Ambulatory Surgical Center Quality Reporting Program Specifications Manual

Release Notes Version: 2.0 **Release Notes Completed: December 20, 2012**

Guidelines for Using Release Notes

Release Notes provide modifications to the *Ambulatory Surgical Center (ASC) Quality Reporting Program Specifications Manual*. They are provided as a reference tool and are not intended to be used to program abstraction tools. Please refer to the *ASC Specifications Manual* for the complete and current technical specifications 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 beginning with general changes. The **implementation date is 01/01/2013** 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.
- **Rationale -** provided for the change being made.
- **Description of Changes -** used to identify the section within the document where the change occurs.

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ASC Release Notes version 2.0 - The notes in the tables below are organized to follow the Table of Contents in the specifications manual. The **implementation date is 01/01/2013** unless otherwise specified.

BACKGROUND

Impacts: Table 1

Measure(s)

ASC-1
ASC-2
ASC-3
ASC-4
ASC-5
ASC-8

Rationale: Updates are required to reflect CY 2015 payment determination reporting periods and align with the Rule.

Description of Changes:

Table 1: For ASC-1, ASC-2, ASC-3, ASC-4, and ASC-5

Reporting Period

Change to:

January 1, 2013 thru December 31, 2013

Payments Affected

Change to:

CY 2015

Table 1: For ASC-8

Change to:

Influenza Vaccination Coverage among Healthcare Personnel

Impacts:

Measure(s)

All ASC measures

Rationale: Information on reporting is being updated.

Description of Changes:

Data Collection and Submission

Add: "and Medicare Secondary Payer patients" in first paragraph, second sentence.

Change first paragraph to:

Data for claims-based measures included in this specifications manual are to be reported for Medicare Part B fee-for-service (FFS) patients admitted to the ASC during required reporting periods (see Table 1). Medicare Part B FFS patients include Medicare Railroad Retirement Board patients and Medicare Secondary payer patients. Medicare Advantage patients are not included.

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Change: "begins" in second paragraph, first sentence
To: "began"

Remove: "with the exception of Medicare Secondary Payer patients" in second paragraph, first sentence.

Change second paragraph to:
Reporting on claims-based measures began October 1, 2012 for all Medicare Part B FFS patients. Reporting on claims-based measures for Medicare Secondary Payer patients begins on January 1, 2013.

Change third paragraph, second sentence to "For example, if a service was provided on December 30, 2012 with claim submission on January 1, 2013, this claim would not be included because the service date was prior to the reporting period."

Change third paragraph to:
For claims-based measures, the reporting period refers to dates of service, not to any other date associated with claims processing such as the claim submission date. For example, if a service was provided on December 30, 2012 with claim submission on January 1, 2013, this claim would not be included because the service date was prior to the reporting period.

Change:
"Health Care Workers" in fifth paragraph to: "Healthcare Personnel"

Claims-based Measures
Add: "all" in the second paragraph, first sentence

IMPORTANT Note box

Under ASC-5

Add: "all" in first paragraph, second sentence

Impacts:

Measure(s)
All ASC measures

Rationale: Information on reporting is being updated.

Description of Changes:

Public Reporting

Change paragraph to: 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, extraordinary circumstance extension and waiver request process, and reconsideration request process were finalized in the FY 2013 IPPS/LTCH final rule. Proposals regarding publication will be made in future rulemaking.

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Impacts:

Measure(s)
All ASC measures

Rationale: Updates are required to clarify language related to the CY 2015 payment determination reporting periods and align with the rule.

Description of Changes:

Data Collection and Submission

Change second paragraph to:
Reporting on claims-based measures began October 1, 2012 for all Medicare Part B FFS patients where Medicare was the primary payer. Reporting on claims-based measures where Medicare is the primary or secondary payer begins on January 1, 2013. Reporting for Medicare secondary payer claims was delayed until January 2013 due to the timing of commercial payer system code updates.

Change third paragraph to:
For claims-based measures, the reporting period refers to dates of service, not to any other date associated with claims processing such as the claim submission date. For example, if a service was provided on December 30, 2012 with claim submission on January1, 2013, this claim would not be included in the CY 2015 payment decision data because the service date was prior to the reporting period. However, this claim would be included in the CY 2014 payment decision data if it was submitted by the submission deadline in April 2013.

Change fourth paragraph to**:**
Data for structural measures relates to **all** ASC patients (Medicare and non-Medicare).

Impacts:

Measure(s)
All ASC measures

Rationale: Clarifying language on reporting is being added.

Description of Changes:

Public Reporting

Change first paragraph to: 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, extraordinary circumstance extension and waiver request process, and reconsideration request process were finalized in the FY 2013 IPPS/LTCH final rule. Proposals regarding publication of ASC Quality Reporting data will be made in future rulemaking.

Impacts:

Measure(s)
All ASC measures

Rationale: Clarifying language on reporting is being added.

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Description of Changes:

Specifications Manual

Change first paragraph to:
This Specifications Manual provides measure specifications, associated QDCs with definitions, descriptive examples, and references for required claims-based ASC Quality Reporting Program quality measures.

Add third paragraph:
"Note that for data being collected via a Medicare claims-based mechanism, reporting is possible only for cases where a bill is generated; it is not possible to submit a claim for processing for quality reporting where there is no charge as such claims will be rejected by the Medicare Administrative Contractor."

Change definition for Title of Measure to:
Title of Measure - Provides the reference name of the measure

Change definition for Coding options to:
Coding options - A list and definition of the QDC(s) (currently all are G codes) used to report required information for the measure.

IMPORTANT Note box
Change first paragraph under ASC-5 to**:**
Measure ASC-5 applies to all ASC's regardless of specialty or procedure performed. CMS requires all facilities to report on the ASC-5 measure for all Medicare fee-for-service 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.

Change second paragraph under ASC-5 to:

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.

AMBULATORY SURGICAL CENTER (ASC) QUALITY REPORTING MEASURES

Impacts:

Measure(s)

ASC-1
ASC-2
ASC-3
ASC-4
ASC-5

Rationale: Reporting information is being updated for ASC-1 through ASC-5.

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Description of Changes:

Reporting Mechanism

Add: "and Medicare Secondary Payer claims" to the end of the sentence.

Change: October to January

Change: 2012 to 2013

Impacts:

Measure(s)
ASC-7

Rationale: The CPT® codes have been updated.

Description of Changes:

Table 2: Categories and HCPCS for ASC-7

Cardiovascular Organ System section, Surgical Procedure Codes column

Remove: 92980, 92981, 92982, 92984

Add: 92920, 92921, 92924, 92925, 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, 92944

Impacts:

Measure(s)

ASC-1
ASC-2
ASC-3
ASC-4
ASC-5

Rationale: Reporting information is being updated for ASC-1 through ASC-5.

Description of Changes:

Reporting Period
Add "all" before Medicare.

Remove "and Medicare Railroad Retirement Board"

Impacts:

Measure(s)

ASC-1
ASC-2
ASC-3
ASC-4
ASC-5

Rationale: The definitions need to be updated.

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Description of Changes:

Definitions
Change definition for Admission to: completion of registration after physical entry into the facility.

Impacts:

Measure(s)
ASC-4

Rationale: The measure information needs to be updated.

Description of Changes:

Definitions
Add to definition for Hospital Transfer/Admission: "after the patient has been admitted to the ASC."

Selection Basis
Change first sentence to: The need for transfer/admission is an unanticipated, but sometimes necessary outcome.

Impacts:

Appendix A: Data Definitions

Rationale: The definitions need to be updated.

Description of Changes:

Admission
Change to: Completion of registration after physical entry into the facility.

Hospital transfer/admission
Change to: Any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room or emergency department after admission to the ASC.

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