Guidelines for Using Release Notes

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

The notes are organized to follow the order of the Table of Contents. Within each topic section, a row represents a change that begins with general changes and is followed by data elements in alphabetical order. The implementation date is 01/01/2019, unless otherwise specified. The row headings are described below:

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

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

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

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

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

Description of Change: Addition of new section and text

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

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

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

Description of Change: Change header name on Measure Information Form

From: Selection Basis:
To: Rationale:

Impacts: ASC-1

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

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

From:
Clinical Recommendation Statements:
The risk of burns related to laser use can be reduced by adherence to the guidelines published by the American National Standards Institute (ANSI) for safe use of these devices in the health care setting. Similarly, the risk of burns related to the use of electrosurgical devices can be reduced by following the electrosurgery checklist published by ECRI Institute.
The risk of surgical fires can be reduced by minimizing ignition, oxidizer, and fuel risks (the “classic triangle”). The American Society of Anesthesiologist’s Practice Advisory for the Prevention and Management of Operating
Room Fires seeks to prevent the occurrence of OR fires, reduce adverse outcomes associated with OR fires, and identify the elements of a fire response protocol. These guidelines are available at: https://asahq.org/quality-and-practice-management/standards-and-guidelines.

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

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

To:

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

**Impacts:** ASC-1

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

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

**Impacts:** ASC-2

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

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

**From:**

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

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

**To:**

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

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

---

**Impacts:** ASC-2

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

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

---

**Impacts:** ASC-3

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

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

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

**To:**
Rationale:
“Surgery performed on the wrong body part”, “surgery performed on the wrong patient”, and “wrong surgical procedure performed on a patient” have all been endorsed as serious reportable surgical events by NQF. This outcome measure serves as an indirect measure of providers’ adherence to the Joint Commission’s “Universal Protocol” guideline for eliminating wrong site, wrong procedure, wrong person surgery. The Universal Protocol is based on the consensus of experts and is endorsed by more than forty professional medical associations and organizations. In order to encompass the outcomes of all key identification verifications, the ASC Quality Collaboration’s measure incorporates not only wrong site, wrong side, wrong patient and wrong procedure, but also wrong implant in its specifications.
Impacts: ASC-3

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

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

From:
Clinical Recommendation Statements:
The Joint Commission’s “Universal Protocol” is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.
Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

To:
Clinical Practice Guidelines:
The Joint Commission’s “Universal Protocol” is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.
Frequently asked questions (FAQs) about this measure can be found in the ASC Quality Collaboration Implementation Guide online at www.ascquality.org.

Impacts: ASC-3

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

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

Impacts: ASC-4

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

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

From:
Clinical Recommendation Statements:
No clinical practice guidelines specifically addressing transfers or admissions from ASCs to acute care hospitals are available at this time.
Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

To:

ASCQR Specifications Manual
Encounter dates 01-01-19 (1Q19) through 12-31-19 (4Q19) v8.0

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

---

**Impacts:** ASC-4

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

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

---

**Impacts:** ASC-11

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

**Description of Change:**

**Description:**

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

---

**Impacts:** ASC-11

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

**Description of Change:**

**Numerator Statement:**

Add 18 years and older

**Denominator Statement:**

**From:**

Instrument

**To:**

Survey

---

**Impacts:** ASC-11

**Rationale:** Changes will align 2019 Measure Information Form with 2018 changes.
Description of Change:

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

Impacts: ASC-13 and ASC-14

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

Description of Change:

Add: Rationale section to the Measure Information Form

Section 3: Quality-Data Transmission

Impacts: CSV Batch Submission File Layout

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

Description of Change:

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

Appendix B: Preview Section

Impacts: ASC-17 and ASC-18

Rationale: To include a preview of future measures

Description of Change:

Add preview of ASC-17 and ASC-18 that are finalized for the CY2022 payment determination and subsequent years
Ambulatory Surgical Center Quality Reporting Specifications Manual

Release Notes Version: 8.0a

Release Notes Completed: November 26, 2018

Guidelines for Using Release Notes

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

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

- **Description of Changes** – Used to identify the section within the document where the change occurs.
  
  (e.g., Definitions, Numerator, and Denominator).
The notes in the tables below are organized to follow the Table of Contents in the Specifications Manual.

**Table of Contents**

**Impacts:** Table of Contents

**Rationale:** Four Claims-Based Measures have been retained in the ASC Quality Reporting Program; however, data collection has been suspended beginning with CY 2021 payment determination until further action in rulemaking, with the goal of updating the data submission method: ASC-1, ASC-2, ASC-3, and ASC-4. Refer to Specifications Manual v7.0a for these Measure Information Forms.

**Description of Change(s):**

Remove ASC-1, ASC-2, ASC-3, ASC-4 from the Table of Contents

---

**Impacts:** Table of Contents

**Rationale:** Measure finalized for removal in the CY 2019 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System (OPPS/ASC) Final Rule beginning with CY 2020 payment determination.

**Description of Change(s):**

Remove ASC-8 from the Table of Contents

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**Impacts:** Table of Contents

**Rationale:** Measure finalized for removal in the CY 2019 OPPS/ASC Final Rule beginning with CY 2021 payment determination.

**Description of Change(s):**

Remove ASC-10 from the Table of Contents

---

**Program Background and Requirements**

**Impacts:** CMS Quality Initiatives

**Rationale:** Four Claims-Based Measures have been retained in the ASC Quality Reporting Program; however, data collection has been suspended beginning with CY 2021 payment determination until further action in rulemaking, with the goal of updating the data submission method: ASC-1, ASC-2, ASC-3, and ASC-4. Refer to Specifications Manual v7.0a for these Measure Information Forms.

**Description of Change(s):**

*Background*

ASCQR Specifications Manual

Encounter dates **01-01-19 (1Q19)** through **12-31-19 (4Q19)** v8.0a

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Add Measures ASC-1 through ASC-4 have been retained in the ASC Quality Reporting Program; however, data collection has been suspended beginning with the CY 2021 payment determination until further action in rulemaking with the goal of updating the data submission method.

**Impacts:** Program Requirements

**Rationale:** Four Claims-Based Measures have been retained in the ASC Quality Reporting Program; however, data collection has been suspended beginning with CY 2021 payment determination until further action in rulemaking, with the goal of updating the data submission method: ASC-1, ASC-2, ASC-3, and ASC-4. Refer to Specifications Manual v7.0a for these Measure Information Forms.

**Description of Change(s):**

Remove sub-section *Claims-Based Measures* title and language

**Impacts:** Program Requirements

**Rationale:** To provide instructions for the submission of Web-Based Measures to QualityNet authorized users via the secure portal.

**Description of Change(s):**

*Measures Submitted via a Web-Based Tool*

Add Submission Instructions to sub-section *Measures Submitted via a Web-Based Tool*

**Impacts:** Related National Activities

**Rationale:** To include the Paperwork Reduction Act (PRA) disclosure statement to the Specifications Manual.

**Description of Change(s):**

Add PRA disclosure statement after sub-section *Measures Management Systems* text

**Section 1: Measure Information Forms**

**Impacts:** Measure Information Form Introduction

**Rationale:** Four Claims-Based Measures have been retained in the ASC Quality Reporting Program; however, data collection has been suspended beginning with CY 2021 payment determination until further action in rulemaking, with the goal of updating the data submission method: ASC-1, ASC-2, ASC-3, and ASC-4. Refer to Specifications Manual v7.0a for these Measure Information Forms.

**Description of Change:**

Remove references to ASC-1 through ASC-4 from *Measure Title* and *Measure ID #* definitions
**Change** example for *Description* definition

**Remove** Numerator Quality-Data Coding Options for Reporting

---

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

**Rationale:** Four Claims-Based Measures have been retained in the ASC Quality Reporting Program; however, data collection has been suspended beginning with CY 2021 payment determination until further action in rulemaking, with the goal of updating the data submission method: ASC-1, ASC-2, ASC-3, and ASC-4. Refer to Specifications Manual v7.0a for these Measure Information Forms.

**Description of Change:**

**Remove** Measure Information Forms for ASC-1, ASC-2, ASC-3, and ASC-4 from ASC Specifications Manual v8.0a

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**Impacts:** ASC-8

**Rationale:** One Measure Submitted via a Web-Based Tool removed from the ASCQR program beginning with CY 2020 payment determination as finalized in the CY 2019 OPPS/ASC Final Rule.

**Description of Change(s):**

**Remove** ASC-8 from the ASC Specifications Manual v8.0a

---

**Impacts:** ASC-10

**Rationale:** One Measure Submitted via a Web-Based Tool removed from the ASCQR program beginning with the CY 2021 payment determination as finalized in the CY 2019 OPPS/ASC Final Rule.

**Description of Change(s):**

**Remove** ASC-10 from the ASC Specifications Manual v8.0a

---

**Impacts:** ASC-12

**Rationale:** Updated to be in accordance with the 2019 ASC Final Rule.

**Description of Change(s):**

**Cover Page**

*Change* cover page reference to CY2018 as performance period for 2020 payment determination; Performance period has been extended from 1 year to 3 years
Impacts: ASC-12

Rationale: Updated references to the Measure Specifications report to reflect the report currently available on QualityNet.

Description of Change(s):
- Cover Page, Included Populations, Cohort exclusions and Admissions not counted in the outcome
- Change “2016 Measure Updates and Specifications Report” to “2018 Measure Updates and Specifications Report” language
- Included Populations and Cohort Exclusions
- Remove CPT and ICD-10 codes
- Add link directing to current Specifications Report available on the Measure methodology QualityNet page

Section 2: Quality-Data Coding & Sampling Specifications

Impacts: Quality-Data Coding and Sampling

Rationale: Four Claims-Based Measures have been retained in the ASC Quality Reporting Program; however, data collection has been suspended beginning with CY 2021 payment determination until further action in rulemaking, with the goal of updating the data submission method: ASC-1, ASC-2, ASC-3, and ASC-4. Refer to Specifications Manual v7.0a for these Measure Information Forms.

Description of Change(s):
- Remove Quality-Data Coding from Section 2 title
- Remove language referencing Quality-Data Coding and ASC-1 through ASC-4

Section 3: Quality-Data Transmission

Impacts: Quality-Data Transmission

Rationale: One Measures Submitted via a Web-Based Tool removed from the ASCQR program beginning with the CY 2021 payment determination as finalized in the CY 2019 OPPS/ASC Final Rule.

Description of Change(s):
- Remove ASC-10 from sub-section Ambulatory Surgical Center Web-Based Measure Batch Submission File Layout

Appendices

Impacts: Appendix A

Rationale: Glossary of Terms is reduced due to measure removals and measure suspensions therefore not providing value at this time.
Description of Change:

Remove Glossary of Terms

Add Appendix A place holder for future use
Ambulatory Surgical Center Quality Reporting Specifications Manual

Version 8.0a

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

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

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

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Example Acknowledgement: The *ASCQR Specifications Manual* [Version xx, Month, Year] is periodically updated by the Centers for Medicare & Medicaid Services. Users of the *ASCQR Specifications Manual* must update their software and associated documentation based on the published manual production timelines.

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**IMPORTANT SUBMISSION ALERT!!**

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

ASCQR Specifications Manual  
Encounter dates 01-01-19 (1Q19) through 12-31-19 (4Q19) v8.0a  
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Program Background and Requirements

CMS Quality Initiatives

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

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

The claims-based measures ASC-1 through ASC-4, adopted by CMS for the ASCQR Program, were originally developed by the ASC Quality Collaboration and are the intellectual property of the ASC Quality Collaboration. Additional information about the ASC quality measures endorsed by the National Quality Forum (NQF) is available in the ASC Quality Collaboration Implementation Guide (www.ascquality.org).

Measures ASC-1 through ASC-4 have been retained in the ASC Quality Reporting Program; however, data collection has been suspended beginning with the CY 2021 payment determination until further action in rulemaking; with the goal of updating the data submission method.

Objective
The ASCQR Program uses a variety of tools to stimulate and support a significant improvement in the quality of ASC care. This initiative aims to refine and standardize ASC data collection, data transmission, and performance measures in order to construct a robust, prioritized, and standard quality outpatient measure set for ASCs. The goal is for all private and public purchasers, oversight and accrediting entities, and payers and providers of ASC care to use these same measures in their national public reporting activities. Quality improvement support, collaborations, standardization, and assuring compliance with Medicare Conditions of Participation (CoPs) are important additional tools in achieving this objective.
**Program Requirements**
ASCs that do not meet program requirements, which include reporting of quality measure data for the ASCQR Program, may receive a two percent reduction in their ASC payment update. ASCQR Program requirements apply to all entities subject to the ASC Fee Schedule (ASCFS). The definition of an ASC can be found in the Claims Processing Manual, Chapter 14, Section 10.1, located at [www.cms.hhs.gov](http://www.cms.hhs.gov).

**Data Collection and Submission**
Data for claims-based measures included in this specifications manual are captured from Medicare Part B fee-for-service (FFS) claims submitted by the ASC during required reporting periods. Medicare Part B FFS patients include Medicare Railroad Retirement Board patients and Medicare Secondary payer patients. Medicare Advantage patients are not included for reporting purposes. For claims-based measures, the reporting period refers to the dates of service not date of submission. For example, if a service was provided on December 30, 2019, with claim submission on January 1, 2020, this claim would be included in the 2021 payment determination.

**Measures Submitted via a Web-Based Tool**
Data for ASC-9, ASC-11 (ASC-11 is a voluntary measure), ASC-13, and ASC-14 are to be submitted using a web-based tool located on the QualityNet Secure Portal at [www.QualityNet.org](http://www.QualityNet.org).

**Annual Data Submission Period:** See the timeline posted to QualityNet.org for these measures.

**Submission Instruction:**
Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users. After logging into the secure portal:

- Select Hospital Quality Reporting: from the Quality Programs drop-down menu to open the “Quality Reporting System: My Tasks” page.
- Select the Manage Measures option for view/edit of Structural/Web-Based Measures
- Select Ambulatory Surgical Center Web-Based Measures
- Select the appropriate payment year from the drop-down menu
- Select the measure for submitting data, saving each measure as the data are entered.
  - Repeat the process for each required measure until data entry for all required measures are complete (select the measure, submit measure data, and save the data). Facilities that do not have data for a required measure should report “zero’s” in both the Numerator and Denominator
  - All measure data must be submitted by the deadline


**Fewer Than 240 Rule**
CMS determined that some ASCs have relatively small numbers of Medicare claims and instituted a claims threshold for ASCs with fewer than 240 Medicare claims (primary plus secondary payer) per year. For example, an ASC with fewer than 240 Medicare claims in CY 2018 (for the CY 2020 payment determination
year) would not be required to participate in the ASCQR Program in CY 2019 (for the CY 2021 payment
determination year).

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

Related National Activities

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

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 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: 03-31-2021

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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 (i.e., 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 the secure side of QualityNet.org via an online tool available to authorized users.

Description – A brief explanation of the measure’s focus, such as the activity or the area on which the measure centers attention (e.g., 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:** 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 $\geq 50$ and $\leq 75$ on date of encounter

and

ICD-10-CM Diagnosis code: Z12.11

and

CPT or HCPCS: 44388, 45378, G0121

without

CPT Category I Modifiers: 52, 53, 73, 74

without

ICD-10-CM Diagnosis codes: Z83.71, Z86.010, Z80.0, Z85.038

**Denominator Exclusions:**
- Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is $\geq 66$ 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 $\geq 66$ years old, or life expectancy $<10$ years.

Documentation of a medical condition or finding can be used as a medical reason(s) for denominator exclusion purposes only if the documented recommended follow-up interval is less than 10 years.

*Examples:*
- Diverticulitis documented in the medical record and a follow-up interval of 5 years in the colonoscopy report.
- Family history of colon cancer and a follow-up interval of 3 years documented in the colonoscopy report.
- Less than adequate prep documented in the medical record with a repeat colonoscopy in 3 years in the colonoscopy report.

**Annual Data Submission Period:** See the timeline posted to QualityNet.org for this measure; select Ambulatory Surgical Centers and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.
**Additional Instructions:** Patients will be counted in the numerator if there is reference in the final colonoscopy report that the appropriate follow-up interval for the repeat colonoscopy is at least 10 years from the date of the current colonoscopy (i.e., the colonoscopy performed during the measurement period). A range that includes “10 years” (e.g., 7 to 10 years) is not acceptable.
Measure Information Form

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

Measure ID #: ASC-11*

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

Description: Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey.

Numerator Statement: Patients 18 years and older who had improvement in visual function achieved within 90 days following cataract surgery, based on completing both a pre-operative and post-operative visual function instrument.

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

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

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

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

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

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

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

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

ASCQR Specifications Manual
Encounter dates 01-01-19 (1Q19) through 12-31-19 (4Q19) v8.0a

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

CMS will use the measure results in the Ambulatory Surgical Center Quality Reporting (ASCQR) Program for payment determination in calendar year 2021. Beginning with payment determination year 2020, CMS will calculate the measure with three years of claims data. For payment determination year 2021, the performance period is January 2017 through December 2019.

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 (http://www.qualitynet.org/dcs/ContentServer?c=Page&pagemenu=QnetPublic%2FPage%2FQnetTier3&cid=1228775214597). CMS provides a new report each year to align with the most current calendar year. For example, the 2018 Measure Updates and Specifications Report will align 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 here: https://cms-ocsq.custhelp.com/.

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 (MIF)

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 the 12 months prior to the date of procedure to ensure a full year of administrative data for risk adjustment.

The measure is focused on low-risk colonoscopies. Cohort codes are located in the data dictionary that accompanies the Measure Updates and Specifications Report, available on the Measure Methodology QualityNet page (http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid).
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 (http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775214597). 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 (http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775214597).

Risk Adjustment:

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

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

The risk-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

<table>
<thead>
<tr>
<th>Patient-level variables</th>
<th>Risk-adjusted variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>Age (categorized; 65-69; 70-74; 75-79; 80-84; 85+)</td>
</tr>
<tr>
<td>Procedural factors</td>
<td>Concomitant Endoscopy, Polypectomy during Procedure</td>
</tr>
<tr>
<td>Comorbidities</td>
<td>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, Drug and Alcohol Abuse/Dependence, Arrhythmia, Age Categorized x Arrhythmia Interaction</td>
</tr>
</tbody>
</table>

**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.html.

**Data Collection Approach:** Medicare administrative claims and enrollment data

**Data Accuracy:** The administrative claims data used to calculate the measure are maintained by CMS’ Office of Information Services. 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.html.

Selected References:

Measure Information Form

Measure Title: Normothermia

Measure ID #: ASC-13

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

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

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

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

Numerator Exclusions: None

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

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

Data Element Definitions:

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

Arrival in PACU: Time of patient arrival in PACU*

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

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

Neuraxial anesthesia: Epidural or spinal anesthesia

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

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

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

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

**Clinical Practice Guidelines:**

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

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

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

**References**


Measure Information Form

Measure Title: Unplanned Anterior Vitrectomy

Measure ID #: ASC-14

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

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

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

Denominator: All cataract surgery patients

Numerator Exclusions: None

Denominator Exclusions: None

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

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

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

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

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

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

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

References


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 (ASC-13).**

<table>
<thead>
<tr>
<th>Population Per Year</th>
<th>0-900</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yearly Sample Size</td>
<td>63</td>
</tr>
<tr>
<td>Quarterly Sample Size</td>
<td>16</td>
</tr>
<tr>
<td>Monthly Sample Size</td>
<td>6</td>
</tr>
<tr>
<td>Population Per Year</td>
<td>≥ 901</td>
</tr>
<tr>
<td>Yearly Sample Size</td>
<td>96</td>
</tr>
<tr>
<td>Quarterly Sample Size</td>
<td>24</td>
</tr>
<tr>
<td>Monthly Sample Size</td>
<td>8</td>
</tr>
</tbody>
</table>

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

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

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

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

- **ASC_PROVIDER_NPI** – National Provider ID
- **ASC_PYR** – Payment Year
- **ASC_9_POP_SIZE** – What was your facility’s Total population?
- **ASC_9_SAMP_SIZE** – What was your facility’s sample size?
- **ASC_9_SAMP_FREQ** – What was your facility’s sampling frequency?
- **ASC_9_NUMERATOR** – Patients who have a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.
- **ASC_9_DENOMINATOR** – All patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy.
- **ASC_11_POP_SIZE** – What was your facility’s Total Population?
- **ASC_11_SAMP_SIZE** – What was your facility’s sample size?
- **ASC_11_SAMP_FREQ** – What was your facility’s sampling frequency?
- **ASC_11_NUMERATOR** – Patients who had an improvement in visual function achieved within 90 days following cataract surgery, based on completing both a pre-operative and post-operative visual function instrument.
- **ASC_11_DENOMINATOR** – All patients 18 years and older who had cataract surgery and completed both a pre-operative and post-operative visual function instrument.
- **ASC_13_POP_SIZE** – What was your facility’s Total Population?
- **ASC_13_SAMP_SIZE** – What was your facility’s sample size?
- **ASC_13_SAMP_FREQ** – What was your facility’s sampling frequency?
- **ASC_13_NUMERATOR** – Surgery patients with a body temperature equal to or greater than 96.8 Fahrenheit/36 Celsius recorded within fifteen minutes of Arrival in PACU.
- **ASC_13_DENOMINATOR** – All patients, regardless of age, undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes duration.
ASC_14_NUMERATOR – All cataract surgery patients who had an unplanned anterior vitrectomy.

ASC_14_DENOMINATOR – All cataract surgery patients.

Data Upload Process

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

**All data transmitted pass through the following process:**

1. The file(s) are checked for proper naming convention and file type.
   - The correct file naming convention is ASC_WBM_PY20YY_mm_dd_yyyy.csv where YY represent the last two digits of the applicable Payment Year, and mm_dd_yyyy represents the upload date.

2. The file(s) are evaluated upon successful upload and checked for errors in content.
   a. The system sends an upload confirmation email to the registered email for the logged-in account.
   b. The system checks the file for errors, logging each error in the file, and then rejects the file if any errors are found. The error log is attached to the rejection notification email with one error per line.
   c. If no errors are found, the system uploads the file and applies the data to the given Payment Year.

3. Note that there is no ADD, UPDATE, or DELETE action-code associated with the file. To correct errors, you can either:
   - Enter the Web-Based Data Collection Tool for each individual facility and update the values as appropriate, or
   - Upload a corrected CSV file which will overwrite any existing values.
Appendix A: Place Holder
Appendix B: Preview Section

The Preview Section provides information on new measures.

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

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

Measure Background and Overview:

“The patient population served at ASCs has increased not only in volume, but also in age and complexity, which can be partially attributed to improvements in anesthetic care and innovations in minimally invasive surgical techniques. As such, ASCs have become the preferred setting for the provision of low-risk surgical and medical procedures in the United States, as many patients experience shorter wait times, prefer to avoid hospitalization, and are able to return to work more quickly. As the number of orthopedic procedures performed in ASCs increases, it is increasingly important to report the quality of care for patients undergoing these procedures.” (82FR52595)

“Based on the increasing prevalence of orthopedic surgery in the ASC setting, we believe it is important to minimize adverse patient outcomes associated with these orthopedic ASC surgeries. Therefore, in the CY 2018 OPPS/ASC proposed rule (82 FR 33692), we proposed to adopt the ASC–17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures measure into the ASCQR Program for the CY 2022 payment determination and subsequent years.” (82FR52595)

Measure Calculation and Reporting:

“The measure outcome is all-cause, unplanned hospital visits within seven days of an orthopedic procedure performed at an ASC. For the purposes of this measure, “hospital visits” include emergency department visits, observation stays, and unplanned inpatient admissions. When there are two or more qualifying surgical procedures within a 7-day period, the measure considers all procedures as index procedures; however, the timeframe for outcome assessment is defined as the interval between procedures (including the day of the next procedure) and then 7 days after the last procedure. The facility-level score is a risk standardized hospital visit rate, calculated by multiplying the ratio of the predicted to the expected number of post-surgical hospital visits among the given ASC’s patients by the national observed hospital visit rate for all ASCs. For each ASC, the numerator of the ratio is the number of hospital visits predicted for the ASC’s patients accounting for its observed rate, the number of the orthopedic surgeries performed at the ASC, the case-mix, and the surgical complexity mix. The denominator of the ratio is the expected number of hospital visits given the ASC’s case-mix and surgical complexity mix. A ratio of less than one indicates the ASC facility’s patients were estimated as having fewer post-surgical visits than expected compared to ASCs with similar surgical complexity and patients; and a ratio of greater than one indicates the ASC facility’s patients were estimated as having more visits than expected. The national observed hospital visit rate is the national unadjusted proportion of patients who had a hospital visit following an orthopedic ASC surgery.” (82FR52597)

“The data collection period for the proposed ASC–17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures measure would be the two calendar years ending two years prior to the applicable payment determination year. For example, for the CY 2022 payment determination, the data collection period would be CY 2019 to 2020. Because the measure data are collected via claims, ASCs will not need to submit any additional data directly to CMS.” (82FR52596)
ASC-18: Hospital Visits After Urology Ambulatory Surgical Center Procedures

Measure Background and Overview:

“Because urology surgery performed at an ASC is a significant predictive factor for unanticipated admissions compared to other procedures, we believe measuring and reporting 7-day unplanned hospital visits following urology procedures will incentivize ASCs to improve care and care transitions. Many of the reasons for hospital visits following surgery at an ASC are preventable; patients often present to the hospital following urology surgery for complications of medical care, including urinary tract infection, calculus of the ureter, urinary retention, hematuria, and septicemia. However, increased patient and staff education present opportunities to improve the success rate of urology surgeries in ASCs. Therefore, we believe tracking and reporting these events would facilitate efforts to lower the rate of preventable adverse events and to improve the quality of care following urology procedures performed at an ASC.” (82FR52603)

“We believe it is important to minimize adverse patient outcomes associated with urology ASC surgeries. Therefore, in the CY 2018 OPPS/ASC proposed rule (82 FR 33695), we proposed to adopt the ASC–18: Hospital Visits after Urology Ambulatory Surgical Center Procedures measure in the ASCQR Program for the CY 2022 payment determination and subsequent years.” (82FR52603)

Measure Calculation and Reporting:

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

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