Ambulatory Surgical Center Quality Reporting Program

Support Contractor

ASCQR 2016 Specifications Manual Update

Questions & Answers

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Question: Can you please verify that the changes on ASC-9 and ASC-10 occur for data in 2016? Please confirm data being reported in 2016 refers to version 4.1.

Answer: For 2015 encounter periods (the date when the patient is seen in your facility) for 2016 reporting, you would use Specifications Manual Version 4.0a (for the encounter period January 2, 2015 to September 30, 2015). You will use Specifications Manual Version 4.1 (for the encounter period October 1 to December 30, 2015). Now, moving forward a year, if you are looking at 2016 encounter periods that will be reported in 2017, then you would use Specifications Manual 5.0a and 5.1.

Question: We are in the process of obtaining our Medicare certification and are hoping this is completed by the end of March. When do we need to start our ASC quality reporting?

Answer: Administrative requirements apply to all ASCs designated as operating in the CASPER system, Medicare's database for survey and certification purposes, for at least four months prior to January 1. 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.

Question: Where can we find the 5.0a manual?

Answer: You can find all versions of the Specifications Manual on the QualityNet.org website. Click on the Ambulatory Surgical Centers (gray tab at the top of the screen), and a drop-down box will appear for 'Specifications Manual" or access this link: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772475754

Question: Is reporting of ASC-1 through ASC-5 for Medicare patients only or all patients? Do Medicare patients include Medicare Advantage patients?

Answer: These measures include all Medicare Fee-for-Service beneficiaries where Medicare is the primary or secondary. It does not include Medicare Advantage or HMO replacement beneficiaries. It does include Medicare railroad beneficiaries.

Question: If your ASC does not perform colonoscopies, do you just ignore that measure, or do you somehow have to indicate that you do not provide this service?

Answer: If you do not do colonoscopies in your facility, you will enter "zeros" for the numerator and denominator. Do not leave a measure unanswered.

Question: Why did my NHSN reporting not carry over to QualityNet? I have the data, and it was submitted correctly, but my report from QualityNet does not recognize this.

Answer: Data reported through the online tool via the NHSN website does not display on QualityNet.

Question: Will it eventually be on a report and submitted? This was for the 2014/2015 season.

Answer: This is a known issue with QualityNet. We have not been notified of when this change/update will occur.

Question: Is ASC-11 still voluntary?

Answer: Yes, ASC-11 is a voluntary measure.

Question: For ASC-10, to be excluded, do they have to meet all 3 criteria?

Answer: This is correct. This is not really a change but rather a clarification of existing wording.

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Question: In determining how many cases we need to sample for ASC 9-10, are we looking at the total number of cases for patients aged 18+ and then selecting our cases based upon denominator inclusion factors?

Answer: Your initial patient population for each measure (ASC-9 and ASC-10) should be based on the denominator criteria for each measure.

Question: For ASC-12, would an instance where a colonoscopy was performed prior to a planned hospital surgery be excluded? For example, a colonoscopy is not uncommon prior to a gyn cancer surgery.

Answer: Yes, planned admissions are not counted as an outcome for the CMS Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure. Planned admissions are those planned by hospitals for anticipated medical treatment or procedures that must be provided in the inpatient setting. The colonoscopy measure does not count planned hospital visits as an outcome because these are not a signal of quality of care. CMS developed an algorithm that identifies planned readmissions, and applied this algorithm to the colonoscopy measure. The algorithm uses procedure codes and principal discharge diagnosis codes on each hospital claim to identify admissions that are typically planned and may occur after a colonoscopy. A few specific, limited types of care are always considered planned (for example, major organ transplant, rehabilitation, or maintenance chemotherapy). Otherwise, a planned admission is defined as a non-acute admission for a scheduled procedure (for example, total hip replacement or cholecystectomy). Admissions for an acute illness or for complications of care, as well as all emergency department and observation stay hospital visits, are never considered planned. For more information on the planned readmission algorithm as it is adapted for the colonoscopy measure, see the methodology technical report posted at www.qualitynet.org > Hospitals-Outpatient > Measures > Colonoscopy Measure Dry Run > Measure Methodology Report or www.qualitynet.org > Ambulatory Surgical Centers > Measures > Colonoscopy Measure Dry Run > Measure Methodology Report on the QualityNet website.

Question: For ASC 9-12, if none of these procedures are done at our facility, do we still have to enter 0?

Answer: Yes, that is correct. If you do not perform these procedures, you must enter zero for the numerator and denominator. Just for clarification, we wanted to add that ASC-12 is a claims-based measure, so no additional data entry is required.

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Question: Do the new age guidelines for ASC-9 go into effect on January 1, 2016?

Answer: That is correct.

Question: When reporting on measures that are not applicable, how do we report on the measures that are not applicable? Enter 0s?

Answer: Correct. If your facility does not perform procedures related to some measures, you will need to enter "zero" for the numerator and denominator for each measure in the web-based submission tool.

Question: The abbreviation DVT is generally used for Deep Vein Thrombosis; this can be confused with the diverticulitis abbreviation, which was DVT, also on the slide. Will it be changed?

Answer: Thank you for your feedback. We agree, and the next manual update will remove the DVT abbreviation.

Question: What time period of data is being reported by August 15, 2016?

Answer: Data from calendar year 2015 should be submitted through the QualityNet Secure Portal (ASC-6, ASC-7, ASC-9, ASC-10, and voluntary ASC-11) and must be reported by August 15, 2016.

Question: When is the measure deadline for ASC-6?

Answer: The ASC-6 data submission deadline is August 15, 2016.

Question: For ASC-7 reporting for 2015, what version will have the most recent procedures list? In other words, what version do we go by for 2015 reporting of ASC-7?

Answer: ASCs should utilize Specifications Manual v4.1. This manual has been updated to include the most utilized codes of 2015.

Question: I am new in reporting. Is all the data needed for reporting automatically captured by sending the actual claim?

Answer: There are two components of the ASCQR Program: submission of Quality Data Codes (QDCs) and submission of web-based measures. A suggestion may be to read the ASCQR Program Guide for New Facilities. You can find this document on our website:

http://www.qualityreportingcenter.com/asc/tools/. If you need more personal help, call the support contractor at 866-800-8756.

Question: Being new to reporting, is there any document that covers all data requirements without pulling up all versions and making changes? It seems as though annually reported data could be compiled for ASCs/hospitals since much time is spent reviewing and making update changes.

Answer: A suggestion is to read the ASCQR Program Guide for New Facilities. You can find this document on our website: http://www.qualityreportingcenter.com/asc/tools/. If you need more personal help, call the support contractor at 866-800-8756.

Question: Which version of Table 2 am I using to report 2015 data for ASC-7?

Answer: Table 2 in version 4.0a, which covers encounter dates 1/1/2015 through 9/30/2015, and Table 2 in version 4.1, which covers encounter dates 10/1/2016 through 12/31/2016, contain identical procedure categories and identical procedure codes. Either can be used for reporting procedure volumes for 2015.

Question: The explanation of ASC-4 change is not clear. Please restate.

Answer: You can refer to the presentation slides and recorded webinar at any time for review. They are posted at: http://www.qualityreportingcenter.com/asc/events/ .

Question: Is there a percentage goal for ASC-9 and ASC-10?

Answer: There is not a benchmark available for ASC-9 or ASC-10 at this time.

Question: On slide 18, it states the percentage of ASC admissions who were transferred and admitted to a hospital. Currently, this is reported on claims individually. How do we report the percentage?

Answer: ASC-4 data are extracted from the QDCs applied to claims submitted by your facility.

Question: Should I sample the same number of cases for ASC-9 and 10? It sounds like it would be based on the ages 50-75 for ASC-9 and ages 18+ for ASC 10.

Answer: Correct. Your initial patient population for ASC-9 is based on the age range for that measure and the other denominator criteria specified in the ASC-9 measure information form. Your initial patient population for ASC-10 is based on the denominator criteria specified in the ASC-10 measure information form.

Question: For a diagnostic colonoscopy on a patient with a history of polyps, how can they be excluded from ASC-10?

Answer: The only way the case could be excluded is if there is documentation indicating the previous colonoscopy was less than 3 years ago and there is a medical reason for it being less than 3 years. Some examples of medical reasons are provided in the ASC-10 measure information form and, for the most part, are at the discretion of the physician. The only exception is that a history of polyps cannot be used because that is one of the denominator inclusion criteria.

Question: Within ASC-10, there can be 'colonic polyps' diagnosed (and coded) within the ASC-10, but the patient may not have had a **prior colonoscopy**.....as the colonic polyps may have been discovered on a CT or other testing. How do you address these types of coded colonic polyps within a colonoscopy specific measure?

Answer: If there is documentation clearly indicating the polyps were not found by colonoscopy, the case can be excluded because the denominator statement requires the history of prior colonic polyps be in previous colonoscopy findings. If your vendor tool includes a question to the effect "patient has a history of prior colonic polyps in previous colonoscopy findings," you answer "No," and this should exclude the case from the denominator.

Question: If the colonoscopy report states last colonoscopy was done 3 years ago, do you need to look elsewhere to find the report or take that documentation as is? This is for previous care colonoscopy.

Answer: For ASC-10, if the current colonoscopy report states that the last colonoscopy was done three years ago, you have sufficient documentation to indicate there is an interval of three or more years since the last colonoscopy.

Question: On one of the listserves I read states that we are required to complete a safety evaluation prior to March 1st, and that it would be ready in January. Is this ready yet? I believe it is for ASCs.

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Answer: This survey was not sent by the support contractor. You may be referring to the communication sent by the CDC regarding HAI data. For inquiries you can contact their Help Desk at NHSN@cdc.gov