Ambulatory Surgical Center Quality Reporting Program

Support Contractor

Ambulatory Surgical Center Quality Reporting (ASCQR) Program 2015 Specifications Manual, Version 4.0a

Presentation Transcript

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Karen VanBourgondien: Hello and welcome to the ASC Program Webinar. Thank you for joining us today. My name is Karen VanBourgondien, and I'm the Education Coordinator. If you have not yet downloaded today's handouts, you can get them from our website at www.qualityreportingcenter.com. Go to the events banner on the right side of the page, click on Today's Event. Go to Event Resources 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.

Before we begin today's program, I'd just like to highlight some important dates and announcements. As a reminder, the requirement for reporting the claims-based measures is 50 percent or greater of your QDC submission be via a 1500 claims form. It is recommended that you intermittently check this and ensure you are meeting this requirement. There have been incidents where a facility has installed new software and was unaware that the claims were not transferring correctly. Please keep an eye out for that.

The submission period for the web-based measures opened on January 1st and extends through August 15th. We cannot stress enough the importance of not waiting until the last minute to enter this data. As submission deadlines arrive, QualityNet does get congested. We don't want anybody having difficulty submitting their

data due to technical issues. CMS does provide quite a large window of time for you to get your web-based measures completed. So please utilize this time and get your data in early.

As you will see on this slide, there has been a technical issue on QualityNet with regard to ASC-9 and -10 which has proved difficult for some individuals. This seems to be intermittent, and it seems to affect more of the facilities that are trying to enter zero into the ASC-9 and -10 measures. They are working to resolve this issue. In addition, let me just mention that if you are a facility that has already entered your data for ASC-6 and -7, you will have to go back and enter for ASC-9 and -10. Even if you are a facility that does not do colonoscopies – say, if you're an eye center -- you have to go back and put in zeros for this measure, for both of them.

As you all know, ASC-8 is submitted to the CDC and the NHSN. If you have not registered yet, we highly recommend that you do not delay any longer. This process can be lengthy. Again, we don't want to see you unable to submit this measure because you did not register timely. If you are experiencing difficulty with registration, please contact the CDC/NHSN web Help Desk.

Although we are the Support Contractor for the ASC program, if you are having difficulty with regard to ASC-8, you will need to contact them directly. There is no phone support for the NHSN. The only means of contact is through email, and this is noted here on this slide. On April 22nd, we will be presenting the webinar, Understanding the Web-based Measures. We will be discussing all of the web-based measures, but there will be a focus on ASC-9 and -10.

Now, understanding you are currently in the process of entering this data, we have received a lot of feedback from ASCs with questions regarding web-based measures, but in particular with regard to ASC-9. Therefore, we do find it necessary to provide some additional education and to help clarify things and make abstraction for these measures a little smoother. Additional webinars and educational opportunities will be forthcoming, and, as always, we will send notifications through the ListServe.

The learning objectives for this program are listed here on slide four. The program is being recorded. A transcript of today's presentation and the audio portion of today's program will be posted on qualityreportingcenter.com at a later date.

During today's webinar, please do not use the chat feature that you see on your WebEx screen. We do not monitor this function during the program. However, we will follow this presentation with a question-and-answer session until about the top of the hour.

I'm pleased to introduce today's speaker, Renee Parks, who joined FMQAI in 2012 as a Project Coordinator and is now the ASCQR Program Lead. Renee received her bachelor of science in nursing from the University of Central Arkansas. Her previous experience includes coding, reimbursement, home health and infusion services, hospital-based patient care, managed care, and administration. She's developed best practices and implemented healthcare standards and regulations. She was also an instructor for the Surgical Technical Program in the U.S. Army Corp and at the University of Arkansas Fort Smith for surgical services. And now, I'll turn the program over to Reneé.

Reneé Parks: Thank you Karen, and thanks everyone for joining us today. We will be going over the changes from the Specifications Manual. As we will discuss these changes that occurred from the 3.0c which covered the 2014 event to 4.0 which covers the 2015, and then continue as we will highlight some things that occurred from 4.0 to 4.0a.

Now before we begin and discuss these changes, let's talk about the Specifications Manual process briefly. As you know, you have been using the Specifications Manual since the inception of the program and, most recently, 3.0c, and will continue to do so when you are reporting and reflecting back for any of those encounters that occurred up through December 31st of 2014. Starting with the encounters effective January 1, 2015, you will use the version 4.0 that is posted on QualityNet.

So now the question becomes, you may ask, "What is 4.0a then?" And that's a very good question. What happens is that from time to time, a manual is released, and from the time it has the application until you begin to abstract for those application encounter dates, things surface with regard to certain aspects regarding the measures. This will happen, as I said, occasionally. Thus, we provide what are called release notes, and you will also notice on QualityNet that there are some release notes with each manual. These release notes let you know what have -- what changes have occurred. And the release notes and the addendums, or the point as are final tweaks and changes that were made as a result of discoveries that were found once the manual was released. The

important thing to remember is you always use the manual that corresponds to the correct encounter date.

So now let's move forward and discuss briefly some of the changes from the 3.0c to the 4.0 manuals. There were not very many changes, but we will briefly discuss them so that you are aware of them. Again, these are reflected also in the release notes.

First, the copyright changes were revised to reflect the current CPT language. There was also a typo in the data submission date for the measure ASC-7 on Table 1: ASC quality measures, reporting periods, and payment years affected, as there was a change under the reporting period for A - of the column for ASC-7 to reflect January 1, 2014, through December 31, 2014, with the date of submission period reflecting January 1, 2015, through August 15, 2015. Also for ASC-9 and -10, the V code V13.89 was removed, as this code is a non-specific code specifically for the history of colonic polyps.

Now as we transition to the next slide, we're going to highlight the changes from the 4.0 manual to the 4.0a addendum. As noted on the slide -- on this slide, the table of contents will reflect updates and additions for ASC-12. This new measure will be discussed in detail a little later in the presentation. Table 1 will have the changes to reflect the current time period. Essentially, the reporting period and the payment years affected have been updated. Please remember that the reporting period or encounter date for ASC-9, -10 and also -11 will be from January 1 through December 31st moving forward, effective with the January 1, 2015, encounters. You now will have encounter dates with 12 months' worth of data versus nine months that you previously collected in 2014. You will also notice that ASC-12 is added to this table.

With regard to description changes, there is a change in accordance to the final rule. This change is in the name of the Extraordinary Circumstance Extension and Waiver Request Process to now becoming the Extraordinary Circumstance Extension or Exemptions Request Process. Essentially, a name change with the removal of waiver and the insertion of exemption, as this name more accurately reflects the process. Of course, ASC-1 through -5 were updated to reflect the current time period. The reporting period for these Medicare claims begin with January 1st and continue through December 31st of each calendar year.

So that is basically the updates from one manual to another. Now let's look at the specific measure changes, so we're going to switch

gears a little bit. With regard to ASC-7 and ASC-11 or -- you remember ASC-7 is the facility volume data and is on selected ASC's surgical procedures, and then ASC-11 now voluntary for collection, is the Cataract measure or the Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery.

We would like to make one note on the ASC-7 on this next slide for your facility volume data for your selected surgical procedures that are listed. These surgical procedure codes are listed in Table 2. Categories and HCPCS codes for ASC-7 remain unchanged in this addendum to the January 1, 2015, manual. However, the data is currently being analyzed and, if as a result of this data analysis, changes need to be made to the codes and the table that reflect accurately for ASC-7, they will be reflected in a future addendum to the 2015 version of the manual. An addendum is likely as the top 100 codes do change from year to year. The top performing codes, or the top 50, generally do not change, but it is the lower 50 to 100 that may shift, and some on the lower end fall out, and others take their place.

Now let's move to the next slide, Slide 10, where we will discuss the application for ASC-11 or the Cataract Measure – Improvement in Visual Function – Patient's Visual Function within 90 Days Following Cataract Surgery. The following paragraph on this slide in quotes is directly from the final rule. This was added to the Measure Information Form or otherwise referred to -- otherwise known as the MIF, so that it is reflected in the Specifications Manual as well as from the rule.

The ASCs that choose to submit data for ASC-11, such data should be submitted using the data submission requirement and timeline finalized in the calendar year 2014 OPPS/ASC final rule with comment period. ASCs will not be subject to a payment reduction for failing to report this measure during the period of voluntary reporting for this measure. However, if you do report on this measure into QualityNet, that data is subject to be publicly reported.

Now let's talk about ASC-12, and that is your Facility 7-Day Risk-Standardized Hospital Visit Rate after an Outpatient or ASC Colonoscopy. This is an administrative claims database measure, so there is no abstraction and no responsibility on the part of the facility to actually enter data. CMS has finalized the adoption of this measure in the for the ASC Quality Reporting Program for the calendar year 2018 payment determination and subsequent years.

A colonoscopy is a common procedure, and we estimate that 1.7 [million] colonoscopies are performed annually among the Medicare Fee-for-Service patients utilizing the measure's cohort definition from the Specifications Manual. Given the widespread use of colonoscopies in the ASC and outpatient setting, understanding and minimizing procedure-related adverse events is a high priority. Many post-colonoscopy hospital visits are currently not visible to not only the provider performing the procedures, but also they are not visible to the facilities where the procedure was performed.

Furthermore, most of these outcomes are preventable. The leading causes of hospital visits include abdominal pain, abdominal distention, nausea, and vomiting, as well as pulmonary or cardiovascular complications. The most severe cases or causes of hospital visits following a colonoscopy include colonic perforation and gastrointestinal bleeding, or a GI bleed. In addition, the measure shows – with the calculations, the measure will show variation in facilities' performances.

Now let's take a little closer look at the next slide, the second slide of the measure rationale. This measure will address the information gap and promote quality improvement, which is the ultimate goal of the ASC Quality Reporting Program. The technical expert panel favorably reviewed the measure during development, and the measure is supported by the National Quality Forum Steering Committee.

Now let's take a look -- that was rationale behind and some of the things that occurred. Let's take a closer look at the overview of this measure. CMS calculates the facility-level risk-standardized unplanned hospital visit rate, and the facilities do not have sufficient data at their disposal to produce these facilities' risk-standardized unplanned hospital visit rate themselves. CMS utilizes physician's office or Part B claims from Medicare, inpatient and outpatient claims data from the year prior to the colonoscopy, as well as claims data from the colonoscopy to risk-adjust the rate for this measure.

This data is used to determine whether a beneficiary has had a hospital visit within seven days of the colonoscopy. The colonoscopy measure score is an all-cause, unplanned hospital visit within seven days of an outpatient or ASC colonoscopy. This includes colonoscopies performed in both places, whether it be an outpatient, because CMS blends in, crosses programs where they see applicable, and this is one of the measures. So it is also on the

outpatient program as well as for ambulatory surgical centers with the ASC program.

The measure cohort for this particular measure, ASC-12, is your Medicare Fee-for-Service patient under 65 years and older undergoing a colonoscopy, as this measure excludes colonoscopies from patients who have a history of inflammatory bowel disease, or IBD. These are included as colonoscopies performed in the centers. The measured outcome for this hospitalization is any emergency department visit, observation stay, or unplanned inpatient admission within seven days of the colonoscopy. And they are collectively referred to as hospital stays, and knowing that there are some -- and they are listed in the Specifications Manual -- that will always be planned admissions. So please reference that in the Specifications Manual.

The measure cohort is the, again, the Medicare patients that are Fee-for-Service. It excludes those who are on your HMO Medicare Replacement Policy and those who are 65 in Medicare Fee-for-Service who have been enrolled in Medicare Part A&B for the prior 12 months to date and following one month post-colonoscopy. The measure excludes, again, the colonoscopies for history of IBD and also diverticulitis, along with those who are having a concurrent procedure for a high risk upper GI procedure. And note, that if a Medicare beneficiary within that 12 months preceding the colonoscopy is new to Medicare or had for some reason was -- had a break in service, those will be excluded as well.

The hierarchical logistical regression model is the practice of building successive linear regression models, and with each regression, they add another variable into the hierarchy. This particular risk-adjusted model uses 15 variables that are listed on the next slide, but for our discussion, the difference between the hierarchical and the regular models is that in the hierarchy that -- there is a hierarchy that impacts results.

For example, if an ASC level or an ASC corporation level data is associated with the results, the ASC level or the corporation level data should be used and addressed and stated in the model. The level can be more than one. For example, they could also look at rural and urban. The methodology should tell which hierarchy is used.

In brief, the approach simultaneously models two levels with this measure. It looks at the patient and the facility to account for the variance in the patient outcomes within and between facilities. And

again, the data source is the claims data, and then it is risk-adjusted based on the model and the variables. And on the next slide, we will take a look at the risk-adjusted variables.

This model adjusts for clinical comorbidities and procedural variables that vary across patient populations but are unrelated to quality and influence the outcome to help insure that differences in measure score do not reflect differences in case mixes across the facility. The facility-specific rates are adjusted for the differences in patient characteristics such as AIDS, clinical risk factors, and procedural variables. The measure seeks to adjust for factors that are unrelated to quality and case-mix differences across the facility. This slide presents an overview of these 15 risk-adjusted variables for this particular measure.

CMS plans to hold a dry run for this measure later in 2015. The timing of the dry run is to be determined and announced at a future date. The dry run will provide the opportunity for facilities to receive confidential reports of their data prior to any future public reporting. The goal is to give facilities an opportunity to learn and become familiar with the colonoscopy measures and their results confidentially. So I would like to stress here that each facility would need to have an active Security Administrator in order to be able to receive these confidential reports because they will be sent via secure file exchange on the QualityNet Secure Portal.

In addition to reporting the measure score with this dry run, CMS -- and in the future moving forward when it affects payment in 2018, CMS intends to provide facilities with these specific reports that will contain confidential patient-level data where those patients that fall and are included in the measure score. And this will allow ASCs to be better informed and allow the opportunity for each facility to identify potential gaps for areas that could include quality improvement efforts.

CMS will share this information related to the measure scores and address questions from ASCs and other stakeholders during the dry run. And as Karen stated, we encourage everyone to sign up for the ListServe as this is our primary method of communication for information along those lines with this community.

The dry run results are not linked to public reporting or payment determinations with the dry run. Measure development of this that -- from the technical expert panel and the support of the NQF -- was based on a 20 percent sample size of Medicare Fee-for-Service claims. However, testing during the dry run will be a complete 100

percent utilization of claims per facility to assist in determining the appropriate cut-off volume for colonoscopies per facility in the future.

And this concludes the presentation on the changes for the Specifications Manual update, and I will now turn the program back over to Karen.

Karen VanBourgondien: While we wait for the first question, I'd like to remind you that this webinar has been approved for one continuing education credit by the boards listed here on this slide. We now have an online CE certificate process. There are three ways to receive your CEs: two are through WebEx, and one is through the phone only. If you registered for the webinar today through WebEx, you will receive a survey, and this will come from WebEx within the next 48 hours. Please be advised, it will not arrive today.

Once you've completed this survey, you will be sent to a site to download your CE certificate. If you are listening to this webinar with a colleague that did log into WebEx, ask them to forward you the survey from WebEx. And if you are listening to the webinar by phone only, since you did not register with WebEx, you will not receive the survey with the link to the CEs. However, in about three weeks, an online version of this webinar will be posted on the website listed here on this slide qualityreportingcenter.com, and you will be able to get your CE certificate.

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This material was prepared by the Outpatient Quality Reporting Outreach and Education Support Contractor under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). FL-OQR/ASC-Ch8-03102015-02