LONG-TERM CARE HOSPITAL (LTCH) QUALITY REPORTING PROGRAM (QRP)

FREQUENTLY ASKED QUESTIONS WITH ANSWERS

Current as of April 2016
This version replaces all previous versions.

#	Question Category	Question	Answer
1.	Definition of LTCH for LTCH QRP	I need clarification on the definition of an LTCH for the purposes of the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP). Are these long-term acute care hospitals or long-term care hospitals?	Long-term care hospitals (LTCHs) and long-term acute care hospitals (LTACHs) are different names for the same type of hospital. Medicare uses the term long-term care hospitals. These hospitals are certified as acute care hospitals that treat patients requiring extended hospital-level care, typically following initial treatment at a general acute care hospital. If a hospital is classified as an LTCH for purposes of Medicare payments (as denoted by the last four digits of its six-digit CMS Certification Number [CCN] in the range of 2000–2299), it is subject to the requirements of the LTCH Quality Reporting Program (QRP). If your critical access hospital (CAH) has long-term care beds that either provide skilled nursing facility-level or nursing facility-level care, it is not required to comply with any requirements mandated for LTCHs under the LTCH QRP. For further information on the LTCH QRP, please visit http://cms.hhs.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html.
2.	LTCH QRP Overview	When are new LTCHs required to begin reporting quality data to CMS under the LTCH QRP?	New LTCHs are required to begin reporting quality data under the LTCH QRP no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter. For example, if an LTCH's CCN notification letter is dated March 15, then the LTCH would be required to begin reporting quality data to CMS beginning on July 1 (March 15 + 30 days = April 14 (quarter 2). The LTCH would be required to begin collecting quality data on the first day of the quarter subsequent to quarter 2, which is quarter 3, or July 1. The collection of quality data would begin on the first day of the calendar year quarter identified as the start date, and would include all LTCH admissions and subsequent discharges beginning on, and subsequent to, that day; however, submission of quality data would be required by previously finalized or newly proposed quarterly deadlines.
3.	LTCH QRP Overview and Data Submission Deadlines	What are the current quality measures required under the LTCH QRP? What are the new quality measures that will become effective in 2016?	The LTCH QRP is described here: http://cms.hhs.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html. The links on the left of this webpage provide additional details about the LTCH QRP, including: • LTCH Quality Reporting Spotlight Announcements • LTCH Quality Reporting Measures Information • LTCH CARE Data Set & LTCH QRP Manual • LTCH Quality Reporting Technical Information • LTCH Quality Reporting Training • LTCH Quality Reporting FAQs

#	Question Category	Question	Answer
	LTCH QRP Overview and Data Submission Deadlines (continued)		• LTCH Quality Reporting Data Submission Deadlines • LTCH Quality Reporting Reconsideration and Exception & Extension • LTCH Quality Reporting Help • LTCH Quality Reporting Archives The LTCH QRP went into effect on October 1, 2012. Currently, it requires each LTCH to collect and submit data collection for the following quality measures: • National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138): Data for this measure are submitted quarterly to the Centers for Disease Control and Prevention (CDC's) NHSN. For specific questions and details regarding the CAUTI Measure collected by CDC's NHSN, please contact NHSN@cdc.gov. More information related to this quality measure can be found at: http://www.qualityforum.org/QPS/0138 and http://www.cdc.gov/nhsn/LTACH/CAUTI/index.html. • National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139): Data for this measure are submitted to CDC's NHSN. For specific questions and details regarding the CLABSI Measure collected by CDC's NHSN, please contact NHSN@cdc.gov. More information related to this quality measure can be found at: http://www.qualityforum.org/QPS/0139 and http://www.cdc.gov/nhsn/LTACH/clabsi/index.html. • Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678): Data for this measure are collected and submitted using the LTCH CARE Data Set. More information related to this measure can be found at: http://www.qualityforum.org/QPS/0678. • Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680): Data for this quality measure are collected and submitted using the LTCH CARE Data Set. More information related to this measure can be found at: http://www.qualityforum.org/QPS/0680.

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	LTCH QRP Overview and Data Submission Deadlines (continued)		• Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431): Data for this measure are reported to CDC's NHSN. For specific questions and details regarding this measure, please contact NHSN@cdc.gov. More information related to this measure can be found at: http://www.qualityforum.org/QPS/0431 and http://www.cdc.gov/nhsn/LTACH/hcp-flu-vac/index.html. • All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs (NQF #2512): This is a Medicare Fee-For-Service Claims-based readmissions quality measure adopted for the LTCH QRP. LTCHs do not need to submit data for this quality measure; claims data are used to calculate the risk-adjusted readmission rates. More information related to this measure can be found at: http://www.qualityforum.org/QPS/2512 and http://www.qualityforum.org/All-Cause_Admissions_and_Readmissions_Measures.aspx. • National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure (NQF #1716). Data for this measure are reported to CDC's NHSN. For specific questions and details regarding this measure, please contact NHSN@cdc.gov. More information related to this measure can be found at: http://www.qualityforum.org/QPS/1716 and http://www.cdc.gov/nhsn/LTACH/mdro-cdi/. • National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717). Data for this measure are reported to CDC's NHSN. For specific questions and details regarding this measure, please contact NHSN@cdc.gov. More information related to this measure can be found at: http://www.qualityforum.org/QPS/1717 and http://www.cdc.gov/nhsn/LTACH/mdro-cdi/.

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	LTCH QRP Overview and Data Submission Deadlines (continued)		Starting January 1, 2016, the LTCH QRP requires data collection and submission for one additional measure: • National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure. Data for this measure are reported to CDC's NHSN. For specific questions and details regarding this measure, please contact NHSN@cdc.gov. More information related to this measure can be found at: http://www.cdc.gov/nhsn/ltach/vae/index.html. Starting April 1, 2016, the LTCH QRP requires data collection and submission for four additional measures: • Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674). Data for this quality measure are collected and submitted using the LTCH CARE Data Set. More information related to this measure can be found at: http://www.qualityforum.org/QPS/0674. • Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). Data for this quality measure are collected and submitted using the LTCH CARE Data Set. More information related to this measure can be found at: http://www.qualityforum.org/QPS/2631. • Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). Data for this quality measure are collected and submitted using the LTCH CARE Data Set. More information related to this measure can be found at: http://www.qualityforum.org/QPS/2631. • Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632). Data for this quality measure are collected and submitted using the LTCH CARE Data Set. More information related to this measure can be found at: http://www.qualityforum.org/QPS/2632.

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4.	LTCH QRP Data Submission Deadlines	What are the data collection and submission deadlines for the LTCH QRP quality measures LTCHs must report on?	Data collection and submission deadlines for the LTCH QRP measures can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Data-Submission-Deadlines.html and also in the FY 2016 IPPS/LTCH PPS Final Rule at: http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf (80 FR 49750 through 49752). In the FY 2016 IPPS/LTCH PPS Final Rule (80 FR 49749 through 49752), CMS adopted a new data submission deadline beginning with 2015 Quarter 4 data collection (October 1 – December 31, 2015) that extends the submission deadline to approximately 4.5 months (135 days) after the end of the quarter. Beginning with Quarter 4 (October 1-December 31, 2015), the data submission deadlines for quality measures, except Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431), have been modified to give facilities additional time to submit data. These deadlines apply to the payment determinations for FY 2017, FY 2018, and subsequent years.

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5.	LTCH QRP Rulemaking	What new measures have been adopted through the FY 2016 IPPS/LTCH PPS Final Rule?	For the FY 2018 payment determination and subsequent years, in addition to the measures previously finalized in the LTCH QRP, four measures were adopted through the FY 2016 IPPS/LTCH PPS Final Rule. One measure was adopted in order to reflect its NQF endorsement status: • All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs (NQF #2512) Three measures were adopted to meet the requirements of the IMPACT Act: • Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) • Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) • Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678)

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	LTCH QRP Rulemaking (continued)		Additional information regarding the selection of these measures to satisfy the requirements of the IMPACT Act is available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html LTCH Quality Reporting Program Federal Rulemaking Resources: • FY 2016 IPPS/LTCH PPS Final Rule: – http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf • FY 2015 IPPS/LTCH PPS Final Rule: – http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf • FY 2014 IPPS/LTCH PPS Final Rule: – http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf • FY 2013 IPPS/LTCH PPS Final Rule: – http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf • FY 2012 IPPS/LTCH PPS Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf

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6.	LTCH QRP Help Desk	Where can I find contact information for the various LTCH QRP help desks?	The following is a list of LTCH QRP help desks and resources: • LTCH QRP website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html • LTCH QRP Manual V 3.0, for April 1, 2016 implementation of the LTCH CARE Data Set V 3.00, is available for download here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html – Please note that the LTCH CARE Data Set Version 3.00 is available in the LTCH QRP Manual Version 3.0 zip file as Appendix C. • Other useful LTCH QRP Training materials: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html • To receive mailing list notices and announcements about the LTCH QRP, please sign up at: https://public.govdelivery.com/accounts/USCMS/subscriber/new • General inquiries regarding the LTCH QRP including, but not limited to quality measures, quality reporting requirements, and reporting deadlines: LTCHQualityQuestions@cms.hhs.gov • Inquiries regarding technical issues regarding the LTCH CARE Data Set: LTCHTechIssues@cms.hhs.gov • Inquiries regarding access to Quality Improvement Evaluation System (QIES), LTCH Assessment Submission Entry and Reporting tool (LASER) submission, and Certification And Survey Provider Enhanced Reports (CASPER): help@qtso.com, 1-800-339-9313 • Inquiries regarding quality measures submitted using the CDC's NHSN: nhsn@cdc.gov.

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7.	LTCH CARE Data Set – Data Submission Specifications	Which document is the final word when it comes to the submission specifications for the LTCH QRP measures?	For submission of data for the National Healthcare Safety Network (NHSN) CAUTI Outcome Measure (NQF #0138), National Healthcare Safety Network (NHSN) CLABSI Outcome Measure (NQF #0139), National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure (NQF #1716), National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium Difficile Infection (CDI) Outcome Measure (NQF #1717), Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431), and National Healthcare Safety Network (NHSN) Ventilator-Associated Event Outcome Measure please follow CDC definitions and guidelines for data collection and submission via CDC's NHSN (Chapter 5 of the LTCH QRP Manual Version 3.0). Also, please visit the CDC's NHSN website: http://www.cdc.gov/nhsn/ltach/index.html Starting April 1, 2016, for the submission of data for the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678), Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680), Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674), Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), Application of the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), and Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632), LTCHs should follow the LTCH QRP Manual V 3.0 Appendix D as the primary source in addition to the other chapters and sections in the LTCH QRP Manual as well as the LTCH CARE Data Submission Specifications V 2.00.0. The LTCH QRP Manual V 3.0 is available for download on the CMS LTCH QRP website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html.

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	LTCH CARE Data Set – Data Submission Specifications (continued)		The LTCH CARE Data Submission Specifications V 2.00.0 are available for download on the CMS LTCH QRP website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html. The All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs (NQF #2512) measure is a Medicare Fee-For-Service Claims-based readmissions quality measure. LTCHs do not need to submit additional data for this quality measure; claims data are used to calculate the risk-adjusted readmission rates.
8.	LTCH CARE Data Set – All	Where can I find the LTCH CARE Data Set Version 3.00? What are the significant differences between Version 2.01 and Version 3.00 of the LTCH CARE Data Set?	The LTCH CARE Data Set Version 3.00 will be implemented on April 1, 2016 and is currently available for review in the Downloads section of the following CMS LTCH QRP webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html. The LTCH CARE Data Set Change Table, available in the same zip file as the LTCH CARE Data Set Version 3.00, outlines the differences between the LTCH CARE Data Version 2.01 and Version 3.00.
9.	LTCH CARE Data Set – All	Can you clarify which version of the LTCH CARE Data Set should be used for a patient that is admitted prior to April 1, 2016 but discharged *after* April 1, 2016?	The LTCH CARE Data Set V 3.00 goes into effect on April 1, 2016. The applicable LTCH CARE Data Set Version 3.00 (Admission, Planned Discharge, Unplanned Discharge, and Expired) must be completed for eligible patients who have been *admitted on or after* 12:00 a.m. on April 1, 2016. For eligible patients who have been *admitted prior to* 12:00 a.m. on April 1, 2016 and have been discharged (or who die) on or after 12:00 a.m. on April 1, 2016, LTCH CARE Data Set Version 2.01 Admission Assessment should be completed upon admission. For the same patient who is then discharged after April 1, 2016, the applicable LTCH CARE Data Set Version 3.00 Discharge or Expired Assessment should be completed.
10.	LTCH CARE Data Set – All	Do we need to obtain patient consent to submit the data contained within the LTCH CARE Data Sets? And if so, is there a standard consent already in use?	An LTCH is not required to obtain patient consent in order to collect data for quality measures for the LTCH QRP. CMS has the statutory authority to collect quality data for LTCHs under Section 3004(a) of the Patient Protection and Affordable Care Act of 2010, the FY 2012 IPPS/LTCH PPS Final Rule, the FY 2013 IPPS/LTCH PPS Final Rule, the FY 2014 IPPS/LTCH PPS Final Rule, the FY 2015 IPPS/LTCH PPS Final Rule, and the FY 2016 IPPS/LTCH PPS Final Rule.

#	Question Category	Question	Answer
11.	LTCH CARE Data Set – All	Is it a requirement for an RN to collect this data/report it or can a LPN do this?	Appropriate staff members should complete the section(s) of the LTCH CARE Data Set and for CDC's NHSN they are qualified to complete, per facility, State, and Federal policy and requirements.
12.	LTCH CARE Data Set – All	Training materials indicate we have 3 days to enter data on new admissions. Does this include weekends and holidays, or are they excluded?	The facility has 3 days to gather the data and an additional 5 days to complete the LTCH CARE Data Set Admission assessment, which includes weekends and holidays. The Assessment Reference Date (ARD) is the end point of the assessment period for the LTCH CARE Data Set assessment records, so if a patient was admitted on a Friday, the ARD for the Admission assessment is Sunday. The LTCH would have until Tuesday to complete the LTCH CARE Data Admission assessment. More information can be found in Chapter 2 of the CMS LTCH QRP Manual Version 3.0, available in the Downloads section at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html.
13.	LTCH CARE Data Set – All	Will LTCHs be expected to copy the LTCH CARE Data Set and keep it as part of the medical record? Are LTCHs required to print each assessment record?	LTCHs should retain copies of the LTCH CARE Data Set assessment records as part of the patient's medical record in accordance with facility, State, and Federal requirements pertaining to the retention of patient records. Under the LTCH QRP, there is no current requirement for LTCHs regarding the printing of LTCH CARE Data Set assessment records. More information can be found in Chapter 2 of the CMS LTCH QRP Manual Version 3.0, available in the Downloads section at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html.
14.	LTCH CARE Data Set – All	A patient was admitted October 1 and discharged on October 1. All admission and discharge data was exported. If the same patient comes back in December, do I modify the patient for December admission as "01" or do I create a new patient and just ignore the duplicated patient information warning and proceed?	In the example you provide, when the patient is admitted to the LTCH in December, it will be considered a "new" admission and hence, a new record should be created for this "new" admission. For LTCHs using the LTCH Assessment Submission Entry and Reporting (LASER) tool, the software will match patient records using various items in the LTCH CARE Data Set, including, but not limited to: Patient First Name, Patient Last Name, Social Security Number, Date of Birth, and Gender. For questions related to technical issues, please email: LTCHTechIssues@cms.hhs.gov

#	Question Category	Question	Answer
15.	LTCH CARE Data Set – All	If the patient dies during the assessment period, do you fill out Admission and Expired assessments?	Yes, both an Admission assessment and Expired assessment would be completed. The Assessment Reference Date (ARD) for the Expired assessment is the date of death.
16.	LTCH CARE Data Set – All	If a patient is discharged to a short-stay acute care hospital and then dies at the acute care hospital 6 days later, does the LTCH have to complete an expired assessment?	No. If the patient is away from the LTCH for more than 3 days, the LTCH does not have to complete an Expired assessment. You would just submit the Discharge assessment.
17.	LTCH CARE Data Set – Applicable Patients	We have several LTCH hospitals with psychiatric units. Are psychiatric patients included in the mandatory data reporting for LTCHs under the LTCH QRP?	For the FY 2017 and FY 2018 and subsequent payment update determinations, LTCHs must continue reporting data for all quality measures for all patients, including psychiatric patients, receiving inpatient services in a facility certified as a hospital and designated as an LTCH under the Medicare program. Applicable LTCH CARE Data set assessments (Admission, Unplanned Discharge, Planned Discharge, or Expired) must be completed for all patients regardless of payment/payer source, age or diagnosis (i.e., including patients with psychiatric diagnoses). The All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (NQF #2512) is a Medicare Fee-For-Service claims-based measure; hence, no additional LTCH QRP specific data submission is required by LTCHs. The Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) measure is not patient-based, but healthcare personnel based; hence no LTCH QRP specific data submission is required for patients by LTCHs. For additional information regarding the LTCH CARE Data Set requirements, please refer to Chapter 2 of the LTCH QRP Manual Version 3.0. For CMS overview on data collection and submission for reporting to the CDC's NHSN, see Chapter 5 of the LTCH QRP Manual Version 3.0. Both chapters are available for download at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html.

#	Question Category	Question	Answer
18.	LTCH CARE Data Set – Section A – Assessment Reference Date (ARD)	Can you key in an assessment to the LTCH Assessment Submission Entry and Reporting (LASER) tool before the ARD? Does the ARD have to be 3 days past the admission date?	Yes, the Admission assessment can be entered before the Assessment Reference Date (ARD). Please note that the ARD is the date of admission plus two calendar days rather than 3 days past the admission date, as is stated in the question. Also, we ask that you note that the "completion date" cannot be set before the ARD or the record will be rejected. The completion date must be equal to or greater than the ARD, but not greater than the ARD + 5 calendar days. For information related to LTCH CARE Data Set assessment, completion, and submission timing, please refer to Chapter 2 of the LTCH QRP Manual Version 3.0, available for download at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html.
19.	LTCH CARE Data Set – Section A – Assessment Reference Date (ARD)	My understanding is that the ARD for discharge must equal the discharge date itself. However, our nurses often must do the assessment the day before discharge, as our patients leave early in the morning on the day of discharge. These assessments are being rejected because the assessment date is earlier than/less than the ARD/Discharge Date. I am not sure how to work around this. Can you suggest anything?	The assessment period for the LTCH CARE Data Set Planned and Unplanned Discharge assessment records begins two days prior to the date of discharge. The date of discharge is always considered the Assessment Reference Date (ARD) for the Discharge assessment as it is the day on which the assessment reference period ends. With regard to the assessment record rejections you are experiencing, please enter the Date of Discharge as the ARD on the LTCH CARE Data Set Planned and Unplanned Discharge assessment records even though the actual assessment was done the day before discharge. The date of completion must be equal to or greater than the ARD.

#	Question Category	Question	Answer
20.	LTCH CARE Data Set – Section A – Interrupted Stay	Are providers required to submit program interruptions? Are program interruptions included only when a patient is admitted to acute care, or for all follow-up appointments and tests?	Yes, providers are required to submit program interruptions for all follow-up appointments and tests received outside of the LTCH. A program interruption refers to an interruption in a patient's care given by an LTCH because of the transfer of that patient to another hospital/facility per contractual agreement for services (e.g., when the patient requires a higher level of care and is transferred to an acute-care hospital). Such an interruption must not exceed 3 calendar days, whereby day 1 begins on the day of transfer, regardless of hour of transfer. For such an interruption, the LTCH should not complete and submit an LTCH CARE Data Set Discharge assessment (planned or unplanned).
21.	LTCH CARE Data Set – Section A – Interrupted Stay	Can CMS please clarify, for purposes of determining whether an LTCH must submit a Discharge assessment, whether there is a 3-calendar-day rule in the following instances: • When a patient leaves an LTCH to go to another facility and then returns to the LTCH? • When a patient dies within 3 days after leaving an LTCH for another facility?	The 3 day interrupted stay is in accordance with established payment policies. The "3 calendar days" in the interrupted stay policy consist of the day of transfer (day 1), plus 2 calendar days. If a patient dies during an interrupted stay of less than 3 calendar days, the LTCH should submit an Expired assessment. If a patient expires after being transferred to another facility and the LTCH is not notified of the patient's death, the most recent assessment that was completed by the LTCH for that patient is considered the final required assessment. If the LTCH learns of that patient's death outside of the LTCH within 3 calendar days of the transfer, it may, but is not required to, submit an LTCH CARE Data Set Expired assessment. If the patient did not return to the LTCH by day 3 of the transfer, it is no longer considered an "interrupted stay," but rather a "greater than 3-day interrupted stay," and the LTCH should complete an LTCH CARE Data Set Planned or Unplanned Discharge assessment as appropriate. The LTCH QRP Manual V 3.0 is available for download at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html.

#	Question Category	Question	Answer
22.	LTCH CARE Data Set – Planned/ Unplanned Discharge	What is the definition of "unplanned discharge" for the purposes of determining whether to submit an Unplanned Discharge assessment?	An unplanned discharge is: • An unplanned transfer of the patient to be admitted to another hospital/facility that results in the patient's absence from the LTCH for longer than 3 calendar days (including the day of transfer) or the patient's discharge from the LTCH; or • Transfer of the patient to an emergency department of another hospital in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation that results in a transfer lasting greater than 3 days; or • Patient unexpectedly leaving the LTCH against medical advice; or • Patient unexpectedly deciding to go home or to another hospital/facility (e.g., due to the patient deciding to complete treatment in an alternate setting). • Unplanned discharges do not include planned transfers to acute-care inpatient hospitals for admission for planned interventions, treatments, or procedures, unless the patient does not return to the LTCH within 3 calendar days.
23.	LTCH CARE Data Set – Planned/ Unplanned Discharge	What is the definition for "planned discharge" for the purposes of determining whether to submit a Planned Discharge assessment?	A planned discharge is one in which the patient is non-emergently, medically released from care at the LTCH for some reason arranged for in advance.

#	Question Category	Question	Answer
24.	LTCH CARE Data Set – Section A	There are LTCH facilities with multiple buildings or sites working under the same CCN that often have different NPIs for each building – meaning, a single CCN can encompass multiple NPIs. Which NPI would be appropriate to enter for A0100A on the LTCH CARE Data Set: the NPI belonging to the "main facility" under the CCN (where that can be determined) or the NPI for the patient's location?	The National Provider Identifier (NPI) refers to the number used on your LTCH claims. LTCHs should use the NPI for the patient's location. The National Provider Identifier is not the same number as the facility ID number. Additional information can be found in Chapter 3-Section A of the LTCH QRP Manual V 3.0 available in the Downloads section at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html.
25.	LTCH CARE Data Set – Section B	Does the physician documentation need to specifically state the words "comatose" or "persistent vegetative state," or do words like "unresponsive" and "severe encephalopathy" used in MD progress notes support a "yes" response to B0100?	A specific diagnosis must exist in order to code any diagnoses listed in Section B for comatose and persistent vegetative state. A confirmed diagnosis of "comatose" or "persistent vegetative state" in the medical record is necessary in order to include this data in the LTCH CARE Data Set assessment. Other terms, such as "unresponsive" and "severe encephalopathy" should not be used to infer a diagnosis of "comatose."
26.	LTCH CARE Data Set – Section C	How should a patient with communication impairments, such as those who require a ventilator or are comatose, be assessed and coded for Section C?	If a patient is on a ventilator or unable to speak, the patient should be offered the use of alternative communication devices in order to assess the patient's function. Evidence of acute changes in mental status are not only observational, but can also be found in the medical record, and/or from family or staff over the 3-day assessment period. There may be information (prior to the person being sedated, for example) that documents that the person was not at his/her baseline and had experienced an acute change of mental status within the first 3 days of the LTCH stay. You would answer the questions in this section based on all of the information that was gathered. For example, for item C1610A, if after observation, reviewing information in the medical record, talking to family and/or staff, if there was no acute change noted from the patient's normal baseline, then the clinician would code 0. No. If, based on the same information, there was evidence of an acute change in mental status from the patient's baseline, then the clinician would

#	Question Category	Question	Answer
	LTCH CARE Data Set – Section C (continued)		code 1. The provider who is absolutely unable to assess this information, would use a dash: however, it is expected that these instances are rare. For patients who are comatose, the LTCH CARE Data Set V 3.00 Section B item B0100 asks if the patient has been diagnosed as comatose or in a persistent vegetative state with no discernable consciousness. If the answer to this item is 1, Yes, then the clinician is to skip over the remaining Section B items and skip Section C, Cognitive Patterns, which includes all items in C1610. Signs and Symptoms of Delirium.
27.	LTCH CARE Data Set – Section GG	How should section GG be completed for a patient with deteriorating status (such as a patient with deteriorating ALS or degenerative musculoskeletal disease)? Specifically, how should we assign a discharge goal when functional status improvement is clearly not attainable?	All Admission Performance and Discharge Performance items in Section GG are required, unless the response to GG0170H1, GG0170Q1 or GG0170H3, GG0170Q3 leads to a skip pattern. A skip pattern indicates that specific item does not need to be completed, and rather can be skipped. The instructions direct the assessor to skip over the next item (or several items) and go to another area of the assessment. When you encounter a skip pattern, the item is left blank and you go to the next item as directed. For example, on the Admission Assessment, if 0, No, and walking goal is not clinically indicated, is selected for GG0170H1 then the next item to be completed will be GG0170Q1, Does the patient use a wheelchair/scooter? Items GG0170I, GG0170J, and GG0170K are skipped since they are not applicable. With regard to the Discharge Goal, at least one Discharge goal is required for one of the Self-Care or Mobility Items. In other words, one self-care or one mobility item must have a Discharge goal. According to the LTCH QRP Manual, licensed clinicians should establish a patient's discharge goal at the time of admission based on the admission assessment, discussion with the patient and family, professional judgment, and the professional's standard of practice. Goals should be established as part of the patient's care plan. Please remember that a patient's discharge goal code may be higher, at the same level as, or lower than their admission performance code. For more information on establishing discharge goals and coding examples, please refer to the LTCH QRP Manual V 3.0 (Chapter 3, Section GG, page GG-13). The requirements for completing an assessment is the same for all patients, regardless of deteriorating diagnosis or ventilator status. Please note that codes 07, or 88 should not be used to code discharge goals.

#	Question Category	Question	Answer
28.	LTCH CARE Data Set – Section GG	For item GG0100, what is the timeframe for "prior to admission"? Can you provide a definition for "current illness"?	"Prior to admission" is the timeframe for items GG0100 Prior Functioning and GG0110 Prior Device Use. The timeframe for "prior to admission" refers to the patient's functioning and device use immediately before the current illness, injury or exacerbation. If the patient's episode of care started with an acute care hospital stay followed by an LTCH stay, the patient's prior functioning would be based on the patients' status immediately before the illness, injury or event that led to the acute care stay. Examples of current illnesses may include, but are not limited to, pneumonia, cerebral hemorrhage, stroke, brain injury and heart failure.
29.	LTCH CARE Data Set – Section H	Would a patient who requires assistance to maintain the passage of stool (e.g., through manual stimulation, rectal suppositories, enema, etc.) be considered continent?	For the purposes of the LTCH CARE Data Set, this patient would be considered continent. If the patient had no incontinent episodes during the 3-day assessment period, then H0400 should be coded 0, always continent (LTCH QRP Manual Version 3.0, page H-3).
30.	LTCH CARE Data Set - Section I	What is the definition of "active diagnosis"? Would the "primary or secondary diagnoses" be included in the active diagnosis if they have the potential to affect patient goals or outcomes?	Section I refers to a patient's active diagnoses, which are diagnoses that have a direct relationship to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment and are confirmed by a physician or other licensed staff. Items I0500 and I0500A refer to the patient's primary active medical diagnosis that is confirmed by the physician (and becomes the admitting diagnosis) or other authorized licensed staff and is associated with the patient's LTCH admission. Providers should identify a primary medical condition associated with the LTCH admission. If the patient's primary active medical diagnosis is one other than the four listed (1. Acute onset respiratory condition; 2. Chronic respiratory condition; 3. Acute onset and chronic respiratory condition; 4. Chronic cardiac condition), the appropriate ICD code should be entered in the section I0500A "Other medical condition". Following the assessment of active diagnosis, all comorbidities and coexisting conditions that are active and have a documented diagnosis at the time of the assessment should also be reported according to the codes provided in the LTCH CARE Data Set. You should check all comorbidities and/or coexisting conditions that apply, including the patient's primary diagnosis. Please refer to the LTCH QRP Manual V 3.0 (Section I, page I-7) for coding tips and examples of coding active diagnoses.

#	Question Category	Question	Answer
31.	LTCH CARE Data Set – Section K	What if the patient is weighed on the day of admission at 120 pounds and is weighed again on day 2 at 119 pounds? What should be recorded in Section K?	For an Admission assessment, if the patient has been weighed multiple times during the assessment period, use the first weight. In your example, K0200B would be coded "120" (LTCH QRP Manual Version 3.0, page K-1). For an Unplanned or Planned Discharge assessment, record the most recent weight (in pounds) measured since admission.
32.	LTCH CARE Data Set – Section M	Must admission documentation of pressure ulcer(s) be completed within the first 3 days? Is discharge documentation taken from the last 3 days of a patient's stay?	The Assessment Reference Date (ARD) provides the endpoint of the assessment period for any of the LTCH CARE Data Set assessments. For the Admission Assessment, the ARD is the date of admission plus 2 calendar days. The facility has 3 days to actually gather the data and an additional 5 days to complete the LTCH CARE Data Set Admission assessment. For the Discharge and Expired assessments, the ARD is the date of discharge or date of death, respectively. Each of these assessments looks back to the 3-day span of the ARD with the exception of the following item on the Planned Discharge Assessment: M0800 Worsening in Pressure Ulcer Status Since Prior Assessment; and the following item on the Unplanned Discharge Assessment: M0800 Worsening in Pressure Ulcer Status Since Prior Assessment, which also looks back to the Admission assessment. Please note that the item name changed from "M0800. Worsening in Pressure Ulcer Status Since Prior Assessment" on the LTCH CARE Data Set V 2.01 to "M0800. Worsening in Pressure Ulcer Status Since Admission on the LTCH CARE Data Set V 3.00."
33.	LTCH CARE Data Set – Section M	If a pressure ulcer is assessed as a Stage 3 on admission, but by discharge has improved and now has the characteristics of a Stage 2, how would it be staged at discharge?	Due to the tissue loss associated with a Stage 3 pressure ulcer, it will never have characteristics of a Stage 2 ulcer as the tissues lost are not replaced by the same type of tissue. Stage 3 pressure ulcers fill using granulation tissue which would not be seen in a Stage 2 pressure ulcer. Reverse staging is not clinically correct for this reason. Therefore, a Stage 3 pressure ulcer remains a Stage 3 pressure ulcer until it is completely covered with epithelial tissue (i.e. is healed) or worsens to a deeper stage. The LTCH would code the Admission assessment to indicate that a Stage 3 pressure ulcer was present on admission (M0300C1 = 1, M0300C2 = 1). At discharge, because the Stage 3 pressure ulcer has neither healed nor increased in numerical stage, the LTCH would code the Discharge assessment to indicate that a Stage 3 was present on admission and present at discharge (M0300C1 = 1, M0300C2 = 1).

#	Question Category	Question	Answer
34.	LTCH CARE Data Set – Section M	If a Stage 2 pressure ulcer worsens during the stay, but it heals before discharge, how is that recorded on the LTCH CARE Data Set?	The stage of the pressure ulcer is recorded on admission and again at discharge. Any changes that occur between admission and discharge should be entered into the patient's medical record. In this instance, the Admission assessment would indicate that a Stage 2 pressure ulcer was present on admission (M0300B1 = 1, M0300B2 = 1) and if this Stage 2 pressure ulcer, which healed and was the only pressure ulcer that the patient had, the Discharge assessment would indicate that the patient has no pressure ulcers at discharge.
35.	LTCH CARE Data Set – Section M	Can you give examples of worsening pressure ulcers?	A pressure ulcer is considered "worsened" when it has progressed to a deeper level of tissue damage and is therefore staged at a higher numerical scale of 1-4 (using the staging assessment determinations assigned to each stage; starting at Stage 1, and increasing in severity to Stage 4) on a Discharge assessment when compared to the Admission assessment. Some examples include: • A Stage 2 on admission that becomes a Stage 3 by discharge • An unstageable on admission that is debrided to a Stage 3, then evolves to a Stage 4 • A Stage 3 on admission that becomes a Stage 4 by the third day and is still a Stage 4 at discharge • Intact skin on admission that becomes a Stage 2 by discharge • A Stage 1 on admission that becomes a Stage 2 by discharge
36.	LTCH CARE Data Set – Section M	In the event that a patient has more than 9 pressure ulcers at any single stage, I understand that "9" should be entered for the M0300 count of pressure ulcers. How should the facility choose which of the patient's 10+ pressure ulcers to count among the 9 so as to reassess at discharge and determine which have worsened for purposes of M0800?	In the case of a patient admitted to your facility who has more than 9 pressure ulcers at any one stage, you would enter 9. Any additional pressure ulcers will be captured on the Discharge assessment. For example, if you had 12 Stage 2 pressure ulcers at admission, you would enter 9 when asked how many Stage 2 pressure ulcers the patient has, and you would enter 9 Stage 2 pressure ulcers as present on admission. If, for example, during the patient's stay, one of the pressure ulcers remained at a Stage 2, 7 of the pressure ulcers worsened to a Stage 3, one healed, one was covered with a surgical flap, and 2 worsened to a Stage 4, the following would be recorded on LTCH CARE Data Set Discharge assessment: • 2 of the pressure ulcers would not be recorded since one healed, and one became a surgical wound. • 1 would be recorded as a Stage 2 pressure ulcer in M0300B1, and present on admission in M0300B2.

#	Question Category	Question	Answer
	LTCH CARE Data Set – Section M (continued)		• 7 would be recorded as Stage 3 pressure ulcers in M0300C1, but would not be coded as present on admission in M0300C2 since they are considered worsened. • 2 would be recorded as Stage 4 pressure ulcers in M0300D1, but would not be coded as present on admission in M0300D2 since they are considered worsened. • Since 9 of the original 12 pressure ulcers worsened during the LTCH stay, these would also be recorded as worsened at their respective stages in M0800. As you can see from the above example, there are 2 pressure ulcers that the LTCH CARE Data Set does not have items to capture status at discharge, namely the one that healed and the one that converted to a surgical wound. All of the other pressure ulcers that were present on admission can eventually be recorded on the Discharge assessment. Information regarding pressure ulcers that may not be able to be captured on the LTCH CARE Data Set should be documented in the medical record.

#	Question Category	Question	Answer
37.	LTCH CARE Data Set – Section O	What is the influenza vaccination season for LTCH CARE Data Set items O0250A, O0250B, and O0250C for the quality measure Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)? How should I code items O0250A, O0250B, and O0250C during the period from April 1st to September 30th each year (i.e., outside of the influenza vaccination season)?	For the 2015–2016 influenza season, the influenza vaccination season is defined as beginning October 1st, 2015 or when the influenza vaccine becomes available (whichever comes first) through March 31st, 2016. For subsequent influenza seasons, the influenza vaccination season is defined as beginning October 1st or when the influenza vaccine becomes available (whichever comes first) through March 31st of the following year. If the patient's stay included one or more days during this year's influenza vaccination season and the patient was discharged between April 1st and September 30th, we advise LTCHs to code the influenza vaccine items, as follows: O0250A: Code 0 (No) or 1 (Yes) depending on whether the patient received the influenza vaccine in this facility during this year's influenza vaccination season. If 0, Skip to O0250C, and state reason influenza vaccine was not received. If 1, Skip to O0250B to record the date the vaccine was received. Completion of the influenza items is not required on assessments completed with admission and/or discharge dates between April 1st and September 30th. However, the influenza vaccine QM is based on all stays with one or more days during the influenza vaccination season, and the discharge assessment for that stay is used to calculate the QM, even if the discharge occurs after March 31st. The intent is for the influenza items to be coded according to the stay during the influenza vaccination season. Therefore, LTCHS are advised to complete the influenza vaccine items on the discharge assessments for stays that begin before or during the influenza vaccination season and end with a discharge after the influenza vaccination season, that is, patients discharged between April 1st and September 30th of that year. If the patient's stay is completely outside of this year's influenza vaccination season, LTCHs should code the influenza vaccine items with a dash.

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38.	LTCH CARE Data Set – Section O	Due to a two week shipment delay, we will be unable to begin administering the flu vaccine on October 1st. How should section O0250C be coded?	In the event that an LTCH does not have the vaccine available due to a delay in shipment, and was unable to administer the vaccine to the patient before discharge, O0250 should be coded as follows: O0250A: • Code 0, No, if the patient did not receive the influenza vaccine in this facility during this year's influenza vaccination season. Skip to O0250C. O0250C: • Code 9, None of the above, if none of the other listed reasons describe why the influenza vaccine was not administered Note: Code 9 should not be utilized if the unavailability of vaccine is due to a shortage; Code 6 is the appropriate code in that instance.
39.	LTCH CARE Data Set – Section Z	Should the signature sections (Section Z) be filed and held at the hospital and, if so, how long should they be kept?	The signature items from the LTCH CARE Data Set assessment records (i.e. Z0400 and Z0500A) are not transmitted to CMS in LTCH submission files. CMS, however, will receive the submission date (Z0500B). CMS strongly suggests that you retain what you submit to CMS, in addition to the signatures in Section Z, according to your facility, State, and Federal regulations and requirements. Facilities that have or require use of electronic health records should comply with any additional requirements they may have.
40.	LTCH CARE Data Set – All-Cause Unplanned Readmissions Measure Dry Run Activities	Where can I find the slides from the CMS National Dry Run All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals Special Open Door Forum (SODF) held on October 8, 2015 and December 8, 2015?	The slides from the CMS National Dry Run: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals SODF are available in the Downloads section at the following webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Spotlight-Announcements.html. CMS also held a SODF on December 8, 2015 to provide a summary of the dry run for the All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from LTCHs. Slides are available in the Downloads section at this webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Spotlight-Announcements.html

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41.	LTCH CARE Data Set – All-Cause Unplanned Readmissions Measure Dry Run Activities	Do you have instructions and steps on how to access the dry run reports for this measure?	Accessing the Dry Run Reports in the CASPER Reporting Application 1. Follow the steps below to log into CMSNet (CMS Network): • Select the Submission Access page on the QTSO website (https://www.qtso.com/submissions/submissions.html). • Click on the state where your provider is located. • Review the Pre-Sign In Notification. To proceed to log into the CMS Network, select the Proceed button. • On the Welcome to the CMS Secure Access Service page, enter your CMSNet user ID in the username field and the password associated to the CMSNet user ID in the password field. Select the Sign-in button. • A list of Web Bookmarks will display. Select your provider type's link. LTCH providers should select the LTCH link. A CMS Warning message box displays. Read the text of the message. To access the Welcome to the QIES Systems for Providers web page, select the OK button. • If you receive the website certificate error, select the "Continue to this website" link. The Welcome to the CMS QIES Systems for Providers web page displays. 2. Follow the steps below to log into CASPER Reporting application: • Select the CASPER Reporting link on the "Welcome to the CMS QIES Systems for Providers" web page and the QIES National System Login page displays. • In the Welcome to the CASPER Reporting box, enter your QIES user ID in the User ID field. • Enter the password associated to the QIES user ID in the Password box. • Select the Login button and CMS Warning message box displays. Select the OK button and the CASPER Home page displays. 3. Follow the steps below to access the dry run readmission measure reports: • Select the Folders button from the menu bar. The following list of permanent folders display in the left frame: o My Inbox o ST CD LTCH Facility ID • where ST CD is the state code where you provider is located, LTCH is the type of provider and Facility ID is the Facility ID used to submit assessment records to the ASAP system

#	Question Category	Question	Answer
	LTCH CARE Data Set – All-Cause Unplanned Readmissions Measure Dry Run Activities (continued)		o ST CD LTCH Facility ID VR (please note this is not the CCN or Medicare Provider Number) • where ST CD is the state code where you provider is located, LTCH is the type of provider, Facility ID is the Facility ID used to submit assessment records to the ASAP system and VR is Validation Report. This is the folder where the final validation reports are placed. • Select the folder named: ST CD LTCH Facility ID. The dry run report will display in the right frame of the page.
42.	LTCH QRP – Public Reporting	I am looking for the LTCH QRP data. Can you tell me where LTCH QRP data is being published?	At the present time, the LTCH QRP data are not publicly available. In the FY 2016 IPPS/LTCH PPS Final Rule (http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf) we finalized a policy related to public reporting. This policy indicates that CMS will begin publicly reporting LTCH quality data by Fall 2016. Data will be available on a CMS website, such as Hospital Compare, on four quality measures initially: (1) NHSN CAUTI Outcome Measure (NQF #0138); (2) NHSN CLABSI Outcome Measure (NQF #0139); (3) Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678); and (4) All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs (NQF #2512). We refer you to the FY 2016 IPPS/LTCH PPS Final Rule (80 FR 49753 through 49755) for further information: http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf.