## Ambulatory Surgical Center Web-Based Measures: CY 2016 Payment Determination Guidelines

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Guidelines for Data Submission

- The submission period for measures ASC-6 and ASC-7 is January 1, 2015, through August 15, 2015. The reference period is for encounter dates between January 1, 2014 and December 31, 2014.

- The submission period for measures ASC-9 and ASC-10 is the same as the measures above. However, the reference period is for encounter dates between April 1, 2014, and December 31, 2014.

- Submission of ASC-11 is voluntary for CY 2015.

- In order for an ambulatory surgical center (ASC) to submit data, the ASC must authorize and notarize a QualityNet Security Administrator (SA), a prerequisite necessary for accessing the QualityNet Secure Portal. The QualityNet SA must enter measure data via the QualityNet Secure Portal. The SA must log in to the Portal at least once each 120 days in order to maintain active status.

- The Ambulatory Surgical Center Quality Reporting (ASCQR) Program recommends that each facility has two SAs – a primary and an alternate.

ASC-6: Safe Surgery Checklist Use

- **Measure Question:** Does your facility use a safe surgery checklist based on accepted standards of practice? Yes/No

- **Payers:** The response for ASC-6 is for all payers, including Medicare.

- **Safe Surgery Checklist:** There is no one standard or recommended safe surgery checklist for use in the ASC setting. The definition from CMS on the use of a safe surgery checklist for surgical procedures includes safe surgery practices during each of the three critical perioperative periods:
  1. The period prior to the administration of anesthesia,
  2. The period prior to skin incision, and
  3. The period of closure of incision and prior to patient leaving the operating room.

- **Sample Safe Surgery Checklist:** Examples of safe surgery checklists are available from several ASC national and state organizations, as well as from the World Health Organization (WHO). To obtain a copy of WHO’s Surgical Safety Checklist, visit [www.who.int/patientsafety/safesurgery/en/](http://www.who.int/patientsafety/safesurgery/en/).

- **Documentation:** The safe surgery checklist does not need to be a part of the patient’s record.

  **Q:** Does the safe surgery checklist need to be utilized during the entire designated period to select “yes,” or is “yes” correct if it was used at any time during the designated period?

  **A:** For the initial year of data collection, the answer was “yes” if the checklist was used at any time during the year. In current and subsequent years, the checklist will need to be utilized for the entire year to answer “yes” to the measure question.

  **Q:** Does the safe surgery checklist need to be documented in the medical record?

  **A:** No. The safe surgery checklist does not need to be in the medical record. However, the checklist must address the specified time frames listed above.
ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures

- **Measure Question**: What was the aggregate count of selected surgical procedures per category/organ system?

- **Procedure Categories**: An updated listing of the groups and corresponding Healthcare Common Procedure Coding System (HCPCS) codes will be posted in an addendum to the Specifications Manual available at www.qualitynet.org. Program participants will be notified of the posting via ListServe. Data entry is required only for those categories included on the web-based tool.

- **Procedure Counts**: Count the total number of procedures within each organ system performed in your facility during the reference period of January 1, 2014 through December 31, 2014. Some specialty ASCs will have procedures in only one category/organ system; an answer of “0” for organ systems not within the ASC’s specialty is acceptable.

  Q: Does the surgical procedure code (HCPCS) need to be the primary code, or can it be either primary or secondary?
  A: Count any HCPCS code that is billed, whether it is primary or secondary.

  Q: Does the hospital include procedures billed to all payers, or just those billed to Medicare?
  A: All procedures, regardless of whether they are billed to Medicare or to another insurer, are included in the count.

  Q: If a patient has two procedures categorized in one organ system procedure category, is the procedure counted once or twice?
  A: The procedure is counted twice. The measure is intended to capture procedure counts not patient counts.

  Q: If a procedure has a modifier code of 50 (the procedure was performed bilaterally during the same operative session by the same provider), is it counted twice for this measure?
  A: Yes. Procedures done bilaterally are treated as two separate procedures and counted twice.

  Q: For the organ system “Eye,” if the ASC performs 75 procedures assigned HCPCS code 66982, 25 procedures assigned 66984, and 100 procedures assigned 65855, what data would be reported?
  A: The number of procedures for the eye organ system/procedure category would be counted as 200.

ASC-8: Influenza Vaccination Coverage among Healthcare Personnel

- **Description**: Percentage of healthcare personnel (HCP) who receive the influenza vaccination

- **Denominator**: Number of HCP who are working in the healthcare facility for at least one working day between October 1, 2014 and March 31, 2015, regardless of clinical responsibility or patient contact. Denominators are to be calculated separately for employees, licensed independent practitioners, students, trainees, and volunteers.

- **Numerator**: HCP in the denominator population who:
  - Received an influenza vaccination
  - Have a medical condition of allergic reaction or history of Guillain-Barre Syndrome within six weeks after a previous flu vaccination
  - Declined influenza vaccination

Are persons with unknown vaccination status or who do not otherwise meet any of the definitions above

Data for ASC-8 will be submitted to the National Healthcare Safety Network (NHSN) website at www.cdc.gov/nhsn.

Q: Does the ASC report this information to the QualityNet Secure Portal?
A: No. The data must be entered via the Centers for Disease Control and Prevention’s NHSN website at www.cdc.gov/nhsn. The ASC must register at the website prior to data submission.

Q: When information is reported to the NHSN throughout the reporting period, can ASCs enter the data as they are collected (more than once)? If so, is the previous data deleted?
A: Yes. Previous entries will be replaced with the current information; therefore, data must be submitted as a cumulative total each time during the submission period of October 1, 2014 through May 15, 2015.

Q: Should all the HCP categories be entered separately, or can they be entered as the total number of employees?
A: Each category, e.g., employees, independent practitioners, students, etc., should be entered separately on the tool provided by the NHSN.

**ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients**

- **Description:** Percentage of patients aged 50 years and older 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:** All patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy

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

Q: When a patient comes in for a scheduled screening colonoscopy but has a biopsy performed, would this patient be included in the denominator for this measure?
A: No. If the patient has a biopsy performed, they should not be included because the patient would be expected to have a follow-up colonoscopy prior to 10 years from the date of the exam.

Q: Does the follow-up interval have to be documented in the colonoscopy report?
A: Yes. The physician must document the recommended follow-up time (e.g., 10 years) after the exam is performed in the colonoscopy report.

**ASC-10: Endoscopy/Polyp Surveillance: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use**

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

• **Numerator:** Patients who had an interval of three or more years since their last colonoscopy

**Q:** If there is documentation in the medical record of a medical reason (e.g., patients with high-risk for colon cancer, last colonoscopy incomplete, piecemeal removal of adenomas, inadequate prep, etc.) for an interval of fewer than three years since the last colonoscopy, would this patient be included in the denominator for this population?

**A:** No, this patient would be excluded from the population. Patients with documentation of system reasons (e.g., unable to locate previous colonoscopy report) for performing the test in fewer than three years would also be excluded from the population.

**Q:** If there is a medical or system reason documented for performing the colonoscopy in less than three years, would this patient be included in the population?

**A:** No, as long as there is a medical or system reason documented in the current encounter’s medical record for performing the colonoscopy in less than three years, this patient would not be included in the population.

**Q:** If the patient’s past history of colonoscopy with colon polyps is documented in the patient’s history and physical but not in the colonoscopy report, would this patient be included in the population?

**A:** Yes, documentation of the previous colonoscopy with polyps can be anywhere in the current encounter’s medical record and can be documented by any healthcare professional.

**Q:** Does the information regarding the patient’s history and date of last colonoscopy performed need to be documented by the physician in the current encounter record?

**A:** The reason for performing the colonoscopy and the date of the last colonoscopy performed need to be documented in the current encounter’s medical record. This information can be documented by any healthcare professional and does not need to be documented by the physician.

**ASC-11: Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery***

*ASCs may voluntarily submit this data for CY 2015 but will not be subject to a payment reduction with respect to this measure during the voluntary reporting period.

• **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

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

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