Ambulatory Surgical Center Quality Reporting Specifications Manual

Release Notes Version: 8.0

Release Notes Completed: 05/01/2018

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 01/01/2019**, 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.

Measure Information Forms

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

Rationale: Update to be in accordance with the latest version of the ASC Quality Collaboration Implementation Guide.

Description of Change: Addition of new section and text

Add:
Data Sources:
ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.

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

Rationale: Update the current Measure Information Form header to be in accordance with latest version of the ASC Quality Collaboration Implementation Guide.

Description of Change: Change header name on Measure Information Form

From:
Selection Basis:

To:
Rationale:

Impacts: ASC-1
Rationale: Update the current Measure Information Form header and text to be in accordance with latest version of the ASC Quality Collaboration Implementation Guide.

Description of Change: Change header name and text on Measure Information Form

From:
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.

To:
Clinical Practice Guidelines:
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 Emergency Care Research Institute (ECRI).

Impacts: ASC-1

Rationale: Update to be in accordance with latest version of the ASC QC Implementation Guide.

Description of Change: Replace previous reference list with new reference list

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Impacts: ASC-2

Rationale: Update the current Measure Information Form header and text to be in accordance with latest version of the ASC Quality Collaboration Implementation Guide.

Description of Change: Change header name and text on Measure Information Form

From:
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.

To:
Clinical Practice Guidelines:
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.
Frequently asked questions (FAQs) about this measure can be found in the ASC Quality Collaboration Implementation Guide online at www.ascquality.org.

Impacts: ASC-2

Rationale: Update to be in accordance with latest version of the ASC Quality Collaboration Implementation Guide.

Description of Change: Replace previous reference list with new reference list

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Impacts: ASC-3

Rationale: Update the current Measure Information Form to be in accordance with latest version of the ASC Quality Collaboration Implementation Guide.

Description of Change: Replace previous text under new header Rationale on Measure Information Form with updated text.

From:
"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.

To:
Rationale:
"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 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 forty professional medical associations and organizations. In order 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.

Impacts: ASC-3

Rationale: Update the current Measure Information Form header and text to be in accordance with latest version of the ASC QC Implementation Guide.

Description of Change: Change header name and text on Measure Information Form

From:
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

To:
Clinical Practice Guidelines:
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.
Frequently asked questions (FAQs) about this measure can be found in the ASC Quality Collaboration Implementation Guide online at www.ascquality.org.

Impacts: ASC-3

Rationale: Update to be in accordance with latest version of the ASC QC Implementation Guide.

Description of Change: Replace previous reference list with new reference list.

Impacts: ASC-4

Rationale: Update the current Measure Information Form header and text to be in accordance with latest version of the ASC QC Implementation Guide.

Description of Change: Change header name and text on Measure Information Form.

From:
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.

To:

Clinical Practice Guidelines:
No clinical practice guidelines specifically addressing transfers or admissions from ASCs to acute care hospitals are available at this time.
Frequently asked questions (FAQs) about this measure can be found in the ASC Quality Collaboration Implementation Guide online at www.ascquality.org.

Impacts: ASC-4

Rationale: Update to be in accordance with latest version of the ASC QC Implementation Guide.

Description of Change: Replace previous reference list with new reference list.

Impacts: ASC-11

Rationale: An additional clause in the measure description aligns the 2019 Measure Information Form with 2018 changes.

Description of Change:

Description:

Add: based on completing a pre-operative and post-operative visual function survey

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Impacts: ASC-11

Rationale: Changes will align 2019 Measure Information Form with 2018 changes.

Description of Change:

Numerator Statement:

Add 18 years and older

Denominator Statement:

From:

Instrument

To:

Survey

Impacts: ASC-11

Rationale: Changes will align 2019 Measure Information Form with 2018 changes.

Description of Change:

Add Definitions of performance met, not met and denominator exception by HCPCS code

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Impacts: ASC-13 and ASC-14

Rationale: Updated to be in accordance with latest version of the ASC QC Implementation Guide.

Description of Change:

Add: Rationale section to the Measure Information Form

Section 3: Quality-Data Transmission

Impacts: CSV Batch Submission File Layout

Rationale: Updated to include measures ASC-13 and ASC-14

Description of Change:

Add ASC-13 and ASC-14 to CSV file layout

Appendix B: Preview Section

Impacts: ASC-17 and ASC-18

Rationale: To include a preview of future measures

Description of Change:

Add preview of ASC-17 and ASC-18 that are finalized for the CY2022 payment determination and subsequent years

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Ambulatory Surgical Center Quality Reporting Specifications Manual

Version 8.0

Encounter Dates: 01-01-19 (1Q19) through 12-31-19 (4Q19)

OMB # 0938-1270 Expiration Date: 03/31/2021

Table of Contents

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-4, 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).

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, 2018, with claim submission on January 1, 2019, this claim would be included in the 2020 payment determination.

Claims-Based Measures
ASCs are to submit information on the four 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-9, ASC-10, ASC-11 (ASC-11 is a voluntary measure), ASC-13, and ASC-14 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.

Fewer Than 240 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 2018 (for the CY 2020 payment determination year) would not be required to participate in the ASCQR Program in CY 2019 (for the CY 2021 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.

[**Data Sources**:] ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.

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

Rationale:

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 Practice Guidelines:
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.

Selected References:

- American National Standards Institutes (ANSI) Z136.3-2011 - Safe Use of Lasers in Health Care, 2011 Revision.
- Anesthesia Patient Safety Foundation (APSF). Prevention and management of operating room fires [video]. February 2010. http://www.apsf.org/resources/fire-safety/.
- AORN. Fire safety Tool Kit. 2015. https://www.aorn.org/guidelines/clinical-resources/tool-kits/fire-safety-tool-kit.
- Apfelbaum JL, et al. Practice advisory for the prevention and management of operating room fires: an updated report by the American Society of Anesthesiologists Task Force on Operating Room Fires. Anesthesiology. 2013 Feb;118(2):271-90.
- 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.
- Demir E, O'Dey D, and Pallua N. Accidental burns during surgery. *J Burn Care Res.* 2006 ;27(6):895-900.
- ECRI. Electrosurgery Checklist. February 15, 2007.
- 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.
- ECRI Institute. Surgical Fires. June 1, 2016.
- Jones EL, et al. Operating Room Fires and Surgical Skin Preparation. J Am Coll Surg. 2017 Jul;225(1):160-165.
- Jones SB, et al. Fundamental Use of Surgical Energy (FUSE): An Essential Educational Program for Operating Room Safety. Perm J. 2017;21. pii: 16-050.
- Mehta SP, Bhananker SM, Posner KL, Domino KB. Operating room fires: a closed claims analysis. Anesthesiology. 2013 May;118(5):1133-9.
- National Fire Protection Association (NFPA). NFPA 99: Health Care Facilities Code. Quincy, MA: NFPA, 2018.
- Tucker R. Laparoscopic electrosurgical injuries: survey results and their implications. *Surg Laparosc Endosc.* 1995;5(4):311-7.

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.

Data Sources: ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.

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)

Rationale:

"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 Practice Guidelines:

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.

Frequently asked questions (FAQs) about this measure can be found in the ASC Quality Collaboration Implementation Guide online at www.ascquality.org.

Selected References:

Amador LF, Loera JA. Preventing Postoperative Falls in the Older Adult. J. Am. Coll. Surg. 3// 2007; 204(3):447-453.

American Geriatrics Society/British Geriatrics Society Panel on Prevention of Falls in Older Persons. Summary of the Updated American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons. J.Am. Geriatr. Soc. 2011;59(1):148-157.

American Medical Directors Association (AMDA). Falls and fall risk. Columbia, MD: American Medical Directors Association.

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.

Gray-Micelli D. Preventing falls in acute care. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008. p. 161-98.

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.

The Joint Commission. Sentinel Event Alert 55: Preventing falls and fall-related injuries in health care facilities. September 28, 2015.

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 2011 Update. 2011.

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.

(Please note this is not intended to be an exhaustive list of the organizations issuing statements or guidance related to falls.)

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.

Data Sources: ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.

Definitions:

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

Rationale:
"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 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 forty professional medical associations and organizations. In order 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 Practice Guidelines:
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.

Frequently asked questions (FAQs) about this measure can be found in the ASC Quality Collaboration Implementation Guide online at www.ascquality.org.

Selected References:

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/revisedwswiol-document-may-12-2014-august-finalrev-pdf.

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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.

Data Sources: ASC medical records, incident/occurrence reports and variance reports are potential data sources.

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

Rationale:

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

Frequently asked questions (FAQs) about this measure can be found in the ASC Quality Collaboration Implementation Guide online 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.

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Tewfik MA, Frenkiel S, Gasparrini R, Zeitouni A, Daniel SJ, Dolev Y, Kost K, Samaha M, Sweet R, Tewfik TL. Factors affecting unanticipated hospital admission following otolaryngologic day surgery. J Otolaryngol. 2006 Aug;35(4):235-41.

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.,inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is ≥66 years old, or life expectancy <10 years, other medical reasons). 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 ≥66 years old, or life expectancy <10 years. 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,based on completing a pre-operative and post-operative visual function survey

Numerator Statement: Patients 18 years and older 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 survey

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.

Definition of Performance Met: Improvement in visual function achieved within 90 days following cataract surgery (G0913)

Definition of Performance Not Met: Improvement in visual function not achieved within 90 days following cataract surgery (G0915)

Denominator Exception: Patient care survey was not completed by patient (G0914)

*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), the 2016 Measure Updates and Specifications Report https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775214597 and the 2017 Measure Updates and Specifications Report (https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775197506). 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 2017 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 2017 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

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

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. at the flowchart and tables are available in the 2017 Measure Updates and
Specifications Report, located at
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775197506

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 2017 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.

Measure Information Form

Measure Title: Normothermia

Measure ID #: ASC-13

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

Description: This measure is used to assess the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration are normothermic within 15 minutes of arrival in PACU.

Numerator: Surgery patients with a body temperature equal to or greater than 96.8 Fahrenheit/36 Celsius recorded within fifteen minutes of Arrival in PACU

Denominator: All patients, regardless of age, undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes duration

Numerator Exclusions: None

Denominator Exclusions: Patients who did not have general or neuraxial anesthesia; patients whose length of anesthesia was less than 60 minutes; patients with physician/APN/PA documentation of intentional hypothermia for the procedure performed

Data Sources: ASC medical records, as well as anesthesia administration and nursing records may serve as data sources. Clinical logs designed to capture information relevant to normothermia are also potential sources.

Data Element Definitions:

Anesthesia duration: the difference, in minutes, between the time associated with the start of anesthesia for the principal procedure and the time associated with the end of anesthesia for the principal procedure

Arrival in PACU: Time of patient arrival in PACU*

General anesthesia: drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation

Intentional hypothermia: A deliberate, documented effort to lower the patient's body temperature in the perioperative period

Neuraxial anesthesia: Epidural or spinal anesthesia

Temperature: A measure in either Fahrenheit or Celsius of the warmth of a patient's body. Axillary, bladder, core, esophageal, oral, rectal, skin surface, temporal artery, or tympanic temperature measurements may be used.

* Definition of Arrival in PACU is consistent with the definition in the Procedural Times Glossary of the American Association of Clinical Directors as approved by the ASA, ACS and AORN.

Rationale:
Impairment of thermoregulatory control due to anesthesia may result in perioperative hypothermia. Hypothermia, even when mild, is associated with consequences such as increased susceptibility to infection, impaired coagulation, cardiovascular stress and cardiac complications, as well as post-anesthetic shivering and thermal discomfort. Several methods to maintain normothermia are available.

There is no literature available on variation in rates of normothermia among ASC providers. However, variability in maintaining normothermia has been demonstrated in other settings.

Clinical Practice Guidelines:

This performance measure is aligned with current guidelines regarding temperature management in patients undergoing general or neuraxial anesthesia lasting 60 minutes or more.

Measure ascertains response to the following question: What is the percentage of having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration are normothermic within 15 minutes of arrival in PACU?

Annual data submission period: January 1-May 15, 2020

References

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Measure Information Form

Measure Title: Unplanned Anterior Vitrectomy

Measure ID #: ASC-14

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

Description: This measure is used to assess the percentage of cataract surgery patients who have an unplanned anterior vitrectomy.

Numerator: All cataract surgery patients who had an unplanned anterior vitrectomy

Denominator: All cataract surgery patients

Numerator Exclusions: None

Denominator Exclusions: None

Data Sources:

ASC medical records, incident/occurrence reports and variance reports are potential data sources

Definitions:

Cataract surgery: for purposes of this measure, CPT code 66982 (Cataract surgery, complex), CPT code 66983 (Cataract surgery w/IOL, 1 stage) and CPT code 66984 (Cataract surgery w/IOL, 1 stage)

Unplanned anterior vitrectomy: an anterior vitrectomy that was not scheduled at the time of the patient's admission to the ASC

Rationale: The need for unplanned anterior vitrectomy is an unanticipated event that can decrease the probability of good postoperative visual acuity, and generally result in worse long-term outcome after cataract surgery. Because cataract surgery is the most common surgery performed in ASCs, with millions being performed every year, even low unplanned anterior vitrectomy rates translate to relatively high total numbers of affected patients. ASCs can help keep rates low by tracking and comparing rates to established benchmarks, and facilitating mentoring as needed.

Clinical Practice Guidelines: No clinical practice guidelines addressing unplanned anterior vitrectomy in cataract surgery are available at this time. However, rates of unplanned anterior vitrectomy have been published in the clinical literature and can serve as comparative benchmarks of performance.

Measure ascertains response to the following question: What is the percentage of cataract surgery patients who have an unplanned anterior vitrectomy?

Annual data submission period: January 1-May 15, 2020

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Quality-Data Coding & Sampling Specifications

ASC-1 through ASC-4 – A Quality-Data Code (QDC) has been established to report that the patient did **not** experience the events for the four 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.

For more information on measures ASC-1–ASC-4, see individual measure specifications in this manual.

ASC-9, ASC-10, ASC-11*, and ASC-13 – The sampling size specifications for ASC-9, ASC-10, ASC-11*, and ASC-13 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, or Normothermia (ASC-13). **

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.

Quality Data Transmission

Introduction

This section of the manual is provided to highlight the unique data transmission specifications for the Ambulatory Surgical Center measure data for the Centers for Medicare & Medicaid Services (CMS) and the CMS Clinical Data Warehouse.

Guidelines for Submission of Data

Data collected for CMS are transmitted to the CMS Clinical Data Warehouse. All data submitted are required to meet transmission requirements. The file layout requirements are included in this section.

Ambulatory Surgical Center Web-Based Measure Batch Submission File Layout

The Comma-Separated Value (CSV) file layout is one section of content with rows defining unique facilities and columns defining measure data. Please refer to the Ambulatory Surgical Center Web-Based Batch Submission file layout for an example and details of required fields.

ASC_PROVIDER_NPI – National Provider ID

ASC_PYR – Payment Year

ASC_9_POP_SIZE – What was your facility's Total population?

ASC_9_SAMP_SIZE – What was your facility's sample size?

ASC_9_SAMP_FREQ – What was your facility's sampling frequency?

ASC_9_NUMERATOR – Patients who have a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.

ASC_9_DENOMINATOR – All patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy.

ASC_10_POP_SIZE – What was your facility's Total Population?

ASC_10_SAMP_SIZE – What was your facility's sample size?

ASC_10_SAMP_FREQ – What was your facility's sampling frequency?

ASC_10_NUMERATOR – Patients who had an interval of 3 or more years since their last colonoscopy.

ASC_10_DENOMINATOR – All patients 18 years and older receiving a surveillance colonoscopy with a diagnosis for history of colonic polyp(s).

ASC_11_POP_SIZE – What was your facility's Total Population?

ASC_11_SAMP_SIZE – What was your facility's sample size?

ASC_11_SAMP_FREQ – What was your facility's sampling frequency?

ASC_11_NUMERATOR – Patients who had an improvement in visual function achieved within 90 days following cataract surgery, based on completing both a pre-operative and post-operative visual function instrument.

ASC_11_DENOMINATOR – All patients 18 years and older who had cataract surgery and completed both a pre-operative and post-operative visual function instrument.

ASC_13_POP_SIZE – What was your facility's Total Population?

ASC_13_SAMP_SIZE – What was your facility's sample size?

ASC_13_SAMP_FREQ – What was your facility's sampling frequency?

ASC_13_NUMERATOR – Surgery patients with a body temperature equal to or greater than 96.8 Fahrenheit/36 Celsius recorded within fifteen minutes of Arrival in PACU.

ASC_13_DENOMINATOR – All patients, regardless of age, undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes duration.

ASC_14_NUMERATOR – All cataract surgery patients who had an unplanned anterior vitrectomy.

ASC_14_DENOMINATOR – All cataract surgery patients.

Data Upload Process

Data upload is done through the QualityNet External Files Online Tool.

All data transmitted pass through the following process:

1. The file(s) are checked for proper naming convention and file type.
   - The correct file naming convention is ASC_WBM_PY20YY_mm_dd_yyyy.csv where YY represent the last two digits of the applicable Payment Year, and mm_dd_yyyy represents the upload date.
2. The file(s) are evaluated upon successful upload and checked for errors in content.
   a. The system sends an upload confirmation email to the registered email for the logged-in account.
   b. The system checks the file for errors, logging each error in the file, and then rejects the file if any errors are found. The error log is attached to the rejection notification email with one error per line.
   c. If no errors are found, the system uploads the file and applies the data to the given Payment Year.
3. Note that there is no ADD, UPDATE, or DELETE action-code associated with the file. To correct errors, you can either:
   - Enter the Web-Based Data Collection Tool for each individual facility and update the values as appropriate, or
   - Upload a corrected CSV file which will overwrite any existing values.

Appendix A: Glossary of Terms

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.

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.

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

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 measures below were finalized in the ASCQR Program for the CY 2022 payment determination and subsequent years per the Final Rule: https://www.gpo.gov/fdsys/pkg/FR-2017-11-13/pdf/2017-23932.pdf (pp. 52564-52637).

ASC-17: Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures

Measure Background and Overview:

"The patient population served at ASCs has increased not only in volume, but also in age and complexity, which can be partially attributed to improvements in anesthetic care and innovations in minimally invasive surgical techniques. As such, ASCs have become the preferred setting for the provision of low-risk surgical and medical procedures in the United States, as many patients experience shorter wait times, prefer to avoid hospitalization, and are able to return to work more quickly. As the number of orthopedic procedures performed in ASCs increases, it is increasingly important to report the quality of care for patients undergoing these procedures." (82FR52595)
"Based on the increasing prevalence of orthopedic surgery in the ASC setting, we believe it is important to minimize adverse patient outcomes associated with these orthopedic ASC surgeries. Therefore, in the CY 2018 OPPS/ASC proposed rule (82 FR 33692), we proposed to adopt the ASC–17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures measure into the ASCQR Program for the CY 2022 payment determination and subsequent years." (82FR52595)

Measure Calculation and Reporting:

"The measure outcome is all-cause, unplanned hospital visits within seven days of an orthopedic procedure performed at an ASC. For the purposes of this measure, ''hospital visits'' include emergency department visits, observation stays, and unplanned inpatient admissions. When there are two or more qualifying surgical procedures within a 7-day period, the measure considers all procedures as index procedures; however, the timeframe for outcome assessment is defined as the interval between procedures (including the day of the next procedure) and then 7 days after the last procedure. The facility-level score is a risk standardized hospital visit rate, calculated by multiplying the ratio of the predicted to the expected number of post-surgical hospital visits among the given ASC's patients by the national observed hospital visit rate for all ASCs. For each ASC, the numerator of the ratio is the number of hospital visits predicted for the ASC's patients accounting for its observed rate, the number of the orthopedic surgeries performed at the ASC, the case-mix, and the surgical complexity mix. The denominator of the ratio is the expected number of hospital visits given the ASC's case-mix and surgical complexity mix. A ratio of less than one indicates the ASC facility's patients were estimated as having fewer post-surgical visits than expected compared to ASCs with similar surgical complexity and patients; and a ratio of greater than one indicates the ASC facility's patients were estimated as having more visits than expected. The national observed hospital visit rate is the national unadjusted proportion of patients who had a hospital visit following an orthopedic ASC surgery." (82FR52597)
"The data collection period for the proposed ASC–17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures measure would be the two calendar years ending two years prior to the applicable payment determination year. For example, for the CY 2022 payment determination, the data collection

period would be CY 2019 to 2020. **Because the measure data are collected via claims, ASCs will not need to submit any additional data directly to CMS." (82FR52596)**

ASC-18: Hospital Visits After Urology Ambulatory Surgical Center Procedures

Measure Background and Overview:

"Because urology surgery performed at an ASC is a significant predictive factor for unanticipated admissions compared to other procedures, we believe measuring and reporting 7-day unplanned hospital visits following urology procedures will incentivize ASCs to improve care and care transitions. Many of the reasons for hospital visits following surgery at an ASC are preventable; patients often present to the hospital following urology surgery for complications of medical care, including urinary tract infection, calculus of the ureter, urinary retention, hematuria, and septicemia. However, increased patient and staff education present opportunities to improve the success rate of urology surgeries in ASCs. Therefore, we believe tracking and reporting these events would facilitate efforts to lower the rate of preventable adverse events and to improve the quality of care following urology procedures performed at an ASC." (82FR52603)
"We believe it is important to minimize adverse patient outcomes associated with urology ASC surgeries. Therefore, in the CY 2018 OPPS/ASC proposed rule (82 FR 33695), we proposed to adopt the ASC–18: Hospital Visits after Urology Ambulatory Surgical Center Procedures measure in the ASCQR Program for the CY 2022 payment determination and subsequent years." (82FR52603)

Measure Calculation and Reporting:

"The measure outcome is all-cause, unplanned hospital visit occurring within seven days of the urology procedure performed at an ASC. For the purpose of this measure, ''hospital visits'' include emergency department visits, observation stays, and unplanned inpatient admissions. When there are two or more qualifying surgical procedures within a 7-day period, the measure considers all procedures as index procedures. However, the timeframe for outcome assessment is defined as the interval between procedures (including the day of the next procedure) and then 7 days after the last procedure. The facility-level score is a risk standardized hospital visit rate, calculated by multiplying the ratio of the predicted to the expected number of postsurgical hospital visits among the given ASC's patients by the national observed hospital visit rate for all ASCs. For each ASC, the numerator of the ratio is the number of hospital visits predicted for the ASC's patients accounting for its observed rate, the number of the urology procedures performed at the ASCs, the case-mix, and the surgical complexity mix. The denominator of the ratio is the expected number of hospital visits given the ASC's case-mix and surgical complexity mix. A ratio of less than one indicates the ASC facility's patients were estimated as having fewer post-surgical visits than expected compared to ASCs with similar surgical complexity and patients; and a ratio of greater than one indicates the ASC facility's patients were estimated as having more visits than expected. The national observed hospital visit rate is the national unadjusted proportion of patients who had a hospital visit following a urology ASC surgery." (82FR52604)

"The data collection period for the proposed ASC–18: Hospital Visits after Urology Ambulatory Surgical Center Procedures measure would be the 2 calendar years ending 2 years prior to the applicable payment determination year. For example, for the CY 2022 payment determination, the data collection period would be CY 2019 to 2020. **Because these measure data are collected via claims, ASCs will not need to submit any additional data directly to CMS." (82FR52604)**

