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

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December 15, 2016
Announcements

January 1, 2017
- Submission of measures using a web-based tool via QualityNet begins

January 25, 2017
- Next ASC webinar: Help, I Am New: What Do I Do?

Passwords
- Always keep your QualityNet and NHSN passwords active
At the conclusion of the presentation, attendees will be able to:

✓ Identify changes to the Specifications Manual through version 6.0a and list changes in the measure information forms.

✓ Describe how these changes will impact abstracting and reporting for this program.
Formatting Changes
In version 6.0, the following sections were removed:

• Reporting Mechanism – Specific manner in which the quality measures are reported
• Reporting Period – Time period when the Medicare claims are to be reported
• Reporting Required By – Indicates the requirements applied to entities paid under the Medicare Ambulatory Surgical Center Fee Schedule
Measure Information Forms (MIFs)

In version 6.0, the following sections were removed from ASC-1, ASC-2, ASC-3, ASC-4, ASC-5, and ASC-12:

• Reporting Mechanism – Medicare Part B Fee-for-Service Claims, including for Medicare Railroad Retirement Board beneficiaries and Medicare Secondary Payer claims

• Reporting Period – Reporting period for Medicare claims begins January 1 and continues until December 31 of each calendar year

• Reporting Required By – All entities paid under the Medicare Ambulatory Surgical Center Fee Schedule (ASCFS), regardless of specialty or case mix
In version **6.0**, the following sections were **removed** from ASC-6, ASC-7, ASC-8, ASC-9, ASC-10, and ASC-11:

- Reporting Mechanism – “Web-based tool on the QualityNet Secure Portal” **and** “The NHSN is a secure, internet-based surveillance system maintained and managed by the CDC.”

- Reporting Required By – “All separately identifiable entities certified as an ASC by Medicare regardless of specialty or case mix”
In version 6.0, the following statement was added to ASC-6, ASC-7, ASC-9, and ASC-10 under Annual Data Submission Period:

- **Add**: “Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.”
In version 6.0, the following changes were made to ASC-9 and ASC-10:

- **Add**: “Statement” to the Numerator and Denominator descriptions
  - Numerator Statement
  - Denominator Statement
Claims-Based Measures

ASC-1–ASC-5 (Requires ASCs to report Quality Data Codes (QDCs))
ASC-1–ASC-5

No changes were made to these measures:

- ASC-1: Patient Burn
- ASC-2: Patient Fall
- ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
- ASC-4: All-Cause Hospital Transfer/Admission
- ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing

12/15/2016
ASC-6

• Safe Surgery Checklist Use
• No changes were made to this measure.
ASC-7

• ASC Facility Volume Data on Selected ASC Surgical Procedures

• In version 6.0a, the following statement was added:
  ▪ “The Categories and Healthcare Common Procedure Coding System (HCPCS) will be updated at the end of CY 2017.”
ASC-8

- Influenza Vaccination Coverage among Healthcare Personnel
- In version 6.0a, the fourth *optional* category of healthcare personnel will now be addressed on the MIF.
  - Definition for Healthcare Personnel (HCP)
    - **Added**: “Reporting data on the optional, other contract personnel category is not required at this time.”
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

In version 6.0, the following statement was added:

- Denominator Exclusions
  “Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient’s age is documented as the reason.”
ASC-10

- Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use

- In version 6.0a, the following code was removed from Denominator Criteria:
  - Z85.038, history of colonic polyps
ASC-11

• Cataracts – Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery
• In versions 6.0 and 6.0a, no changes were made to this measure.
ASC-12 (Utilizes data from paid Medicare Fee-for-Service (FFS) claims; does not require ASCs to submit QDCs)

Claims-Based Measures
ASC-12: 5.0a and 5.1

- Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
- In versions 5.0a and 5.1, the following changes were made:
  - **Added**: NQF #2539* for ASC-12
  - **Added**: Links to the 2015 Measure Specifications Report and the 2016 Measure Updates and Specifications Report

*National Quality Forum*
In 5.0a and subsequent versions, the following changes were made:

- Summary of updates
  - Denominator Statement
  - Included Populations
  - Cohort Exclusions (excluded colonoscopies)
In 5.0a and subsequent versions, the following change to the Denominator Statement was made:

- **Change**: “The target population for this measure includes colonoscopies performed at hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) for Medicare FFS patients aged 65 years and older.”

- **To**: “The target population for this measure includes low-risk colonoscopies performed in the outpatient setting for Medicare FFS patients aged 65 years and older. For implementation in the ASC Program, the measure will be calculated among ambulatory surgical centers (ASCs).”
In 5.0a and subsequent versions, the following change to Included Populations was made:

- Updated second paragraph:

  “The measure is focused on 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 link to the 2016 Measures Updates and Specifications Report is located in the Introduction section of the measure information form.
In 5.0a and subsequent versions, the following change to the Cohort Exclusions (excluded colonoscopies) was made:

• **Change**: “colonoscopies for patients with a history of inflammatory bowel disease (IBD) or diagnosis of IBD at the time of index colonoscopy”

• **To**: “colonoscopies for patients with a history of inflammatory bowel disease (IBD) or diagnosis of IBD at the time of index colonoscopy or on a subsequent hospital visit outcome claim”
In 5.0a and subsequent versions, the following change to Cohort Exclusions was made:

• **Change:** “Colonoscopies for patients with a history of diverticulitis or diagnosis of diverticulitis at time of index colonoscopy”

• **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”
In 5.0a and subsequent versions, the following changes to Cohort Exclusions were made:

- **Remove:** “Colonoscopies that occur on the same hospital outpatient claim as an ED visit”
- **Remove:** “Colonoscopies that occur on the same hospital outpatient claim as an observation stay”
- **Add:** “The 2016 Measure Updates and Specifications Report contains complete coding for all exclusions.”
In 6.0 and subsequent versions, the following updates were made:

- Summary of updates
  - Cohort Exclusions (excluded colonoscopies)
  - Risk Adjustment
In 6.0 and subsequent versions, the following changes to Cohort Exclusions (excluded colonoscopies) were made:

- Table 1 updates
  - “ICD-9-CM Code” and “ICD-9-CM Code Description” columns removed, table updated to ICD-10-CM diagnoses only
  - Table 1 name updated to “Inflammatory Bowel Disease (IBD) ICD-10-CM Diagnosis Codes”
  - Note added to refer readers to v5.1 of the ASCQR Specifications Manual for ICD-9-CM diagnosis codes listing
In 6.0 and subsequent versions, the following changes to Cohort Exclusions were made:

- Table 2 updates
  - “ICD-9-CM Code” and “ICD-9-CM Code Description” columns removed, table updated to ICD-10-CM diagnoses only
  - Table 2 name updated to “Diverticulitis ICD-10-CM Diagnosis Codes”
  - Note added to refer readers to v9.1 of the ASCQR Specifications Manual for ICD-9-CM diagnosis codes listing
In 6.0 and subsequent versions, the following changes to Risk Adjustment were made:

- Language updated to reference ICD-10-CM diagnosis codes
- Narrative updated to “The measure defines comorbidity variables using condition categories (CCs), which are clinically meaningful groupings of the many thousands of ICD-10-CM diagnosis codes.”
ASC-12: 6.0a

In version **6.0a**, the following changes to Cohort Exclusions (excluded colonoscopies) were made:

- **Table 1 updates**
  - Changes the use of the “X” at the end of ICD-10-CM diagnosis codes to ‘*’
  - Removed ‘without complications’ from some ICD-10 codes’ descriptions
  - Removed duplicate rows for codes 51.8* and 51.80*
Questions
Continuing Education Approval

This program has been approved for 1.0 continuing education (CE) unit for the following professional boards:

• Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
• Florida Board of Nursing Home Administrators
• Florida Council of Dietetics
• Florida Board of Pharmacy
• Board of Registered Nursing (Provider #16578)
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• Another page will open that asks you to register in HSAG’s Learning Management Center.
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CE Credit Process: New User

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CE Credit Process: Existing User
Thank You for Participating!

Please contact the Support Contractor if you have any questions:

- Submit questions online through the QualityNet Question & Answer Tool at [www.qualitynet.org](http://www.qualitynet.org)

Or

- Call the Support Contractor at 866.800.8756.
Biographies

- **Jennifer Witt, RN**
  Jennifer Witt is a Sr. Health Informatics Solutions Coordinator with the Measures Development and Maintenance team at Telligen. Most recently, Jennifer has been supporting CMS with the development and maintenance of hospital clinical quality measures. This includes responding to questions from hospital personnel regarding quality measures, using end user feedback and information from literature reviews in the revision of existing quality measures, and helping develop the specifications for new measures.

- **Marianna Gorbaty, MHSc, MSc (Coll.)**
  Marianna Gorbaty is a Lead Program Analyst at Mathematica Policy Research. Prior to joining Mathematica in 2013, she held a number of leadership healthcare informatics positions, focusing on the application of information technology solutions to advance healthcare delivery and applied research in Canada and in the United States. Mrs. Gorbaty’s programs portfolio at Mathematica includes the implementation of the Value-Based Payment Modifier Program, analytic support for the Advanced Alternative Payment Models track of the Quality Payment Program, and clinical quality measures implementation and maintenance for CMS Quality Reporting Programs.

- **Jacqueline Hudson, BSN, CPHQ**
  Jackie Hudson joined Health Services Advisory Group, HSAG, in 2015 and is a Project Coordinator and Project Lead for the Specifications Manual. Additionally, Jackie works with the Quality Improvement Network in the development of innovative strategies for improving outcomes in hospital outpatient environments. Her background includes extensive clinical, administrative, and Quality Improvement experience in a wide array of healthcare settings.