Ambulatory Surgical Center Quality Reporting Specifications Manual

Version 6.0a

Encounter Dates: 01-01-17 (1Q17) through 12-31-17 (4Q17)

OMB # 0938-1270 Expiration Date:X/X/XXXX

Ambulatory Surgical Center Quality Reporting Specifications Manual Release Notes Version: 6.0

Release Notes Completed: June 22, 2016

Guidelines for Using Release Notes
These Release Notes provide modifications to the Ambulatory Surgical Center Quality Reporting (ASCQR) Specifications Manual. They are provided as a reference tool and are not intended to be used as program abstraction tools. Please refer to the ASCQR Specifications Manual for the complete and current technical specification and abstraction information.

The notes are organized to follow the order of the Table of Contents. Within each topic section, a row represents a change that begins with general changes and is followed by data elements in alphabetical order. The **implementation date is 01/01/2017**, unless otherwise specified. The row headings are described below:

- **Impacts** – Used to identify which portion(s) of the Manual Section is impacted by the change listed. Examples are Measure Information Forms, Quality-Data Coding and Sampling Specifications, or Appendix A.

- **Rationale** – Provided for the change being made.

- **Description of Changes** – Used to identify the section within the document where the change occurs. (e.g., Definitions, Numerator, and Denominator).

The notes in the tables below are organized to follow the Table of Contents in the Specifications Manual.

Table of Contents

No changes in this section.

Acknowledgement

Impacts: N/A

Rationale: To update the CPT® copyright year

Description of Change(s):
Change *CPT® only copyright 2015 American Medical Association. All rights reserved.*
To *CPT® only copyright 2016 American Medical Association. All rights reserved.*

Program Background

No changes in this section.

Using the Manual

No changes in this section.

Section 1: Measure Information Form Introduction

Impacts: N/A

Rationale: To align the ASCQR Specifications Manual with other Quality Reporting Program Specifications Manuals

Description of Change(s):
Remove Reporting Mechanism, Reporting Period, and Reporting Required By overviews in their entirety

Measure Information Forms

Impacts: ASC-1, ASC-2, ASC-3, ASC-4, ASC-5, ASC-12

Rationale: To align the ASCQR Specifications Manual with other Quality Reporting Program Specifications Manuals

Description of Change(s):
Reporting Mechanism, Reporting Period, Reporting Required By
Remove each section in its entirety

Impacts: ASC-6, ASC-7, ASC-8, ASC-9, ASC-10, ASC-11

Rationale: To align the ASCQR Specifications Manual with other Quality Reporting Program Specifications Manuals

Description of Change(s):
Reporting Mechanism, Reporting Required By
Remove each section in its entirety

Impacts: ASC-6

Rationale: To align the ASCQR Specifications Manual with other Quality Reporting Program Specifications Manuals

Description of Change(s):
Annual Data Submission Period
Add Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Impacts: ASC-7

Rationale: To align the ASCQR Specifications Manual with other Quality Reporting Program Specifications Manuals

Description of Change(s):
Annual Data Submission Period
Add Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Table 2
Remove Current table

Add The Categories and HCPCS will be updated at the end of CY 2017.

Impacts: ASC-9

Rationale: To allow for exclusion of patients when their age is documented as the reason the physician did not recommend a follow-up colonoscopy and to align the ASCQR Specifications Manual with other Quality Reporting Program Specifications Manuals.

Description of Change(s):
Add the word *Statement* to the Numerator and Denominator descriptions

Denominator Exclusions

Add Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as the reason.

Annual Data Submission Period
Add Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Impacts: ASC-10

Rationale: To align the ASCQR Specifications Manual with other Quality Reporting Program Specifications Manuals

Description of Change(s):
Add the word *Statement* to the Numerator and Denominator descriptions

Annual Data Submission Period
Add Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Impacts: ASC-11

Rationale: To align the ASCQR Specifications Manual with other Quality Reporting Program Specifications Manuals

Description of Change(s):
Add the word *Statement* to the Numerator and Denominator descriptions

Annual Data Submission Period
Add Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Impacts: ASC-12

Rationale: These changes reflect the removal of references to ICD-9 codes, since by the CY2017 performance period, the measure will not include them (even in one-year lookback period.)

Description of Change(s):
1. Cohort Exclusions
Change the title of Table 1 from:

- "Inflammatory Bowel Disease (IBD) ICD-9 and ICD-10-CM Diagnosis Codes

to

- "Inflammatory Bowel Disease (IBD) ICD-10-CM Diagnosis Codes

2. Cohort Exclusions

Remove the first two columns of Table 1 containing ICD-9 codes and descriptions (not marked as change in MIF mockup)

3. Cohort Exclusions
Add a note under Table 1 that reads**:**

- "Note: For the ICD-9 codes relevant to the calculation of the measure for the CY2016 period, refer to v5.1 of the manual."

4. Cohort Exclusions
Change the title of Table 2 from:

- "Diverticulitis ICD-9 and ICD-10-CM Diagnosis Codes

to

- "Diverticulitis ICD-10-CM Diagnosis Codes

5. Cohort Exclusions

- **Remove** the first two columns of Table 2 (not marked as change in MIF mockup)

6. Cohort Exclusions
Add a note under Table 2 that reads**:**

- "Note: for the ICD-9 codes relevant to the calculation of the measure for the CY2016 period, refer to v5.1 of the manual."

7. Risk Adjustment
Change:

- "The measure defines comorbidity variables using condition categories (CCs), which are clinically meaningful groupings of more than 15,000 ICD-9 diagnosis codes."

to

- "The measure defines comorbidity variables using condition categories (CCs), which are clinically meaningful groupings of the many thousands of ICD-10-CM diagnosis codes."

Section 2: Quality-Data Coding & Sampling Specifications

No changes in this section.

Appendix A: Glossary of Terms

No changes in this section.

Ambulatory Surgical Center Quality Reporting Specifications Manual Release Notes Version: 6.0a

Release Notes Completed: December 15, 2016

Guidelines for Using Release Notes
These Release Notes provide modifications to the Ambulatory Surgical Center Quality Reporting (ASCQR) Specifications Manual. They are provided as a reference tool and are not intended to be used as program abstraction tools. Please refer to the ASCQR Specifications Manual for the complete and current technical specification and abstraction information.

The notes are organized to follow the order of the Table of Contents. Within each topic section, a row represents a change that begins with general changes and is followed by data elements in alphabetical order. The **implementation date is 01/01/2017**, unless otherwise specified. The row headings are described below:

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- **Rationale** – Provided for the change being made.

- **Description of Changes** – Used to identify the section within the document where the change occurs. (e.g., Definitions, Numerator, and Denominator).

The notes in the tables below are organized to follow the Table of Contents in the Specifications Manual.

Table of Contents

Impacts: Added section to Table of Contents

Rationale: To include the Preview Section which will display new measure information.

Description of Change(s):
Add
Appendix B: Preview Section

Acknowledgement

No changes in this section.

Program Background and Requirements

Impacts: This section has been updated to include *Program Requirements*

Rationale: To provide additional information regarding the background and requirements of the ASCQR program

Description of Change(s):
Program Requirements
Add
ASCs that do not meet program requirements, which include reporting of quality measure data for the ASCQR Program, may receive a two percent reduction in their ASC payment update. ASCQR Program requirements apply to all entities subject to the ASC Fee Schedule (ASCFS). The definition of an ASC can be found in the Claims Processing Manual, Chapter 14, Section 10.1, located at (www.cms.hhs.gov).

Data Collection and Submission
Data for claims-based measures included in this specifications manual are captured from Medicare Part B fee-for-service (FFS) claims submitted by the ASC during required reporting periods. Medicare Part B FFS patients include Medicare Railroad Retirement Board patients and Medicare Secondary payer patients. Medicare Advantage patients are not included for reporting purposes. For claims-based measures, the reporting period refers to the dates of service not date of submission. For example, if a service was provided on December 30, 2016, with claim submission on January 1, 2017, this claim would be included in the 2018 payment determination.

Claims-Based Measures
ASCs are to submit information on the five claims-based measures using Quality Data Codes (QDCs) entered on their claims submitted using the CMS-1500 or associated electronic dataset. QDCs are specified CPT Category II codes or Level II G-codes that describe the clinical action evaluated by the measure. Clinical actions can apply to more than one condition and, therefore, can also apply to more than one measure. Facilities should review all reporting instructions carefully.

The appropriate QDC(s) are to be reported for all Medicare Part B FFS patients in addition to any codes that would be standard for billing purposes (e.g., the ICD-10-CM diagnosis and Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) Level II and CPT Category III codes for the services performed) on the ASC claim for the encounter.

Data completeness will be calculated by comparing the number of claims meeting measure specifications with the appropriate QDCs to the number of claims that would meet measure specifications without the appropriate QDCs on the submitted claim.

Measures Submitted via a Web-Based Tool
Data for ASC-6, ASC-7, ASC-9, ASC-10, and ASC-11 (ASC-11 is a voluntary measure) are to be submitted using a web-based tool located on the QualityNet Secure Portal at www.QualityNet.org.

Data for ASC-8 Influenza Vaccination Coverage among Healthcare Personnel will be submitted through the National Healthcare Safety Network (NHSN) at http://www.cdc.gov/nhsn.

Please refer to www.QualityNet.org for data submission deadlines.

240 or Fewer Rule
CMS determined that some ASCs have relatively small numbers of Medicare claims and instituted a claims threshold for ASCs with fewer than 240 Medicare claims (primary plus secondary payer) per year. For example, an ASC with fewer than 240 Medicare claims in CY 2016 (for the CY 2018 payment determination year) would not be required to participate in the ASCQR Program in CY 2017 (for the CY 2019 payment determination year).

Public Reporting
The Secretary of Health and Human Services must establish procedures to make data collected under the ASC Quality Reporting Program publicly available and to supply facilities the opportunity to review their data prior to publication. Details on the ability to withdraw and not have data publicly reported, the extraordinary circumstance extensions or exemptions request process, and the reconsideration request process were finalized in the FY 2013 IPPS/LTCH final rule.

Using the Manual

The *Using the Manual* section has been removed from this manual.

Section 1: Measure Information Form Introduction

Impacts: Measure Information Form Introduction and Measure Information Forms ASC-6, ASC-7, ASC-9, ASC-10, and ASC-11,

Rationale: To align the manual with terminology found in the Final Rule

Description of Change(s):
Quality Reporting Option:
Change
Web-based Measure
To
Measures submitted via a web-based tool

Measure Information Forms

Impacts: ASC-7

Rationale: To inform providers of pending updates to the Volume data measure.

Description of Change(s):
Add
*Please note the categories and HCPCS for ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures will be populated here in November 2017 for encounters from 01-01-17 through 12-31-17.

Impacts: ASC-8

Rationale: To add clarification to the voluntary category of contract personnel.

Description of Change(s):
Definition for Healthcare Personnel (HCP)
After
Facilities must report vaccination data for three categories of HCP: employees on payroll; licensed independent practitioners (who are physicians, advanced practice nurses, and physician assistants affiliated with the hospital and not on payroll); and students, trainees, and volunteers aged 18 or older.
Add
Reporting data on the optional, other contract personnel category is not required at this time.

Impacts: ASC-10

Rationale: To remove ICD-10-CM Code

Description of Change(s):
Denominator Criteria (Eligible Cases)
Remove
Code Z85.038 from Diagnosis for history of colonic polyp(s)

Impacts: ASC-12

Rationale: To reflect clarifications to the ICD-10 codes listed in Table 1 for Inflammatory Bowel Disease (IBD). These do not represent code changes but are changes to the wildcard used to represent ranges of codes and some labels, as well as removing duplicate ICD-10 codes.

Description of Change(s):
Cohort Exclusions
Change
Table 1

- Changed the use of the wildcard 'X' at end of ICD-10 codes to '*' for clarity (since 'X' could be confused with part of code)

- Removed 'without complications' from some of the ICD-10 code labels
- Removed two duplicate rows (for codes 51.80* and 51.8*)

Section 2: Quality-Data Coding & Sampling Specifications

No changes in this section.

Appendix A: Glossary of Terms

No changes in this section.

Appendix B: Preview Section

Impacts: The Preview Section displays new measure information.

Rationale: To provide new measure information finalized for the CY 2020 payment determination. The measures identified in this section are not currently collected.

Description of Change(s):
Add
ASC-13: Normothermia Outcome
ASC-14: Unplanned Anterior Vitrectomy
ASC-15a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey Measures

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Acknowledgement

The *Ambulatory Surgical Center Quality Reporting (ASCQR) Specifications Manual* was developed by the Centers for Medicare & Medicaid Services (CMS) to provide a uniform set of quality measures to be implemented in ASC settings. The primary purpose of these measures is to promote high quality care for patients receiving services in ASC settings.

IMPORTANT SUBMISSION ALERT!!

At this time, for submission of the Ambulatory Surgical Center measures to CMS under the Ambulatory Surgical Center Quality Reporting Program (ASCQR Program), files must meet the specifications in this CMS manual only. Otherwise, the files will be rejected as not meeting CMS quality data submission requirements for receiving the full payment update.

Program Background and Requirements

CMS Quality Initiatives

Background

In November 2001, Health & Human Services' (HHS) Secretary Tommy G. Thompson announced The Quality Initiative, his commitment to assure quality healthcare for all Americans through published consumer information coupled with healthcare quality improvement support through Medicare's Quality Improvement Organizations (QIOs). The Quality Initiative was launched nationally in 2002 as the Nursing Home Quality Initiative (NHQI) and expanded in 2003 with the Home Health Quality Initiative (HHQI) and the Hospital Quality Initiative (HQI). These initiatives are part of a comprehensive look at quality of care that includes hospitals, nursing homes, home health agencies, and physician offices. These efforts have continued to expand under subsequent Secretaries through support and expansion of activities to support healthcare transparency and value-driven healthcare.

The Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act (MIEA-TRHCA) of 2006 (Pub. L. 109-432), enacted on December 20, 2006, made changes in the Outpatient Prospective Payment Systems (OPPS). The Centers for Medicare & Medicaid Services (CMS) became statutorily required in the Calendar Year (CY) 2008 OPPS/ASC Final Rule to have a program under which ASCs will report data on the quality of ASC care using standardized measures to receive the full annual update to the ASC payment rate. The program established under the CY 2012 OPPS/ASC Final Rule with Comment Period (CMS-1525-FC) and supported by this manual is the Ambulatory Surgical Center Quality Reporting Program (ASCQR Program). The measures described in this manual will expand as additional priority areas for quality improvements in ASC settings are identified and will be designed to evaluate the diversity of services and clinical topics provided to adult patients in ASC settings.

The claims-based measures ASC-1 through ASC-5, adopted by CMS for the ASCQR Program, were originally developed by the ASC Quality Collaboration and are the intellectual property of the ASC Quality Collaboration. Additional information about the ASC quality measures endorsed by the National Quality Forum (NQF) is available in the ASC Quality Collaboration Implementation Guide (www.ascquality.org).

Objective

The ASCQR Program uses a variety of tools to stimulate and support a significant improvement in the quality of ASC care. This initiative aims to refine and standardize ASC data collection, data transmission, and performance measures in order to construct a robust, prioritized, and standard quality outpatient measure set for ASCs. The goal is for all private and public purchasers, oversight and accrediting entities, and payers and providers of ASC care to use these same measures in their national public reporting activities. Quality improvement support, collaborations, standardization, and assuring compliance with Medicare Conditions of Participation (CoPs) are important additional tools in achieving this objective.

Program Requirements

ASCs that do not meet program requirements, which include reporting of quality measure data for the ASCQR Program, may receive a two percent reduction in their ASC payment update. ASCQR Program requirements apply to all entities subject to the ASC Fee Schedule (ASCFS). The definition of an ASC can be found in the Claims Processing Manual, Chapter 14, Section 10.1, located at (www.cms.hhs.gov).

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Claims-Based Measures

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The appropriate QDC(s) are to be reported for all Medicare Part B FFS patients in addition to any codes that [would be standard for billing purposes (e.g., the ICD-10-CM diagnosis and Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) Level II and CPT Category III codes for the services performed) on the ASC claim for the encounter.]

Data completeness will be calculated by comparing the number of claims meeting measure specifications [with the appropriate QDCs to the number of claims that would meet measure specifications without the appropriate QDCs on the submitted claim.]

Measures Submitted via a Web-Based Tool

[Data for ASC-6, ASC-7, ASC-9, ASC-10, and ASC-11 (ASC-11 is a voluntary measure) are to be submitted using a web-based tool located on the QualityNet Secure Portal at www.QualityNet.org.]

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Please refer to www.QualityNet.org for data submission deadlines.]

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[CMS determined that some ASCs have relatively small numbers of Medicare claims and instituted a claims threshold for ASCs with fewer than 240 Medicare claims (primary plus secondary payer) per year. For example, an ASC with fewer than 240 Medicare claims in CY 2016 (for the CY 2018 payment determination year) would not be required to participate in the ASCQR Program in CY 2017 (for the CY 2019 payment determination year).]

Public Reporting

[The Secretary of Health and Human Services must establish procedures to make data collected under the ASC Quality Reporting Program publicly available and to supply facilities the opportunity to review their data prior to publication. Details on the ability to withdraw and not have data publicly reported, the extraordinary circumstance extensions or exemptions request process, and the reconsideration request process were finalized in the FY 2013 IPPS/LTCH final rule.]

Related National Activities

National Quality Forum (NQF)
The NQF has approved a set of national voluntary consensus standards for measuring the quality of hospital care. These measures will permit consumers, providers, purchasers, and quality improvement professionals to evaluate and compare the quality of care in a variety of healthcare settings across the nation by using a standard set of measures. Measures that are endorsed by NQF are denoted as such on the measure information forms.

National Quality Measures Clearinghouse
The National Quality Measures Clearinghouse (NQMC), sponsored by the Agency for Healthcare Research and Quality (AHRQ), an agency of the U.S. Department of HHS, has included both CMS and Joint Commission measures in the public database for evidence-based quality measures and measure sets. NQMC is sponsored by AHRQ to promote widespread access to quality measures by the healthcare community and other interested individuals.

Measures Management System
The Measures Management System (MMS) is a set of processes and decision criteria used by CMS to oversee the development, implementation, and maintenance of healthcare quality measures. CMS recognizes the need for quality measures of the highest caliber, maintained throughout their life cycle to ensure they retain the highest level of scientific soundness, importance, feasibility, and usability. Through the use of a standardized process with broadly recognized criteria, the MMS ensures that CMS will have a coherent, transparent system for measuring the quality of care delivered to its beneficiaries.

Measure Information Form Introduction

Measure Information Form (MIF) Format

Measure Title – The specific national ASC quality measure (e.g., *Patient Burn, Patient Fall, All Cause Hospital Transfer/Admission*).

Measure ID # – A unique alphanumeric identifier assigned to the measure. Information associated with a measure is identified by this alphanumeric number (i.e., ASC-1, ASC-2, ASC-3, etc.).

Quality Reporting Option – Indicates what is being evaluated by the measure.

- **Outcome:** A measure that indicates the result of performance (or non-performance) of a function(s) or process(es).
- **Process:** A measure used to assess a goal-directed, interrelated series of actions, events, mechanisms, or steps, such as a measure of performance that describes what is done to, for, or by patients, as in performance of a procedure.
- **Measures Submitted via a Web-based Tool:** A measure used to assess a goal-directed, interrelated series of actions, events, mechanisms, or steps with data entry achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Description – A brief explanation of the measure's focus, such as the activity or the area on which the measure centers attention (e.g., the number of admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC).

Denominator Statement – Represents the population evaluated by the performance measure.

- **Included Population in Denominator:** Specific information describing the population(s) comprising the denominator, not contained in the denominator statement, or not applicable.
- **Excluded Population in Denominator:** Specific information describing the population(s) that should not be included in the denominator, or none.

Numerator Statement – Represents the portion of the denominator that satisfies the conditions of the performance measure.

- **Included Population in Numerator:** Specific information describing the population(s) comprising the numerator, not contained in the numerator statement, or not applicable.
- **Excluded Population in Numerator:** Specific information describing the population(s) that should not be included in the numerator, or none.

Numerator Quality-Data Coding Options for Reporting – A list and definition of the QDC(s) (currently all are G-codes) used to report required information for the measure.

Data Sources – The documents that typically contain the information needed to determine the numerator and denominator.

Definitions – Specific definitions for the terms included in the numerator and denominator statements.

Selection Basis – The reason for performing a specified process to improve the quality of care outcome. This may include specific literature references, evidence-based information, expert consensus, etc.

Clinical Recommendation Statements – Supporting literature statements for the specified quality of care measure.

Selected References – Specific literature references that are used to support the importance of the performance measure.

Measure Information Form

Measure Title: Patient Burn

Measure ID #: ASC-1

Quality Reporting Option: Claims-based outcome measure

Description: The number of admissions (patients) who experience a burn prior to discharge from the ASC

Denominator: All ASC admissions

Inclusions: All ASC admissions

Exclusions: None

Numerator: ASC admissions experiencing a burn prior to discharge

Inclusions: ASC admissions experiencing a burn prior to discharge

Exclusions: None

Numerator Quality-Data Coding Options for Reporting:
- G8908: Patient documented to have received a burn prior to discharge
- G8909: Patient documented not to have received a burn prior to discharge
- G8907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility

Note: If using code G8908 or G8909, do not use code G8907.

Definitions:
- **Admission** – Completion of registration upon entry into the facility
- **Burn** – Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical, or radiation (e.g., warming devices, prep solutions, electrosurgical unit, or laser)
- **Discharge** – Occurs when the patient leaves the confines of the ASC

Selection Basis:
There are numerous case reports in the literature regarding patient burns in the surgical and procedural setting. The diversity of the causative agents underscores the multitude of potential risks that must be properly mitigated to avoid patient burns.

The literature on burns suggests that electrosurgical burns are most common. A recent publication from the ECRI Institute (www.ecri.org) highlights the increased risk of burns with newer surgical devices that apply higher currents at longer activation times. Although electrical burns are most prevalent, other mechanisms of burn injury are frequently reported in case studies and case series. These include chemical and thermal burns.

Surgical fires are rare; however, their consequences can be grave, killing or seriously injuring patients and surgical staff. The risk of surgical fire is present whenever and wherever surgery is performed, whether in an operating room (OR), a physician's office, or an outpatient clinic.

Recognizing the diversity of mechanisms by which a patient could sustain an unintentional burn in the ASC setting, the definition of burn is broad, encompassing all six recognized means by which a burn can occur – scalds, contact, fire, chemical, electrical, or radiation. This will allow stakeholders to develop a better understanding of the incidence of these events and further refine means to ensure prevention.

Clinical Recommendation Statements:
The risk of burns related to laser use can be reduced by adherence to the guidelines published by the American National Standards Institute (ANSI) for safe use of these devices in the health care setting. Similarly, the risk of burns related to the use of electrosurgical devices can be reduced by following the electrosurgery checklist published by ECRI Institute.

The risk of surgical fires can be reduced by minimizing ignition, oxidizer, and fuel risks (the "classic triangle"). The American Society of Anesthesiologist's Practice Advisory for the Prevention and Management of Operating Room Fires seeks to prevent the occurrence of OR fires, reduce adverse outcomes associated with OR fires, and identify the elements of a fire response protocol. These guidelines are available at: https://asahq.org/quality-and-practice-management/standards-and-guidelines.

Guidance for the prevention of surgical fire has also been published by the Association of Perioperative Registered Nurses (AORN).

Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

Selected References:

- American National Standards Institute (ANSI) Z136.3 (2005) – Safe Use of Lasers in Health Care Facilities, 2005 Revision.
- American Society of Anesthesiologists Task Force on Operating Room Fires, Caplan RA, Barker SJ, et al. Practice advisory for the prevention and management of operating room fires. Anesthesiology 2008 May; 108(5):786-801.
- Anesthesia Patient Safety Foundation (APSF). Prevention and management of surgical fires [video]. February 2010. http://www.apsf.org/resources_video.php.
- ECRI Institute. New clinical guide to surgical fire prevention: patients can catch fire—here's how to keep them safer [guidance article]. Health Devices 2009 Oct; 38(10):314-32.
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- Association of Operating Room Nurses (AORN). AORN Guidance Statement: Fire Prevention in the Operating Room in Standards, Recommended Practices, and Guidelines. Denver, CO: AORN, 2006.
- AORN. Fire safety Tool Kit. 2015. http://www.aorn.org/guidelines/clinical-resources/tool-kits/fire-safety-tool-kit.
- National Quality Forum. Serious Reportable Events in Healthcare 2006 Update. Washington, FC: NQF, 2007.
- Joint Commission. Joint Commission Sentinel Event Alert. Issue 12, February 4, 2000. Operative and Postoperative Complications: Lessons for the Future. Chicago, IL.
- Tucker R. Laparoscopic electrosurgical injuries: survey results and their implications. Surg Laparosc Endosc. 1995; 5(4):311- 7.
- ECRI. Higher currents, greater risks: preventing patient burns at the return-electrode site during high-current electrosurgical procedures. Health Devices. 2005; 34(8):273-9.
- Demir E, O'Dey D, and Pallua N. Accidental burns during surgery. J Burn Care Res. 2006; 27(6):895-900.

- Cheney F, Posner K, Caplan R, and Gild W. Burns from warming devices in anesthesia. A closed claims analysis. Anesthesiology. 1994; 80(4):806-10.
- Barker S and Polson J. Fire in the operating room: a case report and laboratory study. Anesth Anal. 2001; 93:960-965.
- ECRI. Devastation of patient fires. Health Devices. 1992; 21:3-39.
- Bhananker S, Posner K, Cheney F, Caplan R, Lee L, and Domino K. Injury and liability associated with monitored anesthesia care: a closed claims analysis. Anesthesiology. 2006; 104(2):228-34.

Measure Information Form

Measure Title: Patient Fall

Measure ID #: ASC-2

Quality Reporting Option: Claims-based outcome measure

Description: The number of admissions (patients) who experience a fall within the ASC

Denominator: All ASC admissions

Inclusions: All ASC admissions

Exclusions: None

Numerator: ASC admissions experiencing a fall within the confines of the ASC

Inclusions: ASC admissions experiencing a fall within the confines of the ASC

Exclusions: ASC admissions experiencing a fall outside the ASC

Numerator Quality-Data Coding Options for Reporting:
- G8910: Patient documented to have experienced a fall within the ASC
- G8911: Patient documented not to have experienced a fall within the ASC
- G8907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility

Note: If using code G8910 or G8911, do not use code G8907.

Definitions:
- **Admission** – Completion of registration upon entry into the facility
- **Fall** – A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions (source: National Center for Patient Safety)

Selection Basis:
"Falls per 100,000 patient days" has been endorsed as a serious reportable event by the NQF. While ASCs have a relatively low incidence of adverse events in general, information regarding the incidence of patient falls is not currently available. However, stakeholders have expressed a general interest in the public reporting of such adverse events. Due to the use of anxiolytics, sedatives, and anesthetic agents as adjuncts to procedures, patients undergoing outpatient surgery are at increased risk for falls.

Clinical Recommendation Statements:
According to the Agency for Healthcare Research and Quality's Prevention of Falls in Acute Care guideline, patient falls may be reduced by following a four-step approach: 1) evaluating and identifying risk factors for falls in the older patient; 2) developing an appropriate plan of care for prevention; 3) performing a comprehensive evaluation of falls that occur; and 4) performing a post-fall revision of plan of care as appropriate.

Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

Selected References:

- Institute for Clinical Systems Improvement (ICSI). Prevention of falls (acute care). Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Apr. p 34.
- Boushon B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D. Transforming Care at the Bedside How-to-Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2008.
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- American Medical Directors Association (AMDA). Falls and fall risk. Columbia, MD: American Medical Directors Association.
- ECRI Institute: Falls Prevention Strategies in Healthcare Settings (2006). Plymouth Meeting, PA.
- Institute for Clinical Systems Improvement. Prevention of Falls (Acute Care). Second Edition. April 2010.
- Resnick, B. (2003). Preventing falls in acute care. In: M. Mezey, T. Fulmer, I. Abraham (Eds.) & D. Zwicker (Managing Ed.), Geriatric nursing protocols for best practice (2nd ed., pp. 141-164). New York: Springer Publishing Company, Inc.
- University of Iowa Gerontological Nursing Interventions Research Center (UIGN). (2004). Falls prevention for older adults. Iowa City, IA. University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core.

Measure Information Form

Measure Title: Patient Fall

Measure ID #: ASC-2

Quality Reporting Option: Claims-based outcome measure

Description: The number of admissions (patients) who experience a fall within the ASC

Denominator: All ASC admissions

Inclusions: All ASC admissions

Exclusions: None

Numerator: ASC admissions experiencing a fall within the confines of the ASC

Inclusions: ASC admissions experiencing a fall within the confines of the ASC

Exclusions: ASC admissions experiencing a fall outside the ASC

Numerator Quality-Data Coding Options for Reporting:
- G8910: Patient documented to have experienced a fall within the ASC
- G8911: Patient documented not to have experienced a fall within the ASC
- G8907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility

Note: If using code G8910 or G8911, do not use code G8907.

Definitions:
- **Admission** – Completion of registration upon entry into the facility
- **Fall** – A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions (source: National Center for Patient Safety)

Selection Basis:
"Falls per 100,000 patient days" has been endorsed as a serious reportable event by the NQF. While ASCs have a relatively low incidence of adverse events in general, information regarding the incidence of patient falls is not currently available. However, stakeholders have expressed a general interest in the public reporting of such adverse events. Due to the use of anxiolytics, sedatives, and anesthetic agents as adjuncts to procedures, patients undergoing outpatient surgery are at increased risk for falls.

Clinical Recommendation Statements:
According to the Agency for Healthcare Research and Quality's Prevention of Falls in Acute Care guideline, patient falls may be reduced by following a four-step approach: 1) evaluating and identifying risk factors for falls in the older patient; 2) developing an appropriate plan of care for prevention; 3) performing a comprehensive evaluation of falls that occur; and 4) performing a post-fall revision of plan of care as appropriate.

Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

Selected References:

- Institute for Clinical Systems Improvement (ICSI). Prevention of falls (acute care). Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Apr. p 34.
- Boushon B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D. Transforming Care at the Bedside How-to-Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2008.
- ECRI Institute. Fall Injury Prevention Interventions. August 1, 2015.
- Joint Commission. 2011-2012 National Patient Safety Goals: http://www.jointcommission.org/standards_information/npsgs.aspx.
- National Center for Patient Safety: United States Department of Veterans Affairs. http://www.patientsafety.va.gov/professionals/onthejob/falls.asp.
- National Quality Forum. Serious Reportable Events in Healthcare – 2006 Update: A Consensus Report. March 2007.
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- American Geriatrics Society, British Geriatrics Society, American Academy of Orthopedic Surgeons (AGS/BGS/AAOS) Guidelines for the Prevention of Falls in Older Persons (2001). Journal of the American Geriatrics Society, 49, 664-672.
- American Medical Directors Association (AMDA). Falls and fall risk. Columbia, MD: American Medical Directors Association.
- ECRI Institute: Falls Prevention Strategies in Healthcare Settings (2006). Plymouth Meeting, PA.
- Institute for Clinical Systems Improvement. Prevention of Falls (Acute Care). Second Edition. April 2010.
- Resnick, B. (2003). Preventing falls in acute care. In: M. Mezey, T. Fulmer, I. Abraham (Eds.) & D. Zwicker (Managing Ed.), Geriatric nursing protocols for best practice (2nd ed., pp. 141-164). New York: Springer Publishing Company, Inc.
- University of Iowa Gerontological Nursing Interventions Research Center (UIGN). (2004). Falls prevention for older adults. Iowa City, IA. University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core.

Measure Information Form

Measure Title: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Measure ID #: ASC-3

Quality Reporting Option: Claims-based outcome measure

Description: The number of admissions (patients) who experience a wrong site, side, patient, procedure, or implant

Denominator: All ASC admissions

Inclusions: All ASC admissions

Exclusions: None

Numerator: All ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant

Inclusions: All ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant

Exclusions: None

Numerator Quality-Data Coding Options for Reporting:

- G8912: Patient documented to have experienced a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event
- G8913: Patient documented not to have experienced a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event
- G8907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility

Note: If using code G8912 or G8913, do not use code G8907.

Definitions:

- **Admission** – Completion of registration upon entry into the facility
- **Wrong** – Not in accordance with intended site, side, patient, procedure, or implant

Selection Basis:

"Surgery performed on the wrong body part," "surgery performed on the wrong patient," and "wrong surgical procedure performed on a patient" have all been endorsed as serious reportable surgical events by NQF. This outcome measure serves as an indirect measure of providers' adherence to The Joint Commission's "Universal Protocol" guideline. The Joint Commission, an accreditation body, has developed a "Universal Protocol" guideline for eliminating wrong site, wrong procedure, wrong person surgery. The Universal Protocol is based on the consensus of experts and is endorsed by more than 40 professional medical associations and organizations. To encompass the outcomes of all key identification verifications, the ASC Quality Collaboration's measure incorporates not only wrong site, wrong side, wrong patient, and wrong procedure, but also wrong implant in its specifications.

Clinical Recommendation Statements:
The Joint Commission's "Universal Protocol" is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.

Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

Selected References:

- Joint Commission. Universal Protocol For Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. Available at http://jointcommission.org/standards_information/up.aspx. Last accessed December 14, 2010.
- American Academy of Ophthalmology. Recommendations of American Academy of Ophthalmology Wrong Site Task Force. http://www.aao.org/Assets/c85186a8-5f17-422b-861e-fd4e4b061dff/635518426969930000/revised-wswiol-document-may-12-2014-august-finalrev-pdf.
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- Joint Commission. 2011 National Patient Safety Goals. http://www.jointcommission.org/standards_information/npsgs.aspx.
- National Quality Forum. Serious Reportable Events in Healthcare – 2006 Update: A Consensus Report. March 2007.
- World Health Organization. WHO Guidelines for Safe Surgery 2009. http://whqlibdoc.who.int/publications/2009/9789241598552_eng.pdf.

Measure Information Form

Measure Title: All-Cause Hospital Transfer/Admission

Measure ID #: ASC-4

Quality Reporting Option: Claims-based outcome measure

Description: The percentage of ASC admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC

Denominator: All ASC admissions

Inclusions: All ASC admissions

Exclusions: None

Numerator: ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC

Inclusions: ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC

Exclusions: None

Numerator Quality-Data Coding Options for Reporting:
- G8914: Patient documented to have experienced a hospital transfer or hospital admission upon discharge from ASC
- G8915: Patient documented not to have experienced a hospital transfer or hospital admission upon discharge from ASC
- G8907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility

Note: If using code G8914 or G8915, do not use code G8907.

Definitions:
- **Admission** – Completion of registration upon entry into the facility
- **Hospital Transfer/Admission** – Any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room
- **Discharge** – Occurs when the patient leaves the confines of the ASC

Selection Basis:
The need for transfer/admission is an unanticipated, but sometimes necessary outcome. Hospital transfers/admissions can result in unplanned cost and time burdens that must be borne by patients and payers.

Selected states have expressed an interest in the public reporting of such events. While hospital transfers and admissions undoubtedly represent good patient care when necessary, high rates may be an indicator that practice patterns or patient selection guidelines are in need of review.

Clinical Recommendation Statements:
No clinical practice guidelines specifically addressing transfers or admissions from ASCs to acute care hospitals are available at this time.

Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

Selected References:

- Coley K et al. Retrospective evaluation of unanticipated admissions and readmissions after same day surgery and associated costs. J. Clin Anesth. 2002; 14:349-353.
- Lin D, Dalgorf D, Witterick IJ. Predictors of unexpected hospital admissions after outpatient endoscopic sinus surgery: retrospective review. J Otolaryngol Head Neck Surg. 2008 Jun: 37(3):309-11.
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- Shaikh S, Chung F, Imarengiaye C, Yung D, Bernstein M. Pain, nausea, vomiting and ocular complications delay discharge following ambulatory microdiscectomy. Can J Anaesth. 2003 May; 50(5):514-8.

Measure Information Form

Measure Title: Prophylactic Intravenous (IV) Antibiotic Timing

Measure ID #: ASC-5

Quality Reporting Option: Claims-based process measure

Description: Intravenous (IV) antibiotics given for prevention of surgical site infection were administered on time

Denominator: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection

Inclusions: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection

Exclusions: ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of infections other than surgical site infections (e.g., bacterial endocarditis); ASC admissions with a preoperative order for a prophylactic antibiotic not administered by the intravenous route

Numerator: Number of ASC admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection who received the prophylactic antibiotic on time

Inclusions: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection

Exclusions: None

Numerator Quality-Data Coding Options for Reporting:

- G8916: Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time
- G8917: Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time
- G8918*: Patient without preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis

***Note**: G8918 is to be reported for patients with no indication for, or no order for IV antibiotic prophylaxis for surgical site infection. This does not place a case with this code in the denominator, but is necessary for calculating the completeness of reporting.

Definitions:

- **Admission** – completion of registration after physical entry into the facility
- **Antibiotic administered on time** – antibiotic infusion is initiated within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, insertion of needle, inflation of tourniquet) or two hours prior if Vancomycin or fluoroquinolones are administered
- **Intravenous** – administration of a drug within a vein, including bolus, infusion, or IV piggyback
- **Order** – a written order, verbal order, standing order, or standing protocol
- **Prophylactic antibiotic** – an antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of this measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin, and Vancomycin.

Selection Basis:
The CMS Surgical Infection Prevention performance measure states, "Surgical site infections occur in 2–5 percent of clean extra-abdominal surgeries and up to 20 percent of intra-abdominal surgeries. Each infection is estimated to increase a hospital stay by an average of 7 days and add over $3,000 in charges (1992 data). Patients who develop surgical site infections are 60 percent more likely to spend time in an ICU (intensive care unit), five times more likely to be readmitted to the hospital, and have twice the incidence of mortality. Despite advances in infection control practices, surgical site infections remain a substantial cause of morbidity and mortality among hospitalized patients. Studies indicate that appropriate preoperative administration of antibiotics is effective in preventing infection. Systemic and process changes that promote compliance with established guidelines and standards can decrease infectious morbidity."

There is no literature available on variation in adherence to recommended prophylactic IV antibiotic timing among ASC providers. However, variability in the accuracy of timing of administration has been demonstrated in other clinical settings.

Clinical Recommendation Statements:
This performance measure is aligned with current surgical infection prevention guidelines recommending that prophylactic antibiotics be administered within one hour prior to surgical incision, or within two hours prior to incision when vancomycin or fluoroquinolones are used.

Selected References:

- Horan T, Culver D, Gaynes R, Jarvis W, Edwards J, and Reid C. Nosocomial infections in surgical patients in the United States, January 1986-June 1992. National Nosocomial Infections Surveillance (NNIS) System. Infect Control Hosp Epidemiol. 1993; 14(2):73-80.
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- Forbes SS, Stephen WJ, Harper WL, Loeb M, Smith R, Christoffersen EP, McLean RF. Implementation of evidence-based practices for surgical site infection prophylaxis: results of a pre- and post-intervention study. J Am Coll Surg. 2008 Sep; 207(3):336-41.
- Koopman E, Nix DE, Erstad BL, Demeure MJ, Hayes MM, Ruth JT, Mattias KR. End-of-procedure cefazolin concentrations after administration for prevention of surgical-site infection. Am J Health Syst Pharm. 2007 Sep; 64(18):1927-34.
- Manniën J, van Kasteren ME, Nagelkerke NJ, Gyssens IC, Kullberg BJ, Wille JC, de Boer AS. Effect of optimized antibiotic prophylaxis on the incidence of surgical site infection. Infect Control Hosp Epidemiol. 2006; 27(12):1340-6.
- Cruse P. Wound infection surveillance. Rev Infect dis 1981; 3:734-737.
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- Coello R, Glenister H, Fereres J, et al. The cost of infection in surgical patients: a case-control study. J Hosp Infect 1993; 25:239-250.
- Whitehouse JD, Friedman ND, Kirkland KB, Richardson WJ, Sexton DJ. The impact of surgical-site infections following orthopedic surgery at a community hospital and a university hospital: adverse quality of life, excess length of stay, and extra cost. Infect Control Hosp Epidemiol 2002; 23:183-189.
- Apisamthanarak A, Jones M, Waterman BM, Carroll CM, Bernardi R, Fraser VJ. Risk factors for spinal surgical-site infections in a community hospital: a case-control study. Infect Control Hosp Epidemiol 2003; 24:31-36.
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- Ho VP, Barie PS, Stein SL, Trencheva K, Milsom JW, Lee SW, Sonoda T. Antibiotic regimen and the timing of prophylaxis are important for reducing surgical site infection after elective abdominal colorectal surgery. Surg Infect (Larchmt). 2011 Aug: 12(4):255-60.
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Measure Information Form

Measure Title: Safe Surgery Checklist Use

Measure ID #: ASC-6

Quality Reporting Option: Measure submitted via a web-based tool

Description: The use of a Safe Surgery Checklist for surgical procedures that includes safe surgery practices during each of the three critical perioperative periods: the period prior to the administration of anesthesia, the period prior to skin incision, and the period of closure of incision and prior to the patient leaving the operating room

Measure ascertains response to the following question:

- Does/did your facility use a safe surgery checklist based on accepted standards of practice during the designated period? Yes/No

Annual data submission period: See the timeline posted to QualityNet.org for this measure; select ASCs and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Examples for Safe Surgery Practices*

First critical point (period prior to administering anesthesia)	Second critical point (period prior to skin incision)	Third critical point (period of 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

*Safe surgery checklist items are not limited to the examples listed in this table.

Measure Information Form

Measure Title: ASC Facility Volume Data on Selected ASC Surgical Procedures

Measure ID #: ASC-7

Quality Reporting Option: Measure submitted via a web-based tool

Description: The aggregate count of selected surgical procedures – Most ASC procedures fall into one of eight categories: Eye, Gastrointestinal, Genitourinary, Musculoskeletal, Nervous System, Respiratory, Skin, and Multi-system. The eight categories and corresponding HCPCS are listed in the table below.* The procedures and codes in Table 2 were selected based on recent ASC data.

Measure ascertains response to the following question(s):

- What was the aggregate count of selected surgical procedures per category?

Annual data submission period: See the timeline posted to QualityNet.org for this measure; select ASCs and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

***Please note the categories and HCPCS for ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures will be populated here in November 2017 for encounters from 01-01-17 through 12-31-17.**

Measure Information Form

Measure Title: Influenza Vaccination Coverage among Healthcare Personnel

Measure ID #: ASC-8

Quality Reporting Option: CMS required ASCs participating in the CMS Ambulatory Surgical Center Quality Reporting Program to report data collected by the Centers for Disease Control and Prevention (CDC) via the National Healthcare Safety Network (NHSN).

Description: For more information about the NHSN measure, see the resources located at http://www.cdc.gov/nhsn.

Definition for Healthcare Personnel (HCP) – Facilities must report vaccination data for three categories of HCP: employees on payroll; licensed independent practitioners (who are physicians, advanced practice nurses, and physician assistants affiliated with the hospital but not on payroll); and students, trainees, and volunteers aged 18 or older. Reporting data on the optional, other contract personnel category is not required at this time. All HCP physically working in the facility for at least one day or more between October 1 and March 31 should be counted. Data on vaccinations received at the facility, vaccinations received outside of the facility, medical contraindications, and declinations are reported for the three categories of HCP.

Direct questions regarding NHSN training, enrollment, and submission to: NHSN@cdc.gov.

Measure Information Form

Measure Title: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients

Measure ID #: ASC-9

Quality Reporting Option: Measures submitted via a web-based tool

Description: Percentage of patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Numerator Statement: Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Denominator Statement: All patients aged 50 to 75 years of age receiving screening colonoscopy without biopsy or polypectomy

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 and ≤ 75 on date of encounter
and
ICD-10-CM Diagnosis code: Z12.11
and
CPT or HCPCS: 44388, 45378, G0121
without
CPT Category I Modifiers: 52, 53, 73, 74
without
ICD-10-CM Diagnosis codes: Z83.71, Z86.010, Z80.0, Z85.038

Denominator Exclusions:

- Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (e.g., above average risk, inadequate prep). Medical reason(s) are at the discretion of the physician. Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as the reason. Documentation of a medical condition or finding can be used as a medical reason(s) for denominator exclusion purposes only if the documented recommended follow-up interval is less than 10 years.
  Examples:
  - Diverticulitis documented in the medical record and a follow-up interval of 5 years in the colonoscopy report.
  - Family history of colon cancer and a follow-up interval of 3 years documented in the colonoscopy report.
  - Less than adequate prep documented in the medical record with a repeat colonoscopy in 3 years in the colonoscopy report.

Annual Data Submission Period: See the timeline posted to QualityNet.org for this measure; select ASCs and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Additional Instructions: Patients will be counted in the numerator if there is reference in the final colonoscopy report that the appropriate follow-up interval for the repeat colonoscopy is at least 10 years from the date of the current colonoscopy (i.e., the colonoscopy performed during the measurement period). A range that includes "10 years" (e.g., 7 to 10 years) is not acceptable.

Measure Information Form

Measure Title: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use

Measure ID #: ASC-10

Quality Reporting Option: Measures submitted via a web-based tool

Description: Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings, who had a follow-up interval of 3 or more years since their last colonoscopy

Numerator Statement: Patients who had an interval of 3 or more years since their last colonoscopy

Denominator Statement: All patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior colonic polyp(s) in previous colonoscopy findings

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
and
Diagnosis for history of colonic polyp(s) (ICD-10-CM): Z86.010
and
CPT or HCPCS: 44388, 44389, 44392, 44394, 45378, 45380, 45381, 45384, 45385, G0105
without
CPT Category I Modifiers: 52, 53, 73, or 74

Denominator Exclusions:
- Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas/polyps, or last colonoscopy found greater than 10 adenomas/polyps). Medical reason(s) are at the discretion of the physician. "History of colonic polyps" is not an acceptable reason to exclude cases from the denominator. A patient must have a history of colonic polyps to be eligible for the measure. Documentation of a medical condition or finding can be used as a medical reason(s) for denominator exclusion purposes only if the previous colonoscopy was less than 3 years prior.
- Documentation of system reason(s) clearly documented in the current medical record for an interval of less than 3 years since the last colonoscopy (e.g., unable to locate previous colonoscopy report). For a system reason all of the following must be present in the medical record.
    - The interval since the last colonoscopy is less than 3 years; **and**
    - A medical reason for an interval of less than 3 years is not documented; **and**
    - A "system reason" is documented (e.g., previous colonoscopy report not available, unable to locate last colonoscopy report).

Annual Data Submission Period: See the timeline posted to QualityNet.org for this measure; select ASCs and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Additional Instructions: For the purpose of this measure, a surveillance colonoscopy is defined as the colonoscopy performed after a colonic polyp(s) has been detected and removed. The denominator of this measure is the total number of patients ≥ 18 years of age receiving a surveillance colonoscopy. The

numerator is the number of patients receiving a surveillance colonoscopy 3 years or greater after the colonoscopy showing the colonic polyp. Information regarding the performance interval can be obtained from medical record documentation.

Measure Information Form

Measure Title: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

Measure ID #: ASC-11*

Quality Reporting Option: Measure submitted via a web-based tool

Description: Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery

Numerator Statement: Patients who had improvement in visual function achieved within 90 days following cataract surgery, based on completing **both** a pre-operative and post-operative visual function instrument

Denominator Statement: All patients aged 18 years and older who had cataract surgery and completed **both** a pre-operative and post-operative visual function instrument

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years
and
CPT (with or without modifiers): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984

Excluded Population: Patients who did not complete both a pre-operative and post-operative survey

Annual Data Submission Period: See the timeline posted to QualityNet.org for this measure; select ASCs and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Data Collection Approach: Include procedures performed from the beginning of the reporting year through 90 days prior to the end of the reporting period. This will allow the postoperative period to occur.

Additional Instructions: Definition for Survey: An appropriate data collection instrument is an assessment tool that has been validated for the population for which it is being used; this measure utilizes a visual function survey. While it is recommended that the facility obtain the survey results from the appropriate physician or optometrist, the surveys can be administered by the facility via phone, mail, email, or during clinician follow-up. For this measure, the same data collection instrument (i.e., survey) must be used pre-operatively and post-operatively.

Examples of tools for visual function assessment include, but are not limited to: National Eye Institute-Visual Function Questionnaire (VFQ- http://www.rand.org/health/surveys_tools/vfq.html), the Visual Function (VF)-14, the modified VF-8, the Activities of Daily Vision Scale (ADVS), the Catquest, and the modified Catquest-9. For each of the VF tools (VF-14 or VF-8R), all questions have equal weight; only non-missing questions are included, and the total weight is 100.

*Finalized in the CY 2015 OPPS/ASC final rule, ASCs have the option to voluntarily collect and submit data for ASC-11 for the CY 2017 payment determination and subsequent years. All data submitted voluntarily will be publically reported as discussed in the CY 2014 OPPS/ASC proposed rule (Vol. 78, No. 139 Proposed Rule, pp.43664, 43669).

Centers for Medicare & Medicaid Services (CMS)
Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy Measure

Introduction

This section of the manual includes the Measure Information Form (MIF) for the CMS Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure. This is an administrative claims-based measure, so there is no data abstraction responsibility on the part of the facility. The measure includes outpatient colonoscopies performed among Medicare Fee-for-Service (FFS) beneficiaries aged ≥ 65 years.

CMS has finalized adoption of the measure into the ASCQR Program for payment determination beginning in calendar year 2018.

This measure was developed by a team of clinical and statistical experts from the Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE), under contract to CMS. The measure is currently endorsed by the National Quality Forum (NQF #2539).
The information in the following MIF is being provided in the interest of transparency and to promote understanding of methodology on the part of the facility and vendor communities. Additional background information about the measure methodology can be found in the measure technical report (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html), the 2015 Measure Specifications Report (https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775197506), and the 2016 Measure Updates and Specifications Report https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775214597. Questions and comments about the measure should be directed to CMSColonoscopyMeasure@yale.edu.

CMS calculates a facility-level risk-standardized unplanned hospital visit rate for all eligible facilities. Facilities and their ORYX® Vendors do not have sufficient data to produce facilities' risk-standardized results. CMS inpatient and outpatient claims data are used to determine whether a beneficiary has had an unplanned hospital visit to any acute care hospital within 7 days of the outpatient colonoscopy. In addition, CMS extracts and utilizes physician office, inpatient, and outpatient claims data from the year prior to the colonoscopy as well as claims data from the colonoscopy to risk adjust the facility-level outcome rates.

Measure Information Form

Measure Title: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

Measure ID #: ASC-12

Quality Reporting Option: CMS Outcome Measure (Claims-Based)

Description: The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare Fee-for-Service (FFS) patients aged 65 years and older.

Rationale: This measure will reduce adverse patient outcomes associated with preparation for colonoscopy, the procedure itself, and follow-up care by capturing and making more visible to providers and patients all unplanned hospital visits following the procedure. The measure score will assess quality and inform quality improvement.

Type of Measure: Outcome

Improvement Noted As: A decrease in the facility-level risk-standardized unplanned hospital visit rate

Numerator Statement:
This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define the outcome. The calculation of the rate is defined below under Measure Calculation.

The outcome for this measure is all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy. The measure defines a hospital visit as any emergency department (ED) visit, observation stay, or unplanned inpatient admission.

Denominator Statement:
The target population for this measure includes low-risk colonoscopies performed in the outpatient setting for Medicare FFS patients aged 65 years and older. For implementation in the ASCQR Program, the measure will be calculated among ambulatory surgical centers (ASCs).

Included Populations:
Outpatient colonoscopies for Medicare FFS patients aged 65 years and older. CMS FFS beneficiaries with an outpatient colonoscopy are included if the patient has been enrolled in Part A and Part B Medicare for the 12 months prior to the date of procedure to ensure a full year of administrative data for risk-adjustment.

The measure is focused on low-risk colonoscopies. The measure did not include colonoscopy CPT procedure codes that reflected fundamentally higher-risk or different procedures. Qualifying colonoscopies billed with a concurrent high-risk colonoscopy procedure code were not included in the measure; the 2016 Measure Updates and Specifications Report at the link above contains the complete listing of all high-risk procedure codes.

CPT Codes that define the patient cohort:

G0121 Colonoscopy on individual not meeting criteria for high risk
G0105 Colonoscopy on individual at high risk of colorectal cancer
45378 Diagnostic colonoscopy
45380 Colonoscopy with biopsy
45385 Colonoscopy with ablation of lesion(s)/polypectomy by snare
45384 Colonoscopy with ablation of lesion(s)/polypectomy by hot biopsy forceps or bipolar cautery
45383 Colonoscopy with ablation of lesion(s)/polypectomy by other techniques (i.e., techniques other than 45384/45385)
45381 Colonoscopy, with directed submucosal injection, any substance
45388 Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
G6024 Colonoscopy, flexible; proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare

Cohort Exclusions (excluded colonoscopies):

- Colonoscopies for patients who lack continuous enrollment in Medicare FFS Parts A and B in the 7 days after the procedure.
- Colonoscopies that occur concurrently with high-risk upper gastrointestinal (GI) endoscopy procedures.
- Colonoscopies for patients with a history of inflammatory bowel disease (IBD) or diagnosis of IBD at time of index colonoscopy or on a subsequent hospital visit outcome claim.
- Colonoscopies for patients with a history of diverticulitis or diagnosis of diverticulitis at time of index colonoscopy or on a subsequent hospital visit outcome claim.
- Colonoscopies followed by a subsequent outpatient colonoscopy procedure within 7 days.

The 2016 Measure Updates and Specifications Report contains complete coding for all exclusions.

Table 1: Inflammatory Bowel Disease (IBD) ICD-10-CM Diagnosis Codes

ICD-10-CM Code	ICD-10-CM Code Description
K50.0*	Crohn's disease of small intestine
K50.1*	Crohn's disease of large intestine
K50.8*	Crohn's disease of both small and large intestine
K50.9*	Crohn's disease, unspecified
K51.2*	Ulcerative (chronic) proctitis
K51.3*	Ulcerative (chronic) rectosigmoiditis
K51.4*	Inflammatory polyps of colon
K51.5*	Left sided colitis
K51.0*	Ulcerative (chronic) pancolitis
K51.8*	Other ulcerative colitis
K51.9*	Ulcerative colitis, unspecified

Note: for the ICD-9 codes relevant to the calculation of the measure for the CY2016 period, refer to v5.1 of the manual.

Table 2: Diverticulitis ICD-10-CM Diagnosis Codes

ICD-10-CM Code	ICD-10-CM Code Description
K57.20	Diverticulitis of large intestine with perforation and abscess without bleeding
K57.32	Diverticulitis of large intestine without perforation or abscess without bleeding
K57.40	Diverticulitis of both small and large intestine with perforation and abscess without bleeding
K57.52	Diverticulitis of both small and large intestine without perforation or abscess without bleeding
K57.80	Diverticulitis of intestine, part unspecified, with perforation and abscess without bleeding
K57.92	Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding
K57.21	Diverticulitis of large intestine with perforation and abscess with bleeding
K57.33	Diverticulitis of large intestine without perforation or abscess with bleeding
K57.41	Diverticulitis of both small and large intestine with perforation and abscess with bleeding
K57.53	Diverticulitis of both small and large intestine without perforation or abscess with bleeding
K57.81	Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding
K57.93	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding

Note: For the ICD-9 codes relevant to the calculation of the measure for the CY2016 period, refer to v5.1 of the manual.

Admissions not counted in the outcome ("Planned admissions"):
Admissions identified as planned by the planned admission algorithm are not counted in the outcome. The "algorithm" is a set of criteria for classifying admissions as planned using Medicare claims. The algorithm identifies admissions that are typically planned and may occur within 7 days of an outpatient colonoscopy. CMS based the planned admission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (transplant surgery, maintenance chemotherapy, rehabilitation);
2. Otherwise, a planned admission is defined as a non-acute admission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The planned admission algorithm uses a flowchart and four tables of procedures and conditions to operationalize these principles and to classify inpatient admissions as planned. ED visits and observation stays are never considered planned. The flowchart and tables are available in the 2016 Measure Updates and Specifications Report, located at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775214597.

Risk Adjustment:
The measure's approach to risk adjustment is tailored to, and appropriate for, a publicly reported outcome measure as articulated in published scientific guidelines (Krumholz et al., 2006; Normand et al., 2007).

The measure uses a two-level hierarchical logistic regression model to estimate facility-level risk-standardized hospital visit rates. This approach accounts for the clustering of patients within facilities and variation in sample size across facilities.

The risk-standardization model has 15 patient-level variables (age, concomitant upper GI endoscopy, polypectomy during the procedure, and 12 comorbidity variables). The measure defines comorbidity variables using condition categories (CCs), which are clinically meaningful groupings of the many thousands of ICD-10-CM diagnosis codes. Certain CCs are considered possible complications of care; therefore, the measure does not risk-adjust for them if they occur only at the time of the procedure. This is because only comorbidities that convey information about the patient at the time of the procedure or in the 12 months prior, and not complications that arose during the colonoscopy procedure are included in the risk adjustment. The 2016 Measure Updates and Specifications Report contains complete definitions of risk factors and CCs that are considered possible complications of care and are not risk-adjusted for if they occur only at the time of the procedure.

The patient-level risk adjustment variables are:

Demographics	Age (categorized; 65-69; 70-74; 75-79; 80-84; 85+)
Procedural factors	Concomitant Endoscopy Polypectomy during Procedure
Comorbidities	Chronic Heart Failure Ischemic Heart Disease Stroke/Transient Ischemic Attack (TIA) Chronic Lung Disease Metastatic Cancer Liver Disease Iron Deficiency Anemia Disorders of Fluid, Electrolyte, Acid-Base Pneumonia Psychiatric Disorders Drug and Alcohol Abuse/Dependence Arrhythmia Age Categorized x Arrhythmia Interaction

Note: The relationship between age and risk of a hospital visit within 7 days was modified by the presence or absence of a cardiac arrhythmia (p-value for interaction <0.001). Therefore, we included an interaction term (age categorized x arrhythmia) in the final model.

Full details of the development of the risk-standardization model for this measure are available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

Data Collection Approach: Medicare administrative claims and enrollment data

Data Accuracy: The administrative claims data used to calculate the measure are maintained by CMS' Office of Information Services. The data undergo additional quality assurance checks during measure development and maintenance.

Measure Analysis Suggestions: None

Sampling: No

Data Reported As: Facility-level 7-day risk-standardized unplanned hospital visit rate following outpatient colonoscopy

Measure Calculation:
The measure estimates facility-level 7-day risk-standardized unplanned hospital visit rates using hierarchical logistic regression modeling (a form of hierarchical generalized linear modeling [HGLM]). In brief, the approach simultaneously models two levels (patient and facility) to account for the variance in patient outcomes within and between facilities. At the patient level, the model adjusts the log-odds of a hospital visit within 7 days of the procedure for age, procedural factors, and selected clinical covariates. At the facility level, it estimates the facility-specific intercepts as arising from a normal distribution. The facility intercept represents the underlying risk of a hospital visit within 7 days after a colonoscopy at that facility while accounting for patient risk. The facility-specific intercepts also account for the clustering (non-independence) of patients within the same facility. If there were no differences among facilities, then after adjusting for patient risk the facility-specific intercepts would be identical across all facilities.

The statistical modeling approach is described fully in the original technical report: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

Selected References:

- Krumholz HM, Brindis RG, Brush JE, et al. Standards for Statistical Models Used for Public Reporting of Health Outcomes: An American Heart Association Scientific Statement From the Quality of Care and Outcomes Research Interdisciplinary Writing Group: Cosponsored by the Council on Epidemiology and Prevention and the Stroke Council Endorsed by the American College of Cardiology Foundation. Circulation. 2006; 113 (3): 456-462.
- Normand S-LT, Shahian DM. Statistical and Clinical Aspects of Hospital Outcomes Profiling. Stat Sci. 2007; 22-(2): 206-226.

ASC-1 through ASC-4 – A Quality Data Code (QDC) has been established to report that the patient did **not** experience the events for four of the five claims-based outcome measures. If this code is used, none of the other QDCs should be used for these four measures.

G8907: Patient documented **not** to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility.

ASC-5 – Measure ASC-5 applies to all ASCs regardless of specialty or procedure performed. CMS requires all facilities to report on the ASC-5 measure for all Medicare Fee-for-Service (FFS) patients, even if there is no indication for or order for perioperative antibiotics (G8918). This requirement is necessary in order to assess completeness of reporting.

Important: For surgical patients with an order for prophylactic antibiotics, information on the fifth measure, Prophylactic IV Antibiotic Timing, will be reported separately. If the patient received the prophylactic antibiotic on time and did not experience any of the events (a burn prior to discharge; a fall within the facility, wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility), the code listed above (G8907) would be used **in addition** to G8916. See each measure for the list of applicable codes.

For more information on measures ASC-1–ASC-5, see individual measure specifications in this manual.

ASC-9, ASC-10, and ASC-11* – The sampling size specifications for ASC-9, ASC-10, and ASC-11* have been established and are specified in the table below.

Table 3: Sample size requirements per year per ASC for Endoscopy/Polyp Surveillance (ASC-9 and ASC-10) or Cataracts (ASC-11*) measures.**

Population Per Year	**0-900**
Yearly Sample Size	63
Quarterly Sample Size	16
Monthly Sample Size	6
Population Per Year	**≥ 901**
Yearly Sample Size	96
Quarterly Sample Size	24
Monthly Sample Size	8

*Voluntary submission of data for ASC-11 began January 2015.
**For ASCs with fewer than 63 cases, the total population of cases is required.

Appendix A: Glossary of Terms

Admission: Completion of registration upon entry into the facility.

Antibiotic administered on time: Antibiotic infusion is *initiated* within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, insertion of needle, inflation of tourniquet) or two hours prior if vancomycin or fluoroquinolones are administered.

Burn: Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical, or radiation (e.g., warming devices, prep solutions, electrosurgical unit, or laser).

Discharge: Occurs when the patient leaves the confines of the ASC.

Fall: A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions (National Center for Patient Safety).

Healthcare personnel (HCP): Facilities must report vaccination data for three categories of HCP: employees on payroll; licensed independent practitioners (who are physicians, advanced practice nurses, and physician assistants affiliated with the hospital but not on payroll); and students, trainees, and volunteers aged 18 or older. All HCP physically working in the facility for at least one day or more between October 1 and March 31 should be counted. Data on vaccinations received at the facility, vaccinations received outside of the facility, medical contraindications, and declinations are reported for the three categories of HCP.

Hospital transfer/admission: Any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room.

Intravenous: Administration of a drug within a vein, including bolus, infusion, or IV piggyback.

Order: A written order, verbal order, standing order, or standing protocol.

Prophylactic antibiotic: An antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of the Prophylactic IV Antibiotic Timing measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin, and Vancomycin.

Quality Data Code (QDC): Non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified CPT Category II codes and/or G-codes that describe the clinical action required by a measure's numerator.

Wrong: Not in accordance with intended site, side, patient, procedure, or implant.

Appendix B: Preview Section

The Preview Section provides information on new measures. The information provided in this section should not be programmed or submitted. The measure(s) identified in this section are not currently collected.

No new measures have been introduced for the CY 2019 payment determination. The measures below were finalized in the ASCQR Program for the CY 2020 payment determination and subsequent years per the Final Rule: https://www.gpo.gov/fdsys/pkg/FR-2016-11-14/pdf/2016-26515.pdf (pp. 79797-79818).

ASC-13: Normothermia Outcome

Measure Background and Overview:
"Perioperative hypothermia is associated with numerous adverse outcomes, including: Cardiac complications; surgical site infections; impaired coagulation; and colligation of drug effects; as well as post-anesthetic shivering and thermal discomfort. When intraoperative normothermia is maintained, patients experience fewer adverse outcomes and their overall care costs are lower….We expect the measure will promote improvement in patient care over time, because measurement coupled with transparency in publicly reporting of measure information would make patient outcomes following procedures performed under general or neuraxial anesthesia more visible to ASCs and patients and incentivize ASCs to incorporate quality improvement activities to reduce perioperative hypothermia and associated complications where necessary." (81FR79798)

Measure Calculation and Reporting:
"This measure is based on aggregate measure data collected via chart abstraction by the ASC and submitted via a CMS online data submission tool (that is, QualityNet). We proposed that the data collection period for the proposed ASC-13 measure would be the calendar year 2 years prior to the applicable payment determination year. For example, for the CY 2020 payment determination, the data collection period would be CY 2018. We also proposed that ASCs submit these data to CMS during the time period of January 1 to May 15 in the year prior to the affected payment determination year. For example, for the CY 2020 payment determination, the submission period would be January 1, 2019 to May 15, 2019." (81FR79799)
"The outcome measured in the proposed ASC-13 measure is the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the post-anesthesia care unit (PACU). The numerator is the number of surgery patients with a body temperature equal to or greater than 96.8 degrees Fahrenheit/36 degrees Celsius recorded within 15 minutes of arrival in the PACU. The denominator is all patients, regardless of age, undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes in duration." (81FR79799)

ASC-14: Unplanned Anterior Vitrectomy

Measure Background and Overview:
"An unplanned anterior vitrectomy is performed when vitreous inadvertently prolapses into the anterior segment of the eye during cataract surgery….While unplanned anterior vitrectomy rates are relatively low, complications from this procedure may result in poor visual outcomes and other complications, including retinal detachment. Cataract surgery is the most common surgery performed in ASCs; therefore, this measure is of interest to the ASC Program….We expect the measure would promote improvement in patient care over time, because measurement coupled with transparency in publicly reporting measure information would make the rate of this unplanned procedure at ASCs more visible to both ASCs and patients and would incentivize ASCs to incorporate quality improvement activities to reduce the occurrence of unplanned anterior vitrectomies." (81FR79801)

Measure Calculation and Reporting:
"The outcome measured in the proposed ASC–14 measure is the percentage of cataract surgery patients who have an unplanned anterior vitrectomy. The numerator for this measure is all cataract surgery patients who had an unplanned anterior vitrectomy. The denominator is all cataract surgery patients." (81FR79802)
"This measure is based on aggregate measure data collected via chart abstraction by the ASC and submitted via a CMS online data submission tool (that is, QualityNet). We proposed that the data collection period for the proposed ASC–14 measure would be the calendar year 2 years prior to the applicable payment determination year. For example, for the CY 2020 payment determination, the data collection period would be CY 2018. We also proposed that ASCs submit these data to CMS during the time period of January 1 to May 15 in the year prior to the affected payment determination year. For example, for the CY 2020 payment determination, the submission period would be January 1, 2019 to May 15, 2019." (81FR79802)

ASC-15a–e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey Measures
The three OAS CAHPS composite survey based measures are:
ASC-15a: OAS CAHPS—About Facilities and Staff;
ASC-15b: OAS CAHPS—Communication About Procedure; and
ASC-15c: OAS CAHPS—Preparation for Discharge and Recovery.
The two global survey based measures are:
ASC-15d: OAS CAHPS—Overall Rating of Facility; and
ASC-15e: OAS CAHPS—Recommendation of Facility.

Measure Background and Overview:
"Currently…there is not one standardized survey in use to assess patient experiences with care in ASCs that would allow valid comparisons across ASCs. Patient-centered experience of care measures are a component of the 2016 CMS Quality Strategy, which emphasizes patient-centered care by rating patient experience as a means for empowering patients and improving the quality of their care. In addition, information on patient experience with care at a provider/facility is an important quality indicator to help providers and facilities improve services furnished to their patients and to assist patients in choosing a provider/facility at which to seek care….The OAS CAHPS Survey was developed as part of U.S. Department of Health and Human Services' (HHS) Transparency Initiative to measure patient experiences with ASC care." (81FR79803)
"The OAS CAHPS Survey contains 37 questions that cover topics such as access to care, communications, experience at the facility, and interactions with facility staff. The survey also contains two global rating questions and asks for self-reported health status and basic demographic information (race/ethnicity, educational attainment level, languages spoken at home, among others)." (81FR79803)

Measure Calculation and Reporting:
"These measure calculations will be used for public reporting purposes only." (81FR79805)
"We proposed that the data collection period for the OAS CAHPS Survey measures would be the calendar year 2 years prior to the applicable payment determination year. For example, for the CY 2020 payment determination, ASCs would be required to collect data on a monthly basis, and submit this collected data on a quarterly basis, for January 1, 2018–December 31, 2018 (CY 2018)." (81FR79804)
"To meet the OAS CAHPS Survey requirements for the ASCQR Program, we proposed that ASCs contract with a CMS approved vendor to collect survey data for eligible patients at the ASCs on a monthly basis and report that data to CMS on the ASC's behalf by the quarterly deadlines established for each data collection period. (81FR79812)
"Information about the list of approved survey vendors and how to authorize a vendor to collect data on an ASC's behalf is available through the OAS CAHPS Survey Web site at: https://oascahps.org/." (81FR79823)

"We are finalizing our proposal to adopt the ASC-15a–e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey measures for the ASCQR Program for the CY 2020 payment determination and subsequent years as proposed with a clarification that ASCs that anticipate receiving more than 300 surveys are required to either: (1) randomly sample their eligible patient population, or (2) survey their entire OAS CAHPS eligible patient population." (81FR79817)

Reference:

Federal Register /Vol. 81, No. 219 /Monday, November 14, 2016 /Rules and Regulations. Retrieved from https://www.gpo.gov/fdsys/pkg/FR-2016-11-14/pdf/2016-26515.pdf