Ambulatory Surgical Center Quality Reporting Program

Support Contractor

The Abstraction Challenge Show: Real Questions, Real Answers

Questions & Answers

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Question: As a Podiatric Ambulatory Surgical Centers (ASC) whose procedures are only done by podiatrists, these measures (ASC-17 and ASC-18) do not apply to us, correct?

Answer: That is correct. The target populations for these measures are Medicare Fee-For-Service (FFS) patients aged 65 years and older undergoing urology procedures typically performed by urologists or orthopedic procedures typically performed by orthopedists. ASCs performing these procedures are therefore evaluated by these measures.

Question: How do we get a Facility-Specific Report (FSR)?

Answer: At the start of the dry run, FSRs will be sent to the active Security Administrator (SA) via the QualityNet Secure Portal. Corporate-owned ASCs that have assigned their corporation as their vendor, and do not have a QualityNet SA, will be sent to the individual registered under that corporation's Vendor Identification (ID) number.

Question: If our specialty is not orthopedic or urology, are we required to report zero or nothing at all?

Answer: ASCs do not need to submit any additional data for the measure dry run because CMS uses paid FFS claims that are routinely provided to the agency. During the dry run results will not be publicly reported but sent confidentially to facilities.

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Question: For the Orthopedic and Urology Measures, is there any data abstraction that needs to be performed by the ASC?

Answer: No, ASCs do not need to submit any additional data for the measure dry run because CMS uses paid FFS claims that are routinely provided to the agency.

Question: What is considered as neuraxial anesthesia?

Answer: The ASC-13 measure specification defines neuraxial anesthesia as epidural or spinal anesthesia.

Question: If I understand this correctly, the measure is calculated on procedures that have already been performed; therefore, a retrospective look for the dry run?

Answer: Yes, this will be calculated for procedures that occurred between October 1, 2015 and September 30, 2017.

Question: It was stated that a patient will be included if they have Medicare A and B for the 12 months prior. Does that mean that the 12-month timeframe starts when the patient becomes enrolled in both A and B at the same time?

Answer: The measure includes patients who have been enrolled for at least 12 months prior to their index procedure. For example, if a procedure occurred on May 1, 2016, then the patient would need to have been enrolled in Medicare Part A and B since May 1, 2015, to be included in the measure.

Question: Earlier there was a question regarding ASC doing the dry run. So, if we don't have data, does CMS gather the information on their end, however, do we need to begin next year?

Answer: No, ASCs will not need to abstract data in the future for this measure. This measure will use paid fee-for-service (FFS) claims data. As a claims-based measure, there is no manual abstraction required for the ASC.

Question: Which ASC categories are done by FFS data versus actual data gathered by the facility?

Answer: For Payment Year 2020, ASC-12 is an outcome measure calculated using FFS claims. The ASC-1 through ASC-4 measures are calculated using FFS; however, this data is gathered by facilities through the applicable G-code or G-codes placed on the claim form. The ASC will manually collect and report data for ASC-8, ASC-9, and ASC-10. ASC-11 remains a voluntary measure.

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Question: In 13 years, I have never seen an anterior vitrectomy performed as a separate visit. It is not terribly unusual to have an anterior vitrectomy performed due to bag rupture during the cataract surgery. Do we submit only those who come in for a separate procedure?

Answer: No, this measure includes an anterior vitrectomy that was not scheduled at the time of the patient's admission to the ASC. The vitrectomy would have to be performed during the cataract surgery encounter and would not include a vitrectomy done outside of the cataract surgery admission date. In the described scenario, the bag ruptures during the cataract surgery resulting in an anterior vitrectomy performed; therefore this case is unplanned and would be included in the measure.

Question: For the question on slide 56, how many days post-op is considered "unplanned." There is nothing in the Specifications Manual to address this.

Answer: The "unplanned" vitrectomy described on slide 56 is defined an anterior vitrectomy that was not scheduled at the time of the patient's admission to the ASC. The numerator should capture all unplanned vitrectomies, so the fact that the visits were separate has no bearing on whether or not the case should be included. If the vitrectomy is unplanned, it should be included in the numerator.

Question: Are we responsible for reporting only Medicare patients for ASC-13, or all patients?

Answer: You would include Medicare and Non-Medicare patients.

Question: For ASC-14, if the original cataract surgery was performed at one ASC and then went to another facility to have the unplanned anterior vitrectomy, who reports?

Answer: For the vitrectomy to be unplanned, the procedure must not have been scheduled at the time of the patient's admission to the ASC. The vitrectomy would have to be performed during the cataract surgery encounter and would not include a vitrectomy done outside of the cataract surgery admission date. If the vitrectomy was scheduled at the secondary facility, it would not be included in the measure.

Question: Was this recorded so that I may go back and listen a second time?

Answer: Yes, look for the recording on www.qualityreportingcenter.com under the Archived Events tab for this program.