Ambulatory Surgical Center Quality Reporting Specifications Manual
Release Notes Version 12.0

Release Notes Completed: May 1, 2022

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 specifications 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 01/01/2023**, 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, and Appendix A.
- **Rationale** – Provided for the change being made.
- **Description of Changes** – Used to identify the section within the document where the change occurs. Examples are Definitions, Numerator, and Denominator.

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

Program Background and Requirements

Impacts: Program Background and Requirements

Rationale: To align with the Calendar Year (CY) 2022 Ambulatory Surgical Center (ASC) Payment System Final Rule, including the reinstated measures ASC-1 through ASC-4 and the adopted ASC-20 COVID-19 Vaccination Coverage Among Health Care Personnel (HCP COVID-19 Vaccination).

Description of Change:

Background

Add: In the CY 2022 Ambulatory Surgical Center Payment System Final Rule, ASC-1, -2, -3, and -4 were reinstated in the ASCQR Program beginning with CY 2025 payment determination. These measures will be collected and submitted as web-based measure data reported via the Hospital Quality Reporting (HQR) site.

Program Requirements

Add: Program requirements for the ASCQR Program include reporting measure data to the Hospital Quality Reporting (HQR) and National Healthcare Safety Network (NHSN) sites.

Measures Submitted via a Web-Based Tool

Add: Data for ASC-20 are submitted using the web-based tool located on the NHSN portal of the CDC site at https://www.cdc.gov/nhsn/.

Add: Data for ASC-20 are submitted via the NHSN tool: https://auth.cdc.gov/siteminderagent/forms/login.fcc?TYPE=33554433&REALMOID=06-2e4e428f-8768-4f65-a66d-911e49413d9e&GUID=&SMAUTHREASON=0&METHOD=GET&SMAGENTNAME=-SM-VfBllSkkIKR6GkMEZgI2o6e2zk%2fxh2fc%2fe5E0N%2fN98H5LsZWkDhX%2fH618YU%2bV1pFG6Dqc8o%2buj7a7BOjbw3l3DbOwJLzWlX7IAOrlseiUBdD9DB45IS4xFtcl%2fRbqrug&TARGET=-SM-https%3a%2f%2fsams%2ecdc%2egov%2f

Measure Information Forms Introduction

Impacts: Web-based Measures

Rationale: To include both required submission sites for Web-based Measure data entry.

Description of Change:

Measure Information Form (MIF) Format

Add to Measures Submitted via a Web-based Tool: Either the Hospital Quality Reporting (HQR) site or the NHSN site via an online tool available to authorized users.

Measure Information Forms

Impacts: ASC-1: Patient Burn

Rationale: In the CY 2022 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule, CMS established that data collection for ASC-1 will resume beginning with the CY 2023 reporting period/CY 2025 payment determinations and subsequent years. Data for this measure will be reported in HQR as a Web-based Measure.

Description of Change:

Add: ASC-1 Measure Information Form to the 2023 ASCQR Specifications Manual v12.0.

Impacts: ASC-2: Patient Fall

Rationale: In the CY 2022 Hospital OPPS and ASC Payment System Final Rule, CMS established that data collection for ASC-2 will resume beginning with the CY 2023 reporting period/CY 2025 payment determinations and subsequent years. Data for this measure will be reported in HQR as a Web-based Measure.

Description of Change:

Add: ASC-2 Measure Information Form to the 2023 ASC Specifications Manual v12.0.

Impacts: ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Rationale: In the CY 2022 Hospital OPPS and ASC Payment System Final Rule Final Rule, CMS established that data collection for ASC-3 will resume beginning with the CY 2023 reporting period/CY 2025 payment determinations and subsequent years. Data for this measure will be reported in HQR as a Web-based Measure.

Description of Change:

Add: ASC-3 Measure Information Form to the 2023 ASCQR Specifications Manual v12.0.

Impacts: ASC-4: All-Cause Hospital Transfer/Admission

Rationale: In the CY 2022 Hospital OPPS and ASC Payment System Final Rule Final Rule, CMS established that data collection for ASC-4 will resume beginning with the CY 2023 reporting period/CY 2025 payment determinations and subsequent years. Data for this measure will be reported in HQR as a Web-based Measure.

Description of Change:

Add: ASC-4 Measure Information Form to the 2023 ASC Specifications Manual v12.0.

Impacts: ASC-11: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

Rationale: To include CY 2022 Hospital OPPS and ASC Payment System Final Rule Final Rule for mandatory reporting in CY 2027 payment determination.

Description of Change:

Footnotes

Add: Data submission will be mandatory for CY 2027 payment determination and subsequent years per the CY 2022 Hospital OPPS and ASC Payment System Final Rule (Vol. 86, pp. 63885–63887).

Impacts: ASC-13

Rationale: Add additional reference that supports the measure as currently specified.

Description of Change:

References

Add: Ban KA, Minei JP, Laronga C, Harbrecht BG, Jensen EH, Fry DE, Itani KM, Dellinger EP, Ko CY, Duane TM. American College of Surgeons and Surgical Infection Society: Surgical Site Infection Guidelines, 2016 Update. J Am Coll Surg. 2017 Jan;224(1):59-74.

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Version 12.0

Encounter Dates: 01-01-23 (1Q23) through 12-31-23 (4Q23)

OMB #0938-1270 Expiration Date: 08-31-2025

Table of Contents

Acknowledgement

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

IMPORTANT SUBMISSION ALERT!!

To submit Ambulatory Surgical Center Quality Reporting (ASCQR) Program measures to CMS, files must meet the specifications found only in this CMS manual. Otherwise, the files will be rejected for not meeting CMS quality data submission requirements and may not receive the full payment update.

Program Background and Requirements

CMS Quality Initiatives

Background

In November 2001, U.S. Department of 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 from 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 the quality of care provided in hospitals, nursing homes, home health agencies, and physician offices. These efforts grew under subsequent Secretaries through support and expansion of activities that strengthen 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 Hospital Outpatient Prospective Payment System (OPPS). In the Calendar Year (CY) 2008 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center (ASC) Payment Systems Final Rule, the Centers for Medicare & Medicaid Services (CMS) became statutorily required to have a program under which ASCs will report data on the quality of their care using standardized measures to receive the full annual update (APU) 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 (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.

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). Measures ASC-1 through ASC-4 have been retained in the ASCQR Program; however, data collection was suspended beginning with the CY 2021 payment determination until further action in rulemaking, with the goal of updating the data submission method. In the CY 2022 Ambulatory Surgical Center Payment System Final Rule, ASC-1, -2, -3, and -4 were reinstated in the ASCQR Program beginning with CY 2025 payment determination. These measures will be collected and submitted as web-based measure data reported via the Hospital Quality Reporting (HQR) site.

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 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

Program requirements for the ASCQR Program include reporting measure data to the HQR and National Healthcare Safety Network (NHSN) sites. ASCs that do not meet program requirements may receive a two-percent point 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, located on the Regulations page of CMS.gov (https://www.cms.gov/Regulations).

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, 2021, with claim submission on January 1, 2022, this claim would be included in the CY 2023 payment determination.

Measures Submitted via a Web-Based Tool

Data for ASC-1, ASC-2, ASC-3, ASC-4, ASC-9, ASC-11 (a voluntary measure), ASC-13, and ASC-14 are to be submitted using a web-based tool located on HQR at https://hqr.cms.gov/.

Data for ASC-20 are submitted using the web-based tool located on the NHSN portal of the Centers for Disease Control and Prevention (CDC) site at https://www.cdc.gov/nhsn/.

Annual Data Submission Period: See the timeline posted to the ASCQR Program page of QualityNet (https://qualitynet.cms.gov/asc/ascqr) for these measures.

Submission Instructions: Data entry achieved through the HQR site via an online tool is available to authorized users. After logging into the site:

- Select **Data Submission** from the left side screen Lock Menu.
- Select **Data Form**.
- Select **Launch Data Form** to open the submission application.
- Select **Start Measures** to enter data.
- Enter data for a measure and then select the **Save and Return** icon. Repeat this process for each required measure until all required data is complete.
- Facilities that do not have data for a required measure should select the checkbox marked, **"Please enter zeros for this measure, as I have no data to submit."**
- Select "**I'm ready to submit"** dial at the bottom of the page**.** The **All Measures Successfully Submitted** screen will display, and the data submission process is complete.
    - The dial will remain grayed out until all required measures are completed. The dial will turn blue when all required measures are completed.
    - Data are not recognized as officially submitted until the **I'm ready to submit** icon is selected and the **All Measures Successfully Submitted** screen displays.

The **File Upload** option requires the approved CSV template to be used. File upload may be used by vendors or corporations submitting data for more than one ASC at the same time.

Data for ASC-20 are submitted via the NHSN tool at: https://auth.cdc.gov/siteminderagent/forms/login.fcc?TYPE=33554433&REALMOID=06-2e4e428f-8768-4f65-a66d-911e49413d9e&GUID=&SMAUTHREASON=0&METHOD=GET&SMAGENTNAME=-SM-VfBllSkkIKR6GkMEZgI2o6e2zk%2fxh2fc%2fe5E0N%2fN98H5LsZWkDhX%2fH618YU%2bV1pFG6Dqc8o%2buj7a7BOjbw3l3DbOwJLzWlX7IAOrlseiUBdD9DB45IS4xFtcl%2fRbqrug&TARGET=-SM-https%3a%2f%2fsams%2ecdc%2egov%2f

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 2019 (for the CY 2021 payment determination year) would not be required to participate in the ASCQR Program in CY 2020 (for the CY 2022 payment determination year).

Public Reporting

The HHS Secretary must establish procedures to make data collected under the ASCQR 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 (i.e., the Extraordinary Circumstance Exception request process) and the reconsideration request process were finalized in the FY 2013 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) 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 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 MIFs.

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.

Paperwork Reduction Act (PRA)

PRA Disclosure

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is **0938-1270**. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1650.

Expiration Date: 08-31-2025

Measure Information Form Introduction

Measure Information Form (MIF) Format

Measure Title – The specific national ASC quality measure.

Measure ID # – A unique alphanumeric identifier assigned to the measure. Information associated with a measure is identified by this alphanumeric number (e.g., ASC-9, ASC-13, ASC-14, 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 either the Hospital Quality Reporting (HQR) site or the National Healthcare Safety Network (NHSN) site 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., This measure is used to assess the percentage of cataract surgery patients who have an unplanned anterior vitrectomy).

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.

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: Measures Submitted via a Web-based Tool

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

Numerator: ASC admissions experiencing a burn prior to discharge

Denominator: All ASC admissions

Numerator Inclusions: ASC admissions experiencing a burn prior to discharge

Numerator Exclusions: None

Denominator Inclusions: All ASC admissions

Denominator Exclusions: None

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/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.

Annual Data Submission Period:

See the timeline posted to QualityNet.CMS.gov for this measure. Select Ambulatory Surgical Centers. Then, select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be completed through the *Hospital Quality Reporting (HQR) Secure Portal* at https://hqr.cms.gov via an online tool available to authorized users**.**

Selected References:

- American National Standards Institute (ANSI) Z136.3 (2018) – Safe Use of Lasers in Health Care Facilities, 2018 Revision.
- 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.
- Anesthesia Patient Safety Foundation (APSF). Prevention and management of surgical fires video. February 2010. http://www.apsf.org/resources_video.php.
- ECRI Institute. Surgical Fires. June 1, 2016.
- ECRI Institute. Electrosurgery Checklist. 2020.
- National Fire Protection Association (NFPA). NFPA 99: Health Care Facilities Code. Quincy, MA: NFPA, 2018.
- ECRI Institute. Continued use of "flying lead" bipolar electrosurgical cables could result in misconnections and patient burns. *Health Devices.* 2018 Nov 28.
- 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.
- 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.Mehta SP, Bhananker SM, Posner KL, Domino KB. Operating room fires: a closed claims analysis. *Anesthesiology*. 2013 May;118(5):1133-9.
- Jones EL, et al. Operating Room Fires and Surgical Skin Preparation. J Am Coll Surg. 2017 Jul;225(1):160-165.

Measure Information Form

Measure Title: Patient Fall

Measure ID #: ASC-2

Quality Reporting Option: Measures Submitted via a Web-based Tool

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

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

Denominator: All ASC admissions

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

Numerator Exclusions: ASC admissions experiencing a fall outside the ASC

Denominator Inclusions: All ASC admissions

Denominator Exclusions: None

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.

Annual Data Submission Period:

See the timeline posted to https://QualityNet.CMS.gov for this measure. Select Ambulatory Surgical Centers. Then, select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be submitted through the *Hospital Quality Reporting (HQR) Secure Portal* at https://hqr.cms.gov via an online tool available to authorized users**.**

Selected References:

- LeCuyer M, Lockwood B, Locklin M. Development of a Fall Prevention Program in the Ambulatory Surgery Setting. J Perianesth Nurs. 2017 Oct;32(5):472-479.
- 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.
- The Joint Commission. Sentinel Event Alert 55: Preventing falls and fall-related injuries in health care facilities. September 28, 2015.
- VA National Center for Patient Safety: United States Department of Veterans Affairs. Falls Toolkit. http://www.patientsafety.va.gov/professionals/onthejob/falls.asp. Last accessed February 15, 2022.
- National Quality Forum. Serious Reportable Events in Healthcare 2011 Update. 2011.
- 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.
- 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. *Journal of the American Geriatrics Society*, 2011;59(1):148-157.
- Amador LF, Loera JA. Preventing Postoperative Falls in the Older Adult. J Am Coll Surg. 2007 Mar;204(3):447-453.
- 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.
- Kronzer VL, Wildes TM, Stark SL, Avidan MS. Review of perioperative falls. Br J Anaesth. 2016 Dec;117(6):720-732.

Measure Information Form

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

Measure ID #: ASC-3

Quality Reporting Option: Measures Submitted via a Web-based Tool

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

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

Denominator: All ASC admissions

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

Numerator Exclusions: None

Denominator Inclusions: All ASC admissions

Denominator Exclusions: None

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.

Annual Data Submission Period:

See the timeline posted to QualityNet.CMS.gov for this measure. Select Ambulatory Surgical Centers. Then, select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be submitted through the *Hospital Quality Reporting (HQR) Secure Portal* at https://hqr.cms.gov via an online tool available to authorized users.

Selected References:

- Joint Commission. *Universal Protocol For Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.* Available at https://www.jointcommission.org/standards/universal-protocol. Last accessed February 15, 2022.
- American Academy of Ophthalmology. Recommendations of American Academy of Ophthalmology Wrong Site Task Force. https://www.aao.org/patient-safety-statement/recommendations-of-american-academy-ophthalmology-. Aug 2014.
- American Academy of Orthopaedic Surgeons. Surgical Site and Procedure Confirmation. Information Statement 1043. March 2015.
- American College of Obstetricians and Gynecologists. ACOG committee opinion #464: patient safety in the surgical environment. Obstet Gynecol. 2010; 116(3):786-790.
- American College of Surgeons. Revised Statement on Safe Surgery Checklists, and Ensuring Correct Patient, Correct Site, and Correct Procedure Surgery. October 1, 2016. https://www.facs.org/about-acs/statements/93-surgery-checklists.
- AORN. AORN Position Statement on Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events. https://www.aorn.org/guidelines/clinical-resources/position-statements. February 23, 2021.
- Institute of Medicine. To Err is Human: Building a Safer Health System. Washington, DC: National Academy Press, 2000.
- National Quality Forum. Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report. 2011.
- World Health Organization. WHO Guidelines for Safe Surgery 2009.

Measure Information Form

Measure Title: All-Cause Hospital Transfer/Admission

Measure ID #: ASC-4

Quality Reporting Option: Measures Submitted via a Web-based Tool

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

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

Denominator: All ASC admissions

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

Numerator Exclusions: None

Denominator Inclusions: All ASC admissions

Denominator Exclusions: None

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.

Annual Data Submission Period:

See the timeline posted to QualityNet.CMS.gov for this measure. Select Ambulatory Surgical Centers. Then, select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be submitted through the *Hospital Quality Reporting (HQR) Secure Portal* at https://hqr.cms.gov via an online tool available to authorized users**.**

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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 Exclusion:

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.CMS.gov for this measure. Select Ambulatory Surgical Centers, then select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be completed through the Hospital Quality Reporting (HQR) site at https://hqr.cms.gov 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: 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 (without modifiers 55 or 56): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984, 66987, 66988

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.CMS.gov for this measure. Select Ambulatory Surgical Centers, then select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be completed through the Hospital Quality Reporting (HQR) site at https://hqr.cms.gov 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 post-operative 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 (NEI-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 publicly reported as discussed in the CY 2014 OPPS/ASC Proposed Rule (Vol. 78, No. 139 Proposed Rule, pp. 43664, 43669). Data submission will be mandatory for CY 2027 payment determination and subsequent years per the CY 2022 OPPS/ASC Final Rule (Vol. 86, pp. 63885–63887).

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

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 claim-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 will use the measure results in the Ambulatory Surgical Center Quality Reporting (ASCQR) Program for payment determination in calendar year 2025. Beginning with payment determination year 2020, CMS began calculating the measure with three years of claims data. For payment determination year 2025, the performance period is January 2021 through December 2023.

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 aim of the MIF is to provide transparency of the measure methodology to the facility and vendor communities. Additional background information about the measure methodology can be found in the Measure Updates and Specifications Report available on the Measure Methodology *QualityNet* page (https://qualitynet.cms.gov/asc/measures/colonoscopy/methodology).

CMS provides a new report each year to align with the most current calendar year. For example, the 2018 Measure Updates and Specifications Report aligned with a performance period ending in calendar year 2018. If the reevaluation report associated with the performance period of this MIF is not yet available, it is sufficient to use the most recent report.

Please submit questions about the measure to the *QualityNet* Question and Answer Tool: https://cmsqualitysupport.servicenowservices.com/qnet_qa

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

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

Measure ID #: ASC-12

Measure Set: CMS Outcome Measures (Claims-Based)

Description: The Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy Measure, hereafter referred to as the colonoscopy 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: The colonoscopy 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. Lower rate indicates better quality.

Numerator Statement:

The colonoscopy 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 under the Measure Calculation below.

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 Ambulatory Surgical Center Quality Reporting (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. Medicare FFS beneficiaries with an outpatient colonoscopy are included if the patient has been enrolled in Part A and Part B Medicare for up to 12 months prior to the date of procedure to ensure the availability of administrative data for risk adjustment.

The measure is focused on low-risk colonoscopies. Cohort codes are located in the data dictionary that accompanies the Measure Updates and Specifications Report, available on the Measure Methodology *QualityNet* page: https://qualitynet.cms.gov/asc/measures/colonoscopy/methodology (In prior years, all measure codes are located within the Measure Updates and Specifications Reports.)

The measure does not include colonoscopy Current Procedural Terminology (CPT®) procedure codes that reflect fundamentally higher-risk or different procedures. Qualifying colonoscopies billed with a concurrent high-risk colonoscopy procedure code are not included in the measure; the data dictionary that accompanies the most recent Measure Updates and Specifications Report at the link above contains the complete listing of all high-risk procedure codes.

Cohort Exclusions (excluded colonoscopies):

See the Measure Updates and Specifications Report available on the Measure Methodology *QualityNet* page for detailed measure cohort exclusion criteria (https://qualitynet.cms.gov/asc/measures/colonoscopy/methodology). The accompanying data dictionary contains the most current exclusion codes.

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 Measure Updates and Specifications Report available on the Measure Methodology *QualityNet* page: https://qualitynet.cms.gov/asc/measures/colonoscopy/methodology.

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-adjustment model includes 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 International Classification of Diseases, Tenth Revision, Clinical Modification (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 Measure Updates and Specifications Report data dictionary 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.

Table 1: Patient-Level Risk-Adjustment Variables

Patient-Level Variables	Risk-Adjusted Variables
Demographics	Age (categorized; 65–69; 70–74; 75–79; 80–84; 85+)
Procedural Factors	Endoscopy during Procedure Polypectomy during Procedure
Comorbidities	Congestive 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 Substance Abuse 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-adjustment model for this measure are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.

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. These 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-specific 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, the facility- specific intercepts would be identical across all facilities after adjusting for patient risk. 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

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.

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Measure Information Form

Measure Title: Normothermia Outcome

Measure ID #: ASC-13

Quality Reporting Option: Measures 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 who 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/advance practice nurse/physician's assistant 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 (post-anesthesia care unit)*.

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.

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.

* 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.

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 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 PACU?

Annual data submission period: See the timeline posted to QualityNet.CMS.gov for this measure; select Ambulatory Surgical Centers then Data Submission from the banner options, then click the Deadlines tile from the left side of the page. Data will be submitted through the *Hospital Quality Reporting (HQR) Secure Portal* at https://hqr.cms.gov via an online tool available to authorized users.

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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 post-operative 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: See the timeline posted to QualityNet.CMS.gov for this measure. Select Ambulatory Surgical Centers, then select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be completed through the Hospital Quality Reporting (HQR) site at https://hqr.cms.gov via an online tool available to authorized users.

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Centers for Medicare & Medicaid Services (CMS)
Risk-Standardized Hospital Visits within 7 Days after Orthopedic Ambulatory Surgical Center (ASC) Procedures Measure

Introduction

This section of the manual includes the Measure Information Form (MIF) for the Risk-Standardized Hospital Visits within 7 days after Orthopedic Ambulatory Surgical Center (ASC) Procedures measure. Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (YNHHSC/CORE) developed the measure for the CMS under a contract supporting the development of ambulatory surgical center measures.

This is an administrative claims-based measure, so there is no data abstraction responsibility on the part of the facility. 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 orthopedic surgery procedure. In addition, CMS extracts and utilizes physician office, inpatient, and outpatient claims data from the year prior to the surgery as well as claims data from the surgery to risk adjust the facility-level results.

CMS has finalized adoption of the measure into the Ambulatory Surgical Center Quality Reporting (ASCQR) Program for payment determination beginning in calendar year 2022.

The information in the following MIF is being provided in the interest of transparency and to promote understanding of the 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).

Please submit questions about the measure to the QualityNet Question and Answer Tool: https://cmsqualitysupport.servicenowservices.com/qnet_qa

Measure Information Form

Performance Measure Name: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures

Measure ID #: ASC-17

Measure Set: CMS Outcome Measures (Claims-Based)

Description: The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an orthopedic surgery at an ASC among Medicare fee-for-service (FFS) patients aged 65 years and older.

Rationale: Nearly 70% of all surgeries in the US are performed in an outpatient setting, with an expanding number and variety of surgeries being performed at stand-alone ASCs (Cullen et al., 2009). This measure will serve to improve transparency, inform patients and providers, and foster quality improvement efforts for hospital visits following orthopedic surgery at ASCs.

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 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 orthopedic surgery at an ASC. 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 is Medicare FFS patients aged 65 years and older undergoing outpatient orthopedic surgeries, typically performed by an orthopedist, at ASCs.

Included Populations:

The target population is Medicare FFS patients aged 65 years and older undergoing outpatient orthopedic surgeries at ASCs who have been enrolled in Part A and Part B Medicare for up to 12 months prior to the date of surgery to ensure the availability of data for identifying comorbidities for risk adjustment.

The measure includes procedures that are routinely performed at ASCs, involve increased risk of post- surgery hospital visits, and are routinely performed by orthopedists. For a list of procedure codes included in the measure cohort, see: https://qualitynet.cms.gov > Ambulatory Surgical Centers > Measures > Orthopedic Measure > Methodology.

Exclusion:

1. Surgeries for patients who survived at least 7 days but were not continuously enrolled in Medicare FFS Parts A and B in the 7 days after the surgery. The measure excludes these patients to ensure all patients have full data available for outcome assessment.

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 surgery. 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 measure technical report, see https://qualitynet.cms.gov > Ambulatory Surgical Centers > Measures > Orthopedic Measure > Methodology.

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 measure adjusts for differences across facilities in patient demographics, clinical factors, and surgery-related risk. Potential candidate risk factors were identified from related quality measures and the literature; a preliminary list of risk factors was developed and then revised based on TEP and expert clinical input.

The risk-adjustment model has 28 patient-level variables (age and 27 comorbidity variables) and work relative value units (RVU) to adjust for surgical complexity (see Table 1). With the exception of morbid obesity, opioid abuse, tobacco use disorder, and chronic anticoagulant use which we define using an individual ICD-10-CM diagnosis code, we define comorbidity variables using

CMS Condition Categories (CCs), which are clinically meaningful groupings of many thousands of ICD-10-CM diagnosis codes.

Table 1: Patient-Level Risk-Adjustment Variables

Patient-Level Variables	Risk-Adjusted Variables
Demographics	Age (years greater than 65)
Comorbidities	Cancer Disorder of fluid/electrolyte/acid-base Other gastrointestinal disorders Bone/joint/muscle infections/necrosis Rheumatoid and osteoarthritis Dementia Psychiatric disorders Multiple sclerosis Seizure disorders and convulsions Congestive heart failure Ischemic heart disease Hypertension and hypertensive disease Stroke Vascular disease Chronic lung disease Pneumonia Other respiratory disorders Chronic renal disease Chronic ulcers Head injury Major traumatic fracture or internal injury Major symptoms, abnormalities Minor symptoms, signs, findings Morbid obesity Opioid abuse Tobacco use Chronic anticoagulant use
Surgical Procedural Complexity	Work RVU

Full details of the development of the risk standardization model for this measure are available at https://qualitynet.cms.gov > Ambulatory Surgical Centers > Measures > Orthopedic Measure > Methodology.

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. These data undergo additional quality assurance checks during measure development and maintenance.

Measure Analysis Suggestions: None

Sampling: No

Data Reported As: ASC-level 7-day risk-standardized, all-cause, unplanned hospital visit rate following orthopedic surgery

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 surgery 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 an orthopedic surgery at an ASC 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:

Cullen KA, Hall MJ, Golosinskiy A, National Center for Health Statistics. *Ambulatory surgery in the United States, 2006.* US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics; 2009.

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. *Statistical Science.* 2007;22(2):206–226.

Medicare & Medicaid Services (CMS) Risk Standardized Hospital Visits within 7 Days after Urology Ambulatory Surgical Center (ASC) Procedures Measure

This section of the manual includes the Measure Information Form (MIF) for the Risk-Standardized Hospital Visits within 7 days after Urology Ambulatory Surgical Center (ASC) Procedures measure. Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (YNHHSC/CORE) developed the measure for the Centers for Medicare & Medicaid Services (CMS) under a contract supporting the development of ambulatory surgical center measures.

This is an administrative claims-based measure, so there is no data abstraction responsibility on the part of the facility. 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 urology surgery procedure. In addition, CMS extracts and utilizes physician office, inpatient, and outpatient claims data from the year prior to the surgery as well as claims data from the surgery to risk adjust the facility-level results.

CMS has finalized adoption of the measure into the Ambulatory Surgical Center Quality Reporting (ASCQR) Program for payment determination beginning in calendar year 2022.

The information in the following MIF is being provided in the interest of transparency and to promote understanding of the 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). Please submit questions about the measure to the *QualityNet* Question and Answer Tool: https://cmsqualitysupport.servicenowservices.com/qnet_qa.

Measure Information Form

Performance Measure Name: Hospital Visits after Urology Ambulatory Surgical Center Procedures

Measure ID #: ASC-18

Measure Set: CMS Outcome Measures (Claims-Based)

Description: The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of a urology surgery at an ASC among Medicare fee-for-service (FFS) patients aged 65 years and older.

Rationale: Nearly 70% of all surgeries in the US are performed in an outpatient setting, with an expanding number and variety of surgeries being performed at stand-alone ASCs (Cullen et al., 2009). This measure will serve to improve transparency, inform patients and providers, and foster quality improvement efforts for hospital visits following urology surgery at ASCs.

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 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 a urology surgery at an ASC. 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 is Medicare FFS patients aged 65 years and older undergoing outpatient urology surgeries, typically performed by a urologist, at ASCs.

Included Populations:

The target population is Medicare FFS patients aged 65 years and older undergoing outpatient urology surgeries at ASCs who have been enrolled in Part A and Part B Medicare for up to 12 months prior to the date of surgery to ensure the availability of data for identifying comorbidities adjustment.

The measure includes surgeries that are routinely performed at ASCs, involve increased risk of post-surgery hospital visits, and are routinely performed by urologists. For a list of procedure codes included in the measure cohort, see: https://qualitynet.cms.gov/ > Ambulatory Surgical Centers > Measures > Urology Measure > Methodology.

Exclusion:

1. Surgeries for patients who survived at least 7 days but were not continuously enrolled in Medicare FFS Parts A and B in the 7 days after the surgery. The measure excludes these patients to ensure all patients have full data available for outcome assessment.

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 surgery. 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 measure technical report: https://qualitynet.cms.gov/ > Ambulatory Surgical Centers > Measures > Urology Measure > Methodology

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 measure adjusts for differences across facilities in patient demographics, clinical factors, and surgery-related risk. Potential candidate risk factors were identified from related quality measures and the literature; a preliminary list of risk factors was developed and then revised based on a Technical Expert Panel (TEP) and expert clinical input.

The risk-adjustment model has 7 patient-level variables (age and 6 comorbidity variables), number of qualifying procedures, and work relative value units (RVU) to adjust for surgical complexity (see Table 1). With the exception of benign prostatic hyperplasia with obstruction which we define using an individual ICD-10-CM diagnosis code, we define comorbidity variables using CMS Condition Categories (CCs), which are clinically meaningful groupings of many thousands of ICD-10-CM diagnosis codes.

Table 1: Patient-Level Risk-Adjustment Variables

Patient-Level Variables	Risk-Adjusted Variables
Demographics	Age (years greater than 65)
Comorbidities	Benign prostatic hyperplasia with obstruction Complications of specified implanted device or graft Poisonings and inflammatory allergic reactions Major symptoms, abnormalities Parkinson's and Huntington's diseases; seizure disorders and convulsions Ischemic heart disease
Number of Qualifying Procedures	Defined as 2 vs. 1, 3, or more vs. 1
Surgical Procedural Complexity	Work RVU

Full details of the development of the risk standardization model for this measure are available at: https://qualitynet.cms.gov/ > Ambulatory Surgical Centers > Measures > Urology Measure > Methodology.

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. These data undergo additional quality assurance checks during measure development and maintenance.

Measure Analysis Suggestions: None

Sampling: No

Data Reported As: ASC-level 7-day risk-standardized, all-cause, unplanned hospital visit rate following urology surgery

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 surgery 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 urology surgery at an ASC 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:

Cullen KA, Hall MJ, Golosinskiy A, National Center for Health Statistics. *Ambulatory surgery in the United States, 2006.* US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics; 2009.

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. *Statistical Science.* 2007;22(2):206–226.

Centers for Medicare & Medicaid Services (CMS)
General Surgery Ambulatory Surgical Center Procedures Measure

Introduction

This section of the manual includes the Measure Information Form (MIF) for the Facility-Level-7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers (ASC) measure. Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE) developed the measure for the Centers for Medicare & Medicaid Services (CMS) under a contract supporting the development of ambulatory surgical center measures.

This is an administrative claims-based measure, so there is no data abstraction responsibility on the part of the facility. 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 general surgery procedure. In addition, CMS extracts and utilizes physician office, inpatient, and outpatient claims data from the year prior to the surgery as well as claims data from the surgery to risk adjust the facility-level results.

CMS has finalized adoption of the measure into the Ambulatory Surgical Center Quality Reporting (ASCQR) Program for payment determination beginning in calendar year 2024.

The information in the following MIF is being provided in the interest of transparency and to promote understanding of the 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/Hospital QualityInits/Measure-Methodology.html). Please submit questions about the measure to the *QualityNet* Question and Answer Tool: https://cmsqualitysupport.servicenowservices.com/qnet_qa

Measure Information Form

Performance Measure Name: Facility-Level-7-Day Hospital Visits after General Surgery Procedures

Measure ID #: ASC-19

Measure Set: CMS Outcome Measures (Claims-Based)

Description: The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of a general surgery at an ASC among Medicare fee-for-service (FFS) patients aged 65 years and older.

Rationale: Nearly 70% of all surgeries in the US are performed in an outpatient setting, with an expanding number and variety of surgeries being performed at stand-alone ASCs (Cullen et al., 2009). This measure will serve to improve transparency, inform patients and providers, and foster quality improvement efforts for hospital visits following general surgery at ASCs.

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 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 a general surgery at an ASC. 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 is Medicare FFS patients aged 65 years and older undergoing outpatient general surgeries, typically performed by a general surgeon, at ASCs.

Included Populations:

The target population is Medicare FFS patients aged 65 years and older undergoing outpatient general surgeries at ASCs who have been enrolled in Part A and Part B Medicare for the 12 months prior to the date of surgery to ensure adequate data for identifying comorbidities for risk adjustment.

The measure includes surgeries that are routinely performed at ASCs, involve increased risk of post-surgery hospital visits, and are routinely performed by general surgeons. For a list of procedure codes included in the measure cohort, see: https://qualitynet.cms.gov/ > Ambulatory Surgical Centers > Measures > General Surgery Measure Dry Run > Measure Methodology

Exclusion:

1. Surgeries for patients who survived at least 7 days but were not continuously enrolled in Medicare FFS Parts A and B in the 7 days after the surgery. The measure excludes these patients to ensure all patients have full data available for outcome assessment.

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 surgery. CMS based the planned admission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (major organ transplant, rehabilitation, or maintenance chemotherapy);
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 measure technical report, see: https://qualitynet.cms.gov/ > Ambulatory Surgical Centers > Measures > General Surgery Measure Dry Run > Measure Methodology.

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 measure adjusts for differences across facilities in patient demographics, clinical factors, and surgery-related risk. Potential candidate risk factors were identified from related quality measures and the literature; a preliminary list of risk factors was developed and then revised based on a Technical Expert Panel (TEP) and expert clinical input.

The risk-adjustment model has 19 patient-level variables (age and 18 comorbidity variables), six procedure types, and work relative value units (RVU) to adjust for surgical complexity (see Table 1). We define comorbidity variables using CMS Condition Categories (CCs), which are clinically meaningful groupings of many thousands of ICD-10-CM diagnosis codes.

Table 1: Patient-Level Risk-Adjustment Variables

Patient-Level Variables	Risk-Adjusted Variables
Demographics	Age (years greater than 65)
Procedure Type	Abdomen and its contents Alimentary tract Breast Skin/soft tissue Wound
Comorbidities	Other benign tumors Liver or biliary disease Intestinal obstruction or perforation Dementia or senility Psychiatric disorders Other significant central nervous system (CNS) disease Ischemic heart disease Specified arrhythmias and other heart rhythm disorders Stroke Chronic lung disease Pneumonia Dialysis or sever chronic kidney disease Benign prostatic hyperplasia Cellulitis, local skin infection Major traumatic fracture or internal injury Complicates of care Chronic anticoagulant
Surgical Procedural Complexity	Work RVU

Full details of the development of the risk standardization model for this measure are available at https://qualitynet.cms.gov/ > Ambulatory Surgical Centers > Measures > General Surgery Measure Dry Run > Measure Methodology.

Data Collection Approach: Medicare administrative claims and enrollment data

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

Measure Analysis Suggestions: None

Sampling: No

Data Reported As: ASC-level 7-day risk-standardized, all-cause, unplanned hospital visit rate following general surgery

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 surgery 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 general surgery at an ASC 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:

Cullen KA, Hall MJ, Golosinskiy A, National Center for Health Statistics. *Ambulatory surgery in the United States, 2006.* US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics; 2009.

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. *Statistical Science.* 2007;22(2):206–226.

Measure Information Form

Performance Measure Name: COVID-19 Vaccination Coverage Among Health Care Personnel (HCP COVID-19 Vaccination)

Measure ID #: ASC-20

Measure Set: Measures submitted via a web-based tool (NHSN)

Description: Percentage of All Core Healthcare Personnel (HCP) eligible to work at the ASC for at least one day of the self-selected week, in each month of quarterly data reporting, who received a complete primary series of COVID–19 vaccine*.

Annual data submission period: See the timeline posted to QualityNet.cms.gov for this measure; select Ambulatory Surgical Centers (ASC) then click the Learn More dial, then select Participation from the banner options.

Denominator: Number of All Core HCP eligible to work in the ASC for at least one day during the self-selected week, excluding persons with contraindications to COVID-19 vaccination.

Numerator: Cumulative number of All Core HCP eligible to work in at the ASC for at least one day during the self- selected week and who received a complete vaccination course against COVID-19 using an FDA-authorized or FDA-approved vaccine for COVID-19 (whether the FDA issued an approval or EUA).160 A complete vaccination course is defined under the specific FDA authorization and may require multiple doses or regular revaccination.

Definitions*:

All Core HCP: Sum of Employees (staff on facility payroll), Licensed independent practitioners: Physicians, advanced practice nurses, & physician assistants, and Adult students/trainees & volunteers.

Complete Primary Series: Completing a primary vaccine series means receiving: 2-dose series of an mRNA COVID-19 vaccine (Pfizer-BioNTech and Moderna), OR a single dose of Johnson & Johnson's Janssen COVID-19 vaccine.

Information on Key Terms and Up to Date Vaccination can be downloaded here:
https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-May2022-508.pdf

Sampling Specifications

ASC-9, ASC-11*, and ASC-13 – The sampling size specifications for ASC-9, 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) or Cataracts (ASC-11*) measures, or Normothermia Outcome (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

*Submission of data for ASC-11 is voluntary for CY 2023 reporting period.
**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 Hospital Quality Reporting Data Form.

Guidelines for Submission of Data

Data collected for CMS are transmitted to the Hospital Quality Reporting Data Form. 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_1_NUMERATOR – ASC admissions experiencing a burn prior to discharge.

ASC_1_DENOMINATOR – All ASC admissions.

ASC_2_NUMERATOR – ASC admissions experiencing a fall within the confines of the ASC.

ASC_2_DENOMINATOR – All ASC admissions.

ASC_3_NUMERATOR – All ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant.

ASC_3_DENOMINATOR – All ASC admissions.

ASC_4_NUMERATOR – ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC.

ASC_4_DENOMINATOR – All ASC admissions.

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 to 75 years of age receiving screening colonoscopy without biopsy or polypectomy.

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 18 years and older who had an improvement in visual function achieved within90 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 through the Hospital Quality Reporting (HQR) Data Submission File Upload.

All data transmitted pass through the following process:

1. The file(s) are checked for proper naming convention and file type.
    a. 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 checks the file for errors, logging each one in the file, and then rejects the file if any errors are found. The error log is attached to the "File Processing Complete" notification email.
    b. If no errors are found, the "File Processing Complete" notification email is sent and lists the number of records processed in the file, after the system uploads the file and applies the data to the given Payment Year.
3. Note that there are no ADD, UPDATE, or DELETE action-codes associated with the file. To correct errors, you can either:
    a. Enter the HQR Data Form for each individual facility and update the values as appropriate, or
    b. Upload a corrected CSV file which will overwrite any existing values.

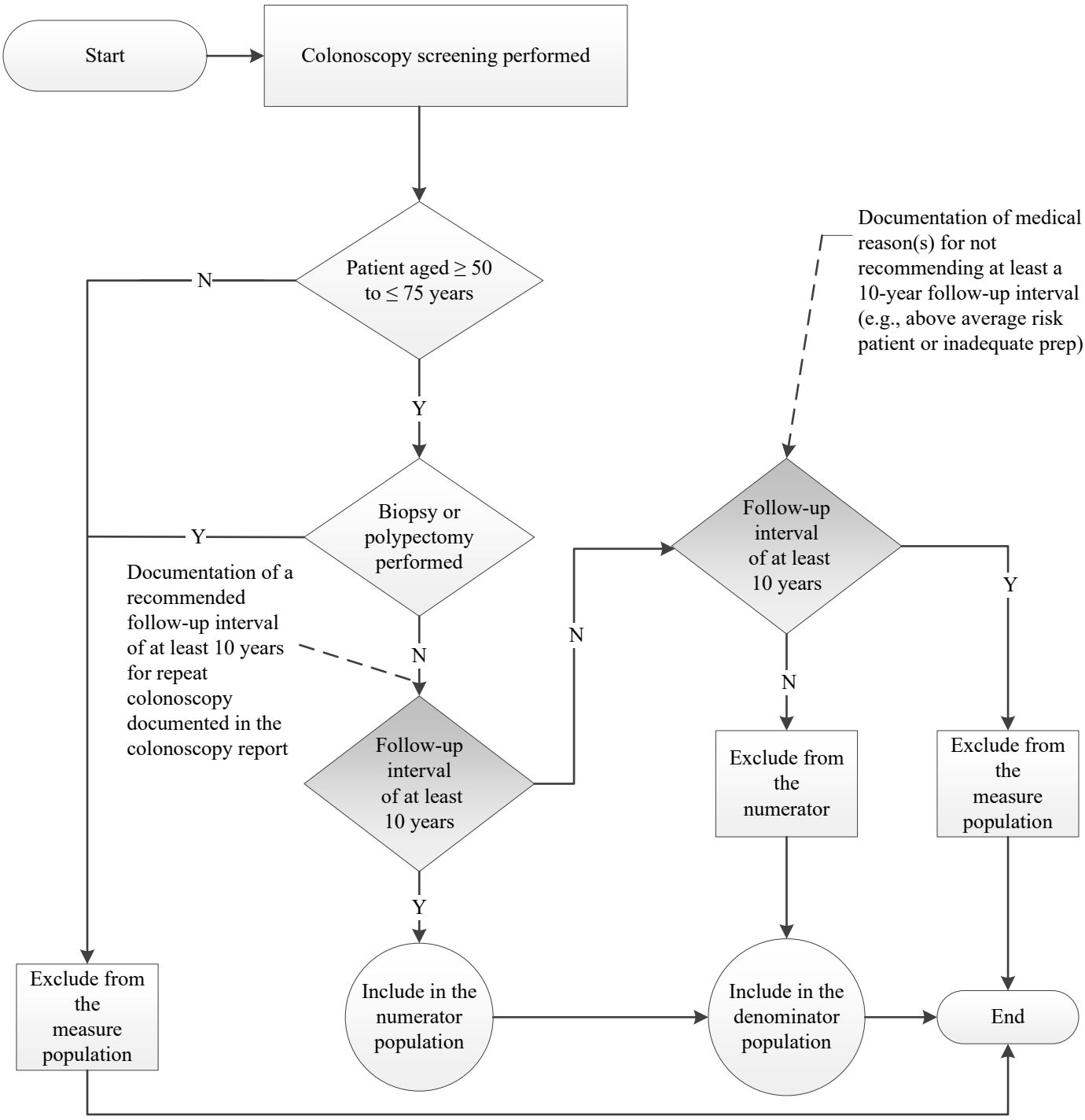
Appendix A: Tools and Resources

Alphabetical Tools and Resources List

ASC-9: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

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 ≥ 50 to ≤ 75 years of age receiving screening colonoscopy without biopsy or polypectomy



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For use with encounter dates 010123-123123;
Specifications Manual version 12.0

ASC-9: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients Data Collection Tool

Answer the questions in the tables below to determine whether colonoscopy patients fall into the measures indicated, keeping in mind that ASC-9 looks forward to recommendations for future care.

ASC-9		
ASC-9: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients		
Measure Criteria	**Circle One**	**Denominator/Numerator Determination**
1. Patient had a screening colonoscopy, without biopsy or polypectomy, **and** is ≥ 50 to ≤ 75 years of age on date of encounter	Yes →	Include in ***denominator*** population, continue to 1(a)
	No →	Exclude from ***denominator*** population
a) Documentation of medical reason(s) for not recommending at least a 10-year follow-up interval (e.g., above average risk patient or inadequate prep or if age is documented as a medical reason)	Yes →	Exclude from ***denominator*** population
	No →	Continue to Question 2
2. Recommended follow-up interval of at least 10 years for repeat colonoscopy is documented in colonoscopy report	Yes →	Include in ***numerator*** population
	No →	Exclude from ***numerator*** population

ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients Denominator Codes

- For ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients, the codes appropriate for use for the denominator are listed below.
- These codes are derived from the measure information form for ASC-9 that can be found in the Specifications Manual.
- **Denominator Criteria:**
  Patients aged ≥ 50 and ≤ 75 on date of encounter
  and
  Z12.11: Encounter for screening for malignant neoplasm of colon
  and
  44388: Colonoscopy through Stoma
  45378: Diagnostic/screening colonoscopy for non-Medicare patients
  G0121: Screening colonoscopy for other Medicare patients
  without
  Modifier **52**: Reduced Services–Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion
  Modifier **53**: Discontinued Procedure–Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure
  Modifier **73**: Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia–Due to extenuating circumstances
  or those that threaten the well-being of the patient
  Modifier **74**: Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia–Due to extenuating circumstances or those that threaten the well-being of the patient
  without
  Z83.71: Family history of colonic polyps
  Z86.010: Personal history of colonic polyps
  Z80.0: Family history of malignant neoplasm of gastrointestinal tract
  Z85.038: Personal history of malignant neoplasm of large intestine

ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients-Fact Sheet

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.

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

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

When abstracting for this measure:

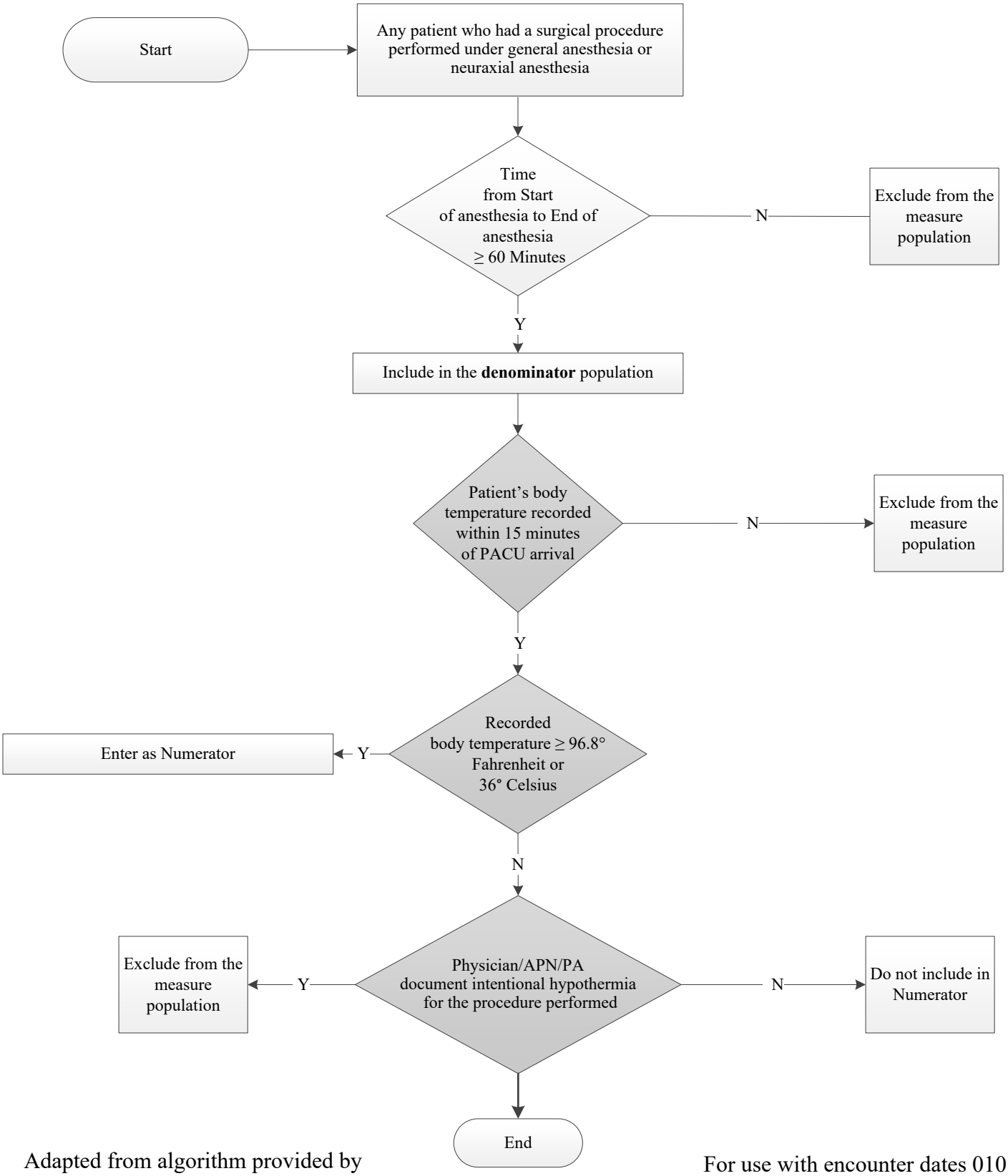
- **Do** use the final colonoscopy report to abstract the recommended follow-up interval. If your facility utilizes another report that is equivalent to or contains the final colonoscopy report, utilize this report for abstraction.
- **Do** exclude a case based on age if there is documentation indicating no follow-up colonoscopy is needed or recommended **and** patient's age is identified as the reason.
- **Do** use any medical reason, such as a diagnosis, symptom, or condition that is documented in the medical record to exclude a case from the denominator population **only** when the recommended follow-up interval is less than 10 years. Please note that you must have **both** an interval of less than 10 years and the medical reason documented in order to use this as an exclusion from the denominator. Some examples are:
    - Above average risk patient
    - Inadequate prep
    - Family history of colon cancer
    - Diverticulitis documented in the medical record

  Please remember that medical reasons are at the discretion of the physician.
- **Do not** include records with CPT/HCPCS modifiers 52, 53, 73, or 74.
- **Do not** use time frames, such as "5–10 years," "many," "prn," or "when symptomatic," since they are not acceptable terms for the recommended follow-up interval of at least 10 years.

ASC-13: Normothermia Outcome

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



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ASC-13: Normothermia Outcome Example Questions

Step 1: Identify surgical patients with general or neuraxial (epidural or spinal) anesthesia equal to or greater than 60 minutes in duration (**Denominator**).

- Did the patient have a general or neuraxial anesthetic?
  - Cases with strictly sedation or local anesthesia would not be included.
- What was the Start time of anesthesia?
  - If there is no Start time, do **not** include patient in the Denominator.
  - If both Start time and Induction time are documented, use Start time.
  - If there is no Start time but there is an Induction time, do **not** include patient in the Denominator.
- What is the End time of anesthesia?
  - If there is no End time, do NOT include patient in the Denominator.
  - If there is no End time documented, do NOT include patient in the Denominator.

If the duration between Start time and End time is equal to or greater than 60 minutes, the patient can be included in the Denominator.

Step 2: Determine how many patients in the Denominator population had the required body temperature within 15 minutes of arriving in the PACU (**Numerator**).

If the patient had a body temperature greater than or equal to **96.8°F or 36°C** 15 minutes after arrival in the PACU, then the patient can be included in the Numerator.

Step 3: Determine if the number of cases meet the Sampling Specifications.

If the population is 0–900, a sample of 63 may be used: If the population is greater than or equal to 901, a sample of at least 96 should be used. If the population is fewer than 63 cases, the total population of cases is required.

Example: An ASC performed **903** surgical procedures. The number of procedures exceeds 901 and can be sampled using at least 96 cases.

Scenario 1
Medicare patient has surgical procedure using **general** anesthesia.
Start time of anesthesia was **0615.**
End time of anesthesia was documented on the operating room (OR) form at **0720.**
Patient's arrival to PACU was documented at **0725.**
Body temperature was **36°C** at **0730.**

Denominator criteria met? Yes
Numerator criteria met? Yes

✅ The patient received **general** anesthesia for the duration of **65** minutes and had a documented body temperature of **36°C** within **15** minutes of arrival in the PACU. This patient should be included in this measure.

Scenario 2
Patient started **neuraxial** anesthetic (spinal) for a surgical procedure at **1000.**
End time of anesthesia was documented at **1100.**
Patient arrived into the PACU at **1105.**
At **1110** patient's temperature was documented as **96.5°F.**
Patient's temperature was rechecked at **1115** and documented as **97°F.**

Denominator criteria met? Yes
Numerator criteria met? Yes

✅ The patient received **neuraxial** anesthesia for 60 minutes and had a documented body temperature of **97°F** within 15 minutes of arrival in the PACU. This patient meets the criteria for both the numerator and denominator.

Scenario 3
Private pay patient received **general** anesthesia.
Anesthetist documented the start time as **0730.**
The anesthetist documented the end time as **0825.**
Patient's arrival time into PACU was documented as **0832.**
Patient's body temperature at **0837** was **97.8°F.**

Denominator criteria met? No

X The anesthesia duration time is not equal to or greater than **60** minutes; therefore, this patient should **not** be included in the measure.

Scenario 4
Medicare patient started epidural in pre-op holding at **0800.**
Patient entered the operating suite at **0810.**
Documented End time of anesthesia was **0905.**
Patient's body temperature recorded at **0920** was **96.5°F.**
Nurse Practitioner documented intentional hypothermia for the procedure.

Denominator criteria met? No

X The documentation of intentional hypothermia is a Denominator Exclusion and excludes this case from the population; therefore, this patient should **not** be included in the measure.

Scenario 5
Patient received **general** anesthesia for surgical procedure.
Anesthetist documented Start time at **1010.**
No documented End time.
Patient's arrival in the PACU is recorded at **1115.**
Patient's body temperature was recorded at **1125** at **97°F.**

Denominator criteria met? No

X Arrival time at PACU is only used to determine if patient's body temperature meets the duration and required temperature for inclusion in the Numerator. Anesthesia End time cannot be substituted with Arrival at PACU time; therefore, this patient should **not** be included in the measure.

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.