Ambulatory Surgical Center Quality Reporting Program

Support Contractor

ASCQR 2016 Specifications Manual Update

Presentation

Moderator:
Mary Ellen Wiegand, RN, LHRM, CASC, CNOR

Speakers:
Nina Rose, MA
Bob Dickerson, MSHSA
Angela Merrill, PhD

January 27, 2016
2:00 p.m.

Mary Ellen Wiegand: Hello, and welcome to the ASCQR Program webinar. Thank you for joining us today. My name is Mary Ellen Wiegand, and I am a project coordinator for the ASCQR Program.

If you have not yet downloaded today's handouts, you can get them from our Website at qualityreportingcenter.com. Go to the **Upcoming Events** banner on the right side of the page, click on today's event, and go down to the **Event Resources** tab at the bottom of the page. There will be a link that will allow you to access and print the handouts for today's webinar. As you can see, we are live streaming in lieu of using only phone lines. However, phone lines are available if needed.

Before we begin today's program, I would like to highlight some important announcements. January 1st began the submission period for the web-based measures that are submitted through QualityNet. The deadline for the web-based measures submitted through QualityNet is August 15th. ASC-8, you will recall, is entered into the NHSN website separately, and the submission deadline for that measure is May 15th.

Support Contractor

As a reminder, please keep your QualityNet and NHSN passwords active. Log in to your accounts routinely to keep your account current. You don't want to find yourself in a position where you are ready to enter data but you can't because your password is locked. For any password problem, please contact QualityNet directly. For any password issues with NHSN, please use the contact email you see here on this slide: nhsn@cdc.gov.

On February 24th, we will be presenting a webinar on tools and resources that will assist you in success in reporting for this program. On March 23rd, the presentation will discuss the two-year data analysis for this program. Additional webinars and educational opportunities will be forthcoming. Notifications will be sent via ListServe by the support contractor. ListServe notification is our primary mode of communication with regard to this program.

This program is being recorded. A transcript of today's presentation, including the questions and answers received in the chat box and the audio portion of today's program, will be posted at www.qualityreportingcenter.com at a later date. During the presentation, as stated earlier, if you have a question, please put that question into 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 that are entered during the presentation will be shared at the end of the presentation.

We are fortunate today to have the involvement of many speakers from various contractors. The contractors are an integral part of this program and are the subject matter experts for the measures themselves. For simplicity's sake, I would like to introduce all the speakers now. They will each present different areas of topics as we proceed through the presentation.

Support Contractor

Our first speaker is Nina Rose with HSAG. Miss Rose received her bachelor of science in family and consumer sciences from Ohio University and her master's degree in gerontology from the University of South Florida. She joined the HSAG team several years ago and has assisted in the development of educational materials for both the Outpatient Quality Reporting Program as well as the Ambulatory Surgical Center Quality Reporting Program. Nina is a project coordinator for both of these programs and the Specifications Manual production lead.

Our second speaker is Bob Dickerson with Telligen. Bob Dickerson is a lead health informatics solution contractor for the measures development and maintenance team at Telligen. He is a registered respiratory therapist with a master's of science degree in health service administration from the University of St. Francis in Joliet, Illinois. Most recently he has been supporting the Centers for Medicare & Medicaid Services, CMS, with the development and maintenance of hospital clinical quality measures. Bob has extensive experience with healthcare process and quality improvement, and in supporting the transition to physician order entry in electronic health records. This includes the development and implementation of intervention processes and systems in the hospital setting that support national quality measures and outcome measurement that demonstrate improved processes of care and patient care outcomes.

Our third speaker is Dr. Angela Merrill with the Yale Center for Outcomes Research and Evaluation. Dr. Merrill holds a PhD in health services and policy analysis with concentration on health economics from the University of California, Berkeley. Dr. Merrill has over 20 years of experience in health policy research and is a senior researcher at Mathematica Policy Research. Her experience includes developing, implementing, and evaluating quality measures, and using these measures to monitor trends and quality of care. Dr. Merrill has worked for over 10 years implementing claims-based risk-adjusted outcome measures related

to mortality, re-admissions and admissions, and patient safety and complications for the Medicare program to support a variety of CMS pay-for-reporting and pay-for-performance programs.

Now let me turn the presentation over to our first speaker, Nina Rose.

Nina Rose: Thank you, Mary Ellen. My name is Nina, and I'm the Specifications Manual production lead for the support contractor. Over the next few slides, I will be summarizing the updates to the measures ASC-1 through ASC-5. These five measures are claims-based measures that require ambulatory surgical centers to report quality data codes on their Medicare claims. Changes to these measures were made to align with the measure steward specifications.

The first update we want to bring to your attention applies to all five claims- based measures ASC-1 through 5. The definition for admission in version 5.0a of the ASCQR Specifications Manual was changed from “the completion of registration after physical entry into the facility” to “the completion of registration upon entry into the facility.”

In addition to the definition for admission, revisions for ASC-1, Patient Burn, apply to the Selection Basis, Clinical Recommendation Statements, and the Selected References sections of the measure information form, or MIF. As you can see here on the slide, the fourth paragraph of the Selection Basis has been updated. Please feel free to read over the slide and/or the Release Notes to see all of the changes.

Continuing on with ASC-1, the hyperlink for the Clinical Recommendation Statement section has been made current. This link refers providers to the American Society of Anesthesiologists’ standard guidelines and practice parameters webpage. In fact, the Selected References were updated for all five measures ASC-1 through 5. Please

note that you can see the highlighted changes in the Specifications Manual.

For ASC-2, Patient Fall, the Selection Basis, the Clinical Recommendation Statement, and the Selected References were all updated. The sentence here on this slide has been added after the first sentence of the Selection Basis section. The Clinical Recommendation Statement language has been revised. The description on the actual approach, however, did not change. As with ASC-1, the Selected References section was updated, and the changes are highlighted in the manual.

For ASC-3, Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, and Wrong Implant, the description was updated in the MIF where the ending words “in the ASC” were removed. The new description can be read here on the slide. And, as we discussed in the earlier slides, the Selected References were also updated.

The next three slides discuss updates to the ASC-4, all-cause hospital transfer/admission measure. The first change we want to bring to your attention is the measure title, which was updated from “Hospital Transfer/Admission” to “All-Cause Hospital Transfer/Admission” to align with the measure steward’s specifications. Please note that this change was made in version 5.0 of the Specifications Manual, and all of the other revisions were made between version 5.0 and version 5.0a of the Specifications Manual.

The next change we're going to discuss is specifically for the description. Please note that the description no longer states the number of admissions but rather the percentage of admissions, as you can see here on the slide.

The next update applies to the definition for “hospital transfer/admission.” The words “after the patient has been admitted in the ASC” were removed. You can read the new definition here on the slide.

There was also a small change to the language of the Clinical Recommendation Statement in which the word "specifically" was removed. Again, as we mentioned earlier, the Selected References were updated, and these revisions are highlighted in the manual.

And finally, for ASC-5, the prophylactic intravenous antibiotic timing measure, the two updates include the definition of “admission” and the Selected References, both of which we have covered earlier.

Now I'm going to pass it over to Bob Dickerson to go over the next couple of measures.

Bob Dickerson: Thank you, Nina. As was mentioned in the introduction, I am a lead health informatics solutions coordinator with Telligen. No changes were made in manual versions 5.0 or 5.0a for ASC-6, use of a safe surgery checklist.

For ASC-7, ASC Facility Volume Data on Selected ASC Surgical Procedures, there have been and are plans for some changes related to Table 2. Table 2 contains the categories and procedure codes for outpatient surgical procedures for which volumes are to be reported for this measure. In version 4.1, Table 2 is updated to reflect the most commonly performed ASC surgical procedures and corresponding codes in calendar year 2015.

In version 5.0a of the manual, Table 2 was replaced with a statement to please refer to Specifications Manual version 5.1 for updated categories and procedure codes for ASC surgical procedures. And in upcoming version 5.1, Table 2 will be re-inserted with the most commonly

performed ASC surgical procedures and the corresponding codes from calendar year 2016.

No changes were made to ASC-8, Influenza Vaccination Coverage among Healthcare Personnel. But just a couple of reminders -- that data for this measure is entered via the CDC's National Healthcare Safety Network website using your facility CCN and entered via the Secure Access Management System secure portal. The deadline for submission of this data is May 15th of 2016.

As you are entering your data for ASC-8, please be aware of some challenges that have been identified that may interfere with getting your data entered and submitted accurately. Be sure you are entering your ASC's CMS Certification Number, or CCN, and not using a tax ID number or other number. Be sure you select the correct reporting season. And this site is used by facilities other than ASCs for reporting, so please be sure to select "ASC" and not "Outpatient."

This slide contains some additional resources such as the NHSN Help Desk link, the SAMS technical support link, NHSN training, and a link to the CMS Specifications Manual which includes the measure information.

For ASC-9, appropriate follow-up interval for normal colonoscopy in the average age patient, an age cap was applied to the denominator population criteria for version 5.0a. This entails changing the measure description and denominator statement from 50 years and older to 50 to 75 years of age, and adding to the denominator criteria immediately after "greater than or equal to 50" a "less than or equal to 75." This change is to better synchronize the ASC-9 measure with the U.S. Preventative Services Task Force age-based recommendation regarding follow-up colonoscopy. This will result in patients older than 75 years being removed from the initial patient population instead of them being removed during medical record

abstraction, based upon physician documentation of the age being the reason for not recommending an interval of at least 10 years.

In addition to better synchronizing the measure with the guideline, this change will simplify abstraction because cases for patients that are older than 75 will no longer need to be abstracted. Now, you may recall this was initially a change in version 4.1 of the manual but was rather quickly changed back. The short story behind this is there are three versions of this measure: one for the ASCQR program, ASC-9 that we're talking about now; there's one for the Hospital Outpatient Program; and one for the Physician Quality Reporting System Program. The PQRS measure is on a different update release schedule, which was not fully realized until version 4.1 was released. While the measure steward supported the change, they wanted the timing of this change to occur at the same time for all three versions of the manual. So we had to pull back the change in version 4.1 and then put it back in for version 5.0a.

Additional changes to ASC-9 are the addition of some examples for the denominator exclusion section that are intended to better illustrate what constitutes exclusion based on a medical reason. But we continue to receive questions regarding whether or not a follow-up interval being expressed with a range that is less than 10 years and inclusive of 10 years was acceptable. It is not, and we've added a statement about this to the additional instruction section.

For ASC-10, colonoscopy interval for patients with a history of polyps, three CPT codes, 44393, 45355, and 45383 have been inactivated and removed from the denominator criteria. Now for those folks that are familiar with CPT codes, there are replacement codes. However, the measure stewards have indicated to not add the replacement codes at this time.

Also, for ASC-10 the word “polyps” has been added behind “adenomas” in the denominator exclusion section so that this is consistent with the measure name and definition which tend to use these terms somewhat interchangeably.

ASC-10, the documentation for a system reason for an interval of less than three years since the last colonoscopy, continues to generate a number of questions. While the exclusion statement implies there must be an interval of less than three years to use a system reason, it is not explicitly clear. The purpose of the system reason exclusion is to allow for exclusion of cases with an interval of less than three years and a medical reason cannot be found. To help provide clarity regarding the system reason, we have added some specifics of what must be present to constitute a system reason.

First off, there needs to be documentation requesting it has been less than three years since the last colonoscopy. In most cases there is a medical reason documented by the interval of less than three years. The system reason is available for situations where it is known the interval is less than three years but there's no medical reason documented. So the second requirement for a system reason is that a medical reason is not documented. And the last requirement is there is documentation present reflecting the previous colonoscopy report was either not available or could not be located.

Now at this point, I'm going to turn the presentation over to Angela Merrill for a review of changes to ASC-11 and ASC-12.

Angela Merrill: Thanks, Bob. This is Angela Merrill. I am a senior researcher at Mathematica Policy Research. We are now going to discuss manual revisions to ASC-11, Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery. The two changes that we made reflect the alignment of the measure specifications across the

Outpatient Quality Reporting, OQR, and the ASCQR manuals, as well as alignment with the measure steward specifications. The first update was to the Data Collection Approach section where we added the following statements: "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."

We will now discuss the one claims-based risk-adjusted outcome measure ASC-12. The next five slides describe manual changes for ASC-12, Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. Please note that ASC-12 is a claims-based measure. Facilities do not need to submit data for this measure other than normal billing data. However, this measure is not voluntary. CMS will automatically calculate it for facilities that submit claims for eligible colonoscopies.

The first change to the Specifications Manual was to expand to the full measure title as listed on the slide. In addition, several minor edits were made throughout the Specifications Manual for clarity and will not be reviewed here. The substantive edits on the next four slides reflect changes to update cohort codes and exclusion criteria made prior to and following the July 2015 national dry run for the measure.

We note that the measure is still undergoing reevaluation based on facility feedback from the July 2015 dry run. Additional updates may be made to the measure in the upcoming year and manual amendments would be issued.

The first change reflects that that CPT–HCPCS codes used to define the patient cohort have been revised to reflect two new codes introduced in 2015. The two new codes are 45388 and G6024, as defined on the slide. We note that CPT 45388 replaced CPT 45383 in the cohort. However

(HCPCS) G6024 will be used in 2015 CMS billing, and 45388 will be used in 2016 going forward.

This slide describes the refinement made to a measure exclusion prior to the 2015 dry run. The exclusion, colonoscopies for patients who lack continuous enrollment in Medicare Fee for Service Parts A and B in the month after the procedure, was changed to colonoscopies for patients who lack continuous enrollment in Medicare Fee for Service Parts A and B in the seven days after the procedure. The older exclusion required 30 days of Medicare Fee for Service Parts A and B enrollment, but it was refined to only seven days since the outcome period is seven days for the measure.

This slide describes exclusions that were refined after the 2015 national dry run to exclude patients receiving a diagnosis of inflammatory bowel disease, IBD, or diverticulitis at the time of the index colonoscopy procedure. Specifically, the exclusions were expanded with the underlying text on the slide, so, for example, colonoscopies for patients with a history of inflammatory bowel disease or a diagnosis of IBD at the time of index colonoscopy and colonoscopies for patients with a history of diverticulitis or a diagnosis of diverticulitis at the time of index colonoscopy. These exclusions were refined because admissions for acutely ill IBD or diverticulitis patients who were evaluated with an outpatient colonoscopy and are subsequently admitted for medical treatment of an IBD flair or diverticulitis do not reflect the quality of the colonoscopy. The manual was also updated to add a crosswalk table to the ICD-10 codes for these conditions.

Finally, slide 39 reflects three new exclusions. The first new exclusion, colonoscopies that occur on the same outpatient claim as an emergency department visit, was added to the measure prior to the 2015 dry run. It was added because the sequence of events in these cases is not clear. It is not possible to use claims data to determine whether the colonoscopy was

the cause of, subsequent to, or during the ED visits. We note that this exclusion applies to OPD facilities only, not to ASCs.

The second new exclusion, colonoscopies that occur on the same outpatient claim as an observation stay, was added to the measure after the dry run, based on feedback from facilities. Similar to the first exclusion, the sequence of events in these cases is not clear, and it is not possible to determine whether the colonoscopy was the cause of the observation stay or if the patient was placed into observation to complete the prep for the procedure or due to an acute event such as (GI) bleeds for which the colonoscopy was performed. This exclusion also applies only to OPD facilities, not to ASCs.

The third exclusion, colonoscopies followed by a subsequent outpatient colonoscopy procedure within seven days, was added prior to the 2015 dry run. For cases in which a colonoscopy is followed by another colonoscopy within seven days, the measure will use the subsequent colonoscopy as the index day. The two colonoscopies are considered part of a single episode of care for which the subsequent colonoscopy is considered the index procedure.

This concludes the manual changes for the ASC-12 measure. I will now pass the presentation over to Nina Rose to wrap up.

Nina Rose: Thank you so much, Angela. Well, before we move on to some of your questions, let me first remind you of a few things as it relates to the Specifications Manual. Please always check the updated Release Notes and make sure you are signed up for the ListServe through QualityNet. This is the easiest way to stay informed of everything going on with the ASC Quality Reporting Program.

The Specifications Manual is a vital tool in the success of this program. You can find the Specifications Manual on the QualityNet website. You

can access the various versions of the Specs Manual and Release Notes, and you can also download the individual documents as well.

So that's going to do it for the Specifications Manual update. I would like to thank all the contractors and speakers today for their valuable information. We appreciate all the subject matter experts and their input.

All right, I think it's time for questions-and-answers, so let's see what we have.

The first question I am seeing -- it's for an ASC-9 question. So, Bob this is a good one for you. "If there is documentation of a medical reason for a repeat colonoscopy in less than 10 years, such as diverticulitis or history of colon cancer that is not specifically stated as a reason for the repeat colonoscopy in less than 10 years, can it be used as documentation of a medical reason?"

Bob Dickerson: Thank you, Nina. That's a great question. So the reason for a follow-up in less than 10 years does not need to be explicitly stated in the same statement as the actual follow-up interval. If there is documentation for a medical reason, like the example from the question in the patient's history, and the follow-up interval documented in the colonoscopy report is less than 10 years, you can take it as documentation of a medical reason for not recommending at least the ten-year follow-up interval.

Nina Rose: Thank you, Bob. I'm seeing – here's a good one. Here's another question, and this one's specifically for ASC-12. Angela this is for you. "There are a lot of issues identified with the dry run data. Have those issues been resolved?"

Angela Merrill: Thanks, Nina. The ASC-12 measure is currently undergoing annual reevaluation during which CMS is evaluating all of the issues noted by facilities during this July 2015 dry run. Please see the QualityNet website

for the most recent Specifications Manual, version 5.0. This update does reflect some measure refinements, as I've discussed earlier, to address the dry run feedback. However, we also note that these specifications may be further revised in 2016.

Nina Rose: Thank you, Angela. Here's another question. "Our facility only has about 100 Medicare claims per year. Are we required to participate in the ASC Quality Reporting Program?" I'll take that one, guys.

Actually, no, your facility is not required to participate in the ASCQR Program as long as your yearly Medicare claim count is fewer than 240. You can find more information on this in multiple resources on the QualityNet website as well as qualityreportingcenter.com.

Let's see, another question. This one's ASC-10, Bob. "The ASC-10 measure information form states that history of colonic polyps is not an acceptable reason to exclude cases from the denominator. If there is documentation indicating a large polyp was removed one year ago in a follow-up or multiple polyps were removed during the last colonoscopy a year ago, how do we abstract these cases?"

Bob Dickerson: Thanks, Nina. This is another great question. You are correct; a history of colonic polyps cannot be used to exclude a case for medical reasons because that is one of the denominator inclusion criteria. So the thing to look for is the specificity within the documentation. Now in this example, the physician is specifically referencing a large polyp found in the last colonoscopy one year ago or multiple polyps removed in the last colonoscopy a year ago. They're not referencing a general history of colon polyps, so these cases are very similar to the example of the medical reasons found in the ASC-10 measure information form. In that example is: "last colonoscopy found greater than 10 adenomatous polyps." So, if you know the last colonoscopy was less than three years ago and you have some documentation similar to what's in this question in the medical

record, it can be used as a medical reason for an interval of less than three years.

Nina Rose: Thanks, Bob. I'm seeing a really good question about the ASC-11 voluntary measure, so I think, Angela, this will be a good question for you. "In version 5.0a the new guideline states, "Include procedures from the beginning of the reporting year through 90 days prior to the end of the reporting period. This will allow for the postoperative period to occur." Is the expectation that only procedures performed January 1st 2015 through October 2nd 2015, or 90 days before the end of calendar year 2015, will qualify for the voluntary ASC-11 measure?"

Angela Merrill: Yes, that is correct. We clarified the state of collection approach in the measure specifications in version 5.0. The measure identifies patients 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery. Therefore, for the denominator population, facilities should include procedures performed from the beginning of the reporting year through 90 days prior to the end of the reporting period.

For the numerator, since facilities will need to assess improvement in visual function achieved within 90 days following cataract surgery, this data collection approach allows for that postoperative 90-day period to occur. The numerator thus covers the entire reporting year.

Nina Rose: Thanks, Angela. I have another question here that I think I'll take. "What are some ways to make sure that my ASC is on track with submitting the required amount of quality data codes on our claims?"

Okay, well, one way is to definitely read your Claims Detail Report, and you can find that report on the secure side of the QualityNet Portal, and this is updated on a monthly basis. You can run this report yourself on the QualityNet site. This report will allow your facility to view and check on

the volume of QDCs that have been submitted by your facility. And then another report you can run is your Provider Participation Report. Now this report will give you a summary of your data submission required for a specific payment year and your facility's performance.

All right. I'm seeing another ASC-9 question, Bob. "With the change to ASC-9, if the patient is not 75 but will be older than 75 in 10 years, does the physician need to document age and the reason for not recommending a follow-up colonoscopy?"

Bob Dickerson: And the answer to that one is, yes, they do. The change only excludes cases that are older than 75 years on the date of the encounter from the measure population. So if the patient is 75 or less on the date of the colonoscopy and they will be older than 75 in 10 years, the physician will need to include in the colonoscopy report for the current encounter that age is the reason they are not recommending a follow-up colonoscopy

Nina Rose: Thank you, Bob. All right, here's another question. "For ASC-12, what are the codes that must be billed for this measure, and when does the facility need to start billing these codes?" Angela, would you like to take that one?

Angela Merrill: Sure. The ASC-12 measure is calculated from routine billing claims data from ASCs in hospitals. Facilities do not need to report any specific codes, such as QDC codes used for the other ASC measures, on their claims for this measure. For the calendar year 2018 payment determination, the performance period is anticipated to be based on calendar year 2016 claims data.

And for more information on the measure and the specific codes that are used to identify the cohort, please refer to the most specific Specifications Manual on QualityNet version 5.0, or you can look at detailed methodology reports on the pages for the dry run for this measure. These

are located at qualitynet.org. Follow the **Hospitals-Outpatient** drop-down menu, choose **Measures,** and then choose **Colonoscopy Measure Dry Run**.

Nina Rose: Thank you, Angela. I'm actually seeing another one for you, Angela. "What pre-operative surveys are required to be present in a patient's medical record? What about the case where surveys can be mailed out or patients called for telephone surveys? How do we account for that?"

Angela Merrill: I'll refer to the Additional Instructions section of the measure information form to answer this question. This measure utilizes a visual function survey. Though it is recommended for the facility to obtain survey results from the appropriate physician or optometrist, the surveys can also be administered by the facility via phone, mail, email, or during clinician follow-up. Please remember that for this measure, the same data collection instrument, a survey, must be used both pre-operatively and post-operatively.

Nina Rose: Thank you. I have another ASC-10 question. "If there is not documentation of when the last colonoscopy was, but there is documentation that can count as a medical reason, can we indicate there is a medical reason for an interval of less than three years?" Bob, do you want to take that?

Bob Dickerson: Sure. Thanks, Nina. And in that case, no, you cannot count that as a medical reason. The ASC-10 denominator exclusion specifically states it is for documentation of a medical reason for an interval of less than three years since the last colonoscopy. This reflects the last colonoscopy must have been less than three years ago to consider that documentation a medical reason. If there is no documentation allowing you to determine whether or not the last colonoscopy was less than three years ago, you cannot really say that there is documentation for a medical reason for it being less than three years ago.

Nina Rose: Thank you, Bob. Here's a good question. "Is there a way to see what patient had outcomes if they were not at our facility for ASC-12?" Angela, do you want to take that one?

Angela Merrill: Sure, I can take that, Nina. Yes, Table 3 of the Facility-Specific Report distributed during the dry run in July 2015 provided information on the type of outcomes for each case. And this included the provider ID of the hospital where the inpatient stay, observation stay, or emergency department visit took place. You can see the dry run pages on QualityNet for an example of this table and more information on its data elements. You can find this at qualitynet.org. Follow the drop-down for **ASC**, **Measures**, and then **Colonoscopy Measure Dry Run**. CMS has not yet determined reporting plans for the calendar year 2018 measure implementation, but it will likely provide facilities with a similar table that will include calendar year 2016 data results.

Nina Rose: Thank you, Angela. It was great. Here is a good question about ASC-5, so I'm going to take that one. "We are a GI-facility that almost never has an antibiotic ordered for prophylactic. Does this count against us when we use G8918?"

When using the code G8918, patient without pre-operative order for antibiotics, this does not count against your facility. This code is recorded for patients with no indication for or no order for IV antibiotic prophylaxis for surgical site infection. This does not place a case with this code in the denominator, but it's necessary for calculating the completeness of reporting. Either way, ASC-5 must be answered for complete data submission.

All right, guys, I think we have time for one more question, and I'm seeing it for the ASC-11 measure. So Angela, this will be for you, okay? "Can certain patients be excluded from the denominator population due to a

comorbid ocular condition? If comorbidities, exist there may not be improvement for all of the visual activities."

Angela Merrill: Sure, I can take that. The measure population includes both groups of patients, both with and without ocular comorbidities. An improvement in visual function after cataract surgery would be expected in both groups. However, we recognize the magnitude of the difference would vary by group. Please note how the numerator for the measure as defined. It is patients who had improvement in visual functions achieved within 90 days following the surgery, based on completing both the preoperative and postoperative visual function instrument. But the numerator does not track to the degree of improvement and the functional status.

Nina Rose: Thank you so much, Angela. Well, that's all the time we have for today. Once again, I'd really want to thank all of the contractors that support the measures for this program, and those contractors today were Telligen, Mathematica Policy Research, and the Yale Center for Outcomes Research and Evaluation.

END