

Ambulatory Surgical Center Quality Reporting Specifications Manual

Release Notes Version: 7.0

Release Notes Completed: June 1, 2017

Guidelines for Using Release Notes

These Release Notes provide modifications to the Ambulatory Surgical Center Quality Reporting (ASCQR) Specifications Manual. They are provided as a reference tool and are not intended to be used as program abstraction tools. Please refer to the ASCQR Specifications Manual for the complete and current technical specification and abstraction information.

The notes are organized to follow the order of the Table of Contents. Within each topic section, a row represents a change that begins with general changes and is followed by data elements in alphabetical order. The **implementation date is 01/01/2018**, unless otherwise specified. The row headings are described below:

- **Impacts** – Used to identify which portion(s) of the Manual Section is impacted by the change listed.

Examples are Measure Information Forms, Quality-Data Coding and Sampling Specifications, or Appendix A.
- **Rationale** – Provided for the change being made.
- **Description of Changes** – Used to identify the section within the document where the change occurs.

(e.g., Definitions, Numerator, and Denominator).

The notes in the tables below are organized to follow the Table of Contents in the Specifications Manual.

Table of Contents

Impacts: Added two new measures

Rationale: To include two new Measures Information Forms.

Description of Change(s):

Add

ASC-13: Normothermia

ASC-14: Unplanned Anterior Vitrectomy

Acknowledgement

No changes in this section.

Program Background and Requirements

No changes in this section.

Section 1: Measure Information Form Introduction

No changes in this section.

Measure Information Forms

Impacts: ASC-9

Rationale: This change better aligns denominator exclusions with similar measures in other programs.

Description of Change(s):

Denominator Exclusions

Change: examples in first sentence of first bullet point

From:

(e.g., above average risk patient, inadequate prep).

To:

(e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is ≥ 66 years old, or life expectancy < 10 years, other medical reasons).

Impacts: ASC-13

Rationale: This performance measure is aligned with current guidelines regarding temperature management in patients undergoing general or neuraxial anesthesia lasting 60 minutes or more.

Description of Change(s):

Measure Information Form

Add:

ASC-13 Measure Information form

Impacts: ASC-14

Rationale: No clinical practice guidelines addressing unplanned anterior vitrectomy in cataract surgery are available at this time. However, rates of unplanned anterior vitrectomy have been published in the clinical literature, and can serve as comparative benchmarks of performance.

Description of Change(s):

Measure Information Form

Add:

ASC-14: Unplanned Anterior Vitrectomy

Change: third sentence of first bullet point

From:

Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as the reason.

To:

Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as ≥ 66 years old, or life expectancy <10 years.

Section 2: Quality-Data Coding & Sampling Specifications

No changes in this section.

Appendix A: Glossary of Terms

No changes in this section.

Appendix B: Preview Section

Impacts: The Preview Section displays new measure information.

Rationale: To provide new measure information finalized for the CY 2021 payment determination. The measures identified in this section are not currently collected.

Description of Change(s):

Add:

Ambulatory Surgical Center Quality Reporting Specifications Manual

Version 7.0

Encounter Dates: 01-01-18 (1Q18) through 12-31-18 (4Q18)

OMB # 0938-1270 Expiration Date: 04/30/2018

Table of Contents

Acknowledgement	ii
Program Background and Requirements	iii
Section 1: Measure Information Form Introduction	1-1
Measure Information Forms	
ASC-1: Patient Burn	1-3
ASC-2: Patient Fall.....	1-6
ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant.....	1-8
ASC-4: All Cause Hospital Transfer/Admission.....	1-10
ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing	1-12
ASC-6: Safe Surgery Checklist Use.....	1-15
ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures.....	1-16
ASC-8: Influenza Vaccination Coverage among Healthcare Personnel	1-17
ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	1-18
ASC-10: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	1-20
ASC-11: Cataracts – Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery	1-22
ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	1-23
ASC-13: Normothermia... ..	1-29
ASC-14: Unplanned Anterior Vitrectomy	1-32
Section 2: Quality-Data Coding & Sampling Specifications	2-34
Appendix A: Glossary of Terms	A-35
Appendix B: Preview Section	B-36

Acknowledgement

The *Ambulatory Surgical Center Quality Reporting (ASCQR) Specifications Manual* was developed by the Centers for Medicare & Medicaid Services (CMS) to provide a uniform set of quality measures to be implemented in ASC settings. The primary purpose of these measures is to promote high quality care for patients receiving services in ASC settings.

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Example Acknowledgement: The *ASCQR Specifications Manual* [Version xx, Month, Year] is periodically updated by the Centers for Medicare & Medicaid Services. Users of the *ASCQR Specifications Manual* must update their software and associated documentation based on the published manual production timelines.

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IMPORTANT SUBMISSION ALERT!!

At this time, for submission of the Ambulatory Surgical Center measures to CMS under the Ambulatory Surgical Center Quality Reporting Program (ASCQR Program), files must meet the specifications in this CMS manual only. Otherwise, the files will be rejected as not meeting CMS quality data submission requirements for receiving the full payment update.

Program Background and Requirements

CMS Quality Initiatives

Background

In November 2001, Health & Human Services' (HHS) Secretary Tommy G. Thompson announced The Quality Initiative, his commitment to assure quality healthcare for all Americans through published consumer information coupled with healthcare quality improvement support through Medicare's Quality Improvement Organizations (QIOs). The Quality Initiative was launched nationally in 2002 as the Nursing Home Quality Initiative (NHQI) and expanded in 2003 with the Home Health Quality Initiative (HHQI) and the Hospital Quality Initiative (HQI). These initiatives are part of a comprehensive look at quality of care that includes hospitals, nursing homes, home health agencies, and physician offices. These efforts have continued to expand under subsequent Secretaries through support and expansion of activities to support healthcare transparency and value-driven healthcare.

The Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act (MIEA-TRHCA) of 2006 (Pub. L. 109-432), enacted on December 20, 2006, made changes in the Outpatient Prospective Payment Systems (OPPS). The Centers for Medicare & Medicaid Services (CMS) became statutorily required in the Calendar Year (CY) 2008 OPPS/ASC Final Rule to have a program under which ASCs will report data on the quality of ASC care using standardized measures to receive the full annual update to the ASC payment rate. The program established under the CY 2012 OPPS/ASC Final Rule with Comment Period (CMS-1525-FC) and supported by this manual is the Ambulatory Surgical Center Quality Reporting Program (ASCQR Program). The measures described in this manual will expand as additional priority areas for quality improvements in ASC settings are identified and will be designed to evaluate the diversity of services and clinical topics provided to adult patients in ASC settings.

The claims-based measures ASC-1 through ASC-5, adopted by CMS for the ASCQR Program, were originally developed by the ASC Quality Collaboration and are the intellectual property of the ASC Quality Collaboration. Additional information about the ASC quality measures endorsed by the National Quality Forum (NQF) is available in the ASC Quality Collaboration Implementation Guide (www.ascquality.org).

Objective

The ASCQR Program uses a variety of tools to stimulate and support a significant improvement in the quality of ASC care. This initiative aims to refine and standardize ASC data collection, data transmission, and performance measures in order to construct a robust, prioritized, and standard quality outpatient measure set for ASCs. The goal is for all private and public purchasers, oversight and accrediting entities, and payers and providers of ASC care to use these same measures in their national public reporting activities. Quality improvement support, collaborations, standardization, and assuring compliance with Medicare Conditions of Participation (CoPs) are important additional tools in achieving this objective.

Program Requirements

ASCs that do not meet program requirements, which include reporting of quality measure data for the ASCQR Program, may receive a two percent reduction in their ASC payment update. ASCQR Program requirements apply to all entities subject to the ASC Fee Schedule (ASCFS). The definition of an ASC can be found in the Claims Processing Manual, Chapter 14, Section 10.1, located at (www.cms.hhs.gov).

Data Collection and Submission

Data for claims-based measures included in this specifications manual are captured from Medicare Part B fee-for-service (FFS) claims submitted by the ASC during required reporting periods. Medicare Part B FFS patients include Medicare Railroad Retirement Board patients and Medicare Secondary payer patients. Medicare Advantage patients are not included for reporting purposes. For claims-based measures, the reporting period refers to the dates of service not date of submission. For example, if a service was provided on December 30, 2017, with claim submission on January 1, 2018, this claim would be included in the 2019 payment determination.

Claims-Based Measures

ASCs are to submit information on the five claims-based measures using Quality Data Codes (QDCs) entered on their claims submitted using the CMS-1500 or associated electronic dataset. QDCs are specified CPT Category II codes or Level II G-codes that describe the clinical action evaluated by the measure. Clinical actions can apply to more than one condition and, therefore, can also apply to more than one measure. Facilities should review all reporting instructions carefully.

The appropriate QDC(s) are to be reported for all Medicare Part B FFS patients in addition to any codes that would be standard for billing purposes (e.g., the ICD-10-CM diagnosis and Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) Level II and CPT Category III codes for the services performed) on the ASC claim for the encounter.

Data completeness will be calculated by comparing the number of claims meeting measure specifications with the appropriate QDCs to the number of claims that would meet measure specifications without the appropriate QDCs on the submitted claim.

Measures Submitted via a Web-Based Tool

Data for ASC-6, ASC-7, ASC-9, ASC-10, and ASC-11 (ASC-11 is a voluntary measure) are to be submitted using a web-based tool located on the QualityNet Secure Portal at www.QualityNet.org.

Data for ASC-8 Influenza Vaccination Coverage among Healthcare Personnel will be submitted through the National Healthcare Safety Network (NHSN) at <http://www.cdc.gov/nhsn>.

Please refer to www.QualityNet.org for data submission deadlines.

240 or Fewer Rule

CMS determined that some ASCs have relatively small numbers of Medicare claims and instituted a claims threshold for ASCs with fewer than 240 Medicare claims (primary plus secondary payer) per year. For example, an ASC with fewer than 240 Medicare claims in CY 2017 (for the CY 2019 payment determination year) would not be required to participate in the ASCQR Program in CY 2018 (for the CY 2020 payment determination year).

Public Reporting

The Secretary of Health and Human Services must establish procedures to make data collected under the ASC Quality Reporting Program publicly available and to supply facilities the opportunity to review their data prior to publication. Details on the ability to withdraw and not have data publicly reported, the extraordinary circumstance extensions or exemptions request process, and the reconsideration request process were finalized in the FY 2013 IPPS/LTCH final rule.

Related National Activities

National Quality Forum (NQF)

The NQF has approved a set of national voluntary consensus standards for measuring the quality of hospital care. These measures will permit consumers, providers, purchasers, and quality improvement professionals to evaluate and compare the quality of care in a variety of healthcare settings across the nation by using a standard set of measures. Measures that are endorsed by NQF are denoted as such on the measure information forms.

National Quality Measures Clearinghouse

The National Quality Measures Clearinghouse (NQMC), sponsored by the Agency for Healthcare Research and Quality (AHRQ), an agency of the U.S. Department of HHS, has included both CMS and Joint Commission measures in the public database for evidence-based quality measures and measure sets. NQMC is sponsored by AHRQ to promote widespread access to quality measures by the healthcare community and other interested individuals.

Measures Management System

The Measures Management System (MMS) is a set of processes and decision criteria used by CMS to oversee the development, implementation, and maintenance of healthcare quality measures. CMS recognizes the need for quality measures of the highest caliber, maintained throughout their life cycle to ensure they retain the highest level of scientific soundness, importance, feasibility, and usability. Through the use of a standardized process with broadly recognized criteria, the MMS ensures that CMS will have a coherent, transparent system for measuring the quality of care delivered to its beneficiaries.

Measure Information Form Introduction

Measure Information Form (MIF) Format

Measure Title – The specific national ASC quality measure (e.g., *Patient Burn, Patient Fall, All Cause Hospital Transfer/Admission*).

Measure ID # – A unique alphanumeric identifier assigned to the measure. Information associated with a measure is identified by this alphanumeric number (i.e., ASC-1, ASC-2, ASC-3, etc.).

Quality Reporting Option – Indicates what is being evaluated by the measure.

- **Outcome:** A measure that indicates the result of performance (or non-performance) of a function(s) or process(es).
- **Process:** A measure used to assess a goal-directed, interrelated series of actions, events, mechanisms, or steps, such as a measure of performance that describes what is done to, for, or by patients, as in performance of a procedure.
- **Measures Submitted via a Web-based Tool-** A measure used to assess a goal-directed, interrelated series of actions, events, mechanisms, or steps with data entry achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Description – A brief explanation of the measure’s focus, such as the activity or the area on which the measure centers attention (e.g., the number of admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC).

Denominator Statement – Represents the population evaluated by the performance measure.

- **Included Population in Denominator:** Specific information describing the population(s) comprising the denominator, not contained in the denominator statement, or not applicable.
- **Excluded Population in Denominator:** Specific information describing the population(s) that should not be included in the denominator, or none.

Numerator Statement – Represents the portion of the denominator that satisfies the conditions of the performance measure.

- **Included Population in Numerator:** Specific information describing the population(s) comprising the numerator, not contained in the numerator statement, or not applicable.
- **Excluded Population in Numerator:** Specific information describing the population(s) that should not be included in the numerator, or none.

Numerator Quality-Data Coding Options for Reporting – A list and definition of the QDC(s) (currently all are G-codes) used to report required information for the measure.

Data Sources – The documents that typically contain the information needed to determine the numerator and denominator.

Definitions – Specific definitions for the terms included in the numerator and denominator statements.

Selection Basis – The reason for performing a specified process to improve the quality of care outcome. This may include specific literature references, evidence-based information, expert consensus, etc.

Clinical Recommendation Statements – Supporting literature statements for the specified quality of care measure.

Selected References – Specific literature references that are used to support the importance of the performance measure.

Measure Information Form

Measure Title: Patient Burn

Measure ID #: ASC-1

Quality Reporting Option: Claims-based outcome measure

Description: The number of admissions (patients) who experience a burn prior to discharge from the ASC

Denominator: All ASC admissions

Inclusions: All ASC admissions

Exclusions: None

Numerator: ASC admissions experiencing a burn prior to discharge

Inclusions: ASC admissions experiencing a burn prior to discharge

Exclusions: None

Numerator Quality-Data Coding Options for Reporting:

- G8908: Patient documented to have received a burn prior to discharge
- G8909: Patient documented not to have received a burn prior to discharge
- G8907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility

Note: If using code G8908 or G8909, do not use code G8907.

Definitions:

- **Admission** – Completion of registration upon entry into the facility
- **Burn** – Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical, or radiation (e.g., warming devices, prep solutions, electrosurgical unit, or laser)
- **Discharge** – Occurs when the patient leaves the confines of the ASC

Selection Basis:

There are numerous case reports in the literature regarding patient burns in the surgical and procedural setting. The diversity of the causative agents underscores the multitude of potential risks that must be properly mitigated to avoid patient burns.

The literature on burns suggests that electrosurgical burns are most common. A recent publication from the ECRI Institute (www.ecri.org) highlights the increased risk of burns with newer surgical devices that apply higher currents at longer activation times. Although electrical burns are most prevalent, other mechanisms of burn injury are frequently reported in case studies and case series. These include chemical and thermal burns.

Surgical fires are rare; however, their consequences can be grave, killing or seriously injuring patients and surgical staff. The risk of surgical fire is present whenever and wherever surgery is performed, whether in an operating room (OR), a physician's office, or an outpatient clinic.

Recognizing the diversity of mechanisms by which a patient could sustain an unintentional burn in the ASC setting, the definition of burn is broad, encompassing all six recognized means by which a burn can occur – scalds, contact, fire, chemical, electrical, or radiation. This will allow stakeholders to develop a better understanding of the incidence of these events and further refine means to ensure prevention.

Clinical Recommendation Statements:

The risk of burns related to laser use can be reduced by adherence to the guidelines published by the American National Standards Institute (ANSI) for safe use of these devices in the health care setting. Similarly, the risk of burns related to the use of electrosurgical devices can be reduced by following the electrosurgery checklist published by ECRI Institute.

The risk of surgical fires can be reduced by minimizing ignition, oxidizer, and fuel risks (the “classic triangle”). The American Society of Anesthesiologists’ Practice Advisory for the Prevention and Management of Operating Room Fires seeks to prevent the occurrence of OR fires, reduce adverse outcomes associated with OR fires, and identify the elements of a fire response protocol. These guidelines are available at: <https://asahq.org/quality-and-practice-management/standards-and-guide-lines>.

Guidance for the prevention of surgical fire has also been published by the Association of Perioperative Registered Nurses (AORN).

Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

Selected References:

- American National Standards Institute (ANSI) Z136.3 (2005) – Safe Use of Lasers in Health Care Facilities, 2005 Revision.
- American Society of Anesthesiologists Task Force on Operating Room Fires, Caplan RA, Barker SJ, et al. Practice advisory for the prevention and management of operating room fires. *Anesthesiology* 2008 May; 108(5):786-801.
- Anesthesia Patient Safety Foundation (APSF). Prevention and management of surgical fires [video]. February 2010. http://www.apsf.org/resources_video.php.
- ECRI Institute. New clinical guide to surgical fire prevention: patients can catch fire—here’s how to keep them safer [guidance article]. *Health Devices* 2009 Oct; 38(10):314-32.
- ECRI Institute. Electrosurgery Checklist. http://www.mdsr.ecri.org/summary/detail.aspx?doc_id=8271.
- National Fire Protection Association (NFPA). NFPA 99: standard for health care facilities. Quincy (MA). NFPA; 2005.
- Association of Operating Room Nurses (AORN). AORN Guidance Statement: Fire Prevention in the Operating Room in Standards, Recommended Practices, and Guidelines. Denver, CO: AORN, 2006.
- AORN. Fire safety Tool Kit. 2015. <http://www.aorn.org/guide-lines/clinical-resources/tool-kits/fire-safety-tool-kit>.
- National Quality Forum. Serious Reportable Events in Healthcare 2006 Update. Washington, FC: NQF, 2007.
- Joint Commission. Joint Commission Sentinel Event Alert. Issue 12, February 4, 2000. Operative and Postoperative Complications: Lessons for the Future. Chicago, IL.
- Tucker R. Laparoscopic electrosurgical injuries: survey results and their implications. *Surg Laparosc Endosc*. 1995; 5(4):311- 7.
- ECRI. Higher currents, greater risks: preventing patient burns at the return-electrode site during high-current electrosurgical procedures. *Health Devices*. 2005; 34(8):273-9.
- Demir E, O’Dey D, and Pallua N. Accidental burns during surgery. *J Burn Care Res*. 2006; 27(6):895-900.

- Cheney F, Posner K, Caplan R, and Gild W. Burns from warming devices in anesthesia. A closed claims analysis. *Anesthesiology*. 1994; 80(4):806-10.
- Barker S and Polson J. Fire in the operating room: a case report and laboratory study. *Anesth Anal*. 2001; 93:960-965.
- ECRI. Devastation of patient fires. *Health Devices*. 1992; 21:3-39.
- Bhananker S, Posner K, Cheney F, Caplan R, Lee L, and Domino K. Injury and liability associated with monitored anesthesia care: a closed claims analysis. *Anesthesiology*. 2006; 104(2):228-34.

Measure Information Form

Measure Title: Patient Fall

Measure ID #: ASC-2

Quality Reporting Option: Claims-based outcome measure

Description: The number of admissions (patients) who experience a fall within the ASC

Denominator: All ASC admissions

Inclusions: All ASC admissions

Exclusions: None

Numerator: ASC admissions experiencing a fall within the confines of the ASC

Inclusions: ASC admissions experiencing a fall within the confines of the ASC

Exclusions: ASC admissions experiencing a fall outside the ASC

Numerator Quality-Data Coding Options for Reporting:

- G8910: Patient documented to have experienced a fall within the ASC
- G8911: Patient documented not to have experienced a fall within the ASC
- G8907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility

Note: If using code G8910 or G8911, do not use code G8907.

Definitions:

- **Admission** – Completion of registration upon entry into the facility
- **Fall** – A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions (source: National Center for Patient Safety)

Selection Basis:

“Falls per 100,000 patient days” has been endorsed as a serious reportable event by the NQF. While ASCs have a relatively low incidence of adverse events in general, information regarding the incidence of patient falls is not currently available. However, stakeholders have expressed a general interest in the public reporting of such adverse events. Due to the use of anxiolytics, sedatives, and anesthetic agents as adjuncts to procedures, patients undergoing outpatient surgery are at increased risk for falls.

Clinical Recommendation Statements:

According to the Agency for Healthcare Research and Quality’s Prevention of Falls in Acute Care guideline, patient falls may be reduced by following a four-step approach: 1) evaluating and identifying risk factors for falls in the older patient; 2) developing an appropriate plan of care for prevention; 3) performing a comprehensive evaluation of falls that occur; and 4) performing a post-fall revision of plan of care as appropriate.

Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

Selected References:

- Institute for Clinical Systems Improvement (ICSI). Prevention of falls (acute care). Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Apr. p 34.
- Boushon B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D. Transforming Care at the Bedside How-to-Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2008.
- ECRI Institute. Fall Injury Prevention Interventions. August 1, 2015.
- Joint Commission. 2011-2012 National Patient Safety Goals: http://www.jointcommission.org/standards_information/npsgs.aspx.
- National Center for Patient Safety: United States Department of Veterans Affairs. <http://www.patientsafety.va.gov/professionals/onthejob/falls.asp>.
- National Quality Forum. Serious Reportable Events in Healthcare – 2006 Update: A Consensus Report. March 2007.
- Gray-Micelli D. Preventing falls in acute care. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company. 2008. p. 161-98.
- American Geriatrics Society, British Geriatrics Society, American Academy of Orthopedic Surgeons (AGS/BGS/AAOS) Guidelines for the Prevention of Falls in Older Persons (2001). Journal of the American Geriatrics Society, 49, 664-672.
- American Medical Directors Association (AMDA). Falls and fall risk. Columbia, MD: American Medical Directors Association.
- ECRI Institute: Falls Prevention Strategies in Healthcare Settings (2006). Plymouth Meeting, PA.
- Institute for Clinical Systems Improvement. Prevention of Falls (Acute Care). Second Edition. April 2010.
- Resnick, B. (2003). Preventing falls in acute care. In: M. Mezey, T. Fulmer, I. Abraham (Eds.) & D. Zwicker (Managing Ed.), Geriatric nursing protocols for best practice (2nd ed., pp. 141-164). New York: Springer Publishing Company, Inc.
- University of Iowa Gerontological Nursing Interventions Research Center (UIGN). (2004). Falls prevention for older adults. Iowa City, IA. University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core.

Measure Information Form

Measure Title: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Measure ID #: ASC-3

Quality Reporting Option: Claims-based outcome measure

Description: The number of admissions (patients) who experience a wrong site, side, patient, procedure, or implant

Denominator: All ASC admissions

Inclusions: All ASC admissions

Exclusions: None

Numerator: All ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant

Inclusions: All ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant

Exclusions: None

Numerator Quality-Data Coding Options for Reporting:

- G8912: Patient documented to have experienced a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event
- G8913: Patient documented not to have experienced a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event
- G8907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility

Note: If using code G8912 or G8913, do not use code G8907.

Definitions:

- **Admission** – Completion of registration upon entry into the facility
- **Wrong** – Not in accordance with intended site, side, patient, procedure, or implant

Selection Basis:

“Surgery performed on the wrong body part,” “surgery performed on the wrong patient,” and “wrong surgical procedure performed on a patient” have all been endorsed as serious reportable surgical events by NQF. This outcome measure serves as an indirect measure of providers’ adherence to The Joint Commission’s “Universal Protocol” guideline. The Joint Commission, an accreditation body, has developed a “Universal Protocol” guideline for eliminating wrong site, wrong procedure, wrong person surgery. The Universal Protocol is based on the consensus of experts and is endorsed by more than 40 professional medical associations and organizations. To encompass the outcomes of all key identification verifications, the ASC Quality Collaboration’s measure incorporates not only wrong site, wrong side, wrong patient, and wrong procedure, but also wrong implant in its specifications.

Clinical Recommendation Statements:

The Joint Commission's "Universal Protocol" is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.

Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

Selected References:

- Joint Commission. Universal Protocol For Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. Available at http://jointcommission.org/standards_information/up.aspx. Last accessed December 14, 2010.
- American Academy of Ophthalmology. Recommendations of American Academy of Ophthalmology Wrong Site Task Force. <http://www.aao.org/Assets/c85186a8-5f17-422b-861e-fd4e4b061dff/635518426969930000/revised-wswiol-document-may-12-2014-august-finalrev-pdf>.
- American Academy of Orthopaedic Surgeons. Consistency for Safety in Orthopedic Surgery. Information Statement 1042. <http://www.aaos.org/about/papers/advistmt/1042.asp>.
- American College of Obstetricians and Gynecologists. ACOG committee opinion #464: patient safety in the surgical environment. Obstet Gynecol. 2010; 116(3):786-790.
- American College of Surgeons. [ST-41] Statement on ensuring correct patient, correct site, and correct procedure surgery [Correct Site Surgery - American College of Surgeons](http://www.facs.org/quality-program/standard-of-care/statement-on-ensuring-correct-patient-correct-site-and-correct-procedure-surgery).
- AORN. AORN Position Statement on Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events. [AORN Position Statement Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events](http://www.aorn.org/position-statements/preventing-wrong-patient-wrong-site-wrong-procedure-events).
- Institute of Medicine. To Err is Human: Building a Safer Health System. Washington, DC: National Academy Press, 2000.
- Joint Commission. 2011 National Patient Safety Goals. http://www.jointcommission.org/standards_information/npsgs.aspx.
- National Quality Forum. Serious Reportable Events in Healthcare – 2006 Update: A Consensus Report. March 2007.
- World Health Organization. WHO Guidelines for Safe Surgery 2009. http://whqlibdoc.who.int/publications/2009/9789241598552_eng.pdf.

Measure Information Form

Measure Title: All-Cause Hospital Transfer/Admission

Measure ID #: ASC-4

Quality Reporting Option: Claims-based outcome measure

Description: The percentage of ASC admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC

Denominator: All ASC admissions

Inclusions: All ASC admissions

Exclusions: None

Numerator: ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC

Inclusions: ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC

Exclusions: None

Numerator Quality-Data Coding Options for Reporting:

- G8914: Patient documented to have experienced a hospital transfer or hospital admission upon discharge from ASC
- G8915: Patient documented not to have experienced a hospital transfer or hospital admission upon discharge from ASC
- G8907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility

Note: If using code G8914 or G8915, do not use code G8907.

Definitions:

- **Admission** – Completion of registration upon entry into the facility
- **Hospital Transfer/Admission** – Any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room
- **Discharge** – Occurs when the patient leaves the confines of the ASC

Selection Basis:

The need for transfer/admission is an unanticipated, but sometimes necessary outcome. Hospital transfers/admissions can result in unplanned cost and time burdens that must be borne by patients and payers.

Selected states have expressed an interest in the public reporting of such events. While hospital transfers and admissions undoubtedly represent good patient care when necessary, high rates may be an indicator that practice patterns or patient selection guidelines are in need of review.

Clinical Recommendation Statements:

No clinical practice guidelines specifically addressing transfers or admissions from ASCs to acute care hospitals are available at this time.

Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

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Measure Information Form

Measure Title: Prophylactic Intravenous (IV) Antibiotic Timing

Measure ID #: ASC-5

Quality Reporting Option: Claims-based process measure

Description: Intravenous (IV) antibiotics given for prevention of surgical site infection were administered on time

Denominator: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection

Inclusions: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection

Exclusions: ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of infections other than surgical site infections (e.g., bacterial endocarditis); ASC admissions with a preoperative order for a prophylactic antibiotic not administered by the intravenous route

Numerator: Number of ASC admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection who received the prophylactic antibiotic on time

Inclusions: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection

Exclusions: None

Numerator Quality-Data Coding Options for Reporting:

- G8916: Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time
- G8917: Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time
- G8918*: Patient without preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis

***Note:** G8918 is to be reported for patients with no indication for, or no order for IV antibiotic prophylaxis for surgical site infection. This does not place a case with this code in the denominator, but is necessary for calculating the completeness of reporting.

Definitions:

- **Admission** – completion of registration after physical entry into the facility
- **Antibiotic administered on time** – antibiotic infusion is initiated within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, insertion of needle, inflation of tourniquet) or two hours prior if Vancomycin or fluoroquinolones are administered
- **Intravenous** – administration of a drug within a vein, including bolus, infusion, or IV piggyback
- **Order** – a written order, verbal order, standing order, or standing protocol
- **Prophylactic antibiotic** – an antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of this measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin, and Vancomycin.

Selection Basis:

The CMS Surgical Infection Prevention performance measure states, “Surgical site infections occur in 2–5 percent of clean extra-abdominal surgeries and up to 20 percent of intra-abdominal surgeries. Each infection is estimated to increase a hospital stay by an average of 7 days and add over \$3,000 in charges (1992 data). Patients who develop surgical site infections are 60 percent more likely to spend time in an ICU (intensive care unit), five times more likely to be readmitted to the hospital, and have twice the incidence of mortality. Despite advances in infection control practices, surgical site infections remain a substantial cause of morbidity and mortality among hospitalized patients. Studies indicate that appropriate preoperative administration of antibiotics is effective in preventing infection. Systemic and process changes that promote compliance with established guidelines and standards can decrease infectious morbidity.”

There is no literature available on variation in adherence to recommended prophylactic IV antibiotic timing among ASC providers. However, variability in the accuracy of timing of administration has been demonstrated in other clinical settings.

Clinical Recommendation Statements:

This performance measure is aligned with current surgical infection prevention guidelines recommending that prophylactic antibiotics be administered within one hour prior to surgical incision, or within two hours prior to incision when vancomycin or fluoroquinolones are used.

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Measure Information Form

Measure Title: Safe Surgery Checklist Use

Measure ID #: ASC-6

Quality Reporting Option: Measure submitted via a web-based tool

Description: The use of a Safe Surgery Checklist for surgical procedures that includes safe surgery practices during each of the three critical perioperative periods: the period prior to the administration of anesthesia, the period prior to skin incision, and the period of closure of incision and prior to the patient leaving the operating room

Measure ascertains response to the following question:

- Does/did your facility use a safe surgery checklist based on accepted standards of practice during the designated period? Yes/No

Annual data submission period: See the timeline posted to QualityNet.org for this measure; select ASCs and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Examples for Safe Surgery Practices*

First critical point (period prior to administering anesthesia)	Second critical point (period prior to skin incision)	Third critical point (period of closure of incision and prior to patient leaving the operating room)
<ul style="list-style-type: none">• Verbal confirmation of patient identity• Mark surgical site• Check anesthesia machine/medication• Assessment of allergies, airway, and aspiration risk	<ul style="list-style-type: none">• Confirm surgical team members and roles• Confirm patient identity, procedure, and surgical incision site• Administration of antibiotic prophylaxis within 60 minutes before incision• Communication among surgical team members of anticipated critical events• Display of essential imaging as appropriate	<ul style="list-style-type: none">• Confirm the procedure• Complete count of surgical instruments and accessories• Identify key patient concerns for recovery and management of the patient

*Safe surgery checklist items are not limited to the examples listed in this table.

Measure Information Form

Measure Title: ASC Facility Volume Data on Selected ASC Surgical Procedures

Measure ID #: ASC-7

Quality Reporting Option: Measure submitted via a web-based tool

Description: The aggregate count of selected surgical procedures – Most ASC procedures fall into one of eight categories: Eye, Gastrointestinal, Genitourinary, Musculoskeletal, Nervous System, Respiratory, Skin, and Multi-system. The eight categories and corresponding HCPCS are listed in the table below.* The procedures and codes in Table 2 were selected based on recent ASC data.

Measure ascertains response to the following question(s):

- What was the aggregate count of selected surgical procedures per category?

Annual data submission period: See the timeline posted to QualityNet.org for this measure; select ASCs and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

[*Please note the categories and HCPCS for ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures will be populated here in November 2018 for encounters from 01-01-18 through 12-31-18.]

Measure Information Form

Measure Title: Influenza Vaccination Coverage among Healthcare Personnel

Measure ID #: ASC-8

Quality Reporting Option: CMS required ASCs participating in the CMS Ambulatory Surgical Center Quality Reporting Program to report data collected by the Centers for Disease Control and Prevention (CDC) via the National Healthcare Safety Network (NHSN).

Description: For more information about the NHSN measure, see the resources located at <http://www.cdc.gov/nhsn>.

Definition for Healthcare Personnel (HCP) – Facilities must report vaccination data for three categories of HCP: employees on payroll; licensed independent practitioners (who are physicians, advanced practice nurses, and physician assistants affiliated with the hospital but not on payroll); and students, trainees, and volunteers aged 18 or older. Reporting data on the optional, other contract personnel category is not required at this time. All HCP physically working in the facility for at least one day or more between October 1 and March 31 should be counted. Data on vaccinations received at the facility, vaccinations received outside of the facility, medical contraindications, and declinations are reported for the three categories of HCP.

Direct questions regarding NHSN training, enrollment, and submission to: NHSN@cdc.gov.

Measure Information Form

Measure Title: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients

Measure ID #: ASC-9

Quality Reporting Option: Measures submitted via a web-based tool

Description: Percentage of patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Numerator Statement: Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Denominator Statement: All patients aged 50 to 75 years of age receiving screening colonoscopy without biopsy or polypectomy

Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 and ≤ 75 on date of encounter

and

ICD-10-CM Diagnosis code: Z12.11

and

CPT or HCPCS: 44388, 45378, G0121

without

CPT Category I Modifiers: 52, 53, 73, 74

without

ICD-10-CM Diagnosis codes: Z83.71, Z86.010, Z80.0, Z85.038

Denominator Exclusions:

- Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is ≥ 66 years old, or life expectancy < 10 years, other medical reasons). Medical reason(s) are at the discretion of the physician. Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as ≥ 66 years old, or life expectancy < 10 years. Documentation of a medical condition or finding can be used as a medical reason(s) for denominator exclusion purposes only if the documented recommended follow-up interval is less than 10 years.

Examples:

- Diverticulitis documented in the medical record and a follow-up interval of 5 years in the colonoscopy report.
- Family history of colon cancer and a follow-up interval of 3 years documented in the colonoscopy report.
- Less than adequate prep documented in the medical record with a repeat colonoscopy in 3 years in the colonoscopy report.

Annual Data Submission Period: See the timeline posted to QualityNet.org for this measure; select ASCs and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Additional Instructions: Patients will be counted in the numerator if there is reference in the final colonoscopy report that the appropriate follow-up interval for the repeat colonoscopy is at least 10 years from the date of the current colonoscopy (i.e., the colonoscopy performed during the measurement period). A range that includes “10 years” (e.g., 7 to 10 years) is not acceptable.

Measure Information Form

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

Measure ID #: ASC-10

Quality Reporting Option: Measures submitted via a web-based tool

Description: Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings, who had a follow-up interval of 3 or more years since their last colonoscopy

Numerator Statement: Patients who had an interval of 3 or more years since their last colonoscopy

Denominator Statement: All patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior colonic polyp(s) in previous colonoscopy findings

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

and

Diagnosis for history of colonic polyp(s) (ICD-10-CM): Z86.010

and

CPT or HCPCS: 44388, 44389, 44392, 44394, 45378, 45380, 45381, 45384, 45385, G0105

without

CPT Category I Modifiers: 52, 53, 73, or 74

Denominator Exclusions:

- Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas/polyps, or last colonoscopy found greater than 10 adenomas/polyps). Medical reason(s) are at the discretion of the physician. “History of colonic polyps” is not an acceptable reason to exclude cases from the denominator. A patient must have a history of colonic polyps to be eligible for the measure. Documentation of a medical condition or finding can be used as a medical reason(s) for denominator exclusion purposes only if the previous colonoscopy was less than 3 years prior.
- Documentation of system reason(s) clearly documented in the current medical record for an interval of less than 3 years since the last colonoscopy (e.g., unable to locate previous colonoscopy report). For a system reason all of the following must be present in the medical record.
 - The interval since the last colonoscopy is less than 3 years; **and**
 - A medical reason for an interval of less than 3 years is not documented; **and**
 - A “system reason” is documented (e.g., previous colonoscopy report not available, unable to locate last colonoscopy report).

Annual Data Submission Period: See the timeline posted to QualityNet.org for this measure; select ASCs and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Additional Instructions: For the purpose of this measure, a surveillance colonoscopy is defined as the colonoscopy performed after a colonic polyp(s) has been detected and removed. The denominator of this measure is the total number of patients ≥ 18 years of age receiving a surveillance colonoscopy. The

numerator is the number of patients receiving a surveillance colonoscopy 3 years or greater after the colonoscopy showing the colonic polyp. Information regarding the performance interval can be obtained from medical record documentation.

Measure Information Form

Measure Title: Cataracts – Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery

Measure ID #: ASC-11*

Quality Reporting Option: Measure submitted via a web-based tool

Description: Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery

Numerator Statement: Patients who had improvement in visual function achieved within 90 days following cataract surgery, based on completing **both** a pre-operative and post-operative visual function instrument

Denominator Statement: All patients aged 18 years and older who had cataract surgery and completed **both** a pre-operative and post-operative visual function instrument

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years

and

CPT (with or without modifiers): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984

Excluded Population: Patients who did not complete both a pre-operative and post-operative survey

Annual Data Submission Period: See the timeline posted to QualityNet.org for this measure; select ASCs and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Data Collection Approach: Include procedures performed from the beginning of the reporting year through 90 days prior to the end of the reporting period. This will allow the postoperative period to occur.

Additional Instructions: Definition for Survey: An appropriate data collection instrument is an assessment tool that has been validated for the population for which it is being used; 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 surveys can be administered by the facility via phone, mail, email, or during clinician follow-up. For this measure, the same data collection instrument (i.e., survey) must be used pre-operatively and post-operatively.

Examples of tools for visual function assessment include, but are not limited to: National Eye Institute-Visual Function Questionnaire (VFQ- http://www.rand.org/health/surveys_tools/vfq.html), the Visual Function (VF)-14, the modified VF-8, the Activities of Daily Vision Scale (ADVS), the Catquest, and the modified Catquest-9. For each of the VF tools (VF-14 or VF-8R), all questions have equal weight; only non-missing questions are included, and the total weight is 100.

*Finalized in the CY 2015 OPPI/ASC final rule, ASCs have the option to voluntarily collect and submit data for ASC-11 for the CY 2017 payment determination and subsequent years. All data submitted voluntarily will be publically reported as discussed in the CY 2014 OPPI/ASC proposed rule (Vol. 78, No. 139 Proposed Rule, pp.43664, 43669).

Centers for Medicare & Medicaid Services (CMS)
Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy Measure

Introduction

This section of the manual includes the Measure Information Form (MIF) for the CMS Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure. This is an administrative claims-based measure, so there is no data abstraction responsibility on the part of the facility. The measure includes outpatient colonoscopies performed among Medicare Fee-for-Service (FFS) beneficiaries aged ≥ 65 years.

CMS has finalized adoption of the measure into the ASCQR Program for payment determination beginning in calendar year 2018.

This measure was developed by a team of clinical and statistical experts from the Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE), under contract to CMS. The measure is currently endorsed by the National Quality Forum (NQF #2539).

The information in the following MIF is being provided in the interest of transparency and to promote understanding of methodology on the part of the facility and vendor communities. Additional background information about the measure methodology can be found in the measure technical report

(<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html>), the 2015 Measure Specifications Report (<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775197506>), and the 2016 Measure Updates and Specifications Report (<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775214597>). Questions and comments about the measure should be directed to CMSColonoscopyMeasure@yale.edu.

CMS calculates a facility-level risk-standardized unplanned hospital visit rate for all eligible facilities. Facilities and their ORYX® Vendors do not have sufficient data to produce facilities' risk-standardized results. CMS inpatient and outpatient claims data are used to determine whether a beneficiary has had an unplanned hospital visit to any acute care hospital within 7 days of the outpatient colonoscopy. In addition, CMS extracts and utilizes physician office, inpatient, and outpatient claims data from the year prior to the colonoscopy as well as claims data from the colonoscopy to risk adjust the facility-level outcome rates.

Measure Information Form

Measure Title: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

Measure ID #: ASC-12

Quality Reporting Option: CMS Outcome Measure (Claims-Based)

Description: The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare Fee-for-Service (FFS) patients aged 65 years and older.

Rationale: This measure will reduce adverse patient outcomes associated with preparation for colonoscopy, the procedure itself, and follow-up care by capturing and making more visible to providers and patients all unplanned hospital visits following the procedure. The measure score will assess quality and inform quality improvement.

Type of Measure: Outcome

Improvement Noted As: A decrease in the facility-level risk-standardized unplanned hospital visit rate

Numerator Statement:

This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define the outcome. The calculation of the rate is defined below under Measure Calculation.

The outcome for this measure is all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy. The measure defines a hospital visit as any emergency department (ED) visit, observation stay, or unplanned inpatient admission.

Denominator Statement:

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 ASCQR Program, the measure will be calculated among ambulatory surgical centers (ASCs).

Included Populations:

Outpatient colonoscopies for Medicare FFS patients aged 65 years and older. CMS FFS beneficiaries with an outpatient colonoscopy are included if the patient has been enrolled in Part A and Part B Medicare for the 12 months prior to the date of procedure to ensure a full year of administrative data for risk-adjustment.

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.

CPT Codes that define the patient cohort:

G0121	Colonoscopy on individual not meeting criteria for high risk
G0105	Colonoscopy on individual at high risk of colorectal cancer
45378	Diagnostic colonoscopy
45380	Colonoscopy with biopsy
45385	Colonoscopy with ablation of lesion(s)/polypectomy by snare
45384	Colonoscopy with ablation of lesion(s)/polypectomy by hot biopsy forceps or bipolar cautery
45383	Colonoscopy with ablation of lesion(s)/polypectomy by other techniques (i.e., techniques other than 45384/45385)
45381	Colonoscopy, with directed submucosal injection, any substance
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
G6024	Colonoscopy, flexible; proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare

Cohort Exclusions (excluded colonoscopies):

- Colonoscopies for patients who lack continuous enrollment in Medicare FFS Parts A and B in the 7 days after the procedure.
- Colonoscopies that occur concurrently with high-risk upper gastrointestinal (GI) endoscopy procedures.
- Colonoscopies for patients with a history of inflammatory bowel disease (IBD) or diagnosis of IBD at time of index colonoscopy or on a subsequent hospital visit outcome claim.
- 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.
- Colonoscopies followed by a subsequent outpatient colonoscopy procedure within 7 days.

The 2016 Measure Updates and Specifications Report contains complete coding for all exclusions.

Table 1: Inflammatory Bowel Disease (IBD) ICD-10-CM Diagnosis Codes

ICD-10-CM Code	ICD-10-CM Code Description
K50.0*	Crohn's disease of small intestine
K50.1*	Crohn's disease of large intestine
K50.8*	Crohn's disease of both small and large intestine
K50.9*	Crohn's disease, unspecified
K51.2*	Ulcerative (chronic) proctitis
K51.3*	Ulcerative (chronic) rectosigmoiditis
K51.4*	Inflammatory polyps of colon
K51.5*	Left sided colitis
K51.0*	Ulcerative (chronic) pancolitis
K51.8*	Other ulcerative colitis
K51.9*	Ulcerative colitis, unspecified

Note: for the ICD-9 codes relevant to the calculation of the measure for the CY2016 period, refer to v5.1 of the manual.

Table 2: Diverticulitis ICD-10-CM Diagnosis Codes

ICD-10-CM Code	ICD-10-CM Code Description
K57.20	Diverticulitis of large intestine with perforation and abscess without bleeding
K57.32	Diverticulitis of large intestine without perforation or abscess without bleeding
K57.40	Diverticulitis of both small and large intestine with perforation and abscess without bleeding
K57.52	Diverticulitis of both small and large intestine without perforation or abscess without bleeding
K57.80	Diverticulitis of intestine, part unspecified, with perforation and abscess without bleeding
K57.92	Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding
K57.21	Diverticulitis of large intestine with perforation and abscess with bleeding
K57.33	Diverticulitis of large intestine without perforation or abscess with bleeding
K57.41	Diverticulitis of both small and large intestine with perforation and abscess with bleeding
K57.53	Diverticulitis of both small and large intestine without perforation or abscess with bleeding
K57.81	Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding
K57.93	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding

Note: For the ICD-9 codes relevant to the calculation of the measure for the CY2016 period, refer to v5.1 of the manual.

Admissions not counted in the outcome (“Planned admissions”):

Admissions identified as planned by the planned admission algorithm are not counted in the outcome. The “algorithm” is a set of criteria for classifying admissions as planned using Medicare claims. The algorithm identifies admissions that are typically planned and may occur within 7 days of an outpatient colonoscopy. CMS based the planned admission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (transplant surgery, maintenance chemotherapy, rehabilitation);
2. Otherwise, a planned admission is defined as a non-acute admission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The planned admission algorithm uses a flowchart and four tables of procedures and conditions to operationalize these principles and to classify inpatient admissions as planned. ED visits and observation stays are never considered planned. The flowchart and tables are available in the 2016 Measure Updates and Specifications Report, located at

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPages%2FQnetTier3&c_id=1228775214597.

Risk Adjustment:

The measure’s approach to risk adjustment is tailored to, and appropriate for, a publicly reported outcome measure as articulated in published scientific guidelines (Krumholz et al., 2006; Normand et al., 2007).

The measure uses a two-level hierarchical logistic regression model to estimate facility-level risk-standardized hospital visit rates. This approach accounts for the clustering of patients within facilities and variation in sample size across facilities.

The risk-standardization model has 15 patient-level variables (age, concomitant upper GI endoscopy, polypectomy during the procedure, and 12 comorbidity variables). The measure defines comorbidity variables using condition categories (CCs), which are clinically meaningful groupings of the many thousands of ICD-10-CM diagnosis codes. Certain CCs are considered possible complications of care; therefore, the measure does not risk-adjust for them if they occur only at the time of the procedure. This is because only comorbidities that convey information about the patient at the time of the procedure or in the 12 months prior, and not complications that arose during the colonoscopy procedure are included in the risk adjustment. The 2016 Measure Updates and Specifications Report contains complete definitions of risk factors and CCs that are considered possible complications of care and are not risk-adjusted for if they occur only at the time of the procedure.

The patient-level risk adjustment variables are:

Demographics	Age (categorized; 65-69; 70-74; 75-79; 80-84; 85+)
Procedural factors	Concomitant Endoscopy Polypectomy during Procedure
Comorbidities	Chronic Heart Failure Ischemic Heart Disease Stroke/Transient Ischemic Attack (TIA) Chronic Lung Disease Metastatic Cancer Liver Disease Iron Deficiency Anemia Disorders of Fluid, Electrolyte, Acid-Base Pneumonia Psychiatric Disorders Drug and Alcohol Abuse/Dependence Arrhythmia Age Categorized x Arrhythmia Interaction

Note: The relationship between age and risk of a hospital visit within 7 days was modified by the presence or absence of a cardiac arrhythmia (p-value for interaction <0.001). Therefore, we included an interaction term (age categorized x arrhythmia) in the final model.

Full details of the development of the risk-standardization model for this measure are available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html>.

Data Collection Approach: Medicare administrative claims and enrollment data

Data Accuracy: The administrative claims data used to calculate the measure are maintained by CMS' Office of Information Services. The data undergo additional quality assurance checks during measure development and maintenance.

Measure Analysis Suggestions: None

Sampling: No

Data Reported As: Facility-level 7-day risk-standardized unplanned hospital visit rate following outpatient colonoscopy

Measure Calculation:

The measure estimates facility-level 7-day risk-standardized unplanned hospital visit rates using hierarchical logistic regression modeling (a form of hierarchical generalized linear modeling [HGLM]). In brief, the approach simultaneously models two levels (patient and facility) to account for the variance in patient outcomes within and between facilities. At the patient level, the model adjusts the log-odds of a hospital visit within 7 days of the procedure for age, procedural factors, and selected clinical covariates. At the facility level, it estimates the facility-specific intercepts as arising from a normal distribution. The facility intercept represents the underlying risk of a hospital visit within 7 days after a colonoscopy at that facility while accounting for patient risk. The facility-specific intercepts also account for the clustering (non-independence) of patients within the same facility. If there were no differences among facilities, then after adjusting for patient risk the facility-specific intercepts would be identical across all facilities.

The statistical modeling approach is described fully in the original technical report:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html>.

Selected References:

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Measure Information Form

Measure Title: Normothermia

Measure ID #: ASC-13

Quality Reporting Option: Measure submitted via a web-based tool

Description: This measure is used to assess the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration are normothermic within 15 minutes of arrival in PACU.

Numerator: Surgery patients with a body temperature equal to or greater than 96.8 Fahrenheit/36 Celsius recorded within fifteen minutes of Arrival in PACU

Denominator: All patients, regardless of age, undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes duration

Numerator Exclusions: None

Denominator Exclusions: Patients who did not have general or neuraxial anesthesia; patients whose length of anesthesia was less than 60 minutes; patients with physician/APN/PA documentation of intentional hypothermia for the procedure performed

Data Sources: ASC medical records, as well as anesthesia administration and nursing records may serve as data sources. Clinical logs designed to capture information relevant to normothermia are also potential sources.

Data Element Definitions:

Anesthesia duration: the difference, in minutes, between the time associated with the start of anesthesia for the principal procedure and the time associated with the end of anesthesia for the principal procedure

Arrival in PACU: Time of patient arrival in PACU*

General anesthesia: drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation

Intentional hypothermia: A deliberate, documented effort to lower the patient's body temperature in the perioperative period

Neuraxial anesthesia: Epidural or spinal anesthesia

Temperature: A measure in either Fahrenheit or Celsius of the warmth of a patient's body. Axillary, bladder, core, esophageal, oral, rectal, skin surface, temporal artery, or tympanic temperature measurements may be used.

* Definition of Arrival in PACU is consistent with the definition in the Procedural Times Glossary of the American Association of Clinical Directors as approved by the ASA, ACS and AORN.

Clinical Practice Guidelines:

This performance measure is aligned with current guidelines regarding temperature management in patients undergoing general or neuraxial anesthesia lasting 60 minutes or more.

Measure ascertains response to the following question: What is the percentage of having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration are normothermic within 15 minutes of arrival in PACU?

Annual data submission period: January 1-May15, 2019

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Measure Information Form

Measure Title: Unplanned Anterior Vitrectomy

Measure ID #: ASC-14

Quality Reporting Option: Measure submitted via a web-based tool

Description: This measure is used to assess the percentage of cataract surgery patients who have an unplanned anterior vitrectomy.

Numerator: All cataract surgery patients who had an unplanned anterior vitrectomy

Denominator: All cataract surgery patients

Numerator Exclusions: None

Denominator Exclusions: None

Data Sources:

ASC medical records, incident/occurrence reports and variance reports are potential data sources

Definitions:

Cataract surgery: for purposes of this measure, CPT code 66982 (Cataract surgery, complex), CPT code 66983 (Cataract surgery w/IOL, 1 stage) and CPT code 66984 (Cataract surgery w/IOL, 1 stage)

Unplanned anterior vitrectomy: an anterior vitrectomy that was not scheduled at the time of the patient's admission to the ASC

Clinical Practice Guidelines: No clinical practice guidelines addressing unplanned anterior vitrectomy in cataract surgery are available at this time. However, rates of unplanned anterior vitrectomy have been published in the clinical literature, and can serve as comparative benchmarks of performance.

Measure ascertains response to the following question: What is the percentage of cataract surgery patients who have an unplanned anterior vitrectomy?

Annual data submission period: January 1-May 15, 2019

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Quality-Data Coding & Sampling Specifications

ASC-1 through ASC-4 – A Quality-Data Code (QDC) has been established to report that the patient did **not** experience the events for four of the five claims-based outcome measures. If this code is used, none of the other QDCs should be used for these four measures.

G8907: Patient documented **not** to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility.

ASC-5 – Measure ASC-5 applies to all ASCs regardless of specialty or procedure performed. CMS requires all facilities to report on the ASC-5 measure for all Medicare Fee-for-Service (FFS) patients, even if there is no indication for or order for perioperative antibiotics (G8918). This requirement is necessary in order to assess completeness of reporting.

Important: For surgical patients with an order for prophylactic antibiotics, information on the fifth measure, Prophylactic IV Antibiotic Timing, will be reported separately. If the patient received the prophylactic antibiotic on time and did not experience any of the events (a burn prior to discharge; a fall within the facility, wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility), the code listed above (G8907) would be used **in addition** to G8916. See each measure for the list of applicable codes.

For more information on measures ASC-1–ASC-5, see individual measure specifications in this manual.

ASC-9, ASC-10, and ASC-11* – The sampling size specifications for ASC-9, ASC-10, and ASC-11* have been established and are specified in the table below.

Table 3: Sample size requirements per year per ASC for Endoscopy/Polyp Surveillance (ASC-9 and ASC-10) or Cataracts (ASC-11*) measures.**

Population Per Year	0-900
Yearly Sample Size	63
Quarterly Sample Size	16
Monthly Sample Size	6
Population Per Year	≥ 901
Yearly Sample Size	96
Quarterly Sample Size	24
Monthly Sample Size	8

*Voluntary submission of data for ASC-11 began January 2015.

**For ASCs with fewer than 63 cases, the total population of cases is required.

Appendix A: Glossary of Terms

Admission: Completion of registration upon entry into the facility.

Antibiotic administered on time: Antibiotic infusion is *initiated* within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, insertion of needle, inflation of tourniquet) or two hours prior if vancomycin or fluoroquinolones are administered.

Burn: Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical, or radiation (e.g., warming devices, prep solutions, electrosurgical unit, or laser).

Discharge: Occurs when the patient leaves the confines of the ASC.

Fall: A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions (National Center for Patient Safety).

Healthcare personnel (HCP): Facilities must report vaccination data for three categories of HCP: employees on payroll; licensed independent practitioners (who are physicians, advanced practice nurses, and physician assistants affiliated with the hospital but not on payroll); and students, trainees, and volunteers aged 18 or older. All HCP physically working in the facility for at least one day or more between October 1 and March 31 should be counted. Data on vaccinations received at the facility, vaccinations received outside of the facility, medical contraindications, and declinations are reported for the three categories of HCP.

Hospital transfer/admission: Any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room.

Intravenous: Administration of a drug within a vein, including bolus, infusion, or IV piggyback.

Order: A written order, verbal order, standing order, or standing protocol.

Prophylactic antibiotic: An antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of the Prophylactic IV Antibiotic Timing measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin, and Vancomycin.

Quality-Data Code (QDC): Non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified CPT Category II codes and/or G-codes that describe the clinical action required by a measure's numerator.

Wrong: Not in accordance with intended site, side, patient, procedure, or implant.

Appendix B: Preview Section

The Preview Section provides information on new measures. The information provided in this section should not be programmed or submitted. The measure(s) identified in this section are not currently collected.

The measure(s) listed below have been introduced for the CY 2021 payment determination.

ASC-16: Toxic Anterior Segment Syndrome (TASS)

Measure Background and Overview:

Toxic Anterior Segment Syndrome (TASS), an acute, noninfectious inflammation of the anterior segment of the eye, is a complication of anterior segment eye surgery that typically develops within 24 hours after surgery.¹ The TASS measure assesses the number of ophthalmic anterior segment surgery patients diagnosed with TASS within two days of surgery. We believe it is important to monitor the rate of TASS in the ASC setting because ophthalmologic procedures such as anterior segment surgery are commonly performed in this setting of care. Therefore, we are proposing to adopt the ASC-16: Toxic Anterior Segment Syndrome measure, which is based on aggregate measure data collected by the ASC and submitted via a CMS online data submission tool (QualityNet), in the ASCQR Program for the CY 2021 payment determination and subsequent years. We expect the measure would promote improvement in patient care over time, because measurement coupled with transparency in publicly reporting of measure information would make patient outcomes following anterior segment procedures more visible to ASCs and patients and incentivize ASCs to incorporate quality improvement activities to reduce the incidence of TASS where necessary.

Measure Calculation and Reporting:

The outcome measured in the proposed ASC-16 measure is the number of ophthalmic anterior segment surgery patients diagnosed with TASS within two days of surgery. The numerator for this measure is all anterior segment surgery patients diagnosed with TASS within two days of surgery. The denominator for this measure is all anterior segment surgery patients. The specifications for this measure for the ASC setting can be found at:

<http://ascquality.org/documents/ASC%20QC%20Implementation%20Guide%203.2%20October%202015.pdf>.

¹ Centers for Disease Control and Prevention. Toxic Anterior Segment Syndrome after Cataract Surgery—Maine, 2006. MMWR Morb Mortal Wkly Rep. 2007 Jun 29;56(25):629-630.