Ambulatory Surgical Center Quality Reporting Program

Support Contractor

Understanding Web-Based Measures for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Presentation

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Marty Ball: Hello and welcome to the ASC Program webinar. Thank you for joining us today. My name is Marty Ball, and I am the manager of the Hospital Outpatient Program and have been involved with the ASC Support Contractor since the program's inception.

If you have not yet downloaded today's handouts, you can get them from our website at qualityreportingcenter.com. On the right side of the page, there's a banner which says "Upcoming Events." Click on this event. This will take you to the webinar page.

You can choose the presenter slides as one per page or three per page. As you can see, we are using a different platform this time, as we are live streaming in lieu of using only phone lines.

Before we begin today's program, I would like to highlight some important dates and announcements. As a reminder, the requirement for reporting the claims-based measures is 50 percent or greater for your Quality Data Code submission via the 1500 claim forms.

It is recommended that you intermittently check this through the reports available for the ASCs in the QualityNet Secure Portal to ensure that you're meeting this requirement. There have been incidents where the facility has installed new software and that was causing the claims not to transfer correctly.

The submission period for the web-based measures opened on January 1 and has been extended until August 15. We cannot stress enough the importance of not waiting until the last minute to enter this data. As the submission deadline arrives, QualityNet servers get very congested and slow. We do not want to see anyone have difficulties with data submission due to technical issues. CMS provides quite a large window of time to get your web-based measures completed.

As noted on this slide, there have been technical issues on QualityNet with regard to ASC-9 and -10. This issue has been resolved. All ASCs, including facilities that are entering zeroes, should be able to enter their data without difficulty.

As you all should know, ASC-8 is submitted to CDC. If you've not yet registered with the National Healthcare Safety Network, we highly recommend that you do not delay any longer. The process can be lengthy and may take six to eight weeks.

There was a webinar on this process on May 6. If you missed this, you can access this webinar on the qualityreportingcenter.com website. The submission deadline for ASC-8 is August 15, 2015.

On July 16, Yale will be presenting information regarding the dry run results for the new ASC-12 measure, with more information forthcoming. On July 23, Anita Bhatia from CMS will be presenting the Proposed 2016 Outpatient Prospective Payment System/Ambulatory Surgical Center Rule with Comment Period.

Additional webinars and educational opportunities will be forthcoming. Notifications will be sent via the ListServe. If you're not currently on the ListServe notifications, please take the time to go to qualitynet.org and sign up. It only takes a few minutes. This is an easy way to get up-to-date information regarding the program sent to your email inbox. Please refer to our website at qualityreportingcenter.com, as seen here, for the current information.

The learning objectives for this program are listed here on this slide. This program is being recorded. A transcript of today's presentation and the Q&As asked in the chat box during today's presentation will all be posted again at www.qualityreportingcenter.com at a later date.

Now I am pleased to introduce today's speaker, Karen VanBourgondien. Karen joined HSAG in 2012 and has been working on the ASC team since last year. Karen earned her bachelor's degree in nursing from the University of South Florida. She has extensive clinical experience in ICU, CCU, PACU, Pre-Op, and the emergency department. She also has clinical educational experience, as well as data collection, clinical abstraction, and clinical quality improvement experience. Now I will turn the presentation over to Karen.

Karen VanBourgondien: Thank you, Marty. Hello everyone, thank you for joining us. Today we are going to talk about all the web-based measures, but we are really going to focus on ASC-9 and -10. We have received numerous calls and emails regarding these two measures, so it warrants trying to provide additional information so that, hopefully, we can make your life as abstractors a little easier.

As we move forward in the presentation, you will notice we will spend significant time discussing and analyzing these two measures. On this slide you can see some of the web-based measures. We will discuss these particular measures briefly, as they are relatively straightforward.

ASC-6 – this measure wants to know if your facility used a safe surgery checklist during the entire year. This answer will simply be "yes" or "no."

ASC-7 – this is the aggregate count of surgical codes that match the HCPCS codes found in the Specifications Manual. Please be advised that these codes are updated annually by CMS. Codes from the 4.0a and 4.1 manuals are the same and are for the entire year. Although there are two manuals, the codes are the same, and you will not report more than once.

ASC-8 measures the healthcare vaccination information. The facility must report vaccination data for individuals that fall into the categories and are employed one day or more from October 1, 2014, through March 31, 2015. The measure is reported through the CDC and NHSN. The CDC presented a webinar on May 6 on the reporting of this measure. If you missed that, please go to our website at qualityreportingcenter.com to review this webinar. The recording should be posted in the next couple of weeks. As there is no phone number provided by the NHSN, you will need to use the email address. The helpdesk email for this measure is NHSN@cdc.gov, as shown here on this slide. Please keep this handy.

Okay, we've come to a polling question. At this time I'll turn it over to our host to introduce the question.

Operator: Thank you so much, Karen. And we've come to a spot where we like to ask a few polling questions and get the pulse of the attendees that are on today's call.

And this question is a straightforward question that asks, "Has your facility completed enrollment for ASC-8 with CDC/NHSN?" And your four answers are "yes," "no," "haven't started yet," or "I don't know."

We have 76.8 percent of you that said, "Yes, we've completed enrollment," and then the remainders–most of you don't know– the majority of those who answered, "Not yet," and "Don't know," so it's broken down to about three quarters of you have completed enrollment for this ASC-8 measure; that's great.

The next question we're going to ask here is related to that -- now this is related to that -- now this is for those of you who did not answer yes on the last one; about a quarter of you did not answer yes.

And the question is: If your facility has not completed enrollment, what best describes the reason for that? Have you started it but not completed it? Started it but encountered difficulty during enrollment? It's just too difficult to enroll, or we didn't know about it?

Let's take a look at what our responses were. About 40 percent of you, just the lower 40 percent, have started but not completed, and about 35 said we didn't know about it. So there are your two majority answers there.

So that really -- thank you for answering this question and the previous question. It really does help us understand what's going on in the community and gives us a better idea of where we all stand together as a group. But that's going to do it for our first two polling questions. We'll have another one in just a little bit, but I am going to hand it back to our speakers now to continue the presentation. Thank you.

Karen VanBourgondien: Now we're going to switch gears a little, and we're going to discuss the next couple of measures in detail. ASC-9, as you can see from this slide, is measuring appropriate follow-up interval. First we are going to go over this standard language here, and then we're going to take a few minutes to discuss this in detail.

To begin with, this measure is looking at a patient population of individuals that are 50 years and older who are receiving a screening colonoscopy with no biopsy or polypectomy and no history of biopsy or polypectomy, and with a recommendation of a repeat colonoscopy of at least 10 years documented on the colonoscopy report.

Let's talk about the denominator. As you see on this slide, the patients that are going to be in your denominator are, again, 50 or older that are receiving a screening colonoscopy without biopsy or polypectomy.

Let's say, for example, a patient named John comes in for a screening colonoscopy. He's 57 years old, he has no polyps during his colonoscopy, and he was not biopsied. He will be in your denominator.

Conversely, if the same patient came in but did have a polyp removed, he is not in the denominator. If the patient does not fit into the denominator, you are done.

Let's talk about the numerator. For the numerator, this measure is looking for documentation by the physician in the colonoscopy report that there is a time interval of at least 10 years for a repeat colonoscopy.

The previous patient John, who was in the denominator because he was 57, did not have a polyp removed and did not have a biopsy, then there needs to be documentation on the colonoscopy report that a follow-up colonoscopy is recommended for at least 10 years.

So with this patient, if the physician documents something like, "follow up in five to 10 years," then they will not be in the numerator. Again, the measure is looking for a recommendation for follow-up colonoscopy of at least 10 years. A range of less than this does not meet that criteria.

All right now, let's talk a while about exclusion to this measure in a little more detail.

One exclusion for ASC-9 is in the form of documentation of a medical reason for not recommending at least a 10-year follow-up interval. As you will recall in the previous slide, there had to be a recommendation of at least 10 years. So if there is documentation of a medical reason for not recommending this interval, then this completely excludes these patients from the measure.

Well, what does this mean exactly? Documentation of a medical reason can be a diagnosis, reason, symptom, complaint, or condition documented in the medical record.

Right now, CMS does not have an inclusive list of medical reasons. Additionally, a medical reason could be inadequate prep. So, for example, the physician felt he could not properly view the colon, so he recommended a shorter follow-up. In that case, the physician just needs to document that as the reason for a shorter follow-up interval. The important issue here is there must be documentation of a medical reason if the follow-up interval is less than 10 years. Remember, the intent of the measure is not to justify the current colonoscopy but to avoid inappropriate use.

Although we get various questions with a wide range of scenarios, we have categorized them into the three general themes here on this slide. Some of these have been touched on briefly but warrant more discussion. We're going to discuss each of these individually in greater detail.

Now, we previously discussed medical reasons for exclusions. Again, let's go into more detail regarding this topic. This slide includes medical reasons for exclusion. If the physician documents in the medical record that the patient is above average risk and therefore recommends a shorter interval than 10 years, this would be criteria for exclusion from the measure.

So let's say, for example, the physician documents high risk screening and then recommends follow-up in five years. This would be a reason to exclude the patient from the measure, as the physician has documented the medical reason for a less than 10-year interval because that patient is high risk.

Again, CMS does not have an inclusive list of medical reasons. This is up to the discretion of the physician. It can be a symptom, condition, reason or diagnosis that a physician feels warrants a patient having a less than 10-year follow-up interval for repeat colonoscopy.

If the physician documents a medical reason for a follow-up interval of less than 10 years, then that patient would be excluded from the measure. Inadequate prep is also a reason for exclusion. If a patient had a colonoscopy and the physician was unable to properly view the colon, and this is documented as the medical reason, then this is reason for exclusion.

Remember, it is the physician's discretion to determine if there's a medical reason for recommending a shorter interval of less than 10 years. It is worth mentioning that you should not use a medical reason for exclusion if the recommendation for at least 10 years for follow-up has been made.

If that recommendation has been made, you want to keep that in your population. It would meet the denominator and numerator criteria, so it's a positive. You want credit, so to speak, for meeting the measure criteria. You would only use "medical reason" as an exclusion from the denominator if the recommendation of less than a 10-year follow-up is made.

On this slide there is a question of age and does it matter with the recommendation of the follow-up interval. In order to exclude a patient based on age, the physician should clearly state in the documentation that age is the medical reason for not recommending a follow-up interval of at least 10 years.

An example of that would be "I am not recommending follow-up at this time based on age." The physician has to make clear the medical reason is the age. Now, as stated prior, the decision to continue screening is made by the physician based on clinical judgment.

The guidelines from the U.S. Preventative Services Task Force (USPSTF) recommend that screening should not be continued after the age of 85 because the risk of the procedure could exceed the potential benefit.

For patients that will be between the ages of 75 and 84 at the time of their next colonoscopy, the physicians should document the age-related reason for not scheduling the next colonoscopy for at least 10 years.

Now, next we are going to talk about the documentation of at least 10 years. On this slide, the question is “What if there’s a range?” If there is documentation of, say, five to 10 years, how is this answered?

Well, this is a relatively common question, and we have already discussed it briefly. To answer this, let’s talk about a few things. First, on the Measure Information Form, also referred to as MIF, the numerator of this measure is all the patients who have a recommended follow-up interval of at least 10 years for a repeat colonoscopy documented in their colonoscopy report.

If you have a range of anything less than 10 years, then that does not meet the criteria. This measure is looking for a recommendation of at least 10 years for follow-up.

Remember, the measure is concerned with appropriate follow-up. If you have a patient that meets all the denominator criteria, but the physician did not document a 10-year follow-up, then the patient will be in the denominator but excluded from the numerator.

Let’s take all of this information and put it into practice with some patient scenarios. Patient number one is a 58-year old male with no previous colonoscopy, and the colonoscopy report says “normal exam,” and the physician has documented a follow-up interval of 10 years.

This is a very straightforward example. Let’s first decide if the patient belongs in the denominator. To fit in the denominator, the patient has to be 50 years or older and is receiving a screening colonoscopy without a biopsy or a polypectomy. This patient fits that criteria, so this patient is in the denominator.

Let’s look and see if that’s in the numerator. To fit in the numerator, again looking at the MIF, the patients that are going to be counted in the numerator are patients that have a recommended follow-up interval of at least 10 years for a repeat colonoscopy documented on the colonoscopy report.

This patient would fit into the numerator as well. So this fictional patient fits into the numerator and denominator. If you looked at this same patient, and the physician documented in the colonoscopy report that the follow-up would be in five to 10 years, then the patient would be in the denominator but not in the numerator.

Let's look at another patient. Patient number two is a 68-year old female receiving a screening colonoscopy with no previous colonoscopy. The colonoscopy report states no polyps, no biopsy, and the physician documents that this is a high risk patient and recommends follow-up in five years.

In this particular scenario, the patient is excluded from the denominator because there's a medical reason documented by the physician. This excludes the patient from the measure.

If the physician did not document that the patient was a high risk patient and did not document any other medical reason for recommending a follow-up interval of less than 10 years, then the patient would be in the denominator but not in the numerator.

Our next patient is a 60-year old male receiving a screening colonoscopy. The physician performs a biopsy during a colonoscopy and is awaiting results. The physician documents "awaiting biopsy results, will follow up in office." Well, with this situation, the patient had a biopsy. This case would be excluded from the ASC-9 measure all together.

To meet the criteria for the denominator, the patient has to be 50 years of age or older, which this patient is, without biopsy or polypectomy. So, if this patient had a biopsy or a polypectomy, they are not in the measure. When you are abstracting, first see if they fit in the denominator. If they don't fit in the denominator, then they are excluded from the measure, and you are done. There is no reason to evaluate the numerator.

There are numerous scenarios and situations, as you very well know.

We are just trying to incorporate a few examples to assist you in deciding how to analyze this information and, hopefully, make your abstraction easier.

Now we're going to switch and go to ASC-10 and discuss that measure in a little more detail. On this slide we have the description, numerator, and denominator. The description as it reads in the Specifications Manual is on this slide, but let's take the time to talk about it a little.

The description outlines the measure. It is the percentage of patients 18 years and older receiving a surveillance colonoscopy who have a prior history of polyps in a previous colonoscopy, and it has been three years or more since the last colonoscopy. Right away you can see there are differences between ASC-9 and -10. For ASC-10, the denominator is patients that are 18 or older with history of polyps on a previous colonoscopy.

The numerator is all patients who have had an interval of three or more years since the last colonoscopy. Remember, this measure is interested in the avoidance of inappropriate use.

Various task forces and statistical data show that for patients with a history of polyps it is not beneficial to have a repeat colonoscopy in less than three years. And that is what this measure is all about.

Denominator exclusions: Okay, let's break this down step-by-step. You can see on this slide the denominator exclusions as written in the MIF. As we have stated before, if the physician has a medical reason for doing this repeat colonoscopy in a shorter interval than three years, it should be documented.

In ASC-10, we are looking at the interval since the last colonoscopy and ensuring it has been at least three years. With ASC-9 we are looking for the physician to document in the current colonoscopy report a recommendation of at least a 10-year follow-up; don't get those two confused.

System reason: What does this mean? Let's say the previous report cannot be located, maybe they are out-of-state and you can't get the medical record, you

can't obtain the report … whatever the situation. In this case, there must be documentation in the present medical record event stating that. Essentially, the physician needs to document that there has been an interval of less than three years and the system reason. If this is documented, then this case would be excluded from the measure for a system reason.

On this side, we have once again sort of 'lumped together' the categories of the most frequently asked questions. As you know, sometimes when you are abstracting things, it's not always black and white, and there are a number of variances that can occur, and we definitely understand that.

For simplicity's sake, we are going to use broad examples to hopefully appeal to the situations that arise most frequently. Let's discuss each one of these in a little more detail.

We discussed medical reasons for exclusion in detail when we were discussing ASC-9. Well, the principle's the same. The physician must document a reason as to why they are repeating a colonoscopy in less than three years. On this slide you will see some examples of medical reasons. Again, there is no inclusive list of medical reasons; it is up to the discretion of the physician.

With regards to the last colonoscopy being incomplete, there are numerous reasons why a previous colonoscopy was not completed such as: there was inadequate prep, an adverse reaction of the patient, among others. The important point is, again, there must be documentation. Now with regard to acute symptoms, there are situations when a colonoscopy may be necessary in shorter time intervals due to acute symptoms.

In these cases, the patient would be excluded from your sample. They are excluded from your denominator. This is a medical reason. Remember the intent of the measure is to avoid inappropriate use.

Date of last colonoscopy: With regard to the first issue on this slide, what do we do if we do not know the exact date of the last colonoscopy? If you do not know when that date is and the patient meets the denominator inclusion criteria, then

they would be in the denominator but not in the numerator. Since the numerator states that there have been three or more years since the last colonoscopy, you cannot say that they met that, if you do not know what that was.

Dates of last colonoscopy: This gets very confusing for people. The specifics of the date of the previous colonoscopy must match. In short, if you only have the year of the last colonoscopy, then you use the year. In the situation whether there is a month and a year, then the date of that has to be at least three years. If you have the month, a day, and the year, then the repeat colonoscopy has to be at least three years from that month, that day, and that year. So if the patient had a colonoscopy in December of 2011 and he is there for a repeat colonoscopy in November 2014, he will not meet the numerator criteria.

The issue regarding physician office notes and colonoscopy dates: If this information is not included in the current medical episode, it cannot be used. You cannot go retrospectively and look into physician offices' notes. However, if there is documentation in the current episode of care regarding the office notes and the date, then it can be utilized.

The information regarding the interval between the previous and current colonoscopy can be documented anywhere in the current medical encounter.

Let's put this information into practice with some imaginary patients. Fictitious patient number one is 30-years old with a history of polypectomy. The patient is not sure when the last colonoscopy was, and the colonoscopy report is unavailable. In this example, the patient does not know the date of the last colonoscopy, and the previous report is not available. This will exclude the patient from the denominator due to a system reason if there is appropriate documentation of this by the physician. Remember to use the system reason as a denominator exclusion. There must be documentation of an interval of less than three years and the system reason. Without this documentation, the case would be counted in the denominator but not in the numerator.

Now this scenario was slightly different, and the patient was unable to state the date of the last colonoscopy. The situation is different. If you do not have the previous colonoscopy report, the information regarding the history of colonic polyps and the date of the last colonoscopy may be obtained from the patient or another facility. If the year of the previous colonoscopy is known and documented in the current record, this will establish the interval between the colonoscopies. The previous colonoscopy report does not have to be placed in the current record.

Patient number two is a 48-year old female who had a previous polypectomy and biopsy with previous colonoscopy two years prior. The patient presents the symptoms of abdominal pain, sluggish digestion, and this is documented in the current episode of care. This patient would be excluded from the measure. Again, remember if there is a medical reason documented in the medical record, then the patient is excluded from the denominator. In this case, there is documentation of abdominal pain and sluggish digestion. As stated before, there is no inclusive list of medical reasons. This is always left to the discretion of the physician.

Patient number three is a 62-year old male who had a previous colonoscopy on January 29th 2012. During the last colonoscopy, the patient had multiple polyps removed with biopsy. Let's assume that today is the day the patient returns for his next colonoscopy. The date of the last colonoscopy was January 29th of 2012.

This puts it over three years because, remember, we have a month, a day, and a year in this scenario. So that is what we are going to use for the prior colonoscopy interval date. This patient would be in the denominator and the numerator. Now the month, day, and year is not required, and the interval will be based on whatever is provided.

Let's review this just for a minute. The patient meets the denominator criteria, because the patient is 18 or older, is receiving a surveillance colonoscopy, and

has a history of polyps. That patient also meets the numerator criteria because there is an interval of three or more years since their last colonoscopy. Again, the measure is capturing avoidance of inappropriate use. In this case the prior interval for colonoscopy has been three or more years; this is appropriate use of follow-up colonoscopy.

This concludes our practice patients. Let's discuss some helpful tools that are available to you. We know that patient charts and abstracting them are not always black and white. We do have some tools that are beneficial in trying to figure out who fits in the denominator and who fits in the numerator. If you go to our website at qualityreportingcenter.com, you will choose the tab "Resources and Tools." This will open a page with various tools available. If you go down to the Endoscopy Tools section, you will find the fact sheets, endoscopy tools, denominator codes … all regarding both ASC-9 and ASC-10. The fact sheets go over each measure, the denominator and numerator, and have helpful hints to assist you in abstraction. The tool sheet provides a step-by-step evaluation of what the criteria is to fit in both the numerator and denominator. Please take the time to go to that website and take a look at these; you may find them to be very helpful.

This is a tool for data collection for ASC-9 and ASC-10. The tool is designed to determine whether colonoscopy patients fall into the measures indicated, keeping in mind that ASC-9 looks at recommendations for future care looking forward and ASC-10 looks at previous care looking backwards. It may be beneficial for you to print this out or have an electronic copy available to refer to while you're abstracting. Again, this tool is under the "Resources and Tools" tab that we discussed just a moment ago. Remember, ASC-9 looks into the future; ASC-10 looks at the past history.

We've come to a polling question, so at this time I'll turn it over to our host to introduce the question.

Operator: Thank you, Karen, appreciate that again. We do have one more polling question that we'd like to ask. This will be similar to our last two questions. You'll just make a selection on the screen, and click the Submit button when you are done.

Let's go ahead and launch our third question of the day. This one is, "In what capacity have you utilized the abstraction tools that are available?" Your three choices are: "I've used them before;" "I knew of them, but I've never accessed them before;" or "I had no idea that they were there."

Let's take a look at the answers; 41.8 percent of you said had no idea they were there, so that's good information for us to know. Another 36.2 percent of you said that you have used them before. So let's say we had a nice roughly 30, 30 to 40 breakdown here on answers.

Karen VanBourgondien: Now we're going to move on to ASC-11. This measure is interested in patients that have had cataract surgery and have improvement in visual function over 90 days.

The patients that are going to be in the denominator are all patients that are 18 or older that had a pre- and post-visual function instrument and had cataract surgery. Patients that are in the numerator are going to be patients that achieved improvement in visual function within 90 days after surgery. And this is based on the completion of the pre- and post-visual function instruments.

Let's talk about the visual function instruments, as we already talked about the patient must have a pre- and post-visual function test to be in this measure.

The same tool must be used with pre- and post-evaluations. You cannot use different tools. People will sometimes ask if they can develop their own visual function tool; well, in short, the answer is no.

The visual function tool should be a data collection instrument that has been appropriately validated for the patient population. The visual function

assessment recommendation is the VFQ or the VF-14 and the modified VF-8. You will find this information in the Specifications Manual as well.

As most of you are aware, the final rule stated that this measure will be reported voluntarily. So if you do choose to submit this data, it is subject to public reporting.

That completes the measure-specific information, so now let's talk about a few other issues.

We are going to discuss sample size here briefly, as we do get quite a few questions regarding this issue as well. ASCs have the option to sample their population or submit their entire population. ASCs that choose to sample for these measures should use the simple sample approach, selecting the population from cases that meet requirements to be included in the denominator.

Once the population has been determined, the sample size will be determined. It will either be 63 or 96 cases per year. This is an annual total population for the colonoscopies performed.

Again, you can see by the chart on this slide the number of abstractions required. So let's say, for example, for ASC-9 that your facility does 1,000 screening colonoscopies; your sample size would be 96. So if you pulled 96 charts, and out of those 96 charts, 76 were in your denominator, then you would have to find 20 more charts to meet that 96 sample size requirement.

All of the charts in your sample size will meet denominator criteria. Now we have talked about the web-based measures, so let's talk about how to enter them into the QualityNet Secure Portal.

We will briefly discuss how to put the measures into the QualityNet Secure Portal for those of you that are new or others that just need a refresher. To enter the web-based measures you will go to the QualityNet Secure Portal. This is on

the main page to QualityNet. At this point you will choose the log-in icon shown here on the right to begin your log-in.

You will choose your program, which will be Ambulatory Surgical Center Quality Reporting Program. Log in to the QualityNet Secure Portal. If you are a new user and have not completed the identity proofing, please view the information provided on QualityNet on how to become a Secure Portal user. You will not be able to access the Portal without the proper rights. Assuming you have the appropriate access, you would then sign in as you regularly would into the Portal using your Symantec VIP access as well.

Select the “Quality Programs” drop-down and select “ASCQR Program.” As you can see here, it is the first selection on the drop-down box choices.

From the “My Tasks” page, select “Manage measures,” as circled here in red. It will say, “Manage Measures: View, Edit, Web-Based Measures, Data Acknowledgement.” You will then select “Ambulatory Surgical Center Web-Based Measures.” Be aware that my screens do look a little bit different, as I have national access and you will not.

Select the payment year from the drop-down box. You will be answering the web-based measures for January 1 through August 15, 2015. This is for your encounters in 2014 for payment year 2016, so you will select 2016. Once this page is displayed, you will select the measure you will be entering data for. You will click on the measure that you will be entering. They will be in blue, as shown here on this slide.

Let’s discuss here a minute about how to enter ASC-9 and -10. We have a lot of questions regarding this, and there seems to be a little bit of confusion. Please notice here that there are population and sampling fields. The reason for population and sampling to be included is that is the only way to determine whether you can mark the N/A button for zero colonoscopies. At the bottom of

the screen you will select “Calculate Percentages.” You will then need to select “Save” in order for your data to be captured.

Once again, we recommend you print a screenshot demonstrating that you have successfully entered this data into the QualityNet website. This pop-up box will appear each time “Return to Summary” is selected. If information was changed or if information needs to be changed after “Submit” was selected, then select “Cancel” in the pop-up to return to the submission screen, and then select “Submit” to save the changed information.

If you have submitted all your information and no changes have been made, then select “OK” to move on to the next measure. After answering the pop-up box “OK” question, you will be returned to the summary screen. You will notice on this slide that ASC-9 and -10 are not yet answered. When you have completed all of your web-based measures, it will read “Complete” under each measure.

This is the screen we suggest that you make a screenshot of to confirm all of your web-based measures have been answered. If you fail to answer all of your questions, you will then risk losing 2 percent of your facility’s APU.

Again, please save a screenshot of this screen showing that all your measures have successfully been answered and keep this for your records. We hope this has clarified the web-based measures, particularly ASC-9 and -10. Please take the time to look at the various tools that we mentioned earlier in the presentation that are available to you. Hopefully, they will assist you with the abstraction of these measures.

We’ve covered a lot of information today. In summary, we talked about the web-based measures, but we really focused on ASC-9 and -10. This seems to be what people are really stuck on, and we get that. So these are the new measures, and, hopefully, this presentation has helped you in further understanding these. Hopefully, applying the fictional patients was also of value.

We also discussed how to obtain information on QualityNet, as we looked at some screenshots with regard to this. In all, we hope this information has been informative and helpful to you.

I will now turn it back over to Marty.

Marty Ball: Thank you, Karen, for the information you shared with us today. We would like to share some of the questions we've had come into the chat box during the presentation.

For the first question I am going to share with the audience here is someone's asked, "I am confused about how to determine the population for ASC-9 and -10 can you explain that further?" For both of these measures you will use the ICD CPT codes noted in your Specifications Manual to obtain the population. Once you get your population for each measure, you will refer to the sampling table which is also in your Specifications Manual.

For a population for the size of zero to 900 cases, your sample size will be 63. If your population is 901 or more, then your sample size will be 96. The reason for this is that, if you have a large population, say over 900, well, CMS doesn't want you to abstract 1,000 cases. So you will just take a sample size. All the other cases in your sample size will need to meet the denominator criteria. Once you have this sample size, then you'll see those cases fit into the numerator criteria.

Karen, here is another question. The patient underwent a combination EGD and colonoscopy in the endoscopy suite. The physician obtained upper GI biopsies during the EGD, but no colonic biopsies during the colonoscopy. Will this patient be included in the ASC-9 denominator since no colonic biopsies were obtained?

Karen VanBourgondien: That's a really good question, Marty. The answer is yes. The patient would still be included in ASC-9. Upper GI biopsies are not considered in relation to the colonoscopy and would not be used as an exclusion. Only colon biopsies are cause for exclusion of the patient from the measure.

Here's a question, Marty, and we actually get this quite a bit. Since our facility does not perform many procedures from Medicare Fee-For-Service, are we required to participate in this reporting program?

Marty Ball: Well, Karen, no. Facilities with 240 or fewer Medicare Fee-for-Service primary and secondary Medicare claims in a single year are exempt from the ASCQR Program. And since they are exempt from reporting the measures, they are also exempt from any of the web-based measures with ASC-6, -7, -8, -9 and -10, so those are also all included in this exemption.

Karen VanBourgondien: Here's another question. The documentation -- this is somebody giving us a scenario, and it says the documentation states CMS recommends a 10-year follow-up: the risk and benefits related to this will be discussed on an individual basis. That is what the physician charted on in his colonoscopy report, and the person wants to know is this sufficient documentation to meet ASC-9, if the notation is found on the colonoscopy report. Well, the answer to that is no, this is not a recommended follow-up made by the physician.

He or she must make a recommendation for a follow-up on the colonoscopy report, as we all know. The point of the measure is to demonstrate adequate follow-up without over utilization.

Here's another question that's coming in, it's another scenario. The physician documents the last procedure with 6/6/12. It showed multiple adenomatous

polyps. Does the physician have to list the number of polyps for this to be a medical reason to exclude the patient from the measure?

That's a really good question; the answer is no. The physician does not need to document the number of polyps. If the physician documents the finding of multiple adenomatous polyps as the medical reason for a follow-up interval of less than three years, then that is acceptable. Determination of a medical reason for an interval of less than three years is, again, up to the discretion of the physician.

Marty Ball: Okay, Karen. I think that's going to conclude the presentation for today. I'd like to thank you for providing all of the valuable information you have. We would like to remind everyone that today's webinar is approved for one Continuing Education credit by the boards listed on this slide.

We now have an online CE certificate process. You can receive your CE certificate in two ways. If you registered for this webinar through ReadyTalk®, the survey will automatically pop-up when the webinar closes. The survey takes you to the certificate.

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So this concludes our program for today. We hope you heard some useful information to help you with your Ambulatory Surgical Center Quality Reporting data abstractions. Thank you again, and enjoy the rest of your day.

END

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