Quality Reporting Program

Support Contractor

The Abstraction Challenge Show: Real Questions, Real Answers

Presentation Transcript

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Karen VanBourgondien: Good morning everyone and welcome to the Ambulatory Surgery Center Quality Reporting Program webinar. Thank you for joining us today. My name is Karen VanBourgondien, the Education Lead for the ASC Program. Before we get started we do have an important announcement and I would like to hand things over to Tamara Mohommed. Tamara?

Tamara Mohammed: Welcome everyone and thank you for joining today's webinar. My name is Tamara Mohammed and I am the Measure Implementation Lead at the Yale Center for Outcomes Research and Evaluation. Today I would like to discuss with you the upcoming dry run for these measures and briefly discuss what a dry run is and then give you a quick overview of the two measures; the orthopedic and urology measures that are being included in dry run this year. I'll talk about what's included in the measures, what the outcomes for the measures are, and how we calculate the measures. We'll then wrap up by discussing some of the logistics for the dry run and where you can find additional resources.

So, to begin, this year, CMS is hosting a dry run from August 1, 2018 to August 30, 2018. This dry run will be your first introduction to two new measures: The Hospital Visits after Orthopedic ASC Procedures measure (or ASC-17) and the Hospital Visits after Urology ASC Procedures measure (or ASC-18). This dry run is a precursor to the actual implementation of these measures in the ASCQR (Ambulatory Surgical Center Quality Reporting) Program. As stated in the 2018 Outpatient Perspective Payment System OPPS rule, CMS has finalized both of these measures for inclusion in the ASCQR Program beginning with the Calendar Year 2022 payment determination.

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Now, if you're not familiar with a dry run, then to provide you with some context, CMS hosts a dry run in order to provide facilities with an opportunity to become familiar with the measures that are being introduced into one of the CMS programs.

During this dry run, facilities will receive confidential information on their results, and they will have the opportunity to review their data, understand how they perform on the measures, and also gain information about how the measures work. They can do this by reviewing educational documents that CMS makes available or by asking questions to CMS directly about the measures.

While facilities are provided with information on their results on the measure during a dry run, it is important to note that these dry run results are confidential that is, the dry run results are neither publicly reported nor are they used for payment determination.

In the next few slides, I am going to spend some time talking about the actual measures that are being included in the dry run this year; the ASC Orthopedic and the ASC Urology measures. As these two measures are more alike than they are different, I'll be presenting information on both measures simultaneously and I'll point out areas where they are different. To begin with, both measures are claims-based measures, that is they are calculated using claims data that facilities submit to CMS. And specifically, the measures are calculated using claims data submitted for Medicare Fee-for-Service patients. Results for the measures are calculated at the facility level, which means that we're looking at how each facility performs on these measures.

When calculating the measures, the ASC Orthopedic measure includes orthopedic procedures that are performed by ASCs, and the ASC Urology measure includes urology procedures that are performed by ASCs. However, for both measures, in order to be included in the measure calculation, the procedure must have been performed on a Medicare FFS patient aged 65 or older who had been continuously enrolled in Medicare FFS Parts A and B for the 12 months prior to the date of the procedure.

The types of orthopedic or urology procedures that qualify for inclusion in the measure are those that are routinely performed at an ASC, that are routinely performed by orthopedists (again for the ASC Orthopedic measure) or urologists (for the ASC Urology measure), and that involve increased risk of post-surgery hospital visits.

You can find more information on what these specific procedures are using the technical report for the measures, and I'll tell you how to access those reports at the end of this presentation. Both measures are also risk-adjusted, what this means is they take into consideration and adjust for the complexity of the patient and the

complexity of the procedure. In trying to determine how complex the patient is, the measure specifically adjusts for the patient's age and comorbidities. In trying to adjust for how complex the procedure is, the measure looks at Relative Value Units (RVUs). The use of RVUs, or Relative Value Units, is an approach employed by the American College of Surgeons National Surgical Quality Improvement Program. Simply put, this approach estimates the resources used to perform a procedure. Both measures utilize RVUs as an indicator of the complexity of a procedure. It looks at the relative value units that are assigned to that procedure to determine whether it is a complex procedure; higher RVUs are associated with more complex procedures.

With regard to the outcome, both the ASC Orthopedic and Urology measures consider an outcome to be any unplanned hospital visit that occurs within 7 days of the orthopedic or urology procedure. Again, it would be within 7 days of an eligible orthopedic procedure for the ASC Orthopedic measure and within 7 days of an eligible urology procedure for the ASC Urology measure. And when we say "unplanned hospital visits," this is defined as a visit to the ED, an observation stay, or any unplanned inpatient admission.

If the inpatient admission was planned, then this is not considered to be an outcome for the measure. In order to determine whether an inpatient admission was planned or unplanned, we use a Planned Admission Algorithm, and a copy of this algorithm is included in the technical report for each measure.

Again, at the end of the presentation, I will tell you where you can find this report. So, now I've spoken to you about which procedures are included in the measures, what the outcomes for the measures are, and told you a bit about the risk-adjustment for the measure.

Let's talk now about how we calculate the measures. When we calculate each measure, we produce a risk-standardized hospital visit rate (RSHVR). This RSHVR is calculated by dividing the total number of predicted hospital visits for that facility by the total number of expected hospital visits for that facility and then multiplying that ratio by the national observed rate.

The numerator, the number of predicted hospital visits, is the total number of hospital visits within 7 days of the urology or orthopedic procedure, based on the ASC's observed case mix. The denominator, the number of expected hospital visits, is the total number of hospital visits within 7 days of the urology or orthopedic procedure expected, based on the nation's performance with that ASC's case mix. And when I say 'nation' here, I'm referring to the all the ASCs in the nation.

When this ratio of predicted to expected is greater than 1, it indicates that the ASC's patients have more hospital visits than expected, and when the

ratio is less than 1, it indicates that the ASC's patients have less hospital visits than expected. This is in comparison to an average ASC with a similar mix of patients and procedural complexity.

When we calculate this ratio of predicted to expected hospital visits, we first adjust for the complexity of the patient and then estimate the risk associated with the types and volumes of procedures performed by the ASC.

This approach accounts for clustering of patients within ASCs and differences in sample sizes. During the dry run, each ASC will be provided with a confidential Facility-Specific Report, or FSR. This FSR will contain information on that ASC's results on each of the ASC Urology and ASC Orthopedic measures. You will get one FSR information on both measures during the dry run. FSRs will contain information on how that ASC performed on each measure, how that ASC's state performed on each measure, and how the nation performed on each measure. It will also contain detailed information on that ASC's patients who were included in the measures.

Each ASC with at least one eligible procedure in that time-frame will receive an FSR. If an ASC does not receive an FSR, they can instead access a mock FSR on the QualityNet website. This mock FSR will contain real information on national performance on each of the measures, but simulated information on the state and ASC-level performance for each measure.

Before we end, I want to point out some key resources that will be available to you during the dry run. Firstly, beginning August 1, 2018, the QualityNet website will be updated to include information on both measures. To find the updated pages with the resources, go to www.qualitynet.org, click on Ambulatory Surgical Centers, then Measures, and then select either Orthopedic Measure Dry Run or Urology Measure Dry Run. On these pages, you will be able to find the technical reports for the measures, which I referenced in earlier slides, code sets for the measures, an FAQ document, fact sheets, etc. Additionally, CMS is hosting a National Provider Call on the measures on August 21, 2018 from 2 p.m. to 4 p.m. ET. You can also register for this call via the QualityNet website.

And lastly, from August 1, when the dry run begins, you will be able to email us questions about the measures and your dry run results. Please note that if you're emailing us to ask questions about specific cases used to calculate your measure results, we ask that you be careful not to send us your entire FSR or any protected health information. If you have any questions about the dry run, you can enter your question in the chat box today. You can also enter your question in the Question and Answer tool in QualityNet. Thank you for your time today. I will now turn things back over.

Karen VanBourgondien: Thank you, Tamara, for sharing that information with everybody. We look forward to the dry run for these two new measures. By the way, if you have not yet downloaded today's handouts, you can get them from our website at qualityreportingcenter.com. Just click on today's event and you will be allowed to download the handouts from that link. They are also attached to the invitation you received for this webinar.

Today we will be going over some scenario-based cases dealing with some of the most asked about and common abstracting questions. These scenarios are based on actual questions asked by ASCs. So, as the title says: Real Questions, Real Answers. Although we will be having some fun today, the goal is to present some challenging questions and provide answers in an effort to help you when you are abstracting.

We would like to thank all of the measure writers from Yale, Mathematica, the Lewin Group, and Telligen for their participation in the creation of this webinar as well as being available today in the chat box to answer any questions that you may have. We do appreciate them lending their expertise which is invaluable.

The learning objectives for this program are listed on this slide. 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 on our website qualityreportingcenter.com at a later date.

During the presentation, if you have a question, please put that question in the chat box located on the left side of the screen and one of our subject matter experts will respond. Without any further ado, let's get started.

Answers McFreely: Welcome to The Abstraction Challenge Show, Real Questions, Real Answers, where we invite you to take a front seat to answer some of our most difficult and troubling abstracting questions.

My name is Answers McFreely. I know what you're thinking folks, and yes that is a family name. I am your host today. Also joining me is Hannah Black, my assistant extraordinaire.

Now, let's get started with some game rules. The contestants will be asked questions by yours truly. These questions will vary in category and level of difficulty. The more difficult the question, the more points they are worth. The contestants will have three life lines. This advantage can be used when they do not know the answer to the question. If the life line used provides them with the correct answer, the contestant will receive the full points. The life lines available are: Ask the Audience, Phone an Expert, Ask an SME, or Subject Matter Expert.

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To our folks in the audience, we invite you to play along and see how well you score.

Our first contestant is Marylou, she works for ABC Surgery Center and has been abstracting for this program for five years. Her favorite food is pizza and she loves dogs. Welcome, Marylou.

Marylou: Hello Answers McFreely. I am excited to be here, and I am ready to answer anything you can throw at me.

Answers McFreely: Thank you for joining us today, Marylou. Our second contestant is Spencer. Spencer is with XYZ surgery center and has been abstracting for the ASC program for one year. His favorite food is sushi and he enjoys skiing. Welcome, Spencer. Are you ready to play today?

Spencer: Yes, Answers, I am ready. I am new to abstracting but I think I am ready for any you've got for me.

Answers McFreely: Great to have you, Spencer! Now let's take a look at today's categories. Here are today's categories: ASC-8, ASC-9, ASC-10, ASC-11, ASC-12, ASC-13, ASC-14, and Program Questions. Alright Marylou, you won the coin toss back stage, you're up first. Please choose your category.

Marylou: Thank you, Answers, to start with, I think I will choose ASC-9 please.

Answers McFreely: Marylou, you have selected ASC-9: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients. As you know, this is a colonoscopy measure which is the percentage of patients aged 50-75 years of age receiving a screening colonoscopy without biopsy or polypectomy, who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report. And here is your question: The abstractor states: There is not a documented follow-up interval. The physician documented in the colonoscopy report "Recommendation for a repeat colonoscopy pending pathology results." The abstractor wants to know should this case be a denominator exclusion? Marylou, for 100 points, what is your answer?

Marylou: Well, Mr. McFreely, I am a little confused as to why this case is being reported for ASC-9. It seems like they had a biopsy. So, I would say, yes, this case should be excluded.

Answers McFreely: That is correct Marylou! This case would be excluded. If the patient had a biopsy or polypectomy, they do not meet the denominator statement criteria. This measure includes all patients aged 50-75 years of age receiving screening colonoscopy without biopsy or polypectomy. This case would not meet the denominator criteria for ASC-9. Well done! Alright, Spencer, it's your turn and what is your category?

Spencer: I think I will go with ASC-13. That is a newer measure.

Answers McFreely: Spencer, you have chosen ASC-13: Normothermia. This measure is used to assess the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration and are normothermic within 15 minutes of arrival in PACU. Spencer, here's your question: For 200 points the abstractor asks the following: What if you don't perform any procedures that last for 60 minutes or greater at your facility? What do you record in this measure performance?

Well Spencer, what do you say?

Spencer: Ohh, I am not sure. This is a newer measure and I am still trying to understand things. I would like to use a life line please, Mr. McFreely.

Answers McFreely: Alright Spencer, which one would you like to use? Remember they are Ask the Audience, Phone and Expert or Ask an SME.

Spencer: I want to use Ask an SME.

Answers McFreely: Alright. You have chosen Ask an SME. If you ever want your measure-specific questions answered, you always have access to the subject matter experts. Being able to communicate directly with the measure writers is a great way to receive a response to your question. These experts helped us in developing all the questions and answers used today. Now, let's check out how to contact these experts. Hannah, tell us how to Ask a Subject Matter Expert.

Hannah Black: Thank you, Answers McFreely. To communicate with the various subject matter experts you can access the Question and Answer tool from the home page of QualityNet. The address is noted here at the top of the slide. You can see that in the second box on the right-hand side of the page, it says "Questions & Answers." Simply click on Ambulatory Surgical Centers. You just sign-up with an email address so that the SMEs can respond with your answer. It is very simple and easy. The support contractor did a webinar on this QA platform and you can

access that webinar in the Archived Events tab for this program on qualityreportingcenter.com. Answers, back to you.

Answers McFreely: Thank you, Hannah. So Spencer, that is how you can get your measure-specific abstraction questions answered. Let's see what they said about your question. Now remember, the question is: What if you don't perform any procedures that last for 60 minutes or longer at your facility? What do you record in this measure performance?

And the answer is: This measure includes only procedures performed under general or neuroaxial anesthesia of 60 minutes or more in duration. Cases that do not meet these requirements should not be included in the denominator and would not be included in the measure performance. Remember ladies and gentlemen, if your ASC does not administer general or neuroaxial anesthesia, you will enter zeros for the numerator and denominator when entering this data into the QualityNet on-line submission tool. Do not leave this measure blank, it will be considered "not submitted." Alright, well your lifeline just earned you 200 points Spencer. Marylou you are up next and what is your category?

Marylou: Answers, I think I will go for ASC-11.

Answers McFreely: Alright, Marylou, ASC-11: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery. This is the 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. Now, let's take a look at the question. For 200 Points: What visual function survey tools are acceptable to use for the measure? Well Marylou, what do you think?

Marylou: I do believe the Specifications Manual does have some resources for that and I do know the same tool has to be used both pre-op and post-op.

Answers McFreely: Okay, Marylou. Let's take a look at the answer. Marylou you are correct! The experts say: Examples of the tools for visual function assessment can be found in the Measure Information Form (MIF) of the Specifications Manual. The same data collection instrument must be used pre-operatively and post-operatively. Alright, nicely done, Marylou. Spencer, you are up; and what is your category?

Spencer: I am going to go with ASC-8, Mr. McFreely.

Answers McFreely: ASC-8: Influenza Vaccination Coverage among Healthcare Personnel. This is the measure in which facilities report vaccination data for three categories of

Healthcare Personnel. Spencer, let's take a look at the question. For 300 points, the question is: What if a student or staff member is at the center and then gets their flu shot later in the month? Does that count as a vaccination for the month they were at the center? Spencer, what do you think?

Spencer: Oh yes, they would be included. If they worked at least one day during the flu season, they will be counted.

Answers McFreely: Alright Spencer, now let's take a look. As long as they receive their flu shot during the current flu season, then it should be included in your facility's reporting. Anyone who works at your facility during the reporting period and who is vaccinated anytime during the influenza season (October 1 through March 31) is counted as vaccinated. Nice job, Spencer, you just earned 300 points!

Marylou, you are up and what is your category?

Marylou: Answers, I am going to choose ASC-10.

Answers McFreely: Alright, Marylou, you chose ASC-10: Colonoscopy Interval for Patients with a History of Adenomatous Polyps Avoidance of Inappropriate Use. This measure is the percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of prior colonic polyps in previous colonoscopy findings, who had a follow-up interval of 3 or more years since their last colonoscopy.

Now, let's look at the question. Your scenario for 200 points is: The physician writes on the History and Physical: "White male presents for colon cancer screening, he had a polyp on exam in 2008." The abstractor wants to know: How do I answer documentation that the patient had an interval of 3 or more years since last colonoscopy?

Marylou: Well, it says he had a polyp in 2008, and that is certainly longer than three years. The abstractor would be able to answer "Yes" it has been more than three years.

Answers McFreely: Alright, Marylou, let's look at the answer. The experts say "The documentation provided does not indicate a colonoscopy was performed and would not be used to establish the interval since the last colonoscopy." Tough break, Marylou. It appears that documentation could not be used. Alright, Spencer, it's time to pull ahead. What is your category?

Spencer: I think this time I will choose ASC-14.

Answers McFreely: ASC-14: Unplanned Anterior Vitrectomy. This measure is used to assess the percentage of cataract surgery patients who have an unplanned anterior vitrectomy. Spencer, for 300 points, here is your scenario: If a patient is brought to the hospital for a cataract surgery, there is no mention of an Anterior Vitrectomy noted on that cataract visit, but two days later an Unplanned Anterior Vitrectomy is noted within our ASC medical record. Should this 'secondary vitrectomy' be ignored due to the fact it was completed at a separate outpatient visit? Well Spencer, what do you say?

Spencer: Um, I really don't think I know, Mr. McFreely. I think I would like to use a life line please.

Answers McFreely: Alright, then, and what life line would you like to use?

Spencer: I want to use my Ask the Audience. I think the audience can help me with this one.

Answers McFreely: Alright, Spencer. We will ask the audience to take a minute and read this slide again. Alright folks, let's try and get Spencer some help. Hannah Black, please be so kind as to take this question to the audience. Thank you, Hannah! And thank you to the audience. Let's take a look at that answer.

This is an ASC measure. As a result, in order for a cataract surgery case to be included in the denominator for this measure, the cataract surgery must have originally been performed in the ASC. The case you describe would not be included because the cataract surgery was performed in the hospital.

Alright, great job, everyone! Marylou, you're up and what is your category?

Marylou: I think I am going to ASC-12.

Answers McFreely: ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. This measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare Fee-For-Service (FFS) patients aged 65 years and older. Now, let's take a look at this claims-based outcome measure question. Who reports the ASC-12 data? Alright Marylou, what's your answer?

Marylou: Well, it is a claims-based measure and the data is not manually reported by me as an abstractor. I am pretty sure the data is collected from claims submitted to Medicare.

Answers McFreely: Alright, Marylou, let's see what the experts say. ASC-12 is calculated using Medicare claims submitted for payment; therefore, ASCs do not have to manually abstract and report data for this measure. Marylou, exactly correct! Spencer, you're up; and what is your category?

Spencer: I think I am going to go in a different direction and choose Program Questions.

Answers McFreely: Alright, Spencer, you have chosen Program Questions. This can be anything related to the ASC Quality Reporting Program. Let's take a look at the program question; and for 200 Points, here is your question: I know I can run reports on QualityNet to keep up with my data. Is there a particular report I can run to review the status of my Quality Data Codes? Alright, Spencer, what report can this abstractor run?

Spencer: Oh boy. I have to say I am not sure. I think I would like to use a life line again.

Answers McFreely: Alright Spencer. What life line would you like to use?

Spencer: I am going with Phone an Expert.

Answers McFreely: Alright Spencer, you have chosen Phone an Expert. The Support Contractor Helpdesk will be able to answer all of your program-related questions. Let me turn it over to Hannah Black and she will call the helpdesk number at 866-800-8756. Hannah, take it away!

Hannah Black: Thank you Answers. I have the helpdesk on the line now.

Help Desk: Hello, Quality Reporting, how can I assist you today?

Hannah Black: We have a two-part question, if an ASC wants to keep tabs on the QDCs they have submitted, what report can they run through QualityNet? Oh and also, what report should you run to check on the web-based measures once they are submitted?

Help Desk: Great Questions! This is very important to know. ASCs can run two reports on the QualityNet Secure Portal, the Claims Detail Report and the Provider Participation Report. The Claims Detail Report is a listing of all of the fee-for-service claims submitted by your facility. It is an excellent auditing tool when used in

conjunction with the remittance advice. The report allows you to see what QDCs are being applied most frequently, or if there are claims that were without QDCs, either they were absent from the claim or because they were not accepted into the warehouse.

If you are seeing that your QDCs are not crossing over, you will want to research that issue because, remember, in order to meet the program requirements and receive the full annual payment update, your facility must meet or exceed the 50% QDC submission threshold set by CMS. The Provider Participation Report, or PPR, is a very useful report rich with information about how your facility is performing relative to the program requirements. You will see the total number of claims with QDCs, the total claims volume and the QDC reporting percentage.

Once you have reported your web-based measures in QualityNet, you will be able to view that information on this report as well. We have done webinars in the past explaining these reports in detail. You can access these webinars on qualityreportingcenter.com under the Archived Events tab for this program.

Hannah Black: Ok, great. Thank you.

Help Desk: It's my pleasure; you have a wonderful day.

Answers McFreely: Thank you, Hannah. So, let's recap what the helpdesk just said. Your ASC can generate reports on demand in the QualityNet Secure Portal. There are two reports that ASCs have access to: the Claims Detail Report and the Provider Participation Report. You can run these reports yourself on the secure portal of QualityNet.

The Claims Detail Report is a listing of all of the fee-for-service claims submitted by your facility to Medicare for payment during the time period which you designate. Each line provides details about a claim. The report allows you to see what QDCs are being applied most frequently, or if there are claims that were without QDCs, either because they were absent from the claim or because they were not accepted into the warehouse. And those are the claims that you will want to research because if a claim goes into the warehouse without associated QDCs, your facility is not getting credit for reporting those QDCs. And remember, in order to meet the program requirements and receive the full annual payment update, your facility must meet or exceed the 50% QDC submission threshold.

The Provider Participation Report, or PPR, is a very useful report with information about how your facility is performing relative to the program requirements. You will see the information regarding your QDCs and you will be able to view the information you reported for your web-based measures and those

measures are ASC-9, ASC-10 and ASC-11. Alright Marylou, back to you. What is your category?

Marylou: Answers McFreely, I think I am going back to ASC-13.

Answers McFreely: Alright Marylou, for 400 points here is your scenario: For the Normothermia measure, our surgical records have an Anesthesia Start time and an Induction Time documented. What should we use as the Anesthesia Start Time to determine Anesthesia time?

Marylou, what do you think? What should this abstractor use to determine Anesthesia Time?

Marylou: Wow, it's different in various ASCs. The point is that the ASC understand the time from anesthesia start and anesthesia end. I know our ASC worked with the anesthesia team to understand when that period of time starts and ends.

Answers McFreely: Alright Marylou, let's see what the experts say. The focus of the measure is on the period of time the patient is at risk for hypothermia due to anesthetic-induced impairment of normal thermoregulatory control mechanisms. This measure includes not only general anesthesia but also spinal and epidural anesthesia; therefore, it is important to use the definition of duration in the specifications, which references the time from anesthesia start to anesthesia end. We recommend working with anesthesia providers to gain an understanding of the practices of administration of general/spinal and epidural anesthesia within your center. Anesthesia providers understand when this period of time begins and ends based on their approach to the administration of anesthetics and the processes in their center. Alright, Spencer, it's back to you; and what is your category?

Spencer: Mr. McFreely, I am going to go with ASC-13.

Answers McFreely: Okay, for 400 points: A Medicare patient had an epidural started in Pre-Operative holding at 0800.The patient entered the operating suite at 810. There is a Documented End time of anesthesia of 905. The patient's body temperature of 96.5° Fahrenheit was recorded at 920. The Nurse Practitioner documented intentional hypothermia for the procedure. Is this patient excluded from the measure? Spencer, what do you think?

Spencer: Umm, I don't see how this patient can be included because they intentionally lowered the body temperature. So I think the patient is excluded from the measure.

Answers McFreely: Alright Spencer, let's take a look. Yes. The documentation of intentional hypothermia is a Denominator Exclusion. This case would not be included in the measure. Great job, Spencer. Alright, Marylou, it is back to you; and what is your category?

Marylou: I think I am going to ride on Spencer's idea and go with ASC-13.

Answers McFreely: For 300 points, here's the question: The sample size requirement for ASC-13 is 96 per year, if the population is greater than or equal to 901. As of today, we have a sample size of 148. Can our ASC stop tracking for the year? Alright, Marylou, this ASC has 148 cases so far this year. Can they stop tracking the cases for the year?

Marylou: Sure 148 is more than 96, so they have plenty.

Answers McFreely: Okay, let's see what the answer is. The population and sampling specifications for this measure states that if your facility has greater than or equal to 901 cases annually that have meet the denominator criteria, your minimum sample size is 96.

The ASC-13 denominator criteria are the number of patients who have received general or neuraxial anesthesia for 60 minutes or longer. If you have greater than or equal to 901 cases in this year that have met this criteria, then your sample size is 96 of those charts. It is not recommended to pre-select 96 charts that have met the denominator criteria to avoid tracking the data for the rest of the year. Oooh, so sorry Marylou, this ASC cannot stop tracking.

Alright, Spencer, what is your category?

Spencer: Answers, I am going to go with ASC-14.

Answers McFreely: Alright, Spencer, for 200 points here is your scenario: For this measure, we use CPT codes 66982, 66983, and 66984, which are all related to Cataract surgery. If cataract surgery is completed on day 1 and patient returns on day 3 for the unplanned vitrectomy, are these unplanned vitrectomies captured if the cataract surgery was done on a separate visit? I know that they are 'typically' done at the same visit, but how are the separate visits addressed? Would that separate visit then be considered a planned vitrectomy, since it was then scheduled?

Alright Spencer, and what is your answer?

Spencer: Ummmm, I don't think it matters if the visits are separate. The CPT codes are used to capture the denominator.

Answers McFreely: Okay, Spencer, let's look at the answer. The CPT codes are used simply to identify cataract surgeries which make up the denominator of the measure. 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.

Nice job, Spencer! Marylou, we are back to you, and what is your category?

Marylou: I choose ASC-9.

Answers McFreely: Alright, Marylou, for 400 points: How do we determine the patient population for the measure and subsequently determine the sample size? Is it the total number of patients seen in the ASC?

Marylou: Okay, we kind of just touched on this for another measure but the principle is the same. It is not the total number of patients seen in the ASC. You would determine your total population for that measure, which you would use the CPT codes, ICD-10 codes, and HCPCS codes; you would then use that total number to determine the sample size. You then you would get the sample size number from the table in the Specifications Manual.

Answers McFreely: Alright, Marylou, let's take a look at your answer. The population for the measure includes all cases that meet the denominator criteria using the CPT, ICD-10 and HCPCS Codes. These codes are available within the Measure Information Form in the Specifications Manual.

In Version 7.0a of the Specifications Manual, you will refer to the Quality-Data Coding & Sampling Specifications section, Table 3, to obtain the minimum sample size requirement.

For ASCs with fewer than 63 cases, the total population of cases is required. Nicely done, Marylou! Spencer, it's back to you; and what is your category?

Spencer: I am going to choose the category for Program Question.

Answers McFreely: Alright Spencer, for 300 points, here's your question: We are only reporting ASC-1 through ASC-4 now, right? We do not have to report ASC-5 for the program. Is this correct? Alright Spencer, they seem confused. What do you say?

Spencer: I know this is true. The 2018 Final Rule removed ASC-5. So, we only have to report the other Quality Data Codes, ASC-1 through ASC-4.

Answers McFreely: Alright Spencer, let's take a look at what the experts say. You are correct; ASC-5 was removed from the program in the CY 2018 Final Rule. If you had no adverse events you will report one code, G8907. If you did have an event, you will report four codes to address each of these four measures.

Nicely done, Spencer! Alright, Marylou, back to you; and what is your category?

Marylou: Answers, I am going to go back to ASC-13.

Answers McFreely: Marylou, for 500 points, here is your scenario: A private pay patient received general anesthesia. The anesthetist documented the start time as 0730 and end time as 0825. The patient's arrival time into PACU was documented as 0832. Patient's body temperature at 0837 was 97.8°F. Should I include this patient in the measure? Marylou, what do you think? Is this patient included in the measure?

Marylou: Wait a minute, let me think here. You know, I am just not sure. I would like to use a life line please.

Answers McFreely: Alright, Marylou, no problem. Which life line would you like to use?

Marylou: Well, the audience seems to be really on top of things, so I want to use the Ask the Audience.

Answers McFreely: Alright, Marylou, we will ask the audience, once again, to take a minute and read this slide. Alright folks, let's try and get some help for Marylou. Thank you, Hannah, and thank you to everyone in the audience. The answer is: The anesthesia duration time is not equal to or greater than 60 minutes; therefore, this patient should not be included in the measure.

Great job, everyone! Alright Spencer, it's back to you and what is your category?

Spencer: Okay Answers, my category choice is ASC-14.

Answers McFreely: Spencer, for 400 Points: When submitting facility information for ASC-14, may the facility use the sampling technique? What do you say, Spencer?

Spencer: I say no sampling. Hopefully the numbers would be low since we are tracking a fairly low-incidence event.

Answers McFreely: No, you will not be able to "sample" for ASC 14. This measure will be reported as a numerator and denominator.

The denominator will be the total number of cataract surgery patients. The numerator will be the total number of unplanned anterior vitrectomy. So, if you had 500 cataract surgery patients and 1 unplanned anterior vitrectomy, then your denominator will be 500 and your numerator will be 1. The expected number of unplanned anterior vitrectomy cases should be so small that sampling is not needed. Well done, Spencer.

Now, folks, our contestants have a done an amazing job today! And to reward just one of you, we have a Bonus Question worth 500 points that will tip the scale for one of our contestants. The bonus question is: A patient received general anesthesia for a surgical procedure. The anesthetist documented the start time at 1010. There is no documented end time. The patient's arrival in the PACU is recorded at 1115 with a body temperature recorded at 1125 of 97°F. Is this patient included in the measure? Marylou, for all of the marbles, what do you think?

Marylou: Well, I am troubled by the fact that there is no end time documented. How do we know the anesthesia was at least 60 minutes? So, I say no.

Answers McFreely: Hmm, alright Spencer, now what are your thoughts?

Spencer: Well, the patient arrived at the PACU at 1115; it appears to me that it was at least 60 minutes. I say yes.

Answers McFreely: Alright then, it seems we have a difference of opinion. For 500 points, let's look at what the experts say: No. This patient should not be included in this measure. Arrival time to PACU is only used to determine if the patient's body temperature meets the duration and required temperature for inclusion in the numerator. Anesthesia end time cannot be substituted with arrival at PACU time. Congratulations, Marylou, you've done it!

What a great game! Thank you to both of our contestants! Spencer, for only abstracting for a year, you really given Marylou a run for her money. I would like to thank our audience today on behalf of the contestants; you did a great job as well. And as your Host Answers McFreely, I am signing off for the Abstraction Challenge Show.

Support Contractor

Karen VanBourgondien: Thank you everyone for playing along with us! We hope this was helpful to you in dealing with the abstraction challenges you encounter. We would, again, also like to thank the various measure writers involved in both the questions and answers presented here today as well as being available in the chat box to respond to your questions. As a reminder, a recording of today's event as well as the transcripts for the presentation and all of the questions and answers in the chat box will be posted on our website at qualityreportingcenter.com.