



# Ambulatory Surgical Center Quality Reporting Program

## Support Contractor

### The ASCQR Program: Recipe for Success!

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**September 30, 2015**

**2:00 PM**

Karen  
VanBourgondien:

Hello and welcome to the Ambulatory Surgical Centers Quality Reporting Program. Thank you for joining us today. My name is Karen VanBourgondien, the Education Coordinator for the ASCQR Program. If you have not yet downloaded today's handouts, you can get them from our website at [www.qualityreportingcenter.com](http://www.qualityreportingcenter.com). Go to the events banner on the right side of the page, click on today's **Events**. There will be a link there that will allow you to access and print the handouts for today's webinar.

As you can see, we are streaming live in lieu of using only phone lines. However, phone lines are available should you need them. Before we begin today's program, I would like to highlight some important dates and announcements. Today, September 30, is the deadline for ASCs to submit their web-based measures. This does include ASC-8, which is reported through the NHSN. If you have not completed your web-based measure submission, please do so today.

We sent a ListServe explaining how to get your claims-based data suppressed from public reporting on September 8. Please check this link on this slide to get the full instructions on this process. On October 28, there will be a presentation on public reporting for the ASCQR Program. This webinar will give viewers a basic overview of the "what's" and "why's" of public reporting.

December 2, the calendar year 2016 Final Rule webinar will be presented by CMS' Dr. Anita Bhatia, the Program Lead for the ASCQR Program. Additional webinars and educational opportunities will be forthcoming. Notifications will be sent by ListServe by the support contractor. ListServe notification is our primary mode of communication for this program. If you are not signed up for this, please take a moment to do so. This can be done on the homepage of QualityNet.

The learning objectives for this program are listed here on this slide. The program is being recorded and transcripts of today's presentation, including the questions and

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answers received in the chat box and the audio portion of today's program, will be posted at [qualityreportingcenter.com](http://qualityreportingcenter.com) at a later date.

During the presentation, as stated earlier, if you have a question, please put that question in the chat box located on the left side of the screen. One of our subject matter experts will respond. Again, by having live chat, we hope to accommodate your questions timely and have real time feedback.

Some of the questions will be shared at the end of the presentation. Let me introduce our speaker. I'm pleased to introduce today's speaker Tamara Heron. Tamara earned her Bachelors of Science and went on to earn her MBA in 2012. Tamara joined HSAG in 2008. Now I'll turn the presentation over to Tamara. Tamara the floor is yours.

Tamara Heron:

Thank you, Karen. Hello everyone, and thank you for joining us today. The presentation today is an introduction to the Ambulatory Surgical Center Quality Reporting Program. Putting together a quality improvement program at your ASC is a lot like making brownies to take to work. It takes a little time, but there are ways you can streamline the baking process. And people really appreciate the end product.

First, what's the reason for making brownies? Let's talk a little bit about the background of the ASCQR Program, and how it came about. I don't have to explain to you the rise of the ASCs and the advantages to patients and to the healthcare system of care providers in this setting, but we have to tell other people.

CMS responded to leading organizations within the ASC community who asked for a program where ASCs can report data about the excellent care provided there. The ASC Quality Collaboration supplied the initial set of measures instituted by CMS. The public wants to make informed decisions about their healthcare, and they need the data to do it.

But yes, brownies have to fit in the pan. And that pan would be the big goals of quality measurements; to promote better care, smarter spending, and healthier people. CMS works really hard to insure that the requirements of the ASC Quality Reporting Program work together to further these goals.

To cook brownies properly, you need tools. The tools of the ASCQR Program uses our data reporting, which is putting quality data codes on claims, answering questions about care on a website from CMS or the CDC, mechanisms for reporting the data, and measure alignment. Measuring care similarly, in different settings.

CMS establishes these measures through rulemaking; rules that are published every year in the *Federal Register*. CMS revisits the measures every year to see if any measures need to be revised to reflect the latest standards of care, any patient safety issues that arise, and to respond in an agile way to new procedures or technological development.

The program was introduced in the 2008 Final Rule published in the *Federal Register*. At that time, CMS determined it would be more appropriate to allow ASCs to acquire some experience with the revised ASC payment system before implementing any new quality reporting requirements. The program began with the data collection in the fourth quarter of calendar year 2012.

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So, I just mentioned the term Final Rule. And if you are new to the program, you may or may not know what this means. I'm going to take a moment here to briefly discuss the terms of the Final Rule and the Proposed Rule.

A closer look at rulemaking; one of the cook's tools. CMS first proposes new requirements for the program, and asks for the public and any interested organizations to provide their opinions about the proposals through a comment period. It is a very interactive process. The Proposed Rule is usually published in early July. Any comments are sent to CMS. All of them are read and considered before changes are finalized with the publication of the Final Rule, later in the year.

Providers are highly encouraged by CMS to submit comments on the proposed regulations affecting the rulemaking for the current year and future years. CMS addresses each comment. This is the time when facilities could be involved in policy making. This process is in place to allow feedback, comments, and exchange of ideas. The comment period is open for 60 days following release. You can choose to be anonymous when leaving your comments.

Once all the comments are obtained, CMS makes decisions regarding the Proposed Rule, and thus becomes the Final Rule. The Final Rule is then published annually around November, and by law, must be displayed in the *Federal Register*. As I mentioned in the previous slide, at the inception of the ASC program, it went through this process and in calendar year 2012, the ASC Quality Reporting Program began.

Not everyone bakes, and not everyone participates in the ASCQR Program. If your facility doesn't have enough claims, and by enough, we mean 240 Medicare claims a year, you are not required to participate in the program. You will still get your annual payment update. This is the payment ASCs receive from Medicare based on the Consumer Price Index. If your ASC has more than 240 Medicare claims per year, you have to report data to CMS. If you don't, you will lose 2 percent of your annual payment update or APU.

This 2 percent reduction can affect beneficiary co-payments also. So, reporting data to Medicare about the care your ASC provides is really important. Losing that 2 percent however, is only for that payment determination year. So you can wipe the slate clean, and report next year to get that 2 percent back.

The task of reporting data can sound harder than it seems. Keep in mind that CMS is already capturing the good stuff; the excellent care provided at ASCs that you are already doing. You'll see that, as we talk about the measures. Ok, I think the oven is pre-heated. Now, let's start cooking!

Let's discuss the requirements, the ingredients we are putting together for the ASCQR Program. CMS defines quality measures as tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure or systems that are associated with providing high quality healthcare. There are two kinds of measures in the ASCQR Program. There are claims-based measures which use claims

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you are filing with Medicare to show your ASC is providing the best patient care. Medicare pulls information from the claims you are already submitting.

The second type are web-based measures. Web-based measures consist of answering questions through a web-based tool. I will explain these a little later, I promise. To make the best ever brownies, you have to have quality ingredients. Listed are the key ingredients for the ASCQR Program. We are going to talk about these individually in a moment. So very briefly, you'll be applying quality data codes or QDCs to your Medicare claim forms, annual reporting of information on the web-based measures and having an active Security Administrator at the time of submission.

ASC-12 is a new measure that initiated with a dry run in 2015. The Facility Seven-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy measure will be publicly reported beginning on or after December 1, 2017, and will be used for repayment determination beginning calendar year 2018.

Your facility will not have to do anything for this measure, as it is claims-based. These program requirements will only apply to facilities that have more than 240 Medicare claims per year. These program requirements will also apply to facilities that have been open for at least four months prior to January 1 of the reporting year. Upon successful submission of any quality measure data, the ASC will be deemed as participating in the ASCQR Program for the upcoming payment year determination.

We will spend more time talking about QDCs later. The ASC-12 measure is a claims-based measure, but it's not reported in the same way the QDCs are. ASC-12 estimates a facility level rate of risk-standardized all-cause, unplanned hospital visits within seven days of an outpatient colonoscopy among Medicare Fee for Service patients that are 65 or older.

This information is taken directly from Medicare claims and does not require the ASC to manually enter this data. As this measure was finalized in the 2015 Final Rule, it will not be publicly reported until at least December 2017 and will not affect any payment until the payment year of 2018. And that will be based on claims data from January 1 until December 31, of 2016. For more detailed information on this measure, you should go to QualityNet's website and click on **Measures** under the ASC tab or click the link text on this slide.

Here we have a chart, and I know it's hard to read, but I have linked a document from our website that lists both the claims-based measures and the web-based measures. It has a measure number, the description of the measure, and the submission due date. Please note, this chart reflects measures that are to be submitted in calendar year 2016 next year, and the 2017 payment year, but not for the current period of submission. Let's look at these measures more specifically.

All right, now this slide has a lot of information, but these are the dry ingredients in our recipe, and need to be mixed well. So let's break this down. QDCs which are also referred to as G-codes, are quality data codes that refer to outcome measures. There are a

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total of five QDC codes. Successful submission of QDCs on at least one paid claim designates the ASC as participating in the ASCQR Program.

QDCs must be submitted correctly and completely on a minimum of 50 percent of your ASC's Medicare claims to meet their program requirements. This percentage is based on the number of claims paid by the Medicare Administrative Contractor, or the MAC by April 30 of each year.

This date was selected by CMS to be the closed date for applicable claims for the payment year. Now, each claim must have a minimum of two or a maximum of five QDCs submitted per claim. For ASC 1-4, a blanket code of G8907 can be applied.

The term "blanket code" means no event took place. ASC-5 on the other hand, must be answered separately on each claim regardless of the other measures. This will become a little clearer in a moment when we look at the codes themselves and some screenshots. A CMS Form 1500 Version 02/12 paper claim or electronic form must be used for reporting of QDCs for the ASCQR Program. ASCs must use a unified billing, UB-04 for commercial payers, but QDCs are not collected for the ASC Program. They are applied to Medicare claims only.

All QDCs for an encounter must be reported on the same claim for the same beneficiary for the same date of service. Should a billing submission require more than one CMS claim form, such as a second form will move to item seven, or a third will move to line item to 13. Each claim form must contain a line item charge and the appropriate QDC in order to receive appropriate credit for the ASCQR Program requirement.

Ideally, the QDCs will be submitted under the initial line item charge on the first claim form. QDCs must also be submitted with a line item charge, the submitted field cannot be blank. A charge of zero can be used or if a billing system cannot accept a zero line item charge, a nominal charge of one cent can be used to populate this field.

The beneficiary will not be responsible for this charge. Claims without some dollar charge will be rejected by Medicare. So again, do not leave it blank. A diagnosis point code in the box 24E is required; otherwise, the claim will be rejected by the MAC. Another very important issue is that the provider ID in box 24J must be the facility's NPI. If the physician NPI is used, the G-codes will be dropped and will not be submitted to the ASC program.

This is where it becomes important that you be diligent in checking up on your own processes to insure that the codes are being accepted and crossing over appropriately. We will look at a billing form in a moment that will clarify this a little further. At this point, we are going to turn things over to our host for our polling question.

Matt McDonough:

Thank you very much, Tamara. We'd like to interject the polling question here just to do a quick knowledge check with our audience today to keep things a little more lively. The question that's being asked is what percentage of QDCs must be submitted on Medicare claim forms? Your four options are 25 percent, 45 percent, 50 percent or 80 percent.

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In fact if you'll go back to –if you have the slides in front of you, if you go back to slide 19, it is the second bullet point on slide 19 where we covered this item. So the correct answer is 50 percent. That's going to do it for our first polling question. We'll be back again in a little bit for a second one. But for now, I'm going to go ahead and hand things back to our speakers.

Tamara Heron:

To summarize the QDCs, here we have a chart that indicates which QDCs to use for measures ASC-1-5. As stated before, please note that if measures 1-4 indicate no event occurred, the composite G-code of G8907 may be used in lieu of answering these measures individually.

But remember, ASC-5 must be answered separately for all patients. Patients without a pre-operative order for IV antibiotics are designated with the code G8918. Remember, each claim must have a minimum of two, or a maximum of five QDCs submitted to have complete quality data.

You could also access this document on our website at the linked text on this slide. OK, here on this slide, you can see the billing form on how the G-codes are placed. Please notice that ICW-9 code that is at the top left and on line one is the procedure code. Lines 2-6 are the G-codes or QDCs. There is one billable procedure and five G-codes in this example.

This sample patient was transferred from the ASC to a hospital. So G8914 is used to indicate the occurrence. You have to answer all of the measures, ASC-1-5. As such, you cannot use G8907, which would indicate there was no event. Now, as we stated a couple slides ago, if a claim requires more than one CMS form such as on 7 or 13 line items, these line items will automatically go on another claim if they are greater than six lines.

On this slide, you can see that zeroes are entered as the charge from the QDCs. We also discussed that a few slides ago, but do not use dollar signs or decimal points. If your system does not allow for a zero line item charge, a nominal amount can be substituted—for example, a one cent charge. Again, the beneficiary will not be responsible for this charge.

Also remember, we stated that this facility provider ID must be used. This is for box 24J. Here on the slide, it says facility. This is where you would put your facility's NPI. Again, if a physician NPI is used, the G-codes will be dropped and will not be submitted to this program. And under box 24E, there should be a diagnosis pointer code. If the code is not on the claim, it will be rejected by the MAC.

Before we get to this slide, let's discuss the two acronyms you see here that are EOB and RA. An explanation of benefits, or EOB, is a statement sent by the insurance company explaining what medical treatment services were paid. A remittance advice, or RA, is a notice of payments and adjustments after a claim has been processed.

The remark code N620 is your indication that the ASCQR Program QDCs were received into the National Claims History warehouse. This N620 code will read that it is for reporting purposes only. In order to receive credit for the correctly applied QDCs, the

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place of service must be 24, which indicates the ASC. The N620 remark code will also appear when the place of service is 11 (provider's office), but no QDC credit will be given.

A billable charge, located above the QDCs with the corresponding remark code, must be on the RA in order to receive full credit and be applied for the program requirement. The QDC will appear as denied by Medicare being a non-billable code on the RA/EOB, but the code will be tracked in a national claims history for analysis as long as the QDC is affiliated with a charge and has received payment by Medicare as evidence on the RA.

ASC-6- this question asks, "Does your facility use a safe surgery checklist based on accepted standards of practice?" This will be answered with either a "yes" or "no" into the portal. ASC-7- with this measure, you are counting the number of surgical procedures that your ASC performs that match the codes provided to you in the Specifications Manual. They are divided into organ systems. If you have no procedures done under an organ system, you would then need to enter zero. Do not leave any blank organ systems. You will have to resource your Specifications Manual to get these codes.

ASC-8- this is the healthcare personnel vaccination. Information is reported to the CDC /NHSN. This requires a completely separate registration, and this measure is not entered into QualityNet. ASC-9- this measure looks at the recommended follow-up documented by the physician for patients who have a screening colonoscopy.

To meet the measure requirements, the physician must document a recommended follow up of 10 years on the colonoscopy report. ASC-10- this looks at the interval since the last surveillance colonoscopy.

ASC-10- is a measure designed to look at inappropriate use of the colonoscopy procedure. ASC-11- this measure monitors the patient's visual improvement, post-cataract surgery through a visual assessment tool. This is a voluntary measure. If you do not report on this measure, it will not affect your annual payment update.

But please be advised, if you do report this data, it is subject to public reporting. Up to this point, we have discussed all measures. To get more detailed information and to guide you further into accurate reporting of these measures, you will need to read the Specifications Manual.

To be successful in your reporting for the ASC program, you should become very familiar with this manual. So you're asking yourself, where is this manual? I will answer that question in a few minutes. The web-based measures are entered into the QualityNet Secure Portal annually, with the exception of ASC-8 which is entered through the NHSN website.

To gain some more knowledge on the web-based data submission, we did a webinar in May of this year, regarding all the web-based measures and how to enter that into QualityNet. And we discussed these measures themselves in great detail. So if you feel that you need more information, please, by all means, view that webinar.

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The current annual submission period for entering this data is January 1 through August 15, but we did extend the due date to September 30, 2015. Please know that this is currently projected in the Proposed Rule to move the time frame from January 1 to August 15 to January 1 through May 15 annually, but we will await the release of the Final Rule to see what the decision is.

Now, it's time to mix the wet and dry ingredients together, put them in the pan and set them to bake. Every good baker tests to see whether the ingredients have been combined successfully. You stick a toothpick on the middle of your brownies, right? So for the ASCQR Program, the toothpicks are the reports you can access on QualityNet that will allow you to check your progress and to assure you are meeting the requirements of the program.

We have developed short tutorial videos on how to access and interpret these reports. To access these videos, go to our website at [www.qualityreportingcenter.com](http://www.qualityreportingcenter.com). You will find them under **Videos, Resources and Tools**. For now, we will discuss these reports briefly over the next couple of slides.

The ASC Claims Detail Report identifies claims in final action status in the data warehouse. You could see on the top right of this particular report that it is 33 pages. We are only going to be looking at the first page. On this report, starting from the left, you will have the HIC number, the claim receipt date, the date of service, QDC codes entered, the patient's name, date of birth, and the claim control number.

The last number is an internal QualityNet number and is not PHI. This report is one avenue to check on the volume of QDCs that your facility has submitted. Remember that a facility must submit QDCs at 50 percent to meet the program requirement. Let's look at another report that is also available for the ASCs.

The Provider Participation Report- this report displays the summary of the data submissions required for the payment year and your facility's performance. This is your facility's data that has been accepted into the warehouse. This slide represents a sample of the Provider Participation Report. You can see here on the left side the total number of claims with QDCs, total claims, and data completeness, which is essentially the percent of QDCs your facility is submitting.

On the lower half of this page, it displays a numerator and a denominator breakdown according to the individual measures.

You've already preheated your oven, right? Now, let's look at QualityNet. This is where the information regarding the various CMS programs is made available to you via the web. This site is also used to enter the web-based measures into the Secure Portal.

All right, so remember when I spoke about the Specifications Manual? Here is where you can find it. This is a screenshot of the homepage of QualityNet. You will need to hover your cursor over the Ambulatory Surgical Center tab and then this drop-down box will appear. Select the Specifications Manual from this drop-down.



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All right, we're going to switch gears here a little bit and we're going to talk about Security Administrator. The QualityNet Security Administrator is allowed to submit data for the web-based measures, access secure reports, and facilitate the registration process for the other users within the organization via the Secure Portal. The Security Administrator may also assign a Basic User. This will allow the users to view and submit data via the Secure Portal.

ASCs are encouraged to have more than one SA. The facility should maintain at least one active SA continuously. To remain active, the SA must sign in to QualityNet at least once every 60 days. The SA will get an automated email and a reminder to log in. Please do not ignore these emails.

Each facility with a unique NPI must have an SA, but an SA can be approved for multiple facilities. An SA or basic user requesting access to the QualityNet Secure Portal must be individually approved and verified. This is a mandatory registration process and is required to maintain the confidentiality and security of healthcare information and data transmitted via the portal.

On the next slide, I will show you where to go to download the Security Administrator packet. You will download the SA packet from the link on this slide. You will mail the packet into the address on this slide following the instructions in the packet. Once your completed registration materials have been received by the support contractor, they will process your registration information and forward the materials on to QualityNet.

You will be notified by email when the registration process is complete. You will receive two emails. The first one will contain your user ID, and the second one will contain your temporary password.

Let's discuss the reconsideration process. In order to receive the annual payment update of 2 percent each year, ASCs must meet all the data reporting requirements which we have discussed throughout this whole presentation. Once it has been determined by CMS that an ASC has not met the program requirements for the APU, the facility will be notified in writing.

Once written notification has been received, CMS posts a list of the ASCs on the QualityNet website. If you feel your facility has met the program requirements, you then can file a request for reconsideration. The APU reconsideration request must be received by the support contractor by March 17 of the affected payment year. An email will be sent by the support contractor acknowledging receipt of the request.

In the 2016 Proposed Rule, it has been proposed that the submission date for the reconsideration form must be received no later than the first business day on or after March 17 of the affected payment year. The Final Rule will provide this decision. The request must identify the ASC's specific reason for believing it did meet the annual payment update requirements and why they should receive the full APU.

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CMS will officially respond to the reconsideration request submitted by each ASC. CMS will complete the reconsideration review and communicate the results within 90 days following the deadline for submitting requests for reconsideration.

All reconsideration decisions by CMS are final. The reconsideration process and forms are available on the QualityNet website. To obtain these forms, go to the Ambulatory Surgical Center Program Reconsideration Overview and click on **APU Reconsideration**.

Let's discuss the withdrawal process from the ASCQR reporting program. At this point, we are going to turn things over to our host for a polling question.

Matt McDonough: Thanks Tamara. This is our second and final polling question of our presentation today. And this one is going to refer back to slides 29 through 33. It is a simple, yes or no question. Were you aware that reports existed to help you measure your facility's data submission progress? It's a yes or no question. So, it should be fairly easy to answer.

It is – looks to be about 3 to 1 that you were aware that these reports existed, which is great.

For those of you who were not aware, please do refer back to slides 29 through 33 where they are outlined. And also there are some tutorials that have been created there out on the website as well. That can assist you with accessing and utilizing these reports.

That's going to do it for our second and final polling question. So, without further ado, I'll hand it back to Tamara to finish up today's presentation.

Tamara Heron: Now, we're going to talk about withdrawing from the program. The ASC must formally withdraw from the program by going to QualityNet's website and completing the withdrawal of participation form. Upon withdrawal from the ASCQR program, the ASC will incur a 2 percent point reduction in its annual payment update for that payment determination year and any subsequent payment determination years in which it has withdrawn.

Once the form is completed, it needs to be mailed. The address is seen here on the slide. It may also be faxed. If a facility decides to participate in the ASC program again, they would just need to resubmit a G-code or QDC on a Medicare claim form.

All right, let's wrap all this up. If an ASC shares the same NPI with other ASCs, then all facilities must report as one. Payment determinations will be made and applied by the facility's NPI number which will include all facilities billed under this NPI.

ASCs that have fewer than 240 Medicare claims per year, that includes primary and Medicare secondary payers during a reporting period for that payment determination year, would not be required to participate in the ASCQR program for the next reporting period for that payment determination year.

This includes all program requirements, both claims-based and web-based measures. Please note if your facility submits 241 or more Medicare claims in 2014, then you are subject to all ASCQR Program requirements for the payment year in 2016.

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If an ASC is newly designated as open four months prior to January 1 of the reporting year, then they are required to report, provided they have greater than 240 claims. The date of the Medicare acceptance is what is designated as being open; this is when a facility can bill Medicare for payment.

We're going to talk about a few resources. The support contractor for this program has a website, and the website address is [www.qualityreportingcenter.com](http://www.qualityreportingcenter.com). There is so much information on this website; I encourage you to take the time to look at this website and see what's available to you.

QualityNet is also a great wealth of information, and if you need additional information, please call our call center at 866.800.8756, we'll be glad to assist you in any way.

I think that is going to do it for our presentation, Karen I will now hand it over to you.

Karen

VanBourgondien: Thank you, Tamara. Thank you for all that great information. I think probably what we should do is go ahead and share some of the questions that have come in on the chat box. Some of the questions that people are asking-- I have a question here.

The question is, "Our facility only has about a hundred Medicare claims per year, are we required to participate in the ASCQR program?"

Tamara Heron: That's a great question. No, your facility is not required to participate in the ASCQR program as long as your yearly Medicare claim count is fewer than 240 and you can find this information on multiple resources found on both our QualityNet website as well as [qualityreportingcenter.com](http://qualityreportingcenter.com).

Karen

VanBourgondien: Here's another question Tamara. Our facility began seeing patients in December 2014, are we required to participate in the ASCQR program?

Tamara Heron: No, the program requirement applies to all ASCs that were operating for at least four months prior to January 1 of the reporting year. So this will be January 1 of 2015. Upon successful submission of any quality measure data, the ASC will be deemed as participating in the program for the upcoming payment determination year.

Looks like we have another question. "When we report our data, are we to use the physician's NPI or the facility's NPI?"

Karen

VanBourgondien: Great question. I know we did talk about that. It is very important when submitting data, to use the facility NPI, not the physician's NPI. If a physician NPI is used the G-codes will be dropped and will not be submitted to the ASC program.

We discussed this on slide --I believe it was 19. So, by all means you can refer back to that if you need to. Tamara, I do have another question here. "As I review the information regarding the web-based measures since ASC-11 is voluntary and if we decide not to report that measure, we'll be -- will we be subject to payment reduction?"

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Tamara Heron: All right, I believe on slide 29, I stated that ASC-11 is a voluntary measure and if – and if the facility decides not to report this measure, there would be no impact to your annual payment update. But if you do report this measure, please be known that it is subject to public reporting.

All right Karen, looks like we have another question in here, and this is a good one. “Our facility only does eye procedures, so do we still need to answer the web-based measures 9 and 10?”

Karen

VanBourgondien: Yes, you will still need to answer these measures, even if your facility does not perform these procedures. You will just need to enter zeroes. If you leave it blank, the system interprets that as though you're not completing. So if you do not do these procedures, you just go in under that measure in the portal and you enter zero for that measure.

Tamara, here I see – here's a question, “When I go on to QualityNet to download the Specifications Manual, which version do I use?”

Tamara Heron: Great question. Please download the Specifications Manual version 4.0a. This version covers the current encounter period. Moving forward, you would refer to the other versions. Please keep this handy as it will offer much more detailed information regarding the required measures.

Here's another question, “Is having a Security Administrator a requirement of the program?”

No, having a Security Administrator is not a requirement of the program but in order to submit the web-based measures via the Secure Portal, a Security Administrator is needed.

Here's another question, “Can we have more than one Security Administrator at our facility?”

Karen

VanBourgondien: It's a great question. Absolutely. In fact we encourage facilities to have at least two active Security Administrators on staff. And again to remain active, the SA must sign in to QualityNet routinely. We do recommend signing in at least every 60 days.

Here's another question Tamara. “I would like to receive updates, alerts, and notifications about the program. How do I go about doing that?” I'll go ahead and answer that, if that's OK?

If you remember, we did mention this – the term ListServe. To receive timely information related to the program, we really encourage everybody to register for ListServes. That notification is our primary way to communicate with you, everything going on, updates, deadlines, submission information, all of that.

You can sign up for ListServes from the homepage of QualityNet. You would just go to the third box down on the left on the QualityNet homepage and you would click on the –

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I believe it says the ListServe and notifications. You just click on that and it will take you right to the link to register you for that. It takes less than five minutes.

I think we have time for maybe one more question Tamara. The question is, "Can you go into a little more detail about what the Provider Participation Report is?"

Tamara Heron:

OK, the Provider Participation Report is one of the resources that are provided to the ASCs to view their measures. Remember this was on slide 22. This report gives the total number of claims that contains at least one QDC. It will also contain the total number of claims submitted to Medicare for payment.

This report also shows the data completeness percentage. The data completeness percentage is the total number of claims that contained at least one QDC, divided by the total number of claims.

It also lists your compliance rate, and as you are aware, you must achieve at least a 50 percent threshold to meet the program requirements. You will also see ASC-1-5, the numerator, denominator and the measure value.

This report will also give the submission status of the web-based measures ASC -6, -7, -9 and -10. ASC -8 will not appear until after the submission period deadline of September 30, 2015.

Karen

VanBourgondien:

Tamara, I think that's all the time we have today. Again we want to thank you for all the information that you have given us today. And we're going to go over the continuing education information.

Today's webinar has been approved for one continuing education credit by the boards listed here on this slide. We are now a nationally accredited nursing provider and as such all nurses report their own credits to the boards, using our national provider number. That number is 16578.

Please be aware that CEU's are only available per educational webinar for one week after the webinar.

We have an online CE certificate process. You can receive your CE in two ways. One, if you are registered for this webinar through ReadyTalk, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate.

We will also be sending out a survey link in an email to all participants within the next 48 hours. If there are others listening to this event that are not registered in ReadyTalk, be sure to pass that survey on to them.

This is what the survey will look like. It will pop up at the end of the event, and will be sent to all attendees within 48 hours. Click **Done** at the bottom of this page when you are done with that survey.

# Ambulatory Surgical Center Quality Reporting Program

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## Support Contractor

This is what pops up after you click **Done** on that survey. If you have already attended our webinars and received CEs, click **Existing User**. If this is your first webinar for credit, click **New User**.

This is what the new user screen looks like. Please register a personal email like Yahoo or Gmail since those accounts are typically not blocked by hospital firewalls. Please remember your password because you will use them for all of our events.

This is what the existing user screen looks like. Use your complete email address as your user ID and the password you registered. Again, please register a personal email like yahoo or Gmail since these accounts are typically not blocked by your hospital firewall. Remember your password. You will then be directed to a link that will allow you to print your CE certificate.

That concludes our program for today. We hope you've heard useful information that will help you in the success of reporting for the ASCQR program. Thanks again for joining us and enjoy your day.

Matt McDonough:

And to all of our attendees today, thank you so much for your time on today's call. That does conclude the audio portion of today's event. However, we will – we will leave the chat window open for another few minutes so that you can continue to submit your chat questions and any outstanding questions can be answered.

Again, thank you for your time and we hope you have a wonderful day.

This material was prepared by the Outpatient Quality Reporting Outreach and Education Support Contractor under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). XXXXXXXXXXXXXXXXXXXX