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

FREQUENTLY ASKED QUESTIONS WITH ANSWERS

Current as of December 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 https://www.cms.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.

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3.	LTCH QRP Overview	What are the current quality measures required under the LTCH QRP? What are the new measures that became effective in October 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 Public Reporting • LTCH Quality Reporting FAQs • LTCH Patient Experience of Care • 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 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

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	LTCH QRP Overview (continued)		• 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. • 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 (FFS) 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.

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	LTCH QRP Overview (continued)		• 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/. • 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. • 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.

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	LTCH QRP Overview (continued)		• 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. Starting October 1, 2016, three additional measures went into effect for the LTCH QRP: • Medicare Spending per Beneficiary-Post-Acute Care (PAC) LTCH QRP: This is a Medicare FFS claims-based measure adopted for the LTCH QRP in the FY 2017 IPPS/LTCH PPS Final Rule. LTCHs do not need to submit data for this measure. Measure specifications are available for download at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html. • Discharge to Community-PAC LTCH QRP: This is a Medicare FFS claims-based measure adopted for the LTCH QRP in the FY 2017 IPPS/LTCH PPS Final Rule. LTCHs do not need to submit data for this measure. Measure specifications are available for download at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html.

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	LTCH QRP Overview (continued)		• Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP: This is a Medicare FFS claims-based measure adopted for the LTCH QRP in the FY 2017 IPPS/LTCH PPS Final Rule. LTCHs do not need to submit data for this measure. Measure specifications are available for download at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html.
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.
5.	Measures Adopted in the FY 2017 IPPS/LTCH PPS Final Rule	What new measures have been adopted through the FY 2017 IPPS/LTCH PPS Final Rule?	Four measures were adopted through the FY 2017 IPPS/LTCH PPS Final Rule. Three Medicare FFS claims-based measures were adopted for the FY 2018 payment determination and subsequent years. These measures include: • Medicare Spending Per Beneficiary-PAC LTCH QRP • Discharge to Community-PAC LTCH QRP • Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP One assessment-based quality measure was adopted for the FY 2020 payment determination and subsequent years. • Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC LTCH QRP Finalized measure specifications for these measures are available for download on the LTCH Quality Reporting Measures Information webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html.

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6.	LTCH QRP Rulemaking Resources	Where can I find the IPPS/LTCH PPS final rules and more information about the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)?	LTCH Quality Reporting Program Federal Rulemaking Resources: • FY 2017 IPPS/LTCH PPS Final Rule: – https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf • 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 Additional information regarding 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/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-MeasuresMeasures.html.

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7.	LTCH QRP – Help Desks	Where can I find contact information for the various LTCH QRP resources and help desks?	The following is a list of LTCH QRP 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 the LTCH CARE Data Set V 3.00, implemented on April 1, 2016, 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 V 3.00 is available in the LTCH QRP Manual V 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 and other CMS initiatives, please sign up at: https://public.govdelivery.com/accounts/USCMS/subscriber/new For additional information regarding the different Help Desks and their focus areas, please see the list of the Help Desks and their descriptions displayed on the CMS LTCH QRP Help webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Help.html.

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8.	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. Please visit the CDC's NHSN website: http://www.cdc.gov/nhsn/ltach/index.html. Chapter 5 of the LTCH QRP Manual Version 3.0 also contains pertinent information about these measures. 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

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	LTCH CARE Data Set – Data Submission Specifications (continued)		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 most recent LTCH CARE Data Submission Specifications. 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. The LTCH CARE Data Submission Specifications 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), MSPB-PAC LTCH QRP, Discharge to Community-PAC LTCH QRP, and Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP measures are Medicare Fee-For-Service claims-based measures. LTCHs do not need to submit additional data for these measures.

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9.	LTCH QRP – Public Reporting	I am looking for the LTCH QRP data. Can you tell me where LTCH QRP data is being published?	In the FY 2016 IPPS/LTCH PPS Final Rule (https://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf), we finalized a policy to publish the LTCH QRP data in Fall 2016. This data is now available on the Long-Term Care Hospital (LTCH) Compare Web site (https://www.medicare.gov/longtermcarehospitalcompare/). The published data and other information not reported on LTCH Compare is available to download on https://data.medicare.gov/data/long-term-care-hospital-compare. Two quality measures in the LTCH QRP are now available on LTCH Compare Web site: 1. Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678); and 2. All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs (NQF #2512). CMS will begin publicly displaying the NHSN CAUTI and CLABSI data on LTCH Compare in Spring 2017. For more information, please visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Public-Reporting.html. In the FY 2017 IPPS/LTCH PPS Final Rule four additional quality measures were finalized which will be publicly available on LTCH Compare in CY 2017 pending availability of data: (1) NHSN Facility-wide Inpatient Hospital-onset MRSA Bacteremia Outcome Measure (NQF #1716); (2) NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure (NQF #1717); (3) Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431); and (4) Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680). We refer you to the FY 2017 IPPS/LTCH PPS Final Rule for further information: https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf. We also refer you to the LTCH Quality Public Reporting website for further information: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Public-Reporting.html.

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10.	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 was 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.
11.	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, the FY 2016 IPPS/LTCH PPS Final Rule, and the FY 2017 IPPS/LTCH PPS Final Rule.
12.	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 and State requirements.
13.	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.

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14.	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 are encouraged to retain copies of the LTCH CARE Data Set assessment records as part of the patient's medical record in accordance with facility and State 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.
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 – All	In completing the LTCH CARE Data Set, can we code information based on observation or interview only or does the information need to be documented in the medical record in order to be coded on the LTCH CARE Data Set?	LTCH CARE Data Set coding should be based upon information gathered from the patient's medical record, direct observation, interviews with staff members, patient's family members, or a combination of information from these sources. Facilities should have medical record documentation that matches the data entered into the LTCH CARE Data Set to verify the rationale used for completing the assessment.

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18.	LTCH CARE Data Set – All	Can I use any of the documentation that came with the patient from the referring hospital to complete the LTCH CARE Data Set Admission Assessment?	Responses to items on the LTCH CARE Data Set should be based on assessment of the patient's current condition and other assessment data collected during the assessment period, which on admission is no later than the first 3 calendar days at the time of admission (date of admission [A0220] plus 2 days). When directed, assessments may be required within a specified period of time with the assessment period. For example, the assessment period for GG0100, Prior Functioning: Everyday Activities, is based on the time period prior to the current illness, exacerbation, or injury. Use of documentation from the previous setting can be used to complete the LTCH CARE Data Set to the extent that a specific item refers to the timeframe during which the patient was in that setting.
19.	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 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), MSPB-PAC LTCH QRP, Discharge to Community-PAC LTCH QRP, and Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP are Medicare FFS claims-based measures; 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.

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20.	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, 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.
21.	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
22.	LTCH CARE Data Set – Section A – Assessment Reference Date (ARD)	Does the 3-day assessment period mean that the data to be submitted to CMS must be taken from three consecutive days of assessment of the patient, after being admitted to the facility? For discharge data does it have to be three consecutive days before discharge, or does it imply that the facility has a 3-day time period to have the assessment completed and forwarded to CMS?	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 ARD is the end point of the assessment period for the LTCH CARE Data Set assessment records, so if a patient was admitted on Friday, July 22nd, the ARD for the LTCH CARE Data Set Admission Assessment could be no later than Sunday, July 24th**.** The LTCH would have until Tuesday July 26th to complete the LTCH CARE Data Admission assessment. 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 ARD for the Discharge assessment as it is the day on which the assessment reference period ends. With regard to the assessment record, please enter the Date of Discharge as the ARD on the LTCH CARE Data Set Planned or Unplanned Discharge assessment. More information regarding the ARD can be found in Chapter 3, Section A pages 6 and 7. More information regarding LTCH CARE Data Set requirements and timing for completing the assessments 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.
23.	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).

#	Question Category	Question	Answer
24.	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.
25.	LTCH CARE Data Set – Section A – Interrupted Stay	If a patient goes to a physician's office for a scheduled appointment and returns in a few hours, is this considered an interrupted stay?	For the purposes of the LTCH QRP, if a patient leaves the LTCH for a scheduled appointment (e.g. dialysis or to receive other services unavailable at the LTCH) and returns to the LTCH on the same day, the leave would be considered an interrupted stay. The interruption must last fewer than 3 calendar days (including day of transfer) and should be reported as a program interruption on the LTCH CARE Data Set Discharge assessment when the patient is discharged from the LTCH.

#	Question Category	Question	Answer
26.	LTCH CARE Data Set – Section A – 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.
27.	LTCH CARE Data Set – Section A – Planned/ Unplanned	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
28.	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.
29.	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."

#	Question Category	Question	Answer
30.	LTCH CARE Data Set – Section B	What is the purpose of the items in Section B?	The items in Section B of the LTCH CARE Data Set are used to calculate the quality measure, Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), which is a process measure and is not risk adjusted. These items are also risk adjustors for the quality measure, Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632).
31.	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 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.

#	Question Category	Question	Answer
32.	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). The requirements for completing an assessment is the same for all patients, regardless of deteriorating diagnosis or ventilator status. Please note that codes 07, 09 or 88 should not be used to code discharge goals.
33.	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.

#	Question Category	Question	Answer
34.	LTCH CARE Data Set – Section GG	How are the mobility items assessed? Do we have the patients walk as far as they can? If so, do we introduce two turns during 50 feet? Or, do we assess all three activities as separate items?	The clinician is to assess each walking item individually. Each item has specific activity components or tasks that assess the level of function. Item GG0170I assesses the ability to walk at least 10 feet. Item GG0170J assesses the ability to walk 50 feet and make 2 turns. Item GG0170K assesses the ability to walk 150 feet. The clinician should assess the patient's performance specific to each item. For example, the patient may be able to walk 10 feet without assistance, but may need some assistance to walk further or make turns. Each activity should be assessed by observing the amount of assistance required from the helper.
35.	LTCH CARE Data Set – Section GG	How do you code the function items if the patient's function varies and it varies between two levels? How is "usual" defined for Section GG?	The performance score is to be based on an assessment of the patient in which the patient is allowed to perform the activity as independently as possible, as long as he/she is safe. If the patient's self-care or mobility performance varies during the assessment period, report the patient's usual status, not the patient's most independent performance and not the patient's most dependent episode. If additional information is needed to code the patient's usual performance, the clinician can discuss the patient's abilities with other direct care staff. Usual is defined as how the patient typically performs the activity during an assessment. The performance score is to be based on an assessment of the patient in which the patient is allowed to perform the activity as independently as possible, as long as he/she is safe. If the patient's self-care or mobility performance varies during the assessment period, report the patient's usual status, not the patient's most independent performance and not the patient's most dependent episode.
36.	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?	Yes, 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, Section H).

#	Question Category	Question	Answer
37.	LTCH CARE Data Set – Section H	Regarding item H0350, Bladder Continence, how is stress incontinence distinguished from incontinence? How can this distinction be determined in a non-verbal patient?	H0350 would be coded as 1, Stress incontinence only, if during the 3-day assessment period the patient has episodes of incontinence only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise. H0350 would be coded as 3, Incontinent daily, if during the 3-day assessment period the patient was incontinent of urine at least once a day. Although stress incontinence may occur daily, it only occurs with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise. Staff observations would be helpful in distinguishing incontinence from stress incontinence in non-verbal patients.
38.	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
39.	LTCH CARE Data Set - Section I	What is the definition of "at risk for malnutrition"?	In general, under-nutrition along with other nutritional deficiencies (e.g., protein energy malnutrition, dehydration) are known risk factors for the development of pressure ulcers. "At risk" would simply mean that a patient is susceptible or vulnerable to malnutrition based on their clinical status. For the purposes of coding Section I, this is determined by the patient's physician based on their clinical assessment or in collaboration with a registered dietician. The diagnosis of malnutrition or at risk for malnutrition must be documented in the patient's chart by the physician or physician designee (i.e., nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in order to code either of these items.
40.	LTCH CARE Data Set – Section J	What is the definition of an "intercepted fall"? How does this relate to the definition of a "fall"?	An intercepted fall occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person- this is still considered a fall. The definition of a fall is "unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat)."
41.	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, Section K). For an Unplanned or Planned Discharge assessment, record the most recent weight (in pounds) measured since admission.
42.	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
43.	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.
44.	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
45.	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.

#	Question Category	Question	Answer
	LTCH CARE Data Set – Section M (continued)		• 1 would be recorded as a Stage 2 pressure ulcer in M0300B1, and present on admission in M0300B2. • 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.
46.	LTCH CARE Data Set – Section M	If an ulcer occurs during the last weeks of a patient's life, is it considered a Kennedy ulcer?	The etiology of the ulcer is to be considered when coding whether an ulcer is a pressure ulcer or not. Just because someone develops a pressure ulcer during the last weeks of life, it does not necessarily mean that the ulcer's etiology is that which conforms to the definition of an ulcer that forms at the end of life as a part of the dying process (a.k.a Kennedy Ulcer). Clinically, these ulcers do not follow the typical pressure ulcer trajectory, and are due to multiple organ/skin failure as part of the dying process, usually appearing similar to a Stage 2 ulcer or deep tissue injury, but rapidly progressing to deeper levels of tissue damage. If the physician (or physician designee) diagnoses the ulcer as a terminal (Kennedy) ulcer, it is not coded on the LTCH CARE Data Set.

#	Question Category	Question	Answer
47.	LTCH CARE Data Set – Section M	Can you please provide guidance with the following scenario: On admission (day 1) the nurse performing the admission assessment charts that the patient has a wound on the sacrum (gives a short description but no stage) and a wound on the right heel (gives a short description but no stage). The next day (day 2), the wound care nurse completes the wound care assessment. The wound care nurse charts that there is a pressure wound on the sacrum-stage 3, a pressure wound on the right heel stage- 2, a pressure wound on the right elbow stage 3 (not charted by the admission nurse). Is the right elbow pressure ulcer considered present on admission since it was charted within the first 3 days or is it considered new because it was not in the initial skin assessment completed by the admission nurse?	For the purposes of the LTCH QRP, the right elbow pressure ulcer would not be considered present on admission. The admission skin assessment should be completed by the ARD, which includes the date of admission and the two following calendar days. The 3-day assessment period used in the LTCH CARE Data Set is not intended to replace the timeframe required for clinical Admission assessments as established by accepted standards of practice, facility policy, and State and Federal regulations. Therefore, the LTCH CARE Data Set Admission assessment sections that include patient assessment should be consistent with the initial clinical assessment (e.g., the assessment of skin conditions that are present on admission are based on the skin assessment that is completed in conjunction with the admission assessment). So, if a patient that is clinically assessed upon admission has a pressure ulcer identified and staged, that initial clinical assessment is what should be used to assist in coding the LTCH CARE Data Set Admission assessment pressure ulcer items. If a new pressure ulcer is identified after the initial skin assessment but within the 3-day LTCH assessment period, it should not be documented as present on admission. Rather, the initial skin assessment should be documented on the LTCH CARE Data Set Admission assessment. Therefore, in this scenario the sacral wound and the right heel wound (and any additional pressure ulcers identified on the initial skin assessment) should both be reported as present on admission in the LTCH CARE Data Set Admission assessment. Any subsequent identified pressure ulcers are not considered present on admission and should be reported on the LTCH CARE Data Set Discharge assessment as new or worsened.

#	Question Category	Question	Answer
48.	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)?	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. The *influenza season* is defined as beginning July 1 through June 31st of the following year. Patients who were in the LTCH for one or more days during the influenza vaccination season are included in the quality measure. As finalized in the FY 2017 IPPS/LTCH PPS final rule (https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf), beginning October 1, 2016, LTCHs are required to code the influenza vaccine items year-round. This includes assessments completed outside the influenza vaccination season, which is between April 1st and September 30th. Vaccines received 'for the current influenza vaccination season' include all vaccines received during the influenza season, including those received before or after the influenza vaccination season. For example vaccines received in September or received in April of the following year should be coded as follows: O0250A: Code 0 (No) or 1 (Yes) depending on whether the patient received the influenza vaccine in this facility for the current influenza vaccination season. Code 1 (Yes) for any vaccine received during the current influenza season, even if outside the influenza vaccination season.

#	Question Category	Question	Answer
	LTCH CARE Data Set – Section O (continued)		If 1, Skip to O0250B to record the date the vaccine was received, regardless of whether received during or outside the influenza vaccination season. If 0, Skip to O0250C, and state reason influenza vaccine was not received as follows: • If there is documentation of a contraindication, Code 3 – Not eligible - medical contraindication • If there is no documentation of any of the following: staff offering the vaccine, contraindication, refusal of the vaccine, then Code 9 - none of the above listed reasons describe why the influenza vaccine was not administered. LTCHs should no longer code any of the influenza vaccine items with a dash, including those assessments completed outside the influenza vaccination season.
49.	LTCH CARE Data Set – Section O	How should the influenza vaccine items be coded when a patient stay overlaps influenza seasons?	The discharge assessments should code immunization status according to the patient's stay relative to the vaccination season as of the date of admission and date of discharge. If a stay overlaps influenza seasons (e.g., admitted in March 2016 and discharged October 2016) then the discharge assessment should be coded according to the most recent influenza season. In this scenario, the patient may have been immunized in the previous influenza season (e.g., March 2016) and the admission assessment would reflect this vaccination. The discharge assessment, however, would not code the previous vaccination. The discharge assessment would be coded according to the vaccination status for the most recent influenza season, which began July 1, 2016.

#	Question Category	Question	Answer
50.	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 for 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.
51.	LTCH CARE Data Set – Section O	If the patient does not receive a vaccine in the facility and the item is coded either "not offered" (choice 5) or "none of the above" (choice 9) because the patient cannot cognitively respond appropriately to questions or for a different reason is that considered "not assessed" and count against a facility's compliance?	In this example, the patient has been assessed and O0250A would be coded 0, No, because the patient did not receive the influenza vaccine for the influenza vaccination season; O0250B would be skipped; and O0250C would be coded 9, None of the above. This coding would not count against a facility's compliance.
52.	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.

#	Question Category	Question	Answer
53.	LTCH CARE Data Set – Section Z	If only one person completes the entire assessment, does each section completed have to be noted with the signature e.g., A, B, GG etc. or would noting A-O be acceptable?	Item Z0400 should be signed by the individual(s) completing the assessment to acknowledge that the assessment was completed according to the standards of the LTCH QRP and facility compliance standards and that the information was recorded as accurately as possible. The purpose of this section is for the LTCH to identify the person responsible for completing that section of the LTCH CARE Data Set and to acknowledge that the assessment is complete and accurate for payment and quality reporting purposes. When filling in the information for Z0400, any staff member who has completed a section should identify which specific section(s) he or she completed on the form, even if it's the entire assessment, in the box labeled "Sections". Further, please note that CMS will not be receiving the signatures from LTCH CARE Data Set, Section Z: items Z0400 and Z0500. CMS receives the submission date. We suggest that you retain what you submit to CMS, including Section Z, according to your facility and State and Federal regulations and requirements. Facilities should comply with their requirements pertaining to electronic signatures, should they require them. Item Z0500 involves the signature of the person verifying that the LTCH CARE Data Set assessment is complete and should be signed and dated when the assessment is submitted. The purpose of this item is to identify the person responsible for ensuring a complete and timely submission of the LTCH CARE Data Set assessment.