washington State Legislature passed SSB5801 as part of "Workers Compensation Reform." In that same year, L&I consulted a focus group of provider experts to identify new potential best practices for the full period of recovery. For surgical patients, the focus group recommended three potential new best practices, identified initially through key-informant interviews.

One component of SSB5801: "Promoting additional occupational health best practices and incentives that address the full period of recovery", along with the proposed new best practices resulted in a six year L&I pilot. From that pilot came the SQC Program and the SHSC.

Role of an SHSC in your clinic

SHSCs offer an important contribution to worker recovery following surgery. They act as a liaison between the attending provider(s), surgical provider(s), worker(s), employer(s), and claim manager(s), with a mission to coordinate clinical care and work outcomes. To learn more about the role of an SHSC see:

- Care coordinator standard work categories at Health Services Coordination (wa.gov)
- SHSC Toolkit

SHSC qualifications

A viable SHSC candidate must have:

1. Bachelor's or equivalent degree and three years of experience in direct patient care, return-to-work coordination, occupational health care, or equivalent experience, *OR* Seven years' experience in direct patient care, return-to-work coordination, occupational health care, or equivalent experience.
    - Direct patient care includes nurse, medical assistant, nurse navigators, and existing care coordinators, but does not include referral coordinators, schedulers, or clinical administrative staff.
2. An ability to obtain and maintain an L&I Provider ID, and bill care coordination services. No reported issues at L&I.
3. Experience or demonstrated skills in:
    - Oral and written communication with health care professionals, patients, employers, insurance staff and resources.
    - Data management and tracking.
    - Completing care coordination or similar documentation.

- Analyzing and communicating provider, care coordinator, and best practice reporting data.

4. Upon hire by your clinic, successfully completed the L&I required training and testing.

SHSC Tools/Resources

SHSCs utilize the Occupational Health Management System (OHMS). It supports the implementation and tracking of existing and emerging occupational Best Practice programs. It is not a single system, but rather a group of systems that work together to facilitate coordination of care between providers, employers, and injured workers MAVEN is part of the system that supports care coordination and you may see/hear it used interchangeably with OHMS.

What does this mean to my clinic?

The OHMS system documents the SHSC's work in MAVEN, and is *essential* in order to bill for their services regardless of which method of billing your clinic chooses (manual or automated).

For detailed information about assigning claims to an SHSC's caseload, documenting claims and billing for their work in MAVEN go to (OHMS access required for this hyperlink). http://ohms.apps.lni.wa.gov/ohmsdocs/OHMSSurgicalUserGuide.pdf**.**

Document SHSC Case notes and activities in MAVEN.

SHSCs document their activities by creating an SHSC Case note, which should be done each time they provide support to: a worker, the SHSC's provider(s), the employer, claim manager, other care providers or vocational counselors. At a minimum, we expect them to document:

- Name(s) of contacted parties along with their title/role, along with discussion points.
- What activities you performed to help move the worker towards recovery and release/return to work.
- Any barriers to recovery and release/return to work including your care coordination plan (i.e. what you need to do, by when, and who you need to contact or consult), as well as how this will help move the worker toward recovery and/or release/return to work.

Only documented services are billed/paid.

For points on what documented services may be billed/paid, print and refer to the one page billing status key, Health Services Coordination Activities Checklist in the Health Services Coordinator Toolkit.

MAVEN also tracks SHSC's work

SHSCs use MAVEN Lists to help track their caseload and meet both care coordination and SQC Program goals. Detailed information about SHSC worklists and setting tasks is contained in the OHMS User Guide found at the bottom of the OHMS login page.

MAVEN data informs SQC Program, which may affect your surgeons' Adoption Level

Activities the SHSC documents in their case notes provides information needed for SQC Program best practices. For now, the only method to score two (2) of the surgeons' measures is for the SHSC to document them in MAVEN. Those two (2) surgeon measures are:

- Recording the surgeon's pre-op[1] release to work discussion with the worker is essential to setting expectations about return to work.
- Recording of the surgeons' (or PA-C) signature and return of the Physical Medicine Progress Report (PMPR) demonstrates that the surgeon is involved in the workers' post-op rehabilitation.

Chapter 3 - Billing

Note: Until notified otherwise, continue to use the 1071M billing for provider incentives tied to the Ortho/Neuro project.

It is important to know and understand the payment parameters surrounding the Surgical Health Services Coordinator (SHSC) services.

Surgical Health Service Coordinator (SHSC) Services

Service Description	Code	Details	Rate
Surgical Coordination Intake (SCI)	1083M	Payable once in the life of the claim	$152.70
Surgical Health Services Coordinators' Standard Services	1088M	Billable in six-minute increments for activities that remove claim/treatment barriers or positively influence the recovery and/or release to work.	$9.40

Billing practices:

Local code 1086M pays the lesser of maximum fee allowable for surgeons' adoption level or the amount billed. In other words, don't bill for less than what is allowable. (For the current rate(s) go to the Fee Schedule and Payment Policies (MARFS) webpage fee schedule lookup.)

Is it possible to lose incentive pay?

Yes, aside from patient volume there are two ways to experience a loss in incentive pay.

1. Loss of eligibility to participate in this program, or
2. When the group or surgeon has **not** performed well enough to achieve their currently assigned adoption level for two consecutive measurement cycles.
   a. Groups will fall to a Low Adopter status.
   b. Surgeons will fall to the group level.

A participant's adoption level has **no impact** on other L&I fees payable.

Chapter 4 – Quality Indicators

It is no surprise the success of a clinic and/or surgeon depends on the support network surrounding them. That is absolutely the case in the SQC program!

This chapter includes three (3) parts:

- Part A describes the required quality indicators (APF and Timely Surgery).
- Part B describes the indicators needed for higher adoption levels (Release to work goals and plans, Physical Medicine Progress Report Form).
- Part C describes other best practices that are expected from all participants.

Note: Knowing the content of this chapter is a key to succeeding in the project.

Chapter 4, Part A – Required quality indicators

The APF and Timely Surgery are required quality indicators. For a Group and/or Surgeon(s) to reach their highest earning potential they must meet these performance thresholds. When a Surgeon fails to meet either quality indicator, they fall to the group level. When a Group fails to meet either quality indicator, it will be restricted to the lowest payment level.

Activity Prescription Form (APF)

Why is the APF part of the program?

If the worker needs or has recently had a surgery, the surgeon is the best practitioner to comment on worker's condition, including their 24 hour a day restrictions and work readiness. This is the case regardless of who the attending provider (AP) is, or even if they are also preparing APFs. Too much information is far preferable to not having the right information. Having clear rehabilitation planning, release for work, and estimated abilities will enable employers, claim managers, and vocational counselors to better coordinate care and return to work planning.

APF performance threshold (85%)

Consistent with L&I's standard APF submittal recommendations we expect an APF at the initial office visit and at subsequent visits when there are restrictions or the workers' status changes. SQC program takes it a step further by spelling out that we expect to receive an APF in the 90 days before and the 90 days after surgery for at least 85% of all surgical claims.

- The pre-surgery APF – *personally completed and signed by the participating surgeon*.
  - Needs to be submitted to L&I within two (2) business days of the date of service.
  - APFs completed by the PAs or ARNPs will not count as a pre-surgery APF.
  - APFs completed on the surgery date will not count for pre- or post-surgery APF scores.
- The post-surgery APF – completed and signed by the surgeon – **OR** – the PA – **OR** – the ARNP.
  - Needs to be submitted to L&I within two (2) business days of the date of service.
- Non-compliance with these items will negatively affect Adoption Levels.

Caution! Per WAC 296-20-125(3)(o) it is illegal to bill for services under a non-rendering provider's ID - even if co-signed by the surgeon. Such practices may cause the surgeon to miss their APF incentive pay threshold.

What if there is no surgery or the need for surgery has not yet been determined?

The APF quality indicator only looks at surgical claims and we advise the surgeon adhere to the Standard APF submittal recommendations.

Method of measurement

The project team first uses the surgical billing codes to identify all surgeries performed during the reporting period. We then look to see that the minimum number of APFs have been billed on these claims (1 pre-surgery, and 1 post-surgery).

In analyzing each case, L&I reduces the total number of expected APFs when the claimant:

- Had surgery as the first billed for service by a surgeon (emergency surgery), or
- Was exclusively seen by the surgeon for consultation (no other billing codes), or
- Where the global surgery period reaches beyond the report period and there is no post-surgical office visit yet.

L&I rounds all findings to the nearest whole percent.

What are some tips for meeting the APF quality indicator threshold?

- To determine a need for surgery, Utilization Review (UR) expects the surgeon meet face to face with the patient to perform an evaluation and management (E/M) (when claim manager authorization is required).
- What an opportunity to
  - Complete the required pre-surgery APF, and
  - Document the release-to-work plans and goals with the injured worker (a measured best practice addressed on page 5).
- Follow the APF completeness guidelines.
- Promptly bill for the APF because it cannot be counted if it was not billed.

Is it okay to write only "See chart notes" in the "Key Objective Findings" field?

No, writing only "See chart notes" is not acceptable. Chart notes typically arrive in the claim file later than the APF and they are not standardized. Remember: our intent is for the APF to communicate real-time information to the claim manager for time-loss payment and treatment authorizations.

Is it okay to be requested additional information on a previously completed APF?

Yes. To adjudicate the claim, the Claim Manager, VRC, ONC and even self-insured employer may request more information. This rarely happens on a well-completed APF.

Timely surgery

Why is the timely surgery a quality indicator in this program?

Reducing delays in access to care can enhance recovery, minimize or prevent disability while enhancing return to work options.

Timely surgery performance threshold (80%)

At least 80% of the surgeries requiring both utilization review (UR) and claim manager authorization must be performed within 21 calendar days of the claim managers' notice of authorization.

Why we only measure UR surgeries when you do so much more

Unfortunately, the only way to measure all of your surgeries is to place the administrative burden on your staff. To prevent that, we have elected to restrict this quality indicator to the data we have available. And that data can be found in the authorizations.

Method of measurement

With billing data, we compare the notice of authorization for surgical claims' to the service date. This "notice of authorization" is the specific day a claim manger authorizes a surgical procedure, not the day(s) that the procedure may be performed. Do not confuse the two.

While an authorization window may reach beyond this 21-day window; those procedures performed outside of the 21-days aren't considered timely for this quality indicator's performance threshold.

Tips to help meet the timely surgery threshold

- Offer an appointment for surgery within 21-days of CM authorization, and
- Track the appointment dates offered, noting when worker declines or reschedules, and
- Track delays and report the cause of delay to L&I.
- Assign a person in your clinic who can gather and submit data to L&I when needed, and
- Share your reasoning for surgeries that were scheduled beyond the 21-day window with L&I's project team using secure email.

One way to account for excusable delays

This method has proven to be very effective in accounting for surgeries perceived to be non-timely.

- Keep your own records so you can show us:
  - When a surgery is authorized by the CM, and
  - Causes for delay if/when it is not possible to perform a surgery within 21-days.
  - Not every reason is excusable, but it is more effective than no reason at all.
  - Submit this data to L&I so that our project team may make the appropriate adjustments.
- Causes for delay must be submitted to L&I within 60 days from the date the report is made available.

How to speed up the surgical UR process.

1. Check status of claim:
   - Has a decision been made on the allowance of the claim?
   - Is the claim open?
   - Do you need to submit a reopening application?
2. Verify the condition being treated is accepted under the claim.
3. If a claim hasn't been submitted, complete the Report of Accident (ROA).
   Note: ROAs **only** can be faxed to (800) 941-2976. You can still request UR; however, the request can't be processed until the claim is initiated.
4. Follow the UR guidelines, which are available at: Utilization Review Process (wa.gov)
5. Use a checklist, which is available at: Washington State Department of Labor & Industries | Qualis Health
6. Submit all the information Comagine needs:
   - Patient name,

- L&I claim number,
- Proposed or actual admission date,
- ICD-10-CM admitting diagnosis (or diagnoses),
- CPT® codes for planned procedure(s),
- L&I provider number,
- Relevant clinical information,
- Convenient time for nurse or physician consultant to call physician back.

7. Refer to L&I's Medical Treatment Guidelines for information on what specific clinical information is required for selected procedures. The guidelines are available at: Treatment Guidelines and Resources (wa.gov)
8. Quickly return peer-to-peer calls from Comagine.
9. After surgery, if you need to add or change CPT® codes for outpatient surgeries, fax the operative report and coversheet with the codes that need to be added or replaced to "OMDUR" at (360) 902-6315.

Comagine Health, peer-to-peer reviews, and Group-A provider

Who is Comagine and what do they do?

Comagine Health ("Qualis") is a national, nonprofit organization that offers evidence-based healthcare consulting and improvement services for clients across the nation.

L&I contracts with Comagine to independently review a select list of procedures using L&I's Medical Treatment Guidelines. Comagine uses a network of physician/practitioner consultants with clinical expertise to approve or deny surgical procedures.

For more information on the Comagine contract with L&I, visit the Comagine website: Washington State Department of Labor & Industries | Qualis Health

When and why do peer-to-peer reviews happen?

When clinical information supplied with the request doesn't meet L&I's medical treatment guidelines and/or criteria, the Comagine review nurse will refer the request to a physician consultant for review.

The physician consultant may call the requesting physician to discuss the request or to obtain additional information.

What is a "Group A" provider and how can I become one?

As part of L&I's Utilization Review Simplification Program, "Group A" providers have 100% UR approval recommendations for surgeries on 10 or more reviews for the last year (that is, they have zero denial recommendations for surgeries).

The benefit of being a "Group A" provider is that the surgical UR process is significantly faster than for other providers (see table above). To become a "Group A" provider:

- Familiarize yourself with L&I's medical treatment guidelines, *and*
- Ensure that your surgery requests meet the guidelines.

To learn more about L&I's Utilization Review Simplification Program, see Utilization Review Requirements (wa.gov)

Additional information:

Medical Treatment Information (online):

- Information about L&I's decisions regarding medical technologies and procedures is available online at Conditions and Treatments (wa.gov)
- Medical Treatment Guidelines are available online at Treatment Guidelines and Resources (wa.gov)

Comagine Contacts:

- Comagine may be contacted at (800) 541-2894 or found at http://qualishealth.org/
- A list of Comagine and L&I's contacts is online at Washington State Department of Labor & Industries | Qualis Health

Chapter 4, Part B – Additional Quality Indicators

Reaching the highest performance level

The final two quality indicators may not be reached without utilizing the support of a Surgical Health Services Coordinator (SHSC) and our Occupational Health Management System (OHMS). Let's take a look at what they are and why they're important to you and your patients.

Release-To-Work Plans and Goals

What is the expectation for establishing Release-To-Work Plans and Goals?

For at least 85% of non-emergent surgical claims, the surgeon will have met with the worker and jointly established some release to work plans and goals prior to surgery (not on the day of surgery).

The SHSC will be looking for evidentiary support of this planning and then record their findings in OHMS. Examples of evidentiary support include documentation in chart notes and/or on the APF.

Why is establishing Release-To-Work Plans and Goals part of the program?

A successful outcome for an injured worker involves more than pathophysiology. Returning to work is part of achieving maximal physical recovery. Prolonged disability affects a worker's career, their economic well-being, and their life.

Overemphasis on perceived short-term benefits (like staying off work a few extra weeks) may have unintended, long term consequences and delay needed intervention, promote deconditioning, and increase the risk of the worker's original job being lost. Be sure the worker focuses on what they can do and strives to increase it a little each day.

Some tips to help meet the Release-To-Work Plans and Goals a quality indicator

Standard Practice! When claim manager authorization is required for a surgery, it is Utilization Review's goal to have the surgeon meet face to face with the worker to determine if there is a need for surgery. What an opportunity to

- Complete the required pre-surgery APF, and
- Document the release-to-work plans and goals in the chart notes and/or on the APF.

Review therapy progress

Surgical care is more than surgery. Each worker's blend of conservative care, pain management, vocational recovery and rehabilitation is unique. With all these disparate pieces, communication breakdowns happen; at times requiring a surgeon to make decisions based on assumptions. Adding fuel to this fire, a surgeon often has to decipher an incongruous batch of communications from each ancillary provider.

To help facilitate this communication, L&I has created a Physical Medicine Progress Report Form (PMPR) with input from the provider community. Our target is to substitute the many different types of PT/OT provider monthly reports submitted to your clinic into a standard format and singular document type for quick reference.

Expectation for the review therapy progress quality indicator

Within 14 calendar days of the date they were received a surgeon or their physician's assistant (PA) will have reviewed and signed off on 90% the PMPRs they've received for post-surgical claims with active PT/OT referrals. While it is good to be aware of patient progress, we are only measuring the surgical claims with PT/OT referrals. And does not extend past the global surgery period.

Please note that signing off on the PMPR does not mean that you support/agree to the course of action being taken by the ancillary provider, only that you've reviewed it. There is also a section for you to offer comments or even change or augment the rehabilitation plan submitted on this PMPR prior to returning it to the ancillary provider.

Method of measurement for this quality indicator

The SHSC will be looking to see that this PMPR was signed in the 14-day window and record their findings in OHMS. For the SHSC to find that information it is vital that the form is sent to the ancillary provider AND to L&I. These PMPRs can be a resource in building/maintaining the workers' care plans, filling out APFs and/or job analysis.

Tips to help meet this quality indicator

Standard Practice! Fourteen days is not long so incorporate this PMPR as an alert item. Also, standardize a process for returning this signed PMPR back to the ancillary provider and L&I for imaging in the file.

Chapter 4, Part C – General best practices

Timely access to care (first visit)

The target for timely access to care is for the initial office visit to occur within seven (7) business days of referral. The clock starts on the day the surgeon agrees to see the injured worker (necessary screening

completed). Participating surgeons/clinics may be removed from the SQC program in cases where a surgeon/clinic unreasonably delays care for newly referred workers.

Why is the timely access a consideration?

Reducing delays in access to care can:

- Enhance recovery, and
- Enhance return to work, and
- Minimize or prevent disability.

Tips to help meet the timely access expectation.

- After screening to ensure an appropriate referral, offer the initial appointment within seven (7) business days of referral, and
- Track the appointment dates noting when workers decline or reschedule appointments offered in seven (7) business days.

Chapter 5 – Performance Reports

This chapter includes details on participating surgeons' performance reports issued by L&I's SQC program team, including:

- What's in the report (Surgeons' adoption level report).
- How to affirm or challenge the accuracy of your report (report review process).
- When the reports are produced (reporting schedule).

Note: Knowing the content of this chapter is a key to succeeding in the program.

Surgeons' adoption level report

To communicate a surgeons' performance on the quality indicators, and their resulting adoption level, the SQC program team will either post the report in the OHMS system or share a report with your team's listed contact persons.

- Each report includes:
  - A cover letter from L&I's Medical Director,
  - Principles behind specific best practices along with recommendations for achieving or maintaining High Adopter status in the future.
  - A brief written summary of the surgeons'/group's performance on the quality indicators,
  - The surgeon's/group's resulting adoption level,
  - The surgeon's/group's performance on each indicator.

Note: Sample report contains arbitrary claimant data and make-believe surgeon / clinic specifics.

Report review process

What if I disagree with the report?

You have 60 days from the date the contested report was released to contest the findings.

Submit your written request to:

- SQCProgram@Lni.wa.gov, or fax your content to 360-902-4249

Attn: Surgical Quality Care Program

What can I expect following the review?

L&I's SQC program team will notify you of the results on completion of the review. If we request additional information, you will have 30 days to submit it. Our goal is to complete the review within 60 days of the date we receive your data.

Reporting schedule

When are the reports scheduled to be generated?

Measurement periods	Analysis period	Report delivered	New adoption level assigned
January 1 – June 30	July - September	September	October 1
July 1 – December 31	January - March	March	April 1

If you miss the threshold for any of the quality indicators, you have 60 days from the date the report was made available to provide the SQC program team with additional data for review (see more details under "Report review process" on the next page).

What happens to payments after reports are sent out?

- Incentive payments are paid at the participants' assigned adoption level relative to the date of service.
- If participants' adoption level is reassigned (up or down), payments at their new level are effective as shown in the table above.
- Deflated adoption levels can be elevated in the next measurement cycle when:
  - The surgeon meets all four (4) quality indicator thresholds, or
  - In cases when the surgeon's adoption score is based on their group's performance, the group achieves the two required quality indicators
  - Recall that this limits the surgeon to a Medium adopter level unless the surgeon meets all four (4) quality indicator thresholds.
- Participants' adoption level will only move down after failing to meet the requirements for their current tier assignment for two (2) consecutive measurement cycles.

For more information, contact L&I's project team at
(360) 902-6060 or SQCProgram@Lni.wa.gov
Surgical Quality Care Program (wa.gov)

Reference Page

Reference word/phrase	Explanation
APF	Activity Prescription Form is completed by providers to communicate a worker's: • Ability to work • Functional capacities • Physical restrictions, and • Treatment plan.
SHSC	Surgical Health Services Coordinator is personnel either hired or contracted by your clinic. They coordinate clinical care and worker outcomes by acting as a liaison between the attending provider(s), surgical provider(s), worker(s), employer(s), and claim manager(s).
Orthopedic and Neurological Surgeon Quality Project (ONSQP)	ONSQP was a precursor to this program. It was a pay-for-quality initiative designed to improve injured workers' outcomes through access to high quality surgical care.
Surgical Best Practices Pilot	The Surgical Best Practices Pilot has developed care coordination standard work that allows health services coordinators to collaborate with surgeons to reduce transition times and improve return-to-work planning.
Quality Metric	An administrative best practice identified by project surgeons and L&I as behaviors that are beneficial to the surgeon, patient and L&I.
Quality Metric Threshold	An expected threshold that effectively demonstrates consistent utilization and mastery of said Quality Metric(s).