Ambulatory Surgical Center Quality Reporting (ASCQR) Program 2017 Specifications Manual Update

Presentation

Moderator:
Karen VanBourgondien, BSN, RN
Education Coordinator, Outpatient Quality Reporting Support Contractor

Speakers:
Jennifer Witt, RN
Telligen

Marianna Gorbaty, MHSc, MSc
Mathematica Policy Research

Jacqueline Hudson, BSN, CPHQ
Project Coordinator, Outpatient Quality Reporting Program Support Contractor

December 15, 2016
2:00 p.m. ET

Karen VanBourgondien: Hello, and welcome to the Ambulatory Surgical Center Quality Reporting Program webinar. Thank you for joining us today.

We are fortunate today to have several guest speakers with us. Our first speaker is Jacqueline Hudson with HSAG. Our second speaker is Jennifer Witt with Telligen, followed by Marianna Gorbaty with Mathematica Policy Research. We do invite you to read their biographies that are posted at the end of this presentation.

Before we begin today's program, I just want to take a minute to briefly point out some important dates. The submission period for measures entered through the QualityNet Secure Portal begins on January 1, 2017. Please join us on January 25 for a webinar specifically created for those of you who are new to the ASCQR Program or for those of you that just need a little review.

Lastly, please be sure to keep your QualityNet and your NHSN passwords active by logging into your accounts on a routine basis. If you do not routinely access

your account, they can become locked. Also, please remember that registration and access to QualityNet and NHSN are completely different. These two systems do not speak to each other, so they do require separate registration and separate passwords.

Before we get started today, let me just mention something briefly for those of you who are not familiar with the Specifications Manual. Throughout this presentation you will hear the speakers refer to various versions. Each version corresponds to a data collection time period. These versions are always posted on QualityNet prior to that data collection period. This presentation focuses on versions through 6.0a.

Now without any further delay, let me turn things over to our first subject matter expert, Jackie Hudson. Jackie?

Jackie Hudson: Thank you, Karen. As we continue to make efforts to improve the Specifications Manual, we work to identify areas where we can add clarifications or remove unnecessary information. This slide shows the three sections that were removed from the ASCQR measure information forms for version 6.0 and subsequent. The next few slides will show you more specifically where those changes were applied.

The Reporting Mechanisms, Reporting Periods, and Reporting Required By descriptors were initially placed on the measure information forms to provide additional guidance to the providers. With a focus on streamlining and improving ease of use of the Specifications Manual, we've determined that this information was redundant and did not provide added value. As a result, we have removed these three areas.

So again, much like the measures mentioned on the previous slide, the measure information forms for ASC-6 through -11 also contained unnecessary and redundant information. The Reporting Mechanism and Reporting Required By descriptions were therefore removed from the MIF.

As the subtitle Reporting Mechanism was removed from these identified measure information forms, we have added some guidance directing the provider to enter data through the secure side of the QualityNet website. This information will be found under the Annual Data Submission Period subtitle.

In the colonoscopy measures ASC-9 and ASC-10, you'll notice the addition of the word "statement" following the subtitles of Numerator and Denominator.

This small change was introduced primarily to align the ASCQR Specifications Manual format with other quality reporting programs.

That covers the format changes we have applied to the manual this year. So with that, I would like to hand things over to our next speaker, Jennifer Witt.

Jennifer Witt: Thank you, Jackie. My name is Jennifer Witt, and I'm a senior health informatics solutions coordinator with Telligen. We will now discuss the claims-based measures. There were no changes made in version 6.0 and 6.0a for measures ASC-1 through ASC-5.

We will now move to the web-based measures. There were no changes made to the ASC-6 measure, Safe Surgery Checklist Use. For ASC-7, as a reminder, the categories and HCPCS codes on which procedure volumes are reported will be updated at the end of calendar year 2017. The only change for ASC-8 is in version 6.0a, and it's a clarification to better align the measure information form with the NHSN training materials.

There are three required denominator categories for reporting healthcare personnel, influenza vaccination data, employees, license independent practitioners and adult students, trainees and volunteers. A fourth category denoted as other contract personnel was not initially included in the definition as this category is not required to meet reporting requirements, but facilities can submit this data if desired. The measure information form for version 6.0a will now reference all four denominator categories. Please remember that the flu vaccine measure is entered into the NHSN online submission tool not the QualityNet submission tool.

Under the denominator exclusions for ASC 9, the following sentence was added. Documentation indicating no follow up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as the reason. For ASC 10, the code Z85.038 was removed from the denominator criteria.

I will now turn the presentation over to Marianna. Marianna?

Marianna Gorbaty: Thank you, Jennifer. My name is Marianna Gorbaty and I am a lead program analyst with Mathematica Policy Research. I will wrap up the discussion on the Web based measures and I will just mention that for ASC 11 cataracts improvement in patient's visual function within 90 days following cataract

surgery, there were no changes made in version 6.0 and 6.0a of ASCQR specifications manual. I will now discuss the updates to ASC 12, facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy. CMS has reduced this measure in the Ambulatory Surgical Center Quality Reporting Program in 2016 calendar year.

And I do want to remind that this measure utilizes data from paid Medicare fee for service claims. And it doesn't require facilities to submit quality data quotes unlike they (AC1369) for example. In version 5.0a and 5.1 over the ASCQR manual, in the introduction the measuring submission form we included there National Quality Forum, NQF, measure number for ASC 12, which is 2539. And we also added the links to the 2016 measure specifications report and the 2016 measure updates and specifications report. These reports detail the measure methodology. In the following slides we will go over the version specific updates applicable to versions 5.0a, 6.0 and 6.0a of the ASCQR manual.

Slide 25 lists the sections of the measure information form that the changes apply to in version 5.0a and subsequent version. This includes updates to the denominator statement included populations and cohort exclusions excluded colonoscopies. In version 5.0a and the subsequent version of mix, we updated the denominator statement to the target population for this measure includes low risk colonoscopies performed in the outpatient setting for Medicare fee for service patients aged 65 years and older. For implementation in the ASC program the measure will be calculated among Ambulatory Surgical Centers, ASCs. And on the slide we italicized the specific changes that we made.

We updated the language in the included population section. The updates are italicized on the slide again. The updates, second paragraph now reads, "The measuring focused on the low risk colonoscopies." The measure did not include colonoscopy CPT procedure codes that reflected fundamentally higher-risk or different procedures. Qualifying colonoscopies billed with a concurrent high-risk colonoscopy procedure code were not included in the measure. The 2016 measure updates and specifications report at the link above contains the complete listing of all high-risk procedure codes. The actual link to the statement that references the -- the specifications report is provided in the introduction to the ASC 12. And we also mentioned this report early in this presentation on slide 24.

The next three slides summarize the updates to the cohort exclusion section of the mix that apply to versions 5.0a and subsequent versions. The first change is the update to the third bullet in the cohort exclusion section, which now (fits) colonoscopies for patients with a history of diverticulitis or diagnosis of diverticulitis

at time of index colonoscopy or in a subsequent hospital visit outcome claim. And again, the updated language is italicized on the -- on the slide. We have updated the language in the fourth bullet of the cohort exclusions to colonoscopies for patients with a history of diverticulitis or diagnosis of diverticulitis at time of index colonoscopy or on a subsequent hospital visit outcome claim.

We removed two bullets from the cohort exclusions that used to discuss colonoscopies that occur on the same hospital outpatient claim as an ED visit and Colonoscopies that occur on the same hospital outpatient claim as an observation stay. And we edit the statement that reads the 2016 measure updates and specifications report contains complete coding for all exclusions. As mentioned early in the presentation the link to the specifications report is included in the introduction to the ASC 12 (news).

We made further updates to ASC 12 measure information form that apply to version 6.0 and subsequent versions of the ASCQR specifications manual. These updates apply to the cohort exclusion section tables one and two and to the risk adjustment section of the measure information form. And these updates stem from the removal of the ICD 9 codes from the measure information form. For table one, we removed the ICD 9 diagnosis codes column and updated the table name to inflammatory bowel visits, ICD 10 CM diagnosis codes. And we edited the note that follows table one referring the readers to version 5.1 of the ASC QR specifications manual for the ICD 9 diagnosis code listing. Version 5.1 of the secure manual is used to submit data for encounters July 1, 2016 through December 31, 2016.

This slide summarizes table two updates. As with table one, since we removed the ICD 9 codes column we updated the table name to diverticulitis ICD 10 CM diagnosis codes. And we edited a note referring the readers to version 5.1 of the ASCQR specifications manual for ICD 9 diagnosis codes listing. This slide discusses the updates applicable to the risk adjustment section of the (meet) in version 6.0 subsequent versions of the secure manual. And for this section, too, we updated the language to reference ICD 10 coding system.

Specifically we updated narrative within the risk adjustment section of the MIF, which now states the measure defines comorbidity variables using condition categories which are clinically meaningful groupings of the many thousands of ICD 10 CM diagnosis codes. This slide discusses the updates to table one of the MIF that apply to version 6.0a. Specifically the ICD 10 codes listed in table 1 were ending with an X to indicate that the exclusion applies to all diagnosis codes in a given group. We have replaced an X with an asterisk sign, since X could be confused with part of the code.

And we do want you to know that this change does not affect the underlying measure calculation logic. Following remove the wording without complications from their relevant ICD 10 diagnosis codes descriptions. And finally, we removed the duplicate rows within 51.8 and 51.80 diagnosis codes as this duplication was only applicable in the 2016 version of the MIF, where we had the ICD 9 to ICD 10 mapping. We would also like to (select) that the revisions to the ASC 12 MIF do not change the definition of the outcome for this measure. This concludes the overview of the updates applicable to the ASC 12 facility seven day risk standardized hospital visit rate after outpatient colonoscopy.

Thank you, and I am turning the presentation over to Karen. Thank you.

Karen VanBourgondien: Thank you, Marianna. Thank you to all of our speakers. What we'd like to do now is to share some questions and, hopefully, provide some further clarification. I guess let's start with: "I missed the beginning of this webinar. Is there a way to re-listen to it from the beginning?"

And yes, absolutely. All webinars are posted on our website at www.qualityreportingcenter.com. We will have available the presentation slides, the audio recording, and the transcripts of the presentation, as well as the questions and answers from the chat box, so you will have the benefit of knowing what everybody asks and the answers to those. And additionally, if for some reason your question was missed, it will be answered and posted on our website.

Jennifer, I have a question you might be able to speak to. The question is: "How can a case be excluded from ASC-10 based on a medical reason?" Can you take a stab at that?

Jennifer Witt: I can. To exclude a case from ASC-10 based on a medical reason, there must be documentation indicating the previous colonoscopy was less than three years ago and a medical reason documented. Medical reasons are at the discretion of the Physician, and the measure information form does have some examples of medical reasons in the ASC-10 measure information form.

Karen VanBourgondien: Thank you, Jennifer. Okay. There is another question about ASC-1 through ASC-5, and the question is: "I know you said there were no changes for ASC-1 through -5. Is the reporting of these measures for Medicare patients only or all patients? Do Medicare patients include Medicare Advantage patients?" Okay, that is a really good question, and I will go ahead and respond to that. We actually get this question

a lot. These measures include Medicare Fee-for-Service beneficiaries where Medicare is the primary or secondary. It does not include Medicare Advantage or HMO replacement beneficiaries. However, it does include Medicare Railroad beneficiaries.

Marianna, I believe I have one for you, and that question is: "The measure states to include procedures from the beginning of the reporting year through 90 days prior to the end of the reporting period. This will allow the post-op period to occur, but what about procedures performed in the fourth quarter of the reporting year?"

Marianna Gorbaty: Thank you, Karen. This is a very good question. The measure identifies patients 18 years or older who had cataract surgery and had improvement in their visual function achieved within 90 days following the cataract surgery. So, following the data collection approach for this measure is to include cataract procedures that took place 90 days before the end of the reporting period in order to allow for the post-operative period to occur, which is what they're tracking.

Therefore, for the denominator population, facilities should include procedures performed from the beginning of their reporting year through 90 days prior to the end of their reporting year, that is January 1st to October 2nd of their reporting year, and since facilities need to assess improvement in visual function achieved within 90 days following the cataract surgery, the numerator covers the entire reporting year through December 31st.

Karen VanBourgondien: Thank you, Marianna. Here is a question; I'll speak to this. The question is: "Where can we find the versions, all of the versions, of the manual?" And the answer is that you can find all versions of the Specifications Manual on the qualitynet.org website. You would just click on the Ambulatory Surgical Centers tab, that's the grey tab at the top part of your screen. A drop-down box will appear, and then you would just click on the icon that says Specifications Manual. Jennifer, here's another one for you: "Patient meets the denominator criteria, but documentation within the record indicates that the patient has never had a colonoscopy. How would you address this for ASC-10?"

Jennifer Witt: If there is documentation clearly indicating that the patient has never had a colonoscopy, the case can be excluded because the denominator statement requires a history of prior colonic polyps and of previous colonoscopy findings. So, if your vendor tool -- your tool includes a question to the effect of "patient has a history of

prior colonic polyps" and previous colonoscopy findings, you would answer no, and this case should be excluded from the denominator.

Karen VanBourgondien: Thank you, Jennifer; I appreciate that. Here is another question about the ASC-8 measure. And this is, again, another question we get quite frequently, so I think it's a good question to respond to. The question is: "What is the deadline for the NHSN submission?"

The deadline for submitting ASC-8, the flu vaccination measure, is May 15th. As Jennifer mentioned, submission of this measure is through the web-based submission tool through NHSN. This is the only web-based measure that is not entered into QualityNet, so please make sure that you remember that. All the other measures are submitted through QualityNet, but the flu vaccination measure is recorded on a different platform, and that is through the CDC and the NHSN.

Marianna, here is another one for you. This is with regard to ASC-11. "Are the pre- and post-surveys required to be present in the patient's medical record? What about the case where surveys can be mailed out or if the patient is called for a telephone surgery -- surveys? How do we account for that?"

Marianna Gorbaty: Thank you, Karen. To answer this question, we will refer to the Additional Instructions section of the measure information form. This measure utilizes a visual function survey. While it is recommended that the facility obtain the survey results from the appropriate physician or optometrist, the survey can be administered by the facility via phone, mail, email, or during clinical follow-up. Please remember that, for this measure, the same data collection instrument survey must be used pre-operatively and post-operatively.

Karen VanBourgondien: Thank you, Marianna. Jennifer, I have a question for you, and the question is: "On slide 20 it states that documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as the reason. Can you provide an example of this?"

Jennifer Witt: Yes. Age can be used as a reason to exclude a case when there is a not a specific follow-up interval documented if age is referenced as the reason for not identifying the follow-up interval. For example, "Regular follow-up colonoscopy not indicated due to patient's age," that would be acceptable.

Karen VanBourgondien: Thank you, Jennifer. Here is a question that's not really specifically related to the Specifications Manual, but I am going to go ahead and respond to it because we get this question a lot. And the question is: "How many individuals can be enrolled on the NHSN website? If someone is leaving our organization, how can we help them and add another data entry person?"

The answer there is that there must be one main person designated as the facility administrator. That person may then delegate rights as they see fit. Everyone must have a SAMS card to access NHSN. If the facility administrator is still available, the rights can be transferred in a -- in NHSN. If that person is gone, then you must send notification to NHSN indicating a new administrator will be assigned.

Marianna, I have another question for you for ASC-12. And the question is: "Are planned admissions excluded from the outcome measure -- from the outcome for measure ASC-12?"

Marianna Gorbaty: Yes, planned admissions are not counted as an outcome for this measure. Planned admissions are those planned by the hospital for anticipated medical treatment or procedures that must be provided in an inpatient setting, so the colonoscopy measure doesn't count planned hospital visits as an outcome because these are not signals of quality of care. CMS developed an algorithm that identifies planned readmissions, and this algorithm is applied 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.

If you are specific -- (in the) types of care that are always considered planned, the example would be like major organ transplant, rehabilitation, or maintenance chemotherapy. Otherwise, a planned admission is defined as a non-acute admission for a scheduled procedure. For example, a total hip replacement and admission for an acute illness or for a complication of care, as well as all emergency department and observation stay hospital visits, are never considered planned.

For more information on the planned re-admission algorithm as it is adapted to the colonoscopy measure, please refer to the methodology report the links to which we are -- are available in the introduction to the measure information form for ASC-12. And we also mentioned this on the slides in today's presentation.

Karen VanBourgondien: Thank you, Marianna. And on that note, I have another question for ASC-12, and the question is: "Since measure implementation is based on calendar year 2016 data, when will my facility receive a patient detail report, or will the patient detail report include the ASC-12 measure?"

Marianna Gorbaty: Thank you, Karen. In preparation for the implementation, CMS will make Claims Detail Reports, the reports of CDRs, available at three stages prior to the final measure calculation and public reporting of measure results. The Claim Detail Reports will provide eligible facilities with information on their colonoscopy cases that will be included in the measure calculation. And the first CDR reports were provided to the facilities in September 2016. The second reports with updated data will be provided to facilities in December of 2016. Thank you.

Karen VanBourgondien: Thank you, Marianna, and just a reminder that we did mention that very early on as well in the presentation. Jennifer, I think I have another one for you, and the question is: "If there is documentation that the patient had a colonoscopy in 2013 and documentation that the patient had a colonoscopy in 2015, which one do I use to determine the interval?"

Jennifer Witt: That's a great question. When establishing the interval since the last colonoscopy, use the most recent documentation of their previous colonoscopy. In the example provided, the most recent documentation of a previous colonoscopy appears to be 2015.

Karen VanBourgondien: Yes, thank you, Jennifer. I appreciate that. Marianna, again we have another question for ASC-12. The question is: "Is there a way to see what patients had outcomes if they were not at our facility?" – I'm sorry, let me re-read that – "If there is a way to see what patients had outcomes if they were not at our facility?"

Jennifer Witt: Okay, yes, and thank you, Karen. Yes, Table 1 of the Claims Detail Report provides information on the types of the outcomes for each case included in the provider ID of the hospital where the inpatient stay, observation stay, or emergency department visits took place.

Karen VanBourgondien: Next question: "When are the web-based measures due?" Okay, so we talked about this a little bit, but this person says: "I heard you say the flu vaccination was due May 15th, but I think I heard somewhere that the other measures were due then, too. Is that correct?" Again, a great question. And yes, you are correct. The calendar year 2017 final rule signalled the change in deadline from August 15th to May 15th in the year prior to the affected payment determination.

Now to be clear, right now we are talking about the measures that are entered into QualityNet. This change will go into effect for the calendar year 2019 payment determination and subsequent years. So you will be entering that data in the year 2018. So, when you are entering your data in the year 2018, all of your web-based measures will have the same due date, and that will be May 15th. Just to let you know, CMS did just present a webinar last month discussing the final rule, so please feel free to visit our website to listen to that webinar. That will kind of give you an update of everything that has transpired and what the changes are for the program moving forward. And again, that will be on our website at www.qualityreportingcenter.com.

And I hate to do this, but this is going to be our last question, and it's for you on ASC-12. Here is the question: "In reviewing our facility's Claims Detail Reports, CDRs – I believe you just spoke to that – some hospital visits following colonoscopies performed at our facility were for unrelated reasons. Why is my facility being held responsible?"

Marianna Gorbaty: Yes, we see this question a lot. We discussed that the measure removes the planned hospital admissions from the outcome. The measure measures all-cause hospital visits to current facilities to minimize all types of risks that may lead to the need for a hospital visit after a colonoscopy. Measuring only hospital visits that are potentially related to the colonoscopy, such as gastrointestinal bleeding, would limit the measure on the test of quality improvement efforts. Measuring all-cause patient outcomes encourages facilities to minimize the risk of a broad range of outcomes, including the risk of dehydration, pain, dizziness, and urinary retention. This is a common problem that may be related or unrelated to a recent colonoscopy. We have structured the measure so that the facilities that most effectively minimize patient risk of these outcomes will perform better on the measure. We do not expect the rate of hospital visits to be zero since some patients will have visits for reasons completely unrelated to the colonoscopy.

This measure is risk-adjusted so facilities that are more likely to experience unrelated visits because they have a generally high risk patient mix are not disadvantaged in this measure.

Karen VanBourgondien: Thank you, Marianna. Thanks again, everybody.

That's going to do for us today. Again, I appreciate all our speakers. Have a great day.