

**Ambulatory Surgical Center Quality Reporting Specifications Manual  
Release Notes Version 15.0**

**Release Notes Completed:** May 19, 2025

**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 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 that begins with general changes and is followed by data elements in alphabetical order. The **implementation date is 01/01/2026**, 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, Sampling Specifications, and Appendix A.
- **Rationale** – Provided for the change being made.
- **Description of Changes** – Used to identify the section within the document where the change occurs. Examples are Definitions, Numerator, and Denominator

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

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## Section 1 – Measure Information Forms

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**Impacts:** ASC-1: Patient Burn

**Rationale:** The measure description was revised to more accurately reflect the measure unit.

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

**Add:** The percentage of admissions during which the patient experiences a burn prior to discharge from the ASC.

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**Impacts:** ASC-2: Patient Fall

**Rationale:** The measure description was revised to more accurately reflect the measure unit.

**Description of Change(s):**

**Remove:** The number of admissions (patients) who experience a fall within the ASC.

**Add:** The percentage of admissions during which the patient experiences a fall within the ASC.

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**Impacts:** ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

**Rationale:** The measure description was revised to more accurately reflect the measure unit.

**Description of Change(s):**

**Remove:** The number of admissions (patients) who experience wrong site, side, patient, procedure or wrong implant.

**Add:** The percentage of admissions during which the patient experiences a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant.

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**Impacts:** ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients

**Rationale:** This update is to provide clarification for the measure regarding recommendation of a 10-year follow up interval by removing “at least” from the measure information form. This update also includes clarification on what is considered within the recommended follow-up interval before or after 10 years.

**Description of Change(s):**

Description, Numerator Statement, Denominator Statement, Denominator Exclusions, Additional Instructions

**Remove:** “At least” when referencing 10-year follow up interval.

Additional Instructions

**Add:** A 6-month period before or after 10 years is considered within the recommended follow-up interval.

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**Impacts:** ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

**Rationale:** This update provides clarification on specifications that impact public reporting and clarifies relevant claim fields.

**Description of Change(s):**

Denominator Statement

**Add:** Qualifying codes are identified from the principal or any secondary diagnoses in the claim.

*\* See the Measure Information form for additional highlighted non-substantive updates.*

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**Impacts:** ASC-17: Risk-Standardized Hospital Visits within 7 Days After Orthopedic Ambulatory Surgical Center Procedures

**Rationale:** This update provides clarification on specifications that impact public reporting and clarifies relevant claim fields.

**Description of Change(s):**

Denominator Statement

**Add:** Qualifying codes are identified from the principal or any secondary diagnoses in the claim.

*\* See the Measure Information form for additional highlighted non-substantive updates.*

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**Impacts:** ASC-18: Risk-Standardized Hospital Visits within 7 Days After Urology Ambulatory Surgical Center Procedures

**Rationale:** This update provides clarification on specifications that impact public reporting and clarifies relevant claim fields.

**Description of Change(s):**

Denominator Statement

**Add:** Qualifying codes are identified from the principal or any secondary diagnoses in the claim.

*\* See the Measure Information form for additional highlighted non-substantive updates.*

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**Impacts:** ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers

**Rationale:** This update provides clarification on specifications that impact public reporting and clarifies relevant claim fields.

**Description of Change(s):**

Denominator Statement

**Add:** Qualifying codes are identified from the principal or any secondary diagnoses in the claim.

*\* See the Measure Information form for additional highlighted non-substantive updates.*

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**Impacts:** ASC-21: Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO-PM)

**Rationale:** Included Population and Cohort Exclusions were added to provide clarification on the patient population for the measure.

**Description of Change(s):**

**Add:**

**Included Populations:** This target population is Medicare FFS beneficiaries aged 65 years and older who were enrolled in Medicare FFS Part A and B for the 12 months prior to, and at the time of, the procedure. The measure includes only elective primary outpatient THA/TKA procedures (patients with fractures and revisions are not included) performed in the ASC setting and does not include any inpatient procedures. Qualifying codes are identified from the principal or any secondary diagnoses in the claim. For further information see the data dictionary available on the ASCQR PRO-PM Measure Methodology QualityNet page: <https://qualitynet.cms.gov/asc/measures/PRO-PM/methodology>.

**Cohort Exclusions:** The measure excludes patients with staged procedures (multiple elective primary THA or TKA procedures performed on the same patient during distinct encounter) that occur during the measurement period and excludes procedures that were started but not completed. For procedures on or after January 1, 2026, the measure cohort excludes patients with simultaneous THA/TKA procedures, defined as a qualifying elective primary THA procedure and a qualifying elective primary TKA procedure during the same ASC encounter. Excluded codes are identified from the principal or any secondary diagnoses in the claim. For further information see the data dictionary available on the ASCQR PRO-PM Measure Methodology QualityNet page: <https://qualitynet.cms.gov/asc/measures/PRO-PM/methodology>.

# **Ambulatory Surgical Center Quality Reporting Specifications Manual**

**Version 15.0**

Encounter Dates: 01-01-26 (1Q26) through 12-31-26 (4Q26)

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## 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 for the ambulatory surgical center (ASC) setting. 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 *Ambulatory Surgical Center Quality Reporting Specifications Manual* [Version xx, Month, Year] is periodically updated by the Centers for Medicare & Medicaid Services. Users of the *Ambulatory Surgical Center Quality Reporting Specifications Manual* must update their software and associated documentation based on the published manual production timelines.

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*The International Classification of Diseases, 11th Revision, Clinical Modification (ICD-10-CM) is published by the United States Government. A comprehensive listing of ICD-10-CM codes may be obtained on the [Centers for Disease Control and Prevention \(CDC\)](#) website. ICD-10-CM is an official Health Insurance Portability and Accountability Act standard.*

### **IMPORTANT SUBMISSION ALERT!**

**To submit Ambulatory Surgical Center Quality Reporting (ASCQR) Program measures to CMS, files must meet the specifications found only in this CMS manual. Otherwise, the files will be rejected for not meeting CMS quality data submission requirements.**

# Program Background

## CMS Quality Initiatives

### *Background*

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, authorized the Centers for Medicare & Medicaid Services (CMS) to have a program under which ASCs may report data on the quality of their care using standardized measures to receive the full annual payment update (APU) under the Ambulatory Surgical Center (ASC) payment system. The program established under the Calendar Year (CY) 2012 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center (ASC) Final Rule, with Comment Period (CMS-1525-FC) and supported by this manual is the Ambulatory Surgical Center Quality Reporting (ASCQR) Program.

### *Quality Reporting*

The ASC Quality Reporting (ASCQR) Program seeks to collect data and publicly report on quality metrics so that the information is available to support consumer decision-making and provider improvements regarding the quality and efficiency of care in this setting.

## Related Activities

### *Measure Development*

Sections 1833(i)(7)(B) and 1833(t)(17)(C)(i) of the Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief Health Care Act (MIEA–TRHCA) of 2006, requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by ASCs, and that measures reflect consensus among affected parties. Program measures are not required to be endorsed by any national consensus-based entity.

### *Measures Management System*

The Measures Management System (MMS) is a standardized system for developing and maintaining the quality measures used in various CMS initiatives and programs. MMS also supports quality-related activities across the agency. Quality measures are tools that help improve the quality of healthcare through an approach that is consistent and accountable. The primary goals of the MMS are to:

- Provide support and guidance to measure developers to help them produce high caliber healthcare quality measures, and
- Educate and inform interested parties to promote involvement in and awareness of the Measure Lifecycle.

### *Outpatient and Ambulatory Surgery Consumer Assessment (OAS CAHPS)*

The OAS CAHPS initiative was developed as a patient-experience-of-care survey for patients who had surgery or a procedure at a hospital outpatient department (HOPD) or an ambulatory surgery center (ASC). Prior to OAS CAHPS, there was no standardized survey instrument to assess patient experience with outpatient surgical care received at HOPDs and ASCs. Facilities contract with a CMS-approved OAS CAHPS Survey vendor to conduct the survey. A list of approved survey vendors is available at the following link: <https://oascahps.org/General-Information/Approved-Survey-Vendors>.

Beginning with Calendar Year (CY) 2023 reporting period, ASCs were provided the opportunity to voluntarily submit data for the OAS CAHPS survey, as well as voluntary reporting for CY 2024.

Beginning with CY 2025 reporting period, ASCs will be required to report quarterly data by the submission deadlines provided on the [OAS CAHPS](#) website.

***Paperwork Reduction Act (PRA) Disclosure***

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is **0938-1270**. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1650.

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## Measure Information Form Introduction

### Measure Information Form (MIF) Format

**Measure Title** – The specific national ASC quality measure.

**Measure ID #** – A unique alphanumeric identifier assigned to the measure. Information associated with a measure is identified by this alphanumeric number (e.g., ASC-9, ASC-13, ASC-14, 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 either the Hospital Quality Reporting (HQR) site or the National Healthcare Safety Network (NHSN) site 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., This measure is used to assess the percentage of cataract surgery patients who have an unplanned anterior vitrectomy).

**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.

**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.

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## Measure Information Form

**Measure Title:** Patient Burn

**Measure ID #:** ASC-1

**Quality Reporting Option:** Measures Submitted via a Web-based Tool

**Description:** The **percentage** of admissions **during which the patient experiences** a burn prior to discharge from the ASC

**Numerator:** ASC admissions experiencing a burn prior to discharge

**Denominator:** All ASC admissions

**Numerator Inclusions:** ASC admissions experiencing a burn prior to discharge

**Numerator Exclusions:** None

**Denominator Inclusions:** All ASC admissions

**Denominator Exclusions:** None

**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](http://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 electro-surgical devices can be reduced by following the guidelines for electro-surgical safety from the Association of periOperative Registered Nurses (AORN).

The risk of surgical fires can be reduced by minimizing ignition, oxidizer, and fuel risks (the “classic triangle”). The American Society of Anesthesiologist’s 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://pubs.asahq.org/anesthesiology/article/118/2/271/13592/Practice-Advisory-for-the-Prevention-and->

Guidance for the prevention of surgical fire has also been published by 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](http://www.ascquality.org).

**Annual Data Submission Period:**

See the timeline posted to [QualityNet.CMS.gov](https://www.qualitynet.org) for this measure. Select Ambulatory Surgical Centers. Then, select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be completed through the *Hospital Quality Reporting (HQR) system* at <https://hqr.cms.gov> via an online tool available to authorized users.

**Selected References:**

- American National Standards Institute (ANSI) Z136.3 (2018) – Safe Use of Lasers in Health Care Facilities, 2018 Revision.
- Apfelbaum JL, et al. Practice advisory for the prevention and management of operating room fires: an updated report by the American Society of Anesthesiologists Task Force on Operating Room Fires. *Anesthesiology*. 2013 Feb; 118(2):271-90.
- Anesthesia Patient Safety Foundation (APSF). Prevention and management of surgical fires video. February 2010. [http://www.apsf.org/resources\\_video.php](http://www.apsf.org/resources_video.php).
- Croke L. Guideline for electro-surgical safety. *AORN J*. 2020 Jul;112(1):P9-P11. doi:10.1002/aorn.13124. PMID: 32598069.
- National Fire Protection Association (NFPA). NFPA 99: Health Care Facilities Code. Quincy, MA: NFPA, 2024.
- ECRI Institute. Continued use of "flying lead" bipolar electro-surgical cables could result in misconnections and patient burns. *Health Devices*. 2018 Nov 28.
- Jones SB, et al. Fundamental Use of Surgical Energy (FUSE): An Essential Educational Program for Operating Room Safety. *Perm J*. 2017; 21. pii: 16-050.
- Tucker R. Laparoscopic electro-surgical 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. Mehta SP, Bhananker SM, Posner KL, Domino KB. Operating room fires: a closed claims analysis. *Anesthesiology*. 2013 May; 118(5):1133-9.
- Jones EL, et al. Operating Room Fires and Surgical Skin Preparation. *J Am Coll Surg*. 2017 Jul; 225(1):160-165.

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## Measure Information Form

**Measure Title:** Patient Fall

**Measure ID #:** ASC-2

**Quality Reporting Option:** Measures Submitted via a Web-based Tool

**Description:** The **percentage** of admissions **during which the patient experiences** a fall within the ASC

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

**Denominator:** All ASC admissions

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

**Numerator Exclusions:** ASC admissions experiencing a fall outside the ASC

**Denominator Inclusions:** All ASC admissions

**Denominator Exclusions:** None

**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 1,000 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](http://www.ascquality.org).

**Annual Data Submission Period:**

See the timeline posted to <https://QualityNet.CMS.gov> for this measure. Select Ambulatory Surgical Centers. Then, select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be submitted through the *Hospital Quality Reporting (HQR) system* at <https://hqr.cms.gov> via an online tool available to authorized users.

**Selected References:**

- LeCuyer M, Lockwood B, Locklin M. Development of a Fall Prevention Program in the Ambulatory Surgery Setting. *J Perianesth Nurs*. 2017 Oct; 32(5):472-479.
- 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. *Preventing Fall-Related Injuries*. August 15, 2018.
- The Joint Commission. *Sentinel Event Alert 55: Preventing falls and fall-related injuries in health care facilities*. September 28, 2015.
- VA National Center for Patient Safety: United States Department of Veterans Affairs. *Falls Toolkit*. <http://www.patientsafety.va.gov/professionals/onthejob/falls.asp>. Last accessed January 16, 2024.
- National Quality Forum. *List of Serious Reportable Events*. [https://www.qualityforum.org/topics/sres/list\\_of\\_sres.aspx](https://www.qualityforum.org/topics/sres/list_of_sres.aspx). Last accessed January 16, 2024.
- 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*. 3<sup>rd</sup> ed. New York (NY): Springer Publishing Company. 2008. P. 161-98.
- Amador LF, Loera JA. Preventing Postoperative Falls in the Older Adult. *J Am Coll Surg*. 2007 Mar; 204(3):447-453.
- Fritz BA, King CR, Mehta D, Somerville E, Kronzer A, Ben Abdallah A, Wildes T, Avidan MS, Lenze EJ, Stark S; ENGAGES Research Group. Association of a Perioperative Multicomponent Fall Prevention Intervention With Falls and Quality of Life After Elective Inpatient Surgical Procedures. *JAMA Netw Open*. 2022 Mar 1; 5(3):e221938.
- Kronzer VL, Wildes TM, Stark SL, Avidan MS. Review of perioperative falls. *Br J Anaesth*. 2016 Dec; 117(6):720-732.
- Croke L. Preventing Falls Among Perioperative Patients. *AORN J*. 2022 Nov; 116(5): P8-P10.
- Kaiser TJ, Shanley E, Denninger TR, Reuschel B, Kissenberth MJ, Tolan SJ, Thigpen CA, Pill SG. Preoperative screening in patients having elective shoulder surgery reveals a high rate of fall risk. *J Shoulder Elbow Surg*. 2021 Jul; 30(7S):S84-S88.
- Valencia Morales DJ, Laporta ML, Johnson RL, Schroeder DR, Sprung J, Weingarten TN. A Case-Control Study of Accidental Falls During Surgical Hospitalizations. *Am Surg*. 2023 Jan;89(1):61-68. doi: 10.1177/00031348211011114. Epub 2021 Apr 18. PMID: 33870764.

## Measure Information Form

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

**Measure ID #:** ASC-3

**Quality Reporting Option:** Measures Submitted via a Web-based Tool

**Description:** The percentage of admissions during which the patient experiences a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant

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

**Denominator:** All ASC admissions

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

**Numerator Exclusions:** None

**Denominator Inclusions:** All ASC admissions

**Denominator Exclusions:** None

### 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](http://www.ascquality.org).

**Annual Data Submission Period:**

See the timeline posted to [QualityNet.CMS.gov](https://www.qualitynet.org) for this measure. Select Ambulatory Surgical Centers. Then, select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be submitted through the *Hospital Quality Reporting (HQR) system* at <https://hqr.cms.gov> via an online tool available to authorized users.

**Selected References:**

- Joint Commission. *Universal Protocol For Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery*. Available at <https://www.jointcommission.org/standards/universal-protocol>. Last accessed January 19, 2024.
- American Academy of Ophthalmology. Recommendations of American Academy of Ophthalmology Wrong Site Task Force. <https://www.aao.org/patient-safety-statement/recommendations-of-american-academy-ophthalmology->. Aug 2014.
- American Academy of Orthopaedic Surgeons. Surgical Site and Procedure Confirmation. Information Statement 1043. March 2015.
- 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. Revised Statement on Safe Surgery Checklists, and Ensuring Correct Patient, Correct Site, and Correct Procedure Surgery. October 1, 2016. <https://www.facs.org/about-ac/s/statements/93-surgery-checklists>. Last accessed January 19, 2024.
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- Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 2000.
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## Measure Information Form

**Measure Title:** All-Cause Hospital Transfer/Admission

**Measure ID #:** ASC-4

**Quality Reporting Option:** Measures Submitted via a Web-based Tool

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

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

**Denominator:** All ASC admissions

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

**Numerator Exclusions:** None

**Denominator Inclusions:** All ASC admissions

**Denominator Exclusions:** None

**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.

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. It should be noted that issues identified preoperatively are included because they also represent good patient care when a hospital transfer/admission is necessary.

**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](http://www.ascquality.org).

**Annual Data Submission Period:**

See the timeline posted to [QualityNet.CMS.gov](https://QualityNet.CMS.gov) for this measure. Select Ambulatory Surgical Centers. Then, select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be submitted through the *Hospital Quality Reporting (HQR) system* at <https://hqr.cms.gov> via an online tool available to authorized users.

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## 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 45 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of 10 years for repeat colonoscopy documented in their colonoscopy report.

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

**Denominator Statement:** All patients aged 45 to 75 years of age receiving screening colonoscopy without biopsy or polypectomy.

**Denominator Criteria (Eligible Cases):**

Patients aged  $\geq 45$  and  $\leq 75$  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: Z83.710, Z83.711, Z83.718, Z83.719, Z86.0100, Z86.0101, Z86.0102, Z86.0109, Z80.0, Z85.038

**Denominator Exclusion:**

Documentation of medical reason(s) for not recommending a 10-year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is  $\geq 66$  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  $\geq 66$  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.CMS.gov](https://QualityNet.CMS.gov) for this measure. Select Ambulatory Surgical Centers, then select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be completed through the *Hospital Quality Reporting (HQR) system* at <https://hqr.cms.gov> 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 10 years from the date of the current colonoscopy (i.e., the colonoscopy performed during the measurement period). **A 6-month period before or after 10 years is considered within the recommended follow-up interval.** A range that includes “10 years” (e.g., 7 to 10 years) is not acceptable.

## Measure Information Form

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

**Measure ID #:** ASC-11

ASCs have the option to voluntarily collect and submit data for ASC-11 for the CY 2024 payment determination and subsequent years, as finalized in the CY 2023 OPPS/ASC Final Rule (Vol. 87, pp. 72118-72120).

**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, based on completing a pre-operative and post-operative visual function survey.

**Numerator Statement:** Patients 18 years and older 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 survey.

**Denominator Criteria (Eligible Cases):**

Patients aged  $\geq 18$  years

**And**

CPT (without modifiers 55 or 56): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984, 66987, 66988

**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.CMS.gov](https://QualityNet.CMS.gov) for this measure. Select Ambulatory Surgical Centers, then select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be completed through the *Hospital Quality Reporting (HQR) system* at <https://hqr.cms.gov> 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 post-operative 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.

For the purposes of this measure, survey instruments that may be used to assess changes in a patient’s visual function are limited to the National Eye Institute Visual Function Questionnaire-25 (NEI-VFQ-25) ([http://www.rand.org/health/surveys\\_tools/vfq.html](http://www.rand.org/health/surveys_tools/vfq.html)) and two versions of the Visual Function Index, VF-14 (<https://www.ncbi.nlm.nih.gov/books/NBK259054/bin/appd-m4.pdf>) and VF-8R

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(<https://www.aao.org/Assets/a14d8830-e753-4031-a22b-901fb4fe9498/635863021754000000/pre-cataract-surgery-vf-8r-patient-questionnaire-pdf?inline1>). 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.

**Definition of Performance Met:** Improvement in visual function achieved within 90 days following cataract surgery (Healthcare Common Procedure Coding System [HCPCS]: G0913).

**Definition of Performance Not Met:** Improvement in visual function not achieved within 90 days following cataract surgery (HCPCS: G0915).

**Denominator Exception:** Patient care survey was not completed by patient (HCPCS: G0914).

## Measure Information Form

**Performance Measure Name:** Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

**Measure ID #:** ASC-12

**Measure Set:** CMS Outcome Measures (Claims-Based)

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

**Rationale:** The colonoscopy measure aims to 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 assesses quality and informs quality improvement. CMS uses a comprehensive method for development, testing, and creating final specifications for the measure. For initial measure specifications, CMS assembled a multidisciplinary team of clinicians, health services researchers, and statisticians and convened, through a public process, a national technical expert panel (TEP) consisting of patients, surgeons, methodologists, researchers, and providers. CMS also held a public comment period soliciting stakeholder input on the measure methodology.

**Type of Measure:** Outcome

**Improvement Noted As:** A decrease in the facility-level risk-standardized unplanned hospital visit rate. A lower rate indicates better quality.

### Numerator Statement:

The colonoscopy 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 the Measure Calculation section.

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

### Denominator Statement:

The target population for the measure is Medicare FFS patients aged 65 years and older undergoing an outpatient colonoscopy at an ASC who have been enrolled in Part A and Part B Medicare for 12 months or more prior to the date of procedure to ensure the availability of administrative data for risk adjustment.

The measure is focused on low-risk colonoscopies. **Qualifying codes are identified from the principal or any secondary diagnoses in the claim.** Cohort codes are located in the data dictionary on the Colonoscopy Measure Methodology *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/colonoscopy/methodology>.

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**Cohort Exclusions (Excluded Colonoscopies):**

The measure does not include colonoscopy Current Procedural Terminology (CPT®) procedure codes that reflect fundamentally higher-risk or different procedures. Qualifying colonoscopies billed with a concurrent high-risk colonoscopy procedure code are not included in the measure; the accompanying data dictionary contains the current listing of all high-risk procedure codes.

Excluded codes are identified from the principal or any secondary diagnoses in the claim. See the latest data dictionary for the most current exclusion codes here:

<https://qualitynet.cms.gov/asc/measures/colonoscopy/methodology>.

**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 seven 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 Measure **Release Notes** available on the Colonoscopy Measure Methodology *QualityNet* page:

<https://qualitynet.cms.gov/asc/measures/colonoscopy/methodology>.

**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 **denominator** size across facilities. The measure adjusts for differences across facilities in patient demographics, clinical factors, and procedure-related risk. Potential candidate risk factors were identified from related quality measures and the literature; a preliminary list of risk factors was developed and then revised based on a TEP and expert clinical input.

The risk-adjustment model includes 15 patient-level variables (age, concomitant upper gastrointestinal 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 International Classification of Diseases, Tenth Revision, Clinical Modification (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 data dictionary contains complete definitions of risk factors and CCs that are considered possible complications of care and are not included in risk adjustment if they occur only at the time of the procedure.

**Table 1: Patient-Level Risk-Adjustment Variables**

Patient-Level Variables	Risk-Adjusted Variables
Demographics	Age (Categorized; 65–69; 70–74; 75–79; 80–84; 85+)
Procedural Factors	Endoscopy during Procedure Polypectomy during Procedure
Comorbidities	Congestive Heart Failure Ischemic Heart Disease Stroke/Transient Ischemic Attack Chronic Lung Disease Metastatic Cancer Liver Disease Iron Deficiency Anemia Disorders of Fluid, Electrolyte, Acid Base Pneumonia Psychiatric Disorders Substance Abuse Arrhythmia Age Categorized x Arrhythmia Interaction

**Note:** The relationship between age and risk of a hospital visit within seven 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-adjustment model for this measure are available on the Colonoscopy Measure Archived Resources *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/colonoscopy/resources#tab2>.

**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. These data undergo additional quality assurance checks during measure development and maintenance.

**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 seven-day risk-standardized unplanned hospital visit rates using hierarchical logistic regression modeling (a form of hierarchical generalized linear modeling) to model the probability of the outcome as a function of the patient demographic and clinical characteristics, procedural factors, and a facility-specific random effect. This accounts for within-facility correlation of the observed outcome, and it accommodates the assumption that underlying differences in quality across facilities lead to systematic difference in outcomes. The rates are calculated as the ratio of a facility’s “predicted” number of outcomes to “expected” number of outcomes multiplied by the national observed outcome rate. The

predicted number of outcomes for each facility is the number of outcomes predicted by the model based on the facility's patient case mix and the estimated facility-specific effect. The expected number of outcomes for each facility is calculated based on the same patient case mix, but assuming the average facility-specific effect (that is, the number of outcomes expected if the same cases were treated at the average facility). For ease of interpretation, we transform this ratio to a rate by multiplying by the national observed rate for that outcome.

The statistical modeling approach is described fully in the original technical report available on the Colonoscopy Measure Archived Resources *QualityNet* page:

<https://qualitynet.cms.gov/asc/measures/colonoscopy/resources#tab2>.

#### **Selected References:**

1. Krumholz HM, Brindis RG, Brush JE, et al. Standards for Statistical Models Used for Public Reporting of Health Outcomes: An American Heart Association Scientific Statement From the Quality of Care and Outcomes Research Interdisciplinary Writing Group: Cosponsored by the Council on Epidemiology and Prevention and the Stroke Council Endorsed by the American College of Cardiology Foundation. *Circulation*. 2006; 113 (3): 456-462.
2. Normand S-LT, Shahian DM. Statistical and Clinical Aspects of Hospital Outcomes Profiling. *Statistical Science*. 2007; 22 (2): 206-226.

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## Measure Information Form

**Measure Title:** Normothermia Outcome

**Measure ID #:** ASC-13

**Quality Reporting Option:** Measures 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 who are normothermic within 15 minutes of arrival in a post-anesthesia care unit (PACU).

**Numerator:** Surgery patients with a body temperature equal to or greater than 96.8 Fahrenheit/36 Celsius recorded within 15 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:** Patients with a postoperative body temperature less than 96.8° Fahrenheit (or 36.0° Celsius); patients whose body temperature was recorded 16 minutes or more after arrival in PACU; patients with no postoperative body temperature recorded.

**Denominator Exclusions:** Patients who did not have general or neuraxial anesthesia; patients whose length of anesthesia was less than 60 minutes; patients with physician/advance practice nurse/physician's assistant 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 (post-anesthesia care unit).\*

**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.

**Rationale:** Impairment of thermoregulatory control due to anesthesia may result in perioperative hypothermia. Hypothermia, even when mild, is associated with consequences such as increased susceptibility to infection, impaired coagulation, cardiovascular stress, and cardiac complications, as well as post-anesthetic shivering and thermal discomfort. Several methods to maintain normothermia are available.

There is no literature available on variation in rates of normothermia among ASC providers. However, variability in maintaining normothermia has been demonstrated in other settings.

\* 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 patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in PACU?

**Annual Data Submission Period:** See the timeline posted to [QualityNet.CMS.gov](https://QualityNet.CMS.gov) for this measure; select Ambulatory Surgical Centers then Data Submission from the banner options, then click the Deadlines tile from the left side of the page. Data will be submitted through the *Hospital Quality Reporting (HQR)* system at <https://hqr.cms.gov> via an online tool available to authorized users.

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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:** 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.

**Rationale:** The need for unplanned anterior vitrectomy is an unanticipated event that can decrease the probability of good post-operative visual acuity, and generally result in worse long-term outcome after cataract surgery. Because cataract surgery is the most common surgery performed in ASCs, with millions being performed every year, even low unplanned anterior vitrectomy rates translate to relatively high total numbers of affected patients. ASCs can help keep rates low by tracking and comparing rates to established benchmarks, and facilitating mentoring as needed.

**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.

**Annual Data Submission Period:** See the timeline posted to [QualityNet.CMS.gov](https://qualitynet.cms.gov) for this measure. Select Ambulatory Surgical Centers, then select Data Submission from the banner options. Click the Deadlines tile from the left side of the page. Data will be completed through the *Hospital Quality Reporting (HQR) system* at <https://hqr.cms.gov> via an online tool available to authorized users.

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## Measure Information Form

**Performance Measure Name:** Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures

**Measure ID #:** ASC-17

**Measure Set:** CMS Outcome Measures (Claims-Based)

**Description:** The orthopedic measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within seven days of an orthopedic surgery at an ambulatory surgery center (ASC) among Medicare Fee-for-Service (FFS) patients aged 65 years and older.

**Rationale:** Nearly 70 percent of all surgeries in the US are performed in an outpatient setting, with an expanding number and variety of surgeries being performed at stand-alone ASCs (Cullen et al., 2009). The measure aims to improve transparency, inform patients and providers, and foster quality improvement efforts for hospital visits following orthopedic surgery at ASCs. CMS uses a comprehensive method for development, testing, and creating final specifications for the measure. For initial measure specifications, CMS assembled a multidisciplinary team of clinicians, health services researchers, and statisticians and convened, through a public process, a national technical expert panel (TEP) consisting of patients, surgeons, methodologists, researchers, and providers. CMS also held a public comment period soliciting stakeholder input on the measure methodology.

**Type of Measure:** Outcome

**Improvement Noted As:** A decrease in the facility-level risk-standardized unplanned hospital visit rate. A lower rate indicates better quality.

### Numerator Statement:

The orthopedic measure does not have a traditional numerator and denominator like a 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 the Measure Calculation section.

The outcome for this measure is all-cause, unplanned hospital visits within seven days of orthopedic surgery performed at an ASC. The measure defines a hospital visit as any emergency department (ED) visit, observation stay, or unplanned inpatient admission.

### Denominator Statement:

The target population is Medicare FFS patients aged 65 years and older undergoing outpatient orthopedic surgeries at ASCs who have been enrolled in Part A and Part B Medicare for 12 months or more prior to the date of surgery to ensure the availability of data for identifying comorbidities for risk adjustment.

The measure includes procedures that are routinely performed at ASCs, involve increased risk of post-surgery hospital visits, and are routinely performed by orthopedists. **Qualifying codes are identified from the principal or any secondary diagnoses in the claim.** Cohort codes are located in the data dictionary available on the Orthopedic Measure Methodology QualityNet page: <https://qualitynet.cms.gov/asc/measures/orthopedic/methodology>.

#### **Cohort Exclusions:**

Surgeries for patients who survived at least seven days but were not continuously enrolled in Medicare FFS Parts A and B in the seven days after the surgery. The measure excludes these patients to ensure all patients have full data available for outcome assessment. **Excluded codes are identified from the principal or any secondary diagnoses in the claim.**

See the Orthopedic Measure Methodology *QualityNet* page for the data dictionary containing the most current exclusion codes: <https://qualitynet.cms.gov/asc/measures/orthopedic/methodology>.

#### **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 seven days of an outpatient surgery. 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 Measure **Release Notes** available on the Measure Methodology *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/orthopedic/methodology>.

#### **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 **denominator** size across facilities.

The measure adjusts for differences across facilities in patient demographics, clinical factors, and surgery-related risk. Potential candidate risk factors were identified from related quality measures and the literature; a preliminary list of risk factors was developed and then revised based on technical expert panel and expert clinical input.

The risk-adjustment model has 28 patient-level variables (age and 27 comorbidity variables) and work relative value units (RVU) to adjust for surgical complexity (see Table 1). With the exception of morbid obesity, opioid abuse, tobacco use disorder, and chronic anticoagulant use which we define using an individual ICD-10-CM diagnosis code, we define comorbidity variables using CMS Condition Categories, which are clinically meaningful groupings of many thousands of ICD-10-CM diagnosis codes.

**Table 1: Patient-Level Risk-Adjustment Variables**

Patient-Level Variables	Risk-Adjusted Variables
Demographics	Age (years greater than 65)
Comorbidities	Cancer Disorder of fluid/electrolyte/acid-base Other gastrointestinal disorders Bone/joint/muscle infections/necrosis Rheumatoid and osteoarthritis Dementia Psychiatric disorders Multiple sclerosis Seizure disorders and convulsions Congestive heart failure Ischemic heart disease Hypertension and hypertensive disease Stroke Vascular disease Chronic lung disease Pneumonia Other respiratory disorders Chronic renal disease Chronic ulcers Head injury Major traumatic fracture or internal injury Major symptoms, abnormalities Minor symptoms, signs, findings Morbid obesity Opioid abuse Tobacco use Chronic anticoagulant use
Surgical Procedural Complexity	Work RVU

Full details of the development of the risk standardization model for this measure are available on the Orthopedic Measure Archived Resources *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/orthopedic/resources#tab2>.

**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. These data undergo additional quality assurance checks during measure development and maintenance.

**Sampling:** No

**Data Reported As:** ASC-level seven-day risk-standardized, all-cause, unplanned hospital visit rate following orthopedic surgery

**Measure Calculation:**

The measure estimates facility-level seven-day risk-standardized unplanned hospital visit rates using hierarchical logistic regression modeling (a form of hierarchical generalized linear modeling) to model the probability of the outcome as a function of age, procedural factors, selected clinical covariates, and a facility-specific random effect. This accounts for within-facility correlation of the observed outcome, and it accommodates the assumption that underlying differences in quality across facilities lead to systematic difference in outcomes. The rates are calculated as the ratio of a facility's "predicted" number of outcomes to "expected" number of outcomes multiplied by the national observed outcome rate. The predicted number of outcomes for each facility is the number of outcomes predicted by the model based on the facility's patient case mix and the estimated facility-specific effect. The expected number of outcomes for each facility is calculated based on the same patient case mix, but assuming the average facility-specific effect (that is, the number of outcomes expected if the same cases were treated at the average facility). For ease of interpretation, we transform this ratio to a rate by multiplying by the national observed rate for that outcome.

The statistical modeling approach is described fully in the original technical report available on the Orthopedic Measure Archived Resources *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/orthopedic/resources#tab2>.

**Selected References:**

Cullen KA, Hall MJ, Golosinskiy A, National Center for Health Statistics. *Ambulatory surgery in the United States, 2006*. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics; 2009.

Krumholz HM, Brindis RG, Brush JE, et al. Standards for statistical models used for public reporting of health outcomes An American Heart Association scientific statement from the Quality of Care and Outcomes Research Interdisciplinary Writing Group: Cosponsored by the Council on Epidemiology and Prevention and the Stroke Council endorsed by the American College of Cardiology Foundation. *Circulation*. 2006; 113(3):456–462.

Normand S-LT, Shahian DM. Statistical and clinical aspects of hospital outcomes profiling. *Statistical Science*. 2007; 22(2):206–226.

## Measure Information Form

**Performance Measure Name:** Hospital Visits after Urology Ambulatory Surgical Center Procedures

**Measure ID #:** ASC-18

**Measure Set:** CMS Outcome Measures (Claims-Based)

**Description:** The urology measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within seven days of a urology surgery at an Ambulatory Surgery Center (ASC) among Medicare fee-for-service (FFS) patients aged 65 years and older.

**Rationale:** Nearly 70 percent of all surgeries in the US are performed in an outpatient setting, with an expanding number and variety of surgeries being performed at stand-alone ASCs (Cullen et al., 2009). This measure serves to improve transparency, inform patients and providers, and foster quality improvement efforts for hospital visits following urology surgery at ASCs. CMS uses a comprehensive method for development, testing, and creating final specifications for the measure. For initial measure specifications, CMS assembled a multidisciplinary team of clinicians, health services researchers, and statisticians and convened, through a public process, a national technical expert panel (TEP) consisting of patients, surgeons, methodologists, researchers, and providers. CMS also held a public comment period soliciting stakeholder input on the measure methodology.

**Type of Measure:** Outcome

**Improvement Noted As:** A decrease in the facility-level risk-standardized unplanned hospital visit rate. A lower rate indicates better quality.

**Numerator Statement:**

The urology measure does not have a traditional numerator and denominator like a 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 the Measure Calculation section.

The outcome for the measure is all-cause, unplanned hospital visits within seven days of a urology surgery at an ASC. The measure defines a hospital visit as any emergency department (ED) visit, observation stay, or unplanned inpatient admission.

**Denominator Statement:**

The target population is Medicare FFS patients aged 65 years and older undergoing outpatient urology surgeries typically performed by a urologist, at ASCs who have been enrolled in Part A and Part B Medicare for 12 months or more prior to the date of surgery to ensure the availability of data for identifying comorbidities adjustment. The measure includes surgeries that are routinely performed at ASCs, involve increased risk of post-surgery hospital visits, and are routinely performed by urologists.

Qualifying codes are identified from the principal or any secondary diagnoses codes in the claim. Cohort codes are located in the data available on the Urology Measure Methodology *QualityNet* page:

<https://qualitynet.cms.gov/asc/measures/urology/methodology>.

**Exclusion:**

Surgeries for patients who survived at least seven days but were not continuously enrolled in Medicare FFS Parts A and B in the seven days after the surgery. The measure excludes these patients to ensure all patients have full data available for outcome assessment. Excluded codes are identified from the principal or secondary diagnoses in the claim.

See the Urology Measure Methodology *QualityNet* page for the data dictionary containing the most current exclusion codes: <https://qualitynet.cms.gov/asc/measures/urology/methodology>.

**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 seven days of an outpatient surgery. 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 Measure Release Notes available on the Urology Measure Methodology *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/urology/methodology>

**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 denominator size across facilities.

The measure adjusts for differences across facilities in patient demographics, clinical factors, and surgery-related risk. Potential candidate risk factors were identified from related quality measures and the literature; a preliminary list of risk factors was developed and then revised based on a TEP and expert clinical input.

The risk-adjustment model has seven patient-level variables (age and six comorbidity variables), number of qualifying procedures, and work relative value units (RVU) to adjust for surgical complexity (see Table 1). With the exception of benign prostatic hyperplasia with obstruction which we define using an individual ICD-10-CM diagnosis code, we define comorbidity variables using CMS Condition Categories, which are clinically meaningful groupings of many thousands of ICD-10-CM diagnosis codes.

**Table 1: Patient-Level Risk-Adjustment Variables**

Patient-Level Variables	Risk-Adjusted Variables
Demographics	Age (years greater than 65)
Comorbidities	Benign prostatic hyperplasia with obstruction Complications of specified implanted device or graft Poisonings and inflammatory allergic reactions Major symptoms, abnormalities Parkinson's and Huntington's diseases; seizure disorders and convulsions Ischemic heart disease
Number of Qualifying Procedures	Defined as 2 vs. 1, 3, or more vs. 1
Patient-Level Variables	Risk-Adjusted Variables
Surgical Procedural Complexity	Work RVU

Full details of the development of the risk standardization model for this measure are available on the Urology Measure Archived Resources *QualityNet* page:

<https://qualitynet.cms.gov/asc/measures/urology/resources #tab2>.

**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. These data undergo additional quality assurance checks during measure development and maintenance.

**Sampling:** No

**Data Reported As:** ASC-level seven-day risk-standardized, all-cause, unplanned hospital visit rate following urology surgery.

#### Measure Calculation:

The measure estimates facility-level, seven-day risk-standardized unplanned hospital visit rates using hierarchical logistic regression modeling (a form of hierarchical generalized linear modeling) to model the probability of the outcome as a function of age, procedural factors, selected clinical covariates, and a facility-specific random effect. This accounts for within-facility correlation of the observed outcome, and it accommodates the assumption that underlying differences in quality across facilities lead to systematic difference in outcomes. The rates are calculated as the ratio of a facility's "predicted" number of outcomes to "expected" number of outcomes multiplied by the national observed outcome rate. The predicted number of outcomes for each facility is the number of outcomes predicted by the model based on the facility's patient case mix and the estimated facility-specific effect. The expected number of outcomes for each facility is calculated based on the same patient case mix, but assuming the average facility-specific effect (that is, the number of outcomes expected if the same cases were treated at the average facility). For ease of interpretation, we transform this ratio to a rate by multiplying by the national observed rate for that outcome.

The statistical modeling approach is described fully in the original technical report available on the Urology Measure Archived Resources *QualityNet* page:

<https://qualitynet.cms.gov/asc/measures/urology/resources#tab2>.

**Selected References:**

Cullen KA, Hall MJ, Golosinskiy A, National Center for Health Statistics. *Ambulatory surgery in the United States, 2006*. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics; 2009.

Krumholz HM, Brindis RG, Brush JE, et al. Standards for statistical models used for public reporting of health outcomes An American Heart Association scientific statement from the Quality of Care and Outcomes Research Interdisciplinary Writing Group: Cosponsored by the Council on Epidemiology and Prevention and the Stroke Council endorsed by the American College of Cardiology Foundation. *Circulation*.

2006;113(3):456–462.

Normand S-LT, Shahian DM. Statistical and clinical aspects of hospital outcomes profiling. *Statistical Science*. 2007;22(2):206–226.

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## Measure Information Form

**Performance Measure Name:** Facility-Level-7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers

**Measure ID #:** ASC-19

**Measure Set:** CMS Outcome Measures (Claims-Based)

**Description:** The general surgery measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within seven days of a general surgery at an Ambulatory Surgery Center (ASC) among Medicare fee-for-service (FFS) patients aged 65 years and older.

**Rationale:** Nearly 70 percent of all surgeries in the US are performed in an outpatient setting, with an expanding number and variety of surgeries being performed at stand-alone ASCs (Cullen et al., 2009). This measure serves to improve transparency, inform patients and providers, and foster quality improvement efforts for hospital visits following general surgery at ASCs. CMS uses a comprehensive method for development, testing, and creating final specifications for the measure. For initial measure specifications, CMS assembled a multidisciplinary team of clinicians, health services researchers, and statisticians and convened, through a public process, a national technical expert panel (TEP) consisting of patients, surgeons, methodologists, researchers, and providers. CMS also held a public comment period soliciting stakeholder input on the measure methodology.

**Type of Measure:** Outcome

**Improvement Noted As:** A decrease in the facility-level risk-standardized unplanned hospital visit rate. A lower rate indicates better quality.

**Numerator Statement:**

The general surgery measure does not have a traditional numerator and denominator like a process measure (e.g., percentage of adult patients with diabetes aged 18 to 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 the general surgery measure is all-cause, unplanned hospital visits within seven days of a general surgery at an ASC. The measure defines a hospital visit as any emergency department (ED) visit, observation stay, or unplanned inpatient admission.

**Denominator Statement:**

The target population is Medicare FFS patients aged 65 years and older undergoing outpatient general surgeries at ASCs who have been enrolled in Part A and Part B Medicare for 12 months or more prior to the date of surgery to ensure adequate data for identifying comorbidities for risk adjustment.

The measure includes surgeries that are routinely performed at ASCs, involve increased risk of

post-surgery hospital visits and are routinely performed by general surgeons. **Qualifying codes are identified from the principal or any secondary diagnoses in the claim.** Cohort codes are located in the data dictionary available on the General Surgery Measure Methodology *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/surgery/methodology>.

**Exclusion:**

Surgeries for patients who survived at least seven days but were not continuously enrolled in Medicare FFS Parts A and B in the seven days after the surgery. The measure excludes these patients to ensure all patients have full data available for outcome assessment.

**Excluded codes are identified from the principal or secondary diagnoses in the claim.** The full list of exclusions is located in the data dictionary on the General Surgery Measure Methodology *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/surgery/methodology>.

**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 seven days of an outpatient surgery. CMS based the planned admission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (major organ transplant, rehabilitation, or maintenance chemotherapy);
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 Measure **Release Notes** available on the General Surgery Measure Methodology *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/surgery/methodology>.

**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 **denominator** size across facilities.

The measure adjusts for differences across facilities in patient demographics, clinical factors, and surgery-related risk. Potential candidate risk factors were identified from related quality measures and the literature; a preliminary list of risk factors was developed and then revised based on a technical expert panel and expert clinical input.

The risk-adjustment model has 19 patient-level variables (age and 18 comorbidity variables), six

procedure types and work relative value units (RVU) to adjust for surgical complexity (see Table 1). We define comorbidity variables using CMS Condition Categories, which are clinically meaningful groupings of many thousands of ICD-10-CM diagnosis codes.

**Table 1: Patient-Level Risk-Adjustment Variables**

Patient-Level Variables	Risk-Adjusted Variables
Demographics	Age (years greater than 65)
Procedure Type	Abdomen and its contents Alimentary tract Breast Skin/soft tissue Wound Vascular
Comorbidities	Other benign tumors Liver or biliary disease Intestinal obstruction or perforation Dementia or senility Psychiatric disorders Other significant central nervous system (CNS) disease Ischemic heart disease Specified arrhythmias and other heart rhythm disorders Stroke Chronic lung disease Pneumonia Dialysis or severe chronic kidney disease Benign prostatic hyperplasia Cellulitis, local skin infection Major traumatic fracture or internal injury Complication of care Chronic anticoagulant use Opioid abuse
Surgical Procedural Complexity	Work RVU

Full details of the development of the risk standardization model for this measure are available on the General Surgery Measure Archived Resources *QualityNet* page:  
<https://qualitynet.cms.gov/asc/measures/surgery/resources#tab2>.

**Data Collection Approach:** Medicare administrative claims and enrollment data

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

**Sampling:** No

**Data Reported As:** ASC-level seven-day risk-standardized, all-cause, unplanned hospital visit rate following general surgery.

**Measure Calculation:**

The measure estimates facility-level, seven-day risk-standardized unplanned hospital visit rates using hierarchical logistic regression modeling (a form of hierarchical generalized linear modeling) to model the probability of the outcome as a function of age, procedural factors, selected clinical covariates, and a facility-specific random effect. This accounts for within-facility correlation of the observed outcome, and it accommodates the assumption that underlying differences in quality across facilities lead to systematic difference in outcomes. The rates are calculated as the ratio of a facility's "predicted" number of outcomes to "expected" number of outcomes multiplied by the national observed outcome rate. The predicted number of outcomes for each facility is the number of outcomes predicted by the model based on the facility's patient case mix and the estimated facility-specific effect. The expected number of outcomes for each facility is calculated based on the same patient case mix, but assuming the average facility-specific effect (that is, the number of outcomes expected if the same cases were treated at the average facility). For ease of interpretation, we transform this ratio to a rate by multiplying by the national observed rate for that outcome.

The statistical modeling approach is described fully in the original technical report available on the Surgery Measure Archived Resources *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/surgery/resources#tab2>.

**Selected References:**

Cullen KA, Hall MJ, Golosinskiy A, National Center for Health Statistics. *Ambulatory surgery in the United States, 2006*. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics; 2009.

Krumholz HM, Brindis RG, Brush JE, et al. Standards for statistical models used for public reporting of health outcomes An American Heart Association scientific statement from the Quality of Care and Outcomes Research Interdisciplinary Writing Group: Cosponsored by the Council on Epidemiology and Prevention and the Stroke Council endorsed by the American College of Cardiology Foundation. *Circulation*. 2006;113(3):456–462.

Normand S-LT, Shahian DM. Statistical and clinical aspects of hospital outcomes profiling.

*Statistical Science*. 2007;22(2):206–226.

## Measure Information Form

**Performance Measure Name:** COVID-19 Vaccination Coverage Among Health Care Personnel (HCP COVID-19 Vaccination)

**Measure ID #:** ASC-20

**Measure Set:** Measures submitted via a web-based tool (NHSN)

**Description:** Percentage of All Core Healthcare Personnel (HCP) eligible to work at the ASC for at least one day of the self-selected week, in each month of quarterly data reporting, who received a complete primary vaccination series and are up to date with CDC recommended COVID– 19 vaccines\*.

**Annual data submission period:** See the timeline posted to [QualityNet.cms.gov](https://QualityNet.cms.gov) for this measure; select Ambulatory Surgical Centers (ASC) then click the Learn More dial, then select Participation from the banner options.

**Denominator:** Number of HCP eligible to work in the ASC for at least one day during the reporting period, excluding persons with contraindications to COVID–19 vaccination that are described by the CDC.

**Numerator:** Cumulative number of HCP eligible to work in the ASC for at least one day during the reporting period who received a complete vaccination course and are up to date with CDC recommended COVID– 19 vaccines.

### Definitions:

**All Core HCP:** Sum of Employees (staff on facility payroll), Licensed independent practitioners: Physicians, advanced practice nurses, & physician assistants, and adult students/trainees & volunteers.

**Complete Primary Series:** A complete primary series is defined as receiving a 2-dose series of a monovalent COVID-19 vaccine OR a single dose of Janssen OR a single dose of bivalent vaccine OR a single dose of 2023-2024 updated COVID-19 vaccine.

**\*Information on [Key Terms and Up to Date Vaccination status](#) definitions and examples can be found on the CDC site. Refer to the CDC site at least once per quarter. Report vaccination data according to the definitions corresponding to the week of data being reported.**

## Measure Information Form

**Performance Measure Name:** Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO–PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO–PM)

**Measure ID #:** ASC-21

**Measure Set:** Patient Reported Outcome-Based Performance Measures

**Description:** This measure reports the facility-level risk-standardized improvement rate (RSIR) in patient reported outcomes following elective primary THA/TKA for Medicare FFS beneficiaries aged 65 years and older.

**Rationale:** Approximately 6 million adults aged 65 or older suffer from osteoarthritis in the United States. In 2013, there were approximately 568,000 hospitalizations billed to Medicare for osteoarthritis. Hip and knee osteoarthritis is one of the leading causes of disability among non-institutionalized adults, and roughly 80 percent of patients with osteoarthritis have some limitation in mobility. Elective THA and TKA are most commonly performed for degenerative joint disease or osteoarthritis, which affects more than 30 million Americans. THA and TKA offer the potential for significant improvement in quality of life by decreasing pain and improving function in a majority of patients, without resulting in a high risk of complications or death. However, not all patients experience benefit from these procedures. Many patients note that their pre-operative expectations for functional improvement have not been met. In addition, clinical practice variation has been well documented in the United States, readmission and complication rates vary across hospitals, and international experience documents wide hospital-level variation in patient-reported outcome measure results following THA and TKA.

Elective THA/TKAs are important, effective procedures performed on a broad population, and the patient outcomes for these procedures (such as pain, mobility, and quality of life) can be measured in a scientifically sound way, are influenced by a range of improvements in care, and demonstrate hospital-level variation even after patient case mix adjustment. Further, THA/TKA procedures are specifically intended to improve function and reduce pain, making PROs a meaningful outcome metric to assess.

**Type of Measure:** PRO-PM

**Improvement Noted As:** A higher measure performance score is associated with better quality.

**Included Populations:** This target population is Medicare FFS beneficiaries aged 65 years and older who were enrolled in Medicare FFS Part A and B for the 12 months prior to, and at the time of, the procedure. The measure includes only elective primary outpatient THA/TKA procedures (patients with fractures and revisions are not included) performed in the ASC setting and does not include any inpatient procedures. Qualifying codes are identified from the principal or any secondary diagnoses in the claim.

For further information see the data dictionary available on the ASCQR PRO-PM Measure Methodology *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/PRO-PM/methodology>

**Cohort Exclusions:** The measure excludes patients with staged procedures (multiple elective primary THA or TKA procedures performed on the same patient during distinct encounter) that occur during the measurement period and excludes procedures that were started but not completed. For procedures on or after January 1, 2026, the measure cohort excludes patients with simultaneous THA/TKA procedures, defined as a qualifying elective primary THA procedure and a qualifying elective primary TKA procedure during the same ASC encounter. Excluded codes are identified from the principal or any secondary diagnoses in the claim. For further information see the data dictionary available on the ASCQR PRO-PM Measure Methodology *QualityNet* page: <https://qualitynet.cms.gov/asc/measures/PRO-PM/methodology>

**Measure Calculation:** The ASC facility-level THA/TKA PRO-PM result is calculated by aggregating all patient-level results across the facility. This measure is calculated and presented as a RSIR, producing a performance measure per facility which accounts for patient case-mix, addresses potential non-response bias, and represents a measure of quality of care following elective primary outpatient THA/TKA. Response rates for PRO data are calculated as the percentage of elective primary THA or TKA procedures performed at ASCs for which complete and matched pre- and post-operative PRO data have been submitted, divided by the total number of eligible THA or TKA procedures performed at each facility.

**Clarifying Information:** PRO data are collected with the PRO instruments, including two joint-specific PRO instruments—the **Hip Dysfunction and Osteoarthritis Outcome Score for Joint Replacement** (HOOS, JR) for completion by THA recipients and the **Knee Injury and Osteoarthritis Outcome Score for Joint Replacement** (KOOS, JR) for completion by TKA recipients. Scores are used to assess substantial clinical improvement. For risk-adjustment by pre-operative mental health score, facilities submit one of two additional PRO instruments: (1) Patient-Reported Outcomes Measurement Information System (PROMIS)-Global Mental Health subscale; or (2) Veterans RAND 12-Item Health Survey (VR-12) Mental Health subscale. The risk model also includes a one-question patient-reported assessment of health literacy—the Single Item Literacy Screener questionnaire.

Facilities submit the following variables collected pre-operatively between 90 and zero days prior to the THA/TKA procedure for each patient:

- Medicare provider number;
- Medicare health insurance claim (HIC) number/Medicare beneficiary identifier (MBI);
- Date of birth;
- Date of procedure;
- Date of PRO data collection;
- Procedure type;
- Mode of collection;
- Person completing the survey;

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ASCQR Specifications Manual

Encounter dates **01-01-26 (1Q26)** through **12-31-26 (4Q26)** v15.0

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- Facility admission date;
- Patient reported outcome measure version;
- PROMIS Global (mental health subscale items) or VR-12 (mental health subscale items); HOOS, JR (for THA patients) or KOOS, JR (for TKA patients);
- Single Item Health Literacy Screening (SILS2) questionnaire;
- BMI or weight (kg)/height (cm); chronic ( $\geq 90$  day) narcotic use; total painful joint count (patient reported in non-operative lower extremity joint);
- Quantified spinal pain (patient-reported back pain, Oswestry index question)

Facilities also submit the following variables collected post-operatively between 300 and 425 days following the THA/TKA procedure for each patient:

- Medicare provider number;
- Medicare HIC number/MBI;
- date of birth;
- procedure date,
- date of PRO data collection;
- procedure type;
- mode of collection;
- person completing the survey;
- facility admission date;
- KOOS, JR (TKA patients) or HOOS, JR (THA patients).

Included CPT codes:

- 27130: Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
- 27446: Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
- 27447: Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

Additional resources for calculating the measure are available at

<https://qualitynet.cms.gov/asc/measures/PRO-PM/resources>.

**Annual Data Submission Period:** See the timeline posted to [QualityNet.CMS.gov](https://QualityNet.CMS.gov) for this measure; select Ambulatory Surgical Centers, then Data Submission, and then Deadlines tab. Data will be completed through the Hospital Quality Reporting (HQR) system at <https://hqr.cms.gov/> via an online tool available to authorized users.

**Data Collection Approach:** The measure uses four sources of data for the calculation: (1) PRO data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data.

### Measure Information Form

**Performance Measure Name:** Screening for Social Drivers of Health (SDOH)

**Measure ID #:** ASC-22

**Measure Set:** Social Drivers of Health

**Description:** The Screening for SDOH is a process measure that assesses the total number of patients, who were 18 years or older on the date of service, screened for social risk factors (specifically, food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) during their Ambulatory Surgical Center (ASC) care.

**Rationale:** SDOH is an umbrella term that refers to community-level factors that impact health and well-being, while Health-Related Social Needs (HRSNs) are social and economic needs that individuals experience that affect their ability to maintain their health and well-being. Consistent screening of patients for potential HRSNs helps healthcare facilities identify individuals who have historically been underserved by the healthcare system and could support ongoing quality improvement initiatives at the population level by providing data to stratify patient risk and organizational performance to address SDOH. While widespread interest exists in addressing SDOH at community, state, and national levels and in supporting HRSNs for patients who experience one or more HRSNs, action is inconsistent. Additionally, pilot studies screening for HRSNs have been conducted in the Hospital Outpatient Department (HOPD) and ASC settings, with clinicians and staff agreeing that HRSN data are important and relevant to collect in these settings to improve patient care and communication as well as to connect patients with social-related services.

**Type of Measure:** Process

**Improvement Noted As:** An increase in the rate of patients screened for all five social risk factors. A higher rate indicates better quality.

**Numerator Statement:** The numerator consists of the number of patients with a procedure at an ASC who are 18 years or older on the date of the procedure and are screened for all of the following five HRSNs: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their ambulatory surgical care.

**Denominator Statement:** The denominator consists of the number of patients with a procedure at an ASC and who are 18 years or older on the date of the procedure.

**Denominator Exclusions:** The following patients can be excluded from the denominator: 1) Patients who opt out of screening; and 2) patients who are themselves unable to complete the

screening and have no legal guardian or caregiver able to do so on the patient's behalf, during their care at an ASC.

**Clarifying Information:** The Screening for Social Drivers of Health measure will be calculated as the number of patients admitted to an ASC who are 18 years or older on the date of admission screened for all five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) divided by the total number of patients 18 years or older on the date of admission admitted to an ASC. ASCs would report using their CCN through the Hospital Quality Reporting (HQR) System.

**Annual Data Submission Period:** See the timeline posted to [QualityNet.CMS.gov](https://QualityNet.CMS.gov) for this measure; select Ambulatory Surgical Centers, then Data Submission, and then Deadlines tab. Data will be completed through the Hospital Quality Reporting (HQR) system at <https://hqr.cms.gov> via an online tool available to authorized users.

**Data Collection Approach:** Facilities will use a self-selected screening tool. The Accountable Health Communities (AHC) Model's standard 10-item AHC HRSN Screening Tool, which was used to develop the measure, is one example of a screening tool that could be used; others can be found through evidence-based resources like the Social Interventions Research and Evaluation Network (SIREN) website, which provides comprehensive information about the most widely used HRSN screening tools.

Further information on measure specifications is available in QualityNet:

<https://qualitynet.cms.gov/asc/measures/screening/methodology>

## Measure Information Form

**Performance Measure Name:** Screen Positive Rate for Social Drivers of Health (SDOH)

**Measure ID #:** ASC-23

**Measure Set:** Social Drivers of Health

**Description:** The Screen Positive Rate for SDOH measure provides information on the percent of patients receiving care at an Ambulatory Surgical Center (ASC) who are 18 years or older on the date they received their procedure, were screened for a Health-Related Social Need (HSRN), and who screen positive for one or more of the following five HRSNs: food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

**Rationale:** SDOH is an umbrella term that refers to community-level factors that impact health and well-being, while HRSNs are social and economic needs that individuals experience that affect their ability to maintain their health and well-being. Consistent screening of patients for potential HRSNs helps healthcare facilities identify individuals who have historically been underserved by the healthcare system and could support ongoing quality improvement initiatives at the population level by providing data to stratify patient risk and organizational performance to address SDOH. While widespread interest exists in addressing SDOH at community, state, and national levels and in supporting HRSNs for patients who experience one or more HRSNs, action is inconsistent. Additionally, pilot studies screening for HRSNs have been conducted in the Hospital Outpatient Department (HOPD) and ASC settings, with clinicians and staff agreeing that HRSN data are important and relevant to collect in these settings to improve patient care and communication as well as to connect patients with social-related services.

**Type of Measure:** Process

**Numerator Statement:** The numerator consists of the number of patients receiving care at an ASC who are 18 years or older on the date they received their procedure, who were screened for all five HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety.

**Denominator Statement:** The denominator consists of the number of patients receiving care at an ASC who are 18 years or older on the date they received their procedure and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their care.

**Denominator Exclusions:** The following patients can be excluded from the denominator: 1) Patients who opt out of screening; and 2) patients who are themselves unable to complete the

screening and have no legal guardian or caregiver able to do so on the patient’s behalf, during their care at an ASC.

**Measure Calculation:** The result of this measure would be calculated as five separate rates. Each rate is derived from the number of patients receiving care at an ASC and who are 18 years or older on the date they received their procedure, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date they received their procedure screened for all five HRSNs.

**Clarifying Information:** The result of this measure would be calculated as *five separate rates*. Each rate is derived from the number of patients admitted to an ASC and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.

**Annual Data Submission Period:** See the timeline posted to [QualityNet.CMS.gov](https://QualityNet.CMS.gov) for this measure; select Ambulatory Surgical Centers, then Data Submission, and then Deadlines tab. Data will be completed through the Hospital Quality Reporting (HQR) system at <https://hqr.cms.gov> via an online tool available to authorized users.

**Data Collection Approach:** Facilities will use a self-selected screening tool. The Accountable Health Communities (AHC) Model's standard 10-item AHC HRSN Screening Tool, which was used to develop the measure, is one example of a screening tool that could be used; others can be found through evidence-based resources like the Social Interventions Research and Evaluation Network (SIREN) website, which provides comprehensive information about the most widely used HRSN screening tools.

Further information on measure specifications is available in QualityNet: <https://qualitynet.cms.gov/asc/measures/screening/methodology>

**Additional Resources:**

For more information about the CMMI Accountable Health Communities Model screening tool and case studies about implementing SDOH screening: <https://innovation.cms.gov/innovation-models/ahcm>

For a listing of various screening tools, including those that include the five SDOH domains specified in the measure: <https://sirennetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison>

## Measure Information Form

**Performance Measure Name:** Facility Commitment to Health Equity Measure

**Measure ID #:** ASC-24

**Measure Set:** Facility Commitment to Health Equity

**Description:** This structural measure assesses facility commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, rural populations, religious minorities, and people living near or below poverty level. Facilities will receive one point each for attesting to five different domains of commitment to advancing health equity (equity as a strategic priority, data calculation, data analysis, quality improvement, and leadership engagement) for a total of five points.

**Rationale:** Strong and committed leadership from healthcare facility management is essential in shifting organizational culture to reduce health disparities and reach health equity goals. The Agency for Healthcare Research and Quality and The Joint Commission identified that healthcare facility leadership plays an important role in promoting a culture of quality and safety. The Institute for Healthcare Improvement's research shows that health equity must be a priority championed by leadership teams to improve both patient access to needed healthcare services and outcomes among disadvantaged populations. Based upon these findings, we believe that healthcare facility leadership is instrumental in setting specific, measurable, attainable, realistic, and time-based (SMART) goals to assess progress towards achieving equity priorities and ensuring high-quality care is equally accessible to all individuals.

**Type of Measure:** Structure

**Improvement Noted As:** An increase in the rate of positive attestations. A higher rate indicates better quality.

**Numerator Statement:** The numerator captures the total number of domains to which the facility is able to attest affirmatively, up to a maximum of five domains. A facility only receives a point for a domain if it attested “yes” to all of the elements within that domain. The attestation is not accepted when a facility attests “yes” to some, but not all, of the elements; in the event a facility would not be able to attest “yes” to one or more elements within a domain, or the entirety of a domain, they would respond “no.” For example, for Domain 1, if the facility's strategic plan meets elements (A) and (B), but not (C) and (D) of Domain 1, then the facility would not be able to affirmatively attest “yes” and would receive zero points for Domain 1.

**Denominator Statement:** The denominator for each facility is 5 which represents the total number of questions. The measure is calculated as the number of complete attestations / total number of questions. There is no partial credit for any question. Attestation of all elements is required in order to qualify for the measure numerator.

- **Domain 1: Equity is a Strategic Priority**

Facility commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. Please attest that your facility has a strategic plan for advancing health equity and that it includes all of the following elements. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

- A. Our facility strategic plan identifies priority populations who currently experience health disparities.
- B. Our facility strategic plan identifies health equity goals and discrete action steps to achieving these goals.
- C. Our facility strategic plan outlines specific resources which have been dedicated to achieving our equity goals.
- D. Our facility strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

- **Domain 2: Data Collection**

Collecting valid and reliable demographic and social determinant of health data on patients served in a facility is an important step in identifying and eliminating health disparities. Please attest that your facility engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

- A. Our facility collects demographic information (such as self-reported race, national origin, primary language, and ethnicity data) and/or social determinant of health information on the majority of our patients.
- B. Our facility has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.
- C. Our facility inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using EHR technology.

- **Domain 3: Data Analysis**

Effective data analysis can provide insights into which factors contribute to health

disparities and how to respond. Please attest that your facility engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

- A. Our facility stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on facility performance dashboards.
- **Domain 4: Quality Improvement**

Health disparities are evidence that high quality care has not been delivered equitably to all patients. Engagement in quality improvement activities can improve quality of care for all patients. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

  - A. Our facility participates in local, regional, or national quality improvement activities focused on reducing health disparities.
- **Domain 5: Leadership Engagement**

Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your facility engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

  - A. Our facility senior leadership, such as chief executives and the entire facility board of trustees, annually reviews our strategic plan for achieving health equity.
  - B. Our facility senior leadership, such as chief executives and the entire facility board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

**Clarifying Information:** The Facility Commitment to Health Equity measure includes five attestation-based questions, each representing a separate domain of commitment. **For a facility to affirmatively attest to a domain, and receive credit for that domain, the facility will evaluate and determine whether it engages in each of the elements that comprise the domain.** Facilities receive one point for each domain to which they attest “yes,” stating they are meeting the required competencies; a facility’s score can be a total of zero to five points (**one per domain**). For each domain there are between one and four associated yes/no sub-questions for related structures or activities within the facility. Facilities will only receive a point for each domain if they attest “yes” to all related sub-questions. There is no “partial credit” for sub-questions. For example, in Domain 1, facilities must attest “yes” to sub-questions A-D in order to

earn the point for that domain. If facilities participate or complete qualifying activities at any time within the reporting year, they may attest “yes” for that domain.

**Annual Data Submission Period:** See the timeline posted to [QualityNet.CMS.gov](https://QualityNet.CMS.gov) for this measure; select Ambulatory Surgical Centers, then Data Submission, and then Deadlines tab. Data will be completed through the Hospital Quality Reporting (HQR) system at <https://hqr.cms.gov> via an online tool available to authorized users.

**Data Collection Approach:** Provider data entry (attestation-based statements)

**Definition for Survey:** Ambulatory Surgical Centers (ASCs) will attest to the Facility Commitment to Health Equity measure via the HQR system available to authorized users. The measure includes five attestation-based domains of commitment, comprised of several “yes” / “no” sub-questions. ASCs may attest “yes” for each sub-question where they meet the required competencies.

Further information on attestation is available in QualityNet:

<https://qualitynet.cms.gov/asc/measures/fche/methodology>

**Additional Resources:** This measure is supported by evidence and guidance from the following:

- The CMS Meaningful Measures Framework<sup>1</sup> identifies equity as a priority, and the CMS National Quality Strategy<sup>2</sup> promotes the advancement of health equity as a key goal.
- CMS provides a health equity definition and corresponding fact sheet<sup>3</sup> outlining its vision to advance health equity as a strategic pillar and core agency function. CMS also released an updated framework<sup>4</sup> to further advance health equity, expand coverage and improve health outcomes for the more than 170 million individuals supported by CMS programs.
- The CMS Office of Minority Health (OMH) provides information on building an organizational response to health disparities.<sup>5</sup>
- The National Academy of Medicine (NAM) convened health care quality leaders on strategies to address equity.<sup>6</sup>

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<sup>1</sup> [Meaningful Measures 2.0: Moving from Measure Reduction to Modernization | CMS](#)

<sup>2</sup> [CMS National Quality Strategy](#)

<sup>3</sup> [Health equity definition and Pillar: Health Equity fact sheet | CMS](#)

<sup>4</sup> [CMS Framework for Health Equity 2022-2032](#)

<sup>5</sup> [Building an Organizational Response to Health Disparities | CMS OMH](#)

<sup>6</sup> [An Equity Agenda for the Field of Health Care Quality Improvement | NAM](#)

- The Institute for Healthcare Improvement (IHI) studied 23 health systems to better understand organizational efforts to improve equity and concluded equity must be a strategic priority.<sup>7</sup> IHI also issued a framework for health care organizations on achieving health equity.<sup>8</sup>
- The Joint Commission (TJC) published a roadmap for hospitals to improve communication, cultural competence, and patient- and family-centered care.<sup>9</sup>
- A study published by Health Care Management Review<sup>10</sup> utilized interviews with 19 health equity experts and facility executives to identify approaches for health systems to implement lasting organizational change to advance health equity.

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<sup>7</sup> [Health Equity Must Be a Strategic Priority | NEJM Catalyst](#)

<sup>8</sup> [Achieving Health Equity: A Guide for Health Care Organizations | IHI](#) (this content can be accessed on [ihi.org](#) via a free account login)

<sup>9</sup> [Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care: A Roadmap for Hospitals | TJC](#)

<sup>10</sup> [Advancing health equity through organizational change: Perspectives from health care leaders | Health Care Management Review](#)

### Sampling Specifications

**ASC-9, ASC-11\*, and ASC-13** – The sampling size specifications for ASC-9, ASC-11\*, and ASC-13 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) or Cataracts (ASC-11\*) measures, or Normothermia Outcome (ASC-13)\*\***

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

\*Submission of data for ASC-11 is voluntary for CY 2024 reporting period.

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

### Sampling Frequency Values

When submitting data via CSV as described in the Quality Data Transmission section, sampling frequency is set by numeric values rather than the text value. The table below specifies these values while the table above provides the minimum sample size based on the sampling frequency selected.

Sampling Frequency Value	Sampling Frequency
1	Monthly
2	Quarterly
3	Not Sampled
4	N/A - Submission not required***

\*\*\*If “4 – N/A Submission not required” is used as a sampling frequency then your population size must be zero. If your population size is not zero, then a frequency value of “3” should be selected, to indicate that you have not sampled, and are reporting data based on the entire population.

## Quality Data Transmission

### Introduction

This section of the manual is provided to highlight the unique data transmission specifications for the ambulatory surgical center measure data for the Centers for Medicare & Medicaid Services (CMS) and the Hospital Quality Reporting Data Form.

### Guidelines for Submission of Data

Data collected for CMS is transmitted to the Hospital Quality Reporting Data Form. All data submitted must meet transmission requirements. The file layout requirements are included in this section.

### Ambulatory Surgical Center Web-Based Measure Batch Submission File Layout

The Comma-Separated Value (CSV) file layout is one section of content with rows defining unique facilities and columns defining measure data. Please refer to the Ambulatory Surgical Center Web-Based Batch Submission file layout for an example and details of required fields.

**ASC\_PROVIDER\_NPI** – National Provider ID

**ASC\_PYR** – Payment Year

**ASC\_1\_NUMERATOR** – ASC admissions experiencing a burn prior to discharge.

**ASC\_1\_DENOMINATOR** – All ASC admissions.

**ASC\_2\_NUMERATOR** – ASC admissions experiencing a fall within the confines of the ASC.

**ASC\_2\_DENOMINATOR** – All ASC admissions.

**ASC\_3\_NUMERATOR** – All ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant.

**ASC\_3\_DENOMINATOR** – All ASC admissions.

**ASC\_4\_NUMERATOR** – ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC.

**ASC\_4\_DENOMINATOR** – All ASC admissions.

**ASC\_9\_POP\_SIZE** – What was your facility's total population?

**ASC\_9\_SAMP\_SIZE** – What was your facility's sample size?

**ASC\_9\_SAMP\_FREQ** – What was your facility's sampling frequency?

**ASC\_9\_NUMERATOR** – Patients who have a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.

**ASC\_9\_DENOMINATOR** – All patients aged 50 to 75 years of age receiving screening colonoscopy without biopsy or polypectomy.

**ASC\_11\_POP\_SIZE** – What was your facility's total population?

**ASC\_11\_SAMP\_SIZE** – What was your facility's sample size?

**ASC\_11\_SAMP\_FREQ** – What was your facility's sampling frequency?

**ASC\_11\_NUMERATOR** – Patients 18 years and older who had an improvement in visual function achieved within 90 days following cataract surgery, based on completing both a pre-operative and post-operative visual function instrument.

**ASC\_11\_DENOMINATOR** – All patients 18 years and older who had cataract surgery and completed both a pre-operative and post-operative visual function instrument.

**ASC\_13\_POP\_SIZE** – What was your facility’s total population?

**ASC\_13\_SAMP\_SIZE** – What was your facility’s sample size?

**ASC\_13\_SAMP\_FREQ** – What was your facility’s sampling frequency?

**ASC\_13\_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.

**ASC\_13\_DENOMINATOR** – All patients, regardless of age, undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes duration.

**ASC\_14\_NUMERATOR** – All cataract surgery patients who had an unplanned anterior vitrectomy.

**ASC\_14\_DENOMINATOR** – All cataract surgery patients.

### Data Upload Process

Data upload is through the Hospital Quality Reporting (HQR) Data Submission File Upload.

#### All data transmitted pass through the following process:

1. The file(s) are checked for proper naming convention and file type.
  - a. The correct file naming convention is ASC\_WBM\_PY20YY\_mm\_dd\_yyyy.csv where YY represents the last two digits of the applicable Payment Year, and mm\_dd\_yyyy represents the upload date.
2. The file(s) are evaluated upon successful upload and checked for errors in content.
  - a. The system checks the file for errors, logging each one in the file, and then rejects the file if any errors are found. The error log is attached to the “File Processing Complete” notification email.
  - b. If no errors are found, the “File Processing Complete” notification email is sent and lists the number of records processed in the file, after the system uploads the file and applies the data to the given Payment Year.
3. Note that there are no ADD, UPDATE, or DELETE action-codes associated with the file. To correct errors, you can either:
  - a. Enter the HQR Data Form for each individual facility and update the values as appropriate, or
  - b. Upload a corrected CSV file which will overwrite any existing values.

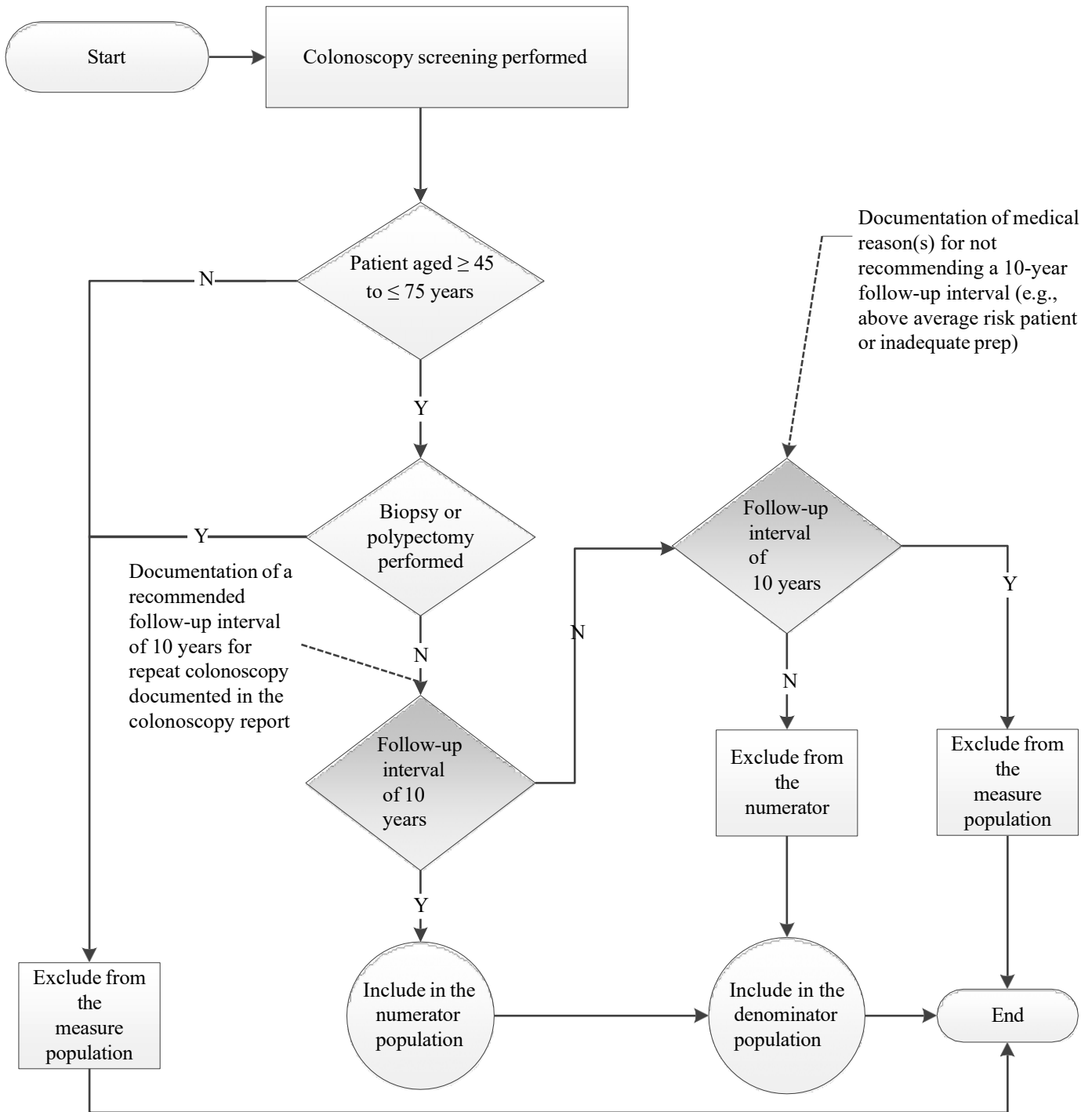
### Alphabetical Tools and Resources List

Measure Name	Page #
ASC-9: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients-Algorithm	A-2
ASC-9: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients-Data Collection Tool	A-3
ASC-9: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients-Denominator Codes	A-4
ASC-9: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients-Fact Sheet	A-5
ASC-13: Normothermia Outcome-Algorithm	A-6
ASC-13: Normothermia Outcome-Example Questions	A-7

# ASC-9: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

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

**Denominator Statement:** All patients  $\geq 45$  to  $\leq 75$  years of age receiving screening colonoscopy without biopsy or polypectomy



Adapted from algorithm provided by clinical services group/HCA; January 2020

For use with encounter dates 010126-123126; Specifications Manual version v15.0



## ASC-9: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients Data Collection Tool

Answer the questions in the tables below to determine whether colonoscopy patients fall into the measures indicated, keeping in mind that ASC-9 looks forward to recommendations for future care.

ASC-9		
ASC-9: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients		
Measure Criteria	Circle One	Denominator/Numerator Determination
1. Patient had a screening colonoscopy, without biopsy or polypectomy, <b>and</b> is $\geq 45$ to $\leq 75$ years of age on date of encounter.	Yes $\longrightarrow$ No $\longrightarrow$	Include in <i>denominator</i> population, continue to 1(a) Exclude from <i>denominator</i> population
a) Documentation of medical reason(s) for not recommending a 10-year follow-up interval (e.g., above average risk patient or inadequate prep or if age is documented as a medical reason).	Yes $\longrightarrow$ No $\longrightarrow$	Exclude from <i>denominator</i> population Continue to Question 2
2. Recommended follow-up interval of 10 years for repeat colonoscopy is documented in colonoscopy report.	Yes $\longrightarrow$ No $\longrightarrow$	Include in <i>numerator</i> population Exclude from <i>numerator</i> population

## ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients Denominator Codes

- For ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients, the codes appropriate for use for the denominator are listed below.
- These codes are derived from the measure information form for ASC-9 that can be found in the Specifications Manual.
- **Denominator Criteria:**  
 Patients aged  $\geq 45$  and  $\leq 75$  on date of encounter  
**and**  
**Z12.11:** Encounter for screening for malignant neoplasm of colon  
**and**  
**44388:** Colonoscopy through Stoma  
**45378:** Diagnostic/screening colonoscopy for non-Medicare patients  
**G0121:** Screening colonoscopy for other Medicare patients  
**without**  
 Modifier **52:** Reduced Services—Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion  
 Modifier **53:** Discontinued Procedure—Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure  
 Modifier **73:** Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia—Due to extenuating circumstances or those that threaten the well-being of the patient  
 Modifier **74:** Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia—Due to extenuating circumstances or those that threaten the well-being of the patient  
**without**  
**Z83.710:** Family history of adenomatous and serrated polyps  
**Z83.711:** Family history of hyperplastic colon polyps  
**Z83.718:** Other family history of colon polyps  
**Z83.719:** Family history of colon polyps, unspecified  
**Z86.0100** Personal history of colon polyps, unspecified  
**Z86.0101** Personal history of adenomatous and serrated colon polyps  
**Z86.0102** Personal history of hyperplastic colon polyps  
**Z86.0109** Personal history of other colon polyps  
**Z80.0:** Family history of malignant neoplasm of digestive organs  
**Z85.038:** Personal history of malignant neoplasm of large intestine

## ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients-Fact Sheet

**Description:** Percentage of patients aged 45 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of 10 years for repeat colonoscopy documented in their colonoscopy report.

**Denominator Statement:** All patients aged 45 to 75 years of age receiving screening colonoscopy without biopsy or polypectomy.

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

When abstracting for this measure:

- **Do** use the final colonoscopy report to abstract the recommended follow-up interval. If your facility utilizes another report that is equivalent to or contains the final colonoscopy report, utilize this report for abstraction.
- **Do** exclude a case based on age if there is documentation indicating no follow-up colonoscopy is needed or recommended **and** patient's age is identified as the reason.
- **Do** use any medical reason, such as a diagnosis, symptom, or condition that is documented in the medical record to exclude a case from the denominator population **only** when the recommended follow-up interval is less than 10 years. Please note that you must have **both** an interval of less than 10 years and the medical reason documented in order to use this as an exclusion from the denominator. Some examples are:
  - Above average risk patient
  - Inadequate prep
  - Family history of colon cancer
  - Diverticulitis documented in the medical record

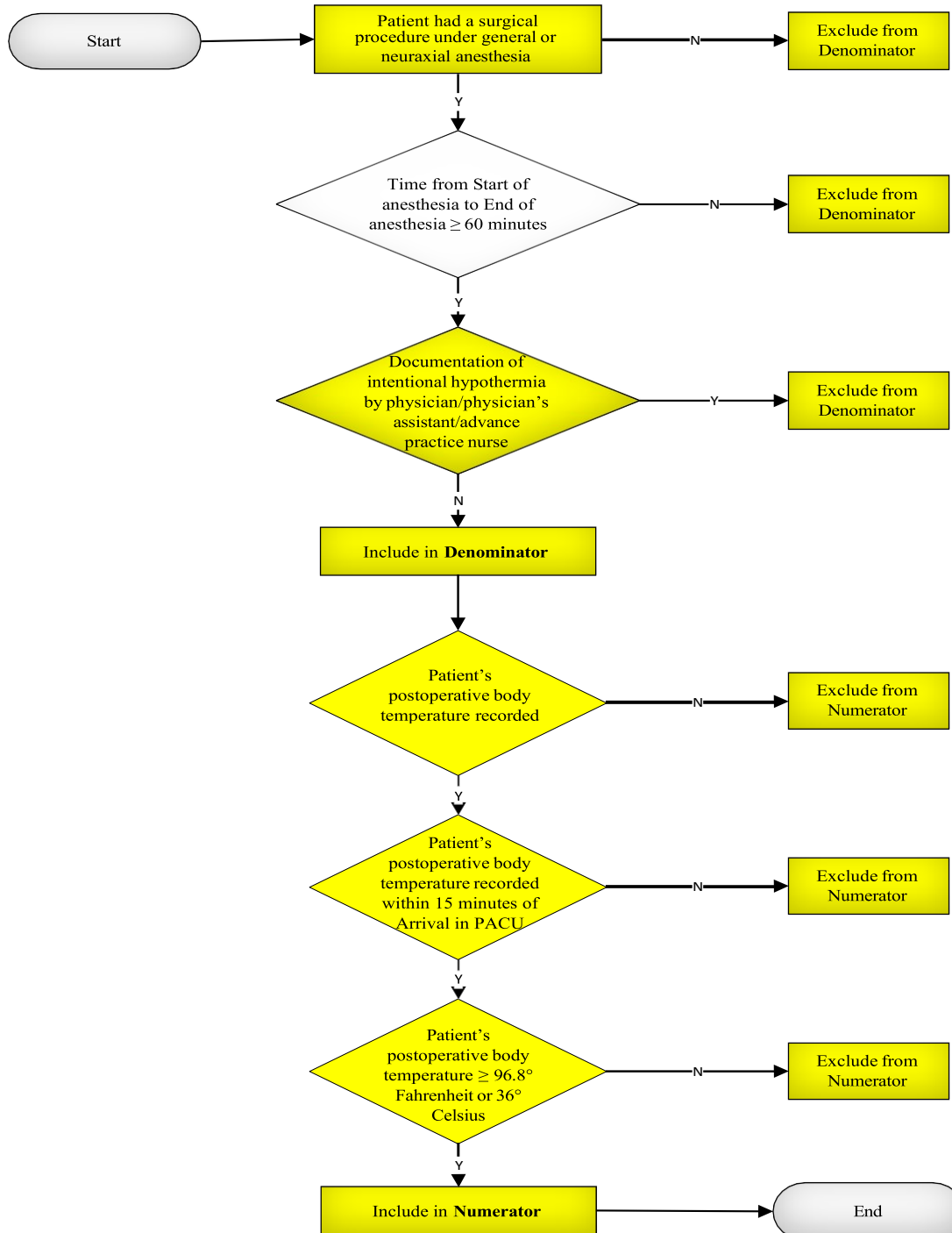
Please remember that medical reasons are at the discretion of the physician.

- **Do not** include records with CPT/HCPCS modifiers 52, 53, 73, or 74.
- **Do not** use time frames, such as “5–10 years,” “many,” “prn,” or “when symptomatic,” since they are not acceptable terms for the recommended follow-up interval of 10 years.

## ASC-13: Normothermia Outcome

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



Adapted from algorithm provided by clinical services group/HCA; January 2020

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## ASC-13: Normothermia Outcome Example Questions

**Step 1:** Identify surgical patients with general or neuraxial (epidural or spinal) anesthesia equal to or greater than 60 minutes in duration (**Denominator**).

- Did the patient have a general or neuraxial anesthetic?
  - Cases with strictly sedation or local anesthesia would not be included.
- What was the Start time of anesthesia?
  - If there is no Start time, do **not** include patient in the Denominator.
  - If both Start time and Induction time are documented, use Start time.
  - If there is no Start time but there is an Induction time, do **not** include patient in the Denominator.
- What is the End time of anesthesia?
  - If there is no End time, do NOT include patient in the Denominator.
  - If there is no End time documented, do NOT include patient in the Denominator.

If the duration between Start time and End time is equal to or greater than 60 minutes, the patient can be included in the Denominator.

**Step 2:** Determine how many patients in the Denominator population had the required body temperature within 15 minutes of arriving in the PACU (**Numerator**).

If the patient had a recorded body temperature greater than or equal to **96.8°F or 36°C** within 15 minutes of arrival in the PACU, then the patient can be included in the Numerator. If there was no postoperative temperature recorded, or the temperature was recorded 16 minutes or more after arrival in the PACU, then the patient should be excluded from the Numerator.

**Step 3:** Determine if the number of cases meet the Sampling Specifications.

If the population is 0–900, a sample of 63 may be used: If the population is greater than or equal to 901, a sample of at least 96 should be used. If the population is fewer than 63 cases, the total population of cases is required.

**Example:** An ASC performed **903** surgical procedures. The number of procedures exceeds 901 and can be sampled using at least 96 cases.

### Scenario 1

Medicare patient has surgical procedure using **general** anesthesia.

Start time of anesthesia was **0615**.

End time of anesthesia was documented on the operating room (OR) form at **0720**.

Patient's arrival to PACU was documented at **0725**.

Body temperature was **36°C** at **0730**.

**Denominator criteria met?** Yes

**Numerator criteria met?** Yes

✓ The patient received **general** anesthesia for the duration of **65** minutes and had a documented body temperature of **36°C** within **15** minutes of arrival in the PACU. This patient should be included in this measure.

**Scenario 2**

Patient started **neuraxial** anesthetic (spinal) for a surgical procedure at **1000**.

End time of anesthesia was documented at **1100**.

Patient arrived into the PACU at **1105**.

At **1110** patient's temperature was documented as **96.5°F**.

Patient's temperature was rechecked at **1115** and documented as **97°F**.

**Denominator criteria met?** Yes

**Numerator criteria met?** Yes

✓ The patient received **neuraxial** anesthesia for 60 minutes and had a documented body temperature of **97°F** within 15 minutes of arrival in the PACU. This patient meets the criteria for both the numerator and denominator.

**Scenario 3**

Patient received **general** anesthesia. Anesthetist

documented the start time as **0730**. The

anesthetist documented the end time as **0825**.

Patient's arrival time into PACU was documented as **0832**.

Patient's body temperature at **0837** was **97.8°F**.

**Denominator criteria met?** No

✗ The anesthesia duration time is not equal to or greater than **60** minutes; therefore, this patient should **not** be included in the measure.

**Scenario 4**

Patient started epidural in pre-op holding at **0800**.

Patient entered the operating suite at **0810**.

Documented End time of anesthesia was **0905**.

Patient's body temperature recorded at **0920** was **96.5°F**.

Nurse Practitioner documented intentional hypothermia for the procedure.

**Denominator criteria met?** No

✗ The documentation of intentional hypothermia is a Denominator Exclusion and excludes this case from the population; therefore, this patient should **not** be included in the measure.

**Scenario 5**

Patient received **general** anesthesia for surgical procedure.

Anesthetist documented Start time at **1010**.

No documented End time.

Patient's arrival in the PACU is recorded at **1115**.

Patient's body temperature was recorded at **1125** at **97°F**.

**Denominator criteria met?** No

✗ Arrival time at PACU is only used to determine if patient's body temperature meets the duration and required temperature for inclusion in the Numerator. Anesthesia End time cannot be substituted with Arrival at PACU time; therefore, this patient should **not** be included in the measure.

Reserved for Future Use

Measure ID	Measure Name	Measure Type*	Data Sources	Applicable Notes
ASC-1	Patient Burn	Outcome	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources. Data submitted through the Hospital Quality Reporting (HQR) system at <a href="https://hqr.cms.gov">https://hqr.cms.gov</a> via an online tool available to authorized users.	All patients are included, not only patients with Medicare Fee-For-Service.  Lower rates are better.
ASC-2	Patient Fall	Outcome	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources. Data submitted through the Hospital Quality Reporting (HQR) system at <a href="https://hqr.cms.gov">https://hqr.cms.gov</a> via an online tool available to authorized users.	All patients are included, not only patients with Medicare Fee-For-Service.  Lower rates are better.
ASC-3	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	Outcome	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources. Data submitted through the Hospital Quality Reporting (HQR) system at <a href="https://hqr.cms.gov">https://hqr.cms.gov</a> via an online tool available to authorized users.	All patients are included, not only patients with Medicare Fee-For-Service.  Lower rates are better.
ASC-4	All-Cause Hospital Transfer/Admission	Outcome	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources. Data submitted through the Hospital Quality Reporting (HQR) system at <a href="https://hqr.cms.gov">https://hqr.cms.gov</a> via an online tool available to authorized users.	All patients are included, not only patients with Medicare Fee-For-Service.  Lower rates are better.
ASC-9	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Process	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources. Use the CPT® codes indicated in the Specifications Manual. Data submitted through the Hospital Quality Reporting (HQR) system at <a href="https://hqr.cms.gov">https://hqr.cms.gov</a> via an online tool available to authorized users.	All patients are included, not only patients with Medicare Fee-For-Service.  Higher rates are better.

Measure ID	Measure Name	Measure Type*	Data Sources	Applicable Notes
ASC-11	Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery	Outcome	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources. Use the CPT® codes indicated in the Specifications Manual. Data submitted through the Hospital Quality Reporting (HQR) system at <a href="https://hqr.cms.gov">https://hqr.cms.gov</a> via an online tool available to authorized users.	All patients are included, not only patients with Medicare Fee-For-Service.  ASCs have the option to voluntarily submit data for ASC-11.  Higher rates are better.
ASC-12	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Claims-based Outcome	Medicare claims and enrollment data.	Only Medicare Fee-For-Service patients aged 65 years and older.  Lower outcome rates are better.
ASC-13	Normothermia	Outcome	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 submitted through the Hospital Quality Reporting (HQR) system at <a href="https://hqr.cms.gov">https://hqr.cms.gov</a> via an online tool available to authorized users.	All patients are included, not only patients with Medicare Fee-For-Service.  Higher rates are better.
ASC-14	Unplanned Anterior Vitrectomy	Outcome	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources. Use the CPT® codes indicated in the Specifications Manual. Data submitted through the Hospital Quality Reporting (HQR) system at <a href="https://hqr.cms.gov">https://hqr.cms.gov</a> via an online tool available to authorized users.	All patients are included, not only patients with Medicare Fee-For-Service.  Lower rates are better.
ASC-17	Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures	Claims-based Outcome	Medicare claims and enrollment data.	Only Medicare Fee-For-Service patients aged 65 years and older.  Lower outcome rates are better.

Measure ID	Measure Name	Measure Type*	Data Sources	Applicable Notes
ASC-18	Hospital Visits after Urology Ambulatory Surgical Center Procedures	Claims-based Outcome	Medicare claims and enrollment data.	Only Medicare Fee-For-Service patients aged 65 years and older.  Lower outcome rates are better.
ASC-19	Facility-Level-7-Day Hospital Visits after General Surgery Procedures	Claims-based Outcome	Medicare claims and enrollment data.	Only Medicare Fee-For-Service patients aged 65 years and older.  Lower outcome rates are better.
ASC-20	COVID-19 Vaccination Coverage Among Health Care Personnel (HCP)	Process	<a href="https://www.cdc.gov/nhsn/ambulatory-surgery/index.html">Data Collection Forms</a> and <a href="https://www.cdc.gov/nhsn/ambulatory-surgery/index.html">data tracking worksheets</a> are available on the CDC site at <a href="https://www.cdc.gov/nhsn/ambulatory-surgery/index.html">https://www.cdc.gov/nhsn/ambulatory-surgery/index.html</a> .	Sum of Employees (staff on facility payroll), Licensed independent practitioners: Physicians, advanced practice nurses, physician assistants, and adult students/trainees and volunteers.
ASC-21	Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO-PM)	PRO-PM	PRO data are collected with the PRO instruments, including two joint-specific PRO instruments—the HOOS, JR for completion by THA recipients and the KOOS, JR for completion by TKA recipients.	All patients are included, not only patients with Medicare Fee-For-Service.  Higher rates are better.
ASC-22	Screening for Social Drivers of Health (SDOH)	Process	ASCs will use a self-selected screening tool. Screening tools can be found through evidence-based resources like the <a href="#">Social Interventions Research and Evaluation Network (SIREN)</a> website, which provides comprehensive information about the most widely used HRSN screening tools.	All patients are included, not only patients with Medicare Fee-For-Service.  Improvement noted as: An increase in the rate of patients screened for all five social risk factors. A higher rate indicates better quality.

ASC-23	Screen Positive Rate for Social Drivers of Health (SDOH)	Process	ASCs will use a self-selected screening tool. Screening tools can be found through evidence-based resources like the <a href="#">Social Interventions Research and Evaluation Network (SIREN)</a> website, which provides comprehensive information about the most widely used HRSN screening tools.	All patients are included, not only patients with Medicare Fee-For-Service.
ASC-24	Facility Commitment to Health Equity Measure (FCHE)	Structure	Ambulatory Surgical Centers (ASCs) will attest to the Facility Commitment to Health Equity measure via the HQR system available to authorized users. The measure includes five attestation-based domains of commitment, comprised of several “yes” / “no” sub-questions. ASCs may attest “yes” for each sub-question where they meet the required competencies.	For a facility to affirmatively attest to a domain, and receive credit for that domain, the facility will evaluate and determine whether it engages in each of the elements that comprise the domain.

**\*Measure Type** – Indicates what is being evaluated by the measure.

- **PRO-PM:** A measure used to capture patients’ reports of their outcomes.
- **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.
- **Outcome:** A measure that indicates the result of performance (or non-performance) of a function(s) or process(es).
- **Structure:** A measure that assesses features of a health care organization or clinician relevant to its capacity to provide health care.