



ASC Quality Collaboration

August 27, 2010

VIA HAND DELIVERY

Donald Berwick, MD, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1504-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1504-P; Reporting Quality Data for Annual Payment Rate Updates

Dear Administrator Berwick:

On behalf of the ASC Quality Collaboration (ASC QC), a cooperative effort of organizations and companies interested in ensuring ambulatory surgical center (ASC) quality data is appropriately developed and reported, please accept the following comments regarding CMS-1504-P, Section XVI. Reporting Quality Data for Annual Payment Rate Updates, particularly as it pertains to ASCs (75 Fed. Reg. 46169, August 3, 2010). The ASC Quality Collaboration's stakeholders include ASC corporations, the ASC industry association, professional societies and accrediting bodies with an interest in ASCs. Please see Appendix A for a list of the ASC QC's participants.

Over the last several years, the ASC QC has communicated periodically with CMS through formal comments, letters, conference calls and a face-to-face meeting. We have provided updates on our progress in the development of ASC facility-level quality measures endorsed by the National Quality Forum (NQF), provided information regarding the characteristics and operational capabilities of the ASC industry, offered recommendations regarding the structure of the future ASC quality reporting system, and shared our thoughts on effective ways of presenting ASC quality data to the public. We appreciate this opportunity to continue to share our perspective.

The ASC QC strongly advocates quality reporting. Our commitment has been reflected in the concrete steps we have taken to facilitate quality reporting by ASCs – all of which have been accomplished without any federal incentive or penalty. Our latest independent initiative resulted in the development and publication of a quarterly public report of ASC quality data that is freely available to all online. This report presents aggregated performance data for the six ASC facility-level quality measures developed by the ASC QC and endorsed by the National

Quality Forum (NQF). These quarterly reports are made possible through the voluntary efforts of participants in the ASC QC and may be accessed at the ASC QC's website at: <http://www.ascquality.org/qualityreport.html>. Over 1100 centers, representing more than 20 percent of all Medicare certified ASCs, participated in the 1Q2010 report.

In addition to our longstanding support for quality reporting, we also support the development and incremental implementation of a value-based purchasing (VBP) program for the outpatient surgical setting. We believe the first step should be the development of a quality reporting infrastructure for outpatient surgical facilities, including ASCs, designed to allow participation across the entire provider spectrum without imposing undue burden on small providers. We look forward to future dialogue on this subject as the Secretary further considers her plans for VBP for ASCs.

I. ASC Quality Reporting System

We are disappointed that the agency did not put forth proposals for an ASC quality reporting system in this year's proposed rule. We do not perceive any significant industry barriers to moving forward. ASCs currently collect quality data for a variety of reasons, including internal performance improvement activities, external benchmarking and fulfillment of various requirements for state licensure, certification and accreditation. We encourage CMS to develop and issue its proposals as soon as possible.

II. Quality Measures for Outpatient Surgery

Outpatient surgical facility quality measures should reflect aspects of patient care that are directly attributable to the facility itself - its staff, equipment, environment of care, and its roles in the delivery of patient care - and for which the facility, by virtue of its specific functions in patient care, may reasonably be held accountable. Only facility-level quality measures endorsed by the NQF through its consensus approval process should be implemented for providers of facility services. We do not believe it is appropriate to implement physician-level quality measures for non-physician provider types, such as ASCs.

A. Outpatient Surgery Quality Measures Endorsed by the National Quality Forum

From the outset, the ASC QC has been mindful of the importance of developing quality measures that are as easy to use as possible, while still providing valid and reliable information that is useful and meaningful to the consumer. Our measures are designed to be implemented with minimal burden to the provider, without requiring additional staff for data collection.

The ASC QC has developed several facility-level measures of outpatient surgical quality. Six of these measures are endorsed by the NQF. Of the six, four are outcome measures that have applicability to all outpatient surgical facilities and thereby would allow broad participation regardless of case mix. These four outcome measures focus on 1) patient falls, 2) patient burns, 3) hospital transfer/admission and 4) wrong site/wrong side/wrong patient/wrong procedure/wrong implant.

The fifth measure is a process measure which evaluates the timing of the administration of intravenous antibiotics for prophylaxis of surgical site infection. This prophylactic antibiotic timing measure has been specifically designed to harmonize with similar measures already being reported by inpatient hospitals and hospital outpatient departments. The prophylactic antibiotic timing measure also addresses the statutory requirement under Section 109 of the Tax Relief and Health Care Act of 2006 (TRHCA) for evaluation of medication errors. Administering antimicrobial agents at the wrong time is a recognized type of medication error. In the *MEDMARX® Data Report: A Chartbook of Medication Error Findings from the Perioperative Settings from 1998-2005*, the U.S. Pharmacopeia detailed the various types of medication errors in outpatient surgery, one of which was “wrong time.” The report specifically recommended “[d]eveloping strategies to ensure that medications, especially antimicrobial agents, are administered at the correct time.”

The sixth ASC facility-level measure developed by the ASC QC is a process measure addressing appropriate surgical site hair removal. This measure harmonizes with a similar measure currently in use for hospital inpatient reporting.

Please see Appendix B for detailed information on the six NQF-endorsed ASC facility-specific quality measures. We strongly recommend CMS implement these facility-specific measures for ASC reporting. They are currently in use in the ASC industry, they provide meaningful information on the quality of the ASC, and we believe their feasibility and usability has been validated by the high levels of voluntary reporting we are experiencing in our quarterly public reporting project.

The ASC facility-level measures currently endorsed by the NQF are appropriate for all outpatient surgical settings. We encourage CMS to implement these measures for other facility providers of outpatient surgical services, such as hospital outpatient departments. Applying the same facility-level quality measures to all settings offering outpatient surgery expands the comparative data available to Medicare beneficiaries and would represent an important step toward full transparency.

B. Outpatient Surgery Quality Measures in Development

The ASC QC has been evaluating and developing other potential outpatient surgery quality measures, encompassing topic areas such as surgical site infection, medication administration variances, medication reconciliation, venous thromboembolism and patient experience.

We have a keen interest in seeing a surgical site infection (SSI) outcome measure developed. However, we recognize that there are a number of challenges to be overcome in developing a feasible and reliable measure of this type. Foremost among these is the matter of reliable and accurate case detection in the post-operative period. The Centers for Disease Control and Prevention’s (CDC) definition of SSI includes specific timeframes for the identification of an SSI related to the index operation: 30 days for cases that do not involve an implant, and one year for cases that do involve an implant. Particularly in the case of outpatient surgery, the patient is not always seen at the 30 day mark (or one year mark if an implant is

placed) by the surgeon or other healthcare provider. As a result, accurately and reliably identifying patients who have developed an SSI within the defined timeframes in a feasible manner remains a challenge. We are not aware of any measure developer who has successfully overcome this obstacle. Nonetheless, we remain committed to the concept and continue to evaluate alternatives for an SSI outcome measure that would meet current standards for consensus approval.

Another recent area of interest has been the area of medication administration variances. We recently developed a draft measure that drew on the definition of medication variance developed for the Common Formats by the Agency for Healthcare Research and Quality (AHRQ). Our goal was to develop a measure with a more global scope, thereby allowing all ASCs to participate in reporting medication errors. (While the Prophylactic IV Antibiotic Timing Measure described above does evaluate a type of medication error, it is not a measure that has applicability to all ASCs due to variation in case mix.) We recently brought this draft measure before the NQF. The NQF's technical advisory panel (TAP) had a number of concerns, including reliable detection of error rates. While the TAP felt that the measure would be useful for internal quality improvement and benchmarking, they did not believe that the measure should be used for public reporting for at least two reasons. First, they were concerned about the potential to create a disincentive for reporting, resulting in unreliable data due to underreporting of variances. They were also concerned that this measure would be difficult for the public to understand and use appropriately in decision-making.

Medication reconciliation is another area of interest due to its importance in patient care coordination. We are currently in the exploratory phase of measure development for this topic. To date we have not made any determination regarding the feasibility of such a process measure in the outpatient surgical setting.

Venous thromboembolism (VTE) is another measure topic we are exploring. We are currently evaluating whether there is a sufficient evidence base to support measures of VTE risk assessment, VTE prophylaxis and VTE outcomes in the outpatient surgical patient population. We note that CMS has not implemented nor proposed to implement VTE measures for the HOP QDRP.

Another area of strong interest for the ASC QC is the development of a patient experience measure for outpatient surgical facilities similar to CAHPS survey tools currently in existence. We have developed a draft survey instrument, but currently lack the resources to complete the necessary testing. We have explored doing so in partnership with both CMS and AHRQ, but have been advised that neither agency currently has funds that could be allocated to a project of this nature.

Our measure development activity is ongoing. We welcome input from CMS regarding potential topics for facility-level outpatient surgery quality measures.

C. Quality Measures in Use in the Hospital Outpatient Setting

CMS has implemented two surgical measures in the hospital outpatient department (HOPD): Timing of Antibiotic Prophylaxis (ID# OP-6) and Prophylactic Antibiotic Selection for Surgical Patients (ID# OP-7). Neither of these measures is appropriate for implementation as part of a measure set for a future ASC quality reporting system.

1. Timing of Antibiotic Prophylaxis (ID# OP-6)

We agree that it is important to ensure that intravenous antibiotics ordered for the prophylaxis of surgical site infection are given in accordance with timeliness guidelines to ensure maximal effectiveness. We have independently developed and secured NQF endorsement for a similar measure, the ASC QC's Prophylactic IV Antibiotic Timing measure, and believe it is more appropriate and usable in the ASC setting.

By comparison, Timing of Antibiotic Prophylaxis (ID# OP-6) is more complex, largely due to the manner in which the included and excluded populations are constructed to determine the denominator. We believe that the ASC QC measure answers the question of whether or not the prophylactic intravenous antibiotic was delivered timely in a simpler way, and because it imposes less burden, is preferable. The ASC QC's measure could readily be applied in the HOPD setting as well, allowing harmonization across settings and giving consumers the opportunity to compare quality metrics across settings.

2. Prophylactic Antibiotic Selection for Surgical Patients (ID# OP-7)

Prophylactic Antibiotic Selection for Surgical Patients (ID# OP-7) was derived from a physician-level measure in use under the PQRI. The ASC QC does not believe that physician-level measures can be appropriately applied to facilities. Specifically, this measure seeks to answer the question of whether or not the physician prescribed the appropriate prophylactic antibiotic for the surgical procedure in question. Prescribing medications is an individual professional activity that is reserved for physicians and other licensed independent practitioners as determined by State scope of practice determinations. Facilities cannot and do not prescribe medications, and therefore it is not appropriate to hold facilities accountable for prescribing decisions.

In addition to the accountability issue, we do not believe this measure is feasible and usable in the ASC setting. Again, the complexity of the measure would require significant resources to implement. As efficient, low-cost providers of outpatient surgical services, ASCs are not positioned to absorb the expenses associated with the additional personnel and systems that would be required to implement this measure.

III. ASC Data Collection

In order to be successful, the future ASC quality reporting system should be designed in a manner that fosters high levels of participation. We believe it will be crucial to develop reporting options that allow the collection of reliable data while minimizing the imposition of additional provider burdens.

As CMS develops its proposals for an ASC quality reporting system, the administrative and financial burden of reporting quality measures should be given all due consideration. CMS has estimated that approximately 73 percent of ASCs would be classified as small businesses according to the Small Business Administration size standards [72 Fed. Reg. 66901]. The predominance of small facilities is corroborated by CMS data which indicates a median of two operating/procedure rooms per facility (mean = 2.5). Further, the ASC Association's 2008 ASC Salary & Benefits Survey shows the majority (61%) of ASCs have 20 or fewer total full time equivalents, including both clinical and non-clinical staff.

In past preambles, the agency has indicated its sensitivity to the burdens associated with chart abstraction. Chart abstraction is indeed cumbersome and expensive. In its April 2007 report to the U.S. Senate Committee on Finance (GAO-07-320), the Government Accountability Office (GAO) found the collection of hospital quality data required six steps, two of which were complex. Hospitals reported they had to increase the amount of staff resources devoted to abstracting quality data for the CMS quality measures as the number of measures on which they reported expanded and found no economies of scale as they expanded the scope of quality data abstraction. Study hospitals estimated that staff resources devoted to abstracting data for the CMS quality measures ranged from 0.7 to 2.5 full-time equivalents, typically registered nurses. ASCs are lean, efficient providers, and this level of staff burden would represent a significant hardship to an ASC. Retrospective chart abstraction represents the most burdensome and least appropriate method of quality measure data collection for the ASC setting.

With the goal of maximizing participation in mind, we continue to strongly recommend the submission of codes on administrative claims as the leading data collection methodology for the ASC industry. CMS has already developed a claims-based quality data collection infrastructure under the Physician's Quality Reporting Initiative (PQRI). Using either HCPCS Level II G codes or AMA Category II CPT codes developed specifically for quality reporting, physician providers are able to submit quality data in conjunction with codes for services rendered on the CMS-1500.

ASCs also submit their Medicare claims using the CMS-1500. However, ASC facility services are not submitted on the same claim form as physician services rendered in the ASC setting, but rather as a separate CMS-1500 claim. Given that ASCs already submit a CMS-1500 form for each Medicare beneficiary served, ASCs would be able to report quality data using HCPCS Level II G codes in the same manner as physicians currently do under the Physician Quality Reporting Initiative (PQRI). This would allow CMS to leverage the processes it has already developed and continues to refine under PQRI. If at some point in the future ASCs are required to submit claims using the UB-04, HCPCS Level II codes can continue to be reported.

By comparison, many alternatives to claims-based reporting would impose significant new administrative burdens. For example, internet-based reporting of patient-level quality data requires many of the same steps found in the challenging quality reporting system the agency has implemented for the hospital setting. It would represent a new process requiring additional resource use, training, and expense. Further, the use of electronic health records (EHRs) in the ASC setting is uncommon. ASCs were not included in provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) establishing an incentive and penalty program to encourage

physicians and hospitals to implement health information technology. Although ASCs were eligible to apply for a very limited portion of \$2 billion in grant and loan money available to states for investment in health information technology, this eligibility has not resulted in a significant increase in the use of EHRs in the ASC industry. Given the very limited use of EHRs in the ASC setting at the present time, the preparation of patient-level data for internet-based reporting would require chart abstraction, entry of significant amounts of data into an electronic format and a new data submission process.

Given that Medicare-certified ASCs are predominantly small providers, any process that is cumbersome and resource-intensive will have a significant impact on day-to-day operations, and may lead some ASCs to consider foregoing quality reporting as they consider the balance between the costs incurred to report quality measures against the payment penalty for not reporting. The claims-based submission of quality codes offers a much simpler, and equally effective, approach to data collection. CMS has already developed extensive experience with this process under PQRI, and could use the infrastructure it has already developed there as a model for an ASC equivalent, modified by the addition of new codes designed for reporting of outpatient surgery quality measures. We shared our specific recommendations for HCPCS Level II quality codes and descriptors with the agency in earlier correspondence dated November 21, 2007 and in our comment letter on last year's NPRM. For your reference, we have abstracted the suggested descriptors from that letter in Appendix C, and have also included suggested code descriptors for the surgical site hair removal measure endorsed in the interim.

We note that CMS has provided physicians with several data reporting options under PQRI. In addition to reporting data to the agency on their Medicare Part B claims, physicians have two other options: reporting via a qualified registry and reporting using a qualified EHR product. While the majority of the industry does not participate in registry-based data reporting and lacks EHRs, we believe these options should be available to ASCs under the future quality reporting system.

We also draw your attention to features of PQRI which allow flexibility in reporting periods to address the burden of data collection on physician practices. Options include alternative, shorter reporting periods and the ability to intensively measure 15 consecutive patients as an alternative to sampling 80 percent of all eligible patients. CMS should give the same consideration to the data collection burden on ASCs and consider similar options for flexibility in future ASC reporting, specifically with respect to process measures.

IV. Public Reporting of Quality Data

The ASC Quality Collaboration supports transparency and welcomes a fair presentation of ASC cost and quality information that will assist consumers in making informed health care decisions. The success of transparency efforts will depend in large part on how effectively information is shared with the public. Consumers should be able to access quality and cost information on websites that are organized to allow easy comparisons, while also protecting the rights of providers by assuring that the information made available is correct, up-to-date, and clearly presented. Specifically, internet-based presentation of quality and cost data should address or incorporate the following principles.

- 1) Consumers should be able to directly compare providers of outpatient surgical services, such as a hospital outpatient department and an ASC.
- 2) There should be a mechanism for providers to raise concerns with any information to be posted prior to its publication.
- 3) There should be a provider narrative section for each provider-specific item presented to the consumer. This narrative box would allow the provider to advise the consumer of any concerns the provider has regarding the reliability or accuracy of the information presented.
- 4) In addition to reporting quality measures, other useful information such as facility accreditation status, state licensure and Medicare certification should be made available.

We encourage CMS to move promptly to develop and issue its proposals for the ASC quality reporting system. In the interim, we request the agency develop and implement a claims-based reporting infrastructure based upon the specific recommendations outlined above, allowing ASCs that wish to do so to voluntarily report quality data on their 2011 claims.

Thank you for considering these comments. We look forward to future opportunities to continue our dialogue with the agency on this very important matter. We would be happy to assist with questions or provide additional information at your request.

Sincerely,



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Appendix A

Current Participants in Activities of the ASC Quality Collaboration

Accreditation Association for Ambulatory HealthCare
Ambulatory Surgery Foundation
Ambulatory Surgical Centers of America
American College of Surgeons
American Osteopathic Association, Healthcare Facilities Accreditation Program
AmSurg
Association of periOperative Registered Nurses
Hospital Corporation of America, Ambulatory Surgery Division
National Surgical Care
Novamed
Nueterra Healthcare
Surgical Care Affiliates
Symbion
The Joint Commission
United Surgical Partners International

Appendix B

ASC Quality Collaboration Measures Currently Endorsed by the National Quality Forum (NQF)

Patient Burn	
<i>Intent</i>	To capture the number of admissions (patients) who experience a burn prior to discharge
<i>Numerator/Denominator</i>	Numerator: Ambulatory Surgery Center (ASC) admissions experiencing a burn prior to discharge Denominator: All ASC admissions
<i>Inclusions/Exclusions</i>	Numerator Inclusions: ASC admissions experiencing a burn prior to discharge Numerator Exclusions: None Denominator Inclusions: All ASC admissions Denominator Exclusions: None
<i>Suggested Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports and quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater 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); Allowable values: The count for this data element would be represented by any whole number 0 or greater

Prophylactic IV Antibiotic Timing	
<i>Intent</i>	To capture whether antibiotics given for prevention of surgical site infection were administered on time
<i>Numerator/Denominator</i>	Numerator: Number of Ambulatory Surgery Center (ASC) admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection who received the prophylactic antibiotic on time Denominator: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection
<i>Inclusions/Exclusions</i>	Numerator Exclusions: None Denominator Exclusions: ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of infections other than surgical site infections (e.g. bacterial endocarditis); ASC admissions with a preoperative order for a prophylactic antibiotic not administered by the intravenous route
<i>Suggested Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports and quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater Antibiotic administered on time: Antibiotic infusion is initiated within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, insertion of needle, inflation of tourniquet) or two hours prior if vancomycin or fluoroquinolones are administered; Allowable values: 0 minutes to 24 hours reporting in military time format from 0:00 to 23:59; hours from 00 to 23 and minutes from 00 to 59. If unable to determine (UTD), "UTD" is assigned. Prophylactic antibiotic: an antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of this measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin and Vancomycin

Patient Fall in the ASC

<i>Intent</i>	To capture the number of admissions (patients) who experience a fall within the ASC
<i>Numerator/Denominator</i>	Numerator: Ambulatory Surgery Center (ASC) admissions experiencing a fall within the confines of the ASC Denominator: All ASC admissions
<i>Inclusions/Exclusions</i>	Numerator Inclusion: ASC admissions experiencing a fall within the confines of the ASC Numerator Exclusion: ASC admissions experiencing a fall outside the ASC Denominator Inclusion: All ASC admissions Denominator Exclusion: ASC admissions experiencing a fall outside the ASC
<i>Suggested Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports and quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater Fall: a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. (National Center for Patient Safety)

Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

<i>Intent</i>	To capture any ASC admissions (patients) who experience a wrong site, side, patient, procedure or implant
<i>Numerator/Denominator</i>	Numerator: All Ambulatory Surgery Center (ASC) admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant Denominator: All ASC admissions
<i>Inclusions/Exclusions</i>	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
<i>Suggested Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports, quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater Wrong: not in accordance with intended site, side, patient, procedure or implant; Allowable values: The count for this data element would be represented by any whole number 0 or greater

Hospital Transfer/Admission

<i>Intent</i>	To capture any admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC
<i>Numerator/Denominator</i>	Numerator: Ambulatory Surgery Center (ASC) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC Denominator: All ASC admissions
<i>Inclusions/Exclusions</i>	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
<i>Suggested Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports and quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater Hospital transfer/admission: any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room; Allowable values: The count for this data element would be represented by any whole number 0 or greater Discharge: occurs when the patient leaves the confines of the ASC

Appropriate Surgical Site Hair Removal

<i>Intent</i>	To capture the number of admissions (patients) who have appropriate surgical site hair removal
<i>Numerator/Denominator</i>	Numerator: Ambulatory Surgery Center (ASC) admissions with surgical site hair removal with clippers or depilatory cream Denominator: All ASC admissions with surgical site hair removal
<i>Inclusions/Exclusions</i>	Numerator Inclusions: ASC admissions with surgical site hair removal with clippers or depilatory cream Numerator Exclusions: None Denominator Inclusions: None Denominator Exclusions: ASC admissions who perform their own hair removal
<i>Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports and quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater

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For further information please contact Donna Slosburg, Executive Director @ donnaslosburg@ascquality.org

Appendix C

Suggested HCPCS Level II G Code Descriptors for Reporting ASC Quality Measures

1. Patient Burn

GXXXX – ASC patient documented to have received a burn prior to discharge

GXXXX – ASC patient documented not to have received a burn prior to discharge

2. Prophylactic IV Antibiotic Timing

GXXXX – ASC patient with order for prophylaxis for surgical site infection documented to have received antibiotic within one hour prior to incision time (two hours for vancomycin or fluoroquinolones)

GXXXX – ASC patient with order for prophylaxis for surgical site infection documented not to have received antibiotic within one hour prior to incision time (two hours for vancomycin or fluoroquinolones)

GXXXX – ASC patient without order for prophylaxis for surgical site infection

3. Patient Fall

GXXXX – ASC patient documented to have experienced a fall within the ASC

GXXXX – ASC patient documented not to have experienced a fall within the ASC

4. Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

GXXXX – ASC patient documented to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event

GXXXX – ASC patient documented not to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event

5. Hospital Transfer/Admission

GXXXX – ASC patient documented to have required a hospital transfer or hospital admission upon discharge from the ASC

GXXXX – ASC patient documented not to have required a hospital transfer or hospital admission upon discharge from the ASC

6. Appropriate Surgical Site Hair Removal

GXXXX – ASC patient with surgical site hair removal documented as performed with clippers or depilatory cream

GXXXX – ASC patient with surgical site hair removal documented as performed with means other than clippers or depilatory cream

GXXXX – ASC patient without surgical site hair removal or ASC patient who performed their own surgical site hair removal