LONG TERM CARE HOSPITAL (LTCH) QUALITY REPORTING PROGRAM (QRP) PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM FOLLOW-UP WEBINAR FOR PROVIDERS ON FEBRUARY 3, 2016

Current as of March 2016

#	Section	Question	Answer
1	General	Are these slides available to save and review with other staff?	Presentations with answers/rationale to scenarios will be posted to the CMS Web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html. Participants in today's webinar will be notified when they are available by email.
2	General	Will a transcript of this webinar be available?	A recording of this webinar will be posted and a link will be shared with you. The video will be closed-captioned and will not be accompanied by a separate transcript.
3	General	What resources are available for questions regarding the LTCH QRP?	The following are the LTCH QRP Resource Web sites: • LTCH QRP Web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html. • Inquiries regarding quality measures: LTCHQualityQuestions@cms.hhs.gov. • Inquiries regarding technical issues regarding the LTCH CARE Data Set: LTCHTechIssues@cms.hhs.gov. • Inquiries regarding access to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, LTCH Assessment Submission Entry and Reporting (LASER), and Certification And Survey Provider Enhanced Reports (CASPER): help@qtso.com, 1-800-339-9313. • Inquiries regarding the CDC's National Healthcare Safety Network (NHSN): nhsn@cdc.gov.

#	Section	Question	Answer
4	Section GG	Section GG: My patient ambulates independently on admission. Do I need to have a function discharge goal for this patient? My patient is only able to walk 50 feet with assistance at discharge. How do I code GG0170 K. Walk 150 feet?	We are interpreting your question to mean that the patient performs all the self-care and mobility activities independently. If a patient is independent with daily activities (code 6 for all self-care and mobility items), then a code of 6, Independent, can be coded as the goal for these activities to indicate the patient should maintain his/her independence. Discharge goals should be established as part of the patient's care plan. Document at least one discharge goal for one of the items in Section GG0130 or GG0170 in order to meet the requirements of the LTCH QRP. For the patient who walks 50 feet, but not 150 feet, code the patient's usual performance for item GG0170J, Walk 50 feet with two turns. For GG0170K, Walk 150 feet, use code 88 to indicate this activity was not completed due to medical condition or safety concerns.
5	Section GG	Who is a "qualified/appropriate" staff member to complete the LTCH CARE Data Set?	CMS does not provide guidance on who can or cannot complete assessment items. Refer to facility, Federal, and State policies and procedures to determine which LTCH staff members may complete an assessment. Each facility delivers patient care according to their unique characteristics and standards (e.g., patient population, bed size). Thus, each facility self-determines their policies and procedures for completing the assessments in compliance with State and Federal requirements. That said, the goal for the assessment is to accurately reflect the patient's status; therefore, staff completing a specific section of the LTCH CARE Data Set should have knowledge of the patient's status in these areas.
6	Section GG	If the patient had multiple admissions to different hospitals and post-acute care settings spanning several months, do we still use the patient's prior level of function prior to the first admission?	If the patient experienced a medical event, such as a stroke, or an injury, such as a brain injury, and received care in multiple acute and post-acute settings as part of the episode of care, the patient's prior functioning would be based on the time immediately before the stroke or brain injury.

#	Section	Question	Answer
7	Section GG	If a patient, who is paralyzed, is unable to perform the activity prior to admission, is GG0100B coded 01, Dependent, or 09, Not applicable?	If the person used a wheelchair and did not walk prior to the current illness/injury, code GG0100B, Prior Functioning: Everyday Activities, Indoor Mobility (Ambulation) as 09, Not Applicable. For this item, code 9 indicates that the activity was not applicable to the patient prior to the current illness, injury, or exacerbation. If the patient used a device prior to the current illness/injury/exacerbation, indicate the type of device in item GG0110, Prior Device Use. For example, check the wheelchair item as a device in GG0110, Prior Device Use if the person used a wheelchair. This is a risk adjustor for the function outcome measure and so it is important to document wheelchair use for item GG0110, Prior Device Use, when applicable.
8	Section GG	How is “usual” defined for Section GG?	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.
9	Section GG	If a patient requires two helpers to complete an activity, is the patient's function coded as 01, Dependent?	If a patient requires two helpers to complete an activity, then code the patient’s function on that activity as 01, Dependent. If the patient attempts any portion of the activity and still requires two helpers, the patient’s level of function is still coded as 01, Dependent, because two helpers were needed to complete the activity.
10	Section GG	If the wheelchair activity was not attempted, is it still required to code GG0170RR1 and GG0170SS1, “Indicate the type of wheelchair/scooter used?” How would you indicate the type of wheelchair/scooter used?	After coding Items GG0170R, Wheel 50 feet with two turns and GG0170S, Wheel 150 feet, indicate the type of wheelchair/scooter the patient used. Coding of these items is required even if GG0170R and GG0170S have been coded 07 or 88. The clinician should code the items based upon the customary type of wheelchair (manual or motorized) the patient would use. For example, if the patient refused to use the wheelchair (code 07), indicate the type of wheelchair the patient would have used.
11	Section GG	How do you code the function items if the patient's function varies and it varies between two levels?	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.

#	Section	Question	Answer
12	Section GG	If a patient requires two helpers to complete an activity, should the item be coded as 01, Dependent, for that activity?	If a patient requires two helpers to complete an activity, then code the patient's function on that activity as 01, Dependent. If the patient completes any portion of the activity and requires two helpers, the patient's level of function is coded 01, Dependent.
13	Section GG	Regarding slide 38, what is the rationale for coding this scenario 01, Dependent? Mr. J is morbidly obese and has several diagnoses, including debility. He requests the use of a bedpan when voiding or having bowel movements and requires two certified nursing assistants to mobilize him onto and off the bedpan. Mr. J is unable to complete any of his perineal/perianal hygiene (even though clothing management was not mentioned in the scenario).	For the example provided in slide 38, Mr. J is unable to complete any perineal/perianal hygiene, and these tasks required the assistance of two helpers to complete. You are correct that clothing management was not mentioned because he was not wearing lower body clothing that needed to be adjusted.
14	Section GG	How do you code a patient's function when the patient has multiple intravenous lines and requires the assistance of two people to complete an activity?	If a patient requires two helpers to complete an activity, code the patient's function on that activity as 01, Dependent. If the patient attempts any portion of the activity and still requires two helpers, the patient's level of function is coded as 01, Dependent, because two helpers were needed to complete the activity. For the example you describe, the assistance of two helpers is needed due to medical devices/intravenous lines and the score would be 01, Dependent.
15	Section GG	Can you explain the documentation requirements for the 3-day assessment for usual performance?	On the LTCH CARE Data Set, record the patient's usual ability to perform each activity. If there is variation in the patient's performance during the assessment period, do not record the patient's best performance and do not record the patient's worst performance. Rather, record the patient's usual performance during the assessment period. Documentation of the patient's performance should be recorded in the patient's medical record according to the facility's standards of practice for documentation of the patient's functional status. Patient assessments are to be completed in compliance with facility, Federal, and State requirements.

#	Section	Question	Answer
16	Section GG	How do you code the function items if the patient's function varies and it varies between two levels?	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. The LTCH QRP Manual provides examples of probing conversations. The LTCH QRP Manual can be located in the Downloads section of the following Web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
17	General	Should the codes recorded on the LTCH CARE Data Set be supported by documentation in the medical record?	As stated in Chapter 2 of the LTCH QRP Manual V 3.0, data collected to complete each item on the LTCH CARE Data Set should include information from direct patient assessments, observations, interviews, and other relevant strategies within the assessment period timeframe.
18	Section GG	What is the best method for identifying function goals? For example, where you expect the most progress?	The LTCH can select the functional status goal(s) reported on the LTCH CARE Data Set based on the patient's care plan and the functional activities and goals that the hospital will find helpful to monitor.
19	Section GG	If a function goal is not established for a particular task, is that discharge goal item left blank?	If you do not code all the function goals, code a "-" (dash) for any self-care or mobility goal that you do not report. Goals should be established as part of the patient's care plan and the clinician reports at least one goal for one of the Self-Care (GG0130) or Mobility (GG0170) items.

#	Section	Question	Answer
20	Section GG	How do you code the function items if the patient's function varies and it varies between two levels? What is the definition of “most usual” and how is it determined?	The performance score for self-care and mobility items 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 direct care staff. The LTCH QRP Manual provides examples of probing conversations. The LTCH QRP Manual can be located in the Downloads section of the following Web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
21	Section GG	Are you able to provide examples of “clean-up” assistance for the Self-Care coding option 05, Setup or clean-up assistance?	The following are examples that illustrate the helper providing “clean-up” assistance that would be coded as 05, Setup or clean-up assistance: • **Oral hygiene:** The certified nursing assistant returns to gather the toothbrush and rinse cup and dispose of the waste after Mrs. C finishes brushing her teeth, which she does without help. • **Wash upper body:** The certified nursing assistant returns to Mr. G’s room after he completes washing his upper body without assistance. The certified nursing assistant collects and removes the washbasin, washcloth, and towel that Mr. G used to wash his upper body.

#	Section	Question	Answer
22	Section GG	How do you code the Self-Care items if the patient's function varies and it varies between several levels?	The admission score should be based on an assessment of the patient's abilities during which the patient is allowed to be as independent as possible as long as he/she is safe. The intent of completing the function items on admission is to capture the patient's status at the time of admission. When a patient is first admitted to the LTCH, he or she may not perform as independently as possible because he/she is in an unfamiliar environment with new clinicians. In addition, the patient may gain function soon after admission due to the initiation of therapy. Usual performance is defined as the patient's typical performs of 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. The admission score should not reflect improvement in function due to therapy services.
23	Section GG	Please clarify the rationale for the response to the following scenario presented during the webinar: Mrs. U has an above-the-knee amputation and severe rheumatoid arthritis. Once the nurse has donned her stump sock and prosthesis, Mrs. U is assisted to stand and uses her rolling walker with only touching assistance provided toward the last half of her 10-foot walk. Why does the response include only supervision or touching assistance as the patient required assistance in donning her stump sock and prosthesis, and required assistance in standing up?	Regarding the example presented during the webinar, the item GG0170I, Walk 10 feet, does not include dressing assistance nor sit to stand assistance, if needed by the patient. Mrs. U walks with only touching assistance; therefore, the score is 4, Supervision/touching assistance. • **GG0170I, WALK 10 FEET:** Mrs. U has an above-the-knee amputation and severe rheumatoid arthritis. Once the nurse has donned her stump sock and prosthesis, Mrs. U is assisted to stand and uses her rolling walker with only touching assistance provided toward the last half of her 10-foot walk. • **CODING:** GG0170I. Walk 10 feet would be coded 04, Supervision or touching assistance. • **RATIONALE:** The helper provided touching assistance for the patient to complete the activity of walk 10 feet. Assistance getting from a sitting to standing position is not coded as part of the Walk 10 Feet item.

#	Section	Question	Answer
24	Section GG	Does the use of an assistive device, for example, a slide board, affect the coding of the activity as the LTCH QRP Manual indicates that activities may be completed with or without assistive device(s)?	The guidance about the use of assistive devices was indicating that a patient's score would not be lowered due to the patient's use of an assistive device. The scores are determined based on the need for assistance from one or more helpers. If the patient uses an assistive device that he can retrieve and use independently, the use of the device would not be considered when coding the activity. If the patient needs assistance in retrieving or using the assistive device, then the assistance would be considered in coding the activity. If the helper retrieves the device, and the patient does not need any other assistance, code 05, Setup or clean-up assistance. If the patient needs assistance in using the assistive device to perform the activity then code the activity according to the amount of assistance that was needed.
25	Section GG	Does Section GG apply to pediatric patients?	The completion and submission of the LTCH CARE Data Set is required for all patients admitted to and discharged from an LTCH, regardless of age. There are no age restrictions.
26	Section GG	How do you clinically assess walking items GG0170I, GG0170J, and GG0170K? All 3 items separately? Or is it considered one progressive episode?	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.
27	Section GG	What version of the LTCH CARE Data Set should be used if a patient is admitted prior to the implementation of the LTCH CARE Data Set V 3.00 on April 1, 2016, and is discharged after April 1, 2016?	The applicable LTCH CARE Data Set V 3.00 (Admission, Planned Discharge, Unplanned Discharge, and Expired) must be completed for eligible patients who have been admitted on or after 12 a.m. on April 1, 2016. For eligible patients who have been admitted prior to 12 a.m. on April 1, 2016, and have been discharged (or who die) on or after 12 a.m. on April 1, 2016, LTCH CARE Data Set V 2.01 Admission Assessment should be completed and the applicable LTCH CARE Data Set V 3.00 Discharge or Expired Assessment should be completed.

#	Section	Question	Answer
28	Section GG	When will the LTCH CARE Data Set V 3.00 go into effect?	The LTCH CARE Data Set V 3.00 will go into effect on April 1, 2016. The LTCH CARE Data Set V 3.00 is available to view in Appendix C of the LTCH QRP Manual V 3.0 zip file, located in the Downloads section of the following Web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html. The applicable LTCH CARE Data Set V 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 V 2.01 Admission Assessment should be completed and the applicable LTCH CARE Data Set V 3.00 Discharge or Expired Assessment should be completed.
29	Section GG	How do you clinically assess GG0170Q1, Does the patient use a wheelchair/scooter? Separately or as one progressive episode?	The clinician is to assess each wheelchair item individually. Each item has specific activity components or tasks that assess the level of function. Item GG0170R assesses the ability to wheel 50 feet with two turns. Item GG0170S assesses the ability to wheel 150 feet. The clinician should assess the patient's performance specific to each item. For example, the patient may be able to wheel 150 feet without assistance, but may need some assistance to wheel 50 feet with two turns. Each activity should be assessed by observing the amount of assistance required from the helper.
30	Section GG	How do you clinically assess GG0170I, Walk 10 feet, GG01701J, Walk 50 feet with two turns, and GG01701K, Walk 150 feet? Do you have the patient walk as far as they can? If so, do you include the turns at 50 feet or do you assess all three activities separately?	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.

#	Section	Question	Answer
31	Section GG	How do you clinically assess GG0170I, Walk 10 feet, GG01701J, Walk 50 feet with two turns, and GG01701K, Walk 150 feet? Do you have the patient walk as far as they can? When do you include the assessment of turns? What is a turn? Does the patient have to turn if they walk 150 feet?	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.
32	Section GG	Who is a "qualified/appropriate" staff member to complete the Self-Care section of the LTCH CARE Data Set? I would assume nursing will complete this section and a physical therapist will complete the Mobility section.	CMS does not provide guidance on who can or cannot complete assessment items. Refer to facility, Federal, and State policies and procedures to determine which LTCH staff members may complete an assessment. Patient assessments are to be done in compliance with facility, Federal, and State requirements. Each facility delivers patient care according to their unique characteristics and standards (e.g., patient population, bed size). Thus, each facility self-determines their policies and procedures for completing the assessments in compliance with State and Federal requirements. That said, the goal for the assessment is to accurately reflect the patient's status, therefore staff completing a specific section of the LTCH CARE Data Set should have knowledge of the patient's status in these activities.
33	Section GG	Can information obtained through an interview from a certified nursing assistant be used to complete Section GG or does it have to be documented in the medical record?	If a certified nursing assistant provides information about a patient's function status that is not in the medical record, the information can be used to determine coding for section GG. Procedures for documentation of functional status in the medical record are to follow facility policies, and patient assessments are to be done in compliance with facility, State, and Federal requirements. Please note that information on the LTCH CARE Data Set must be consistent with information documented in the patient's medical record.

#	Section	Question	Answer
34	Section GG	Is item GG0130D, Wash upper body, part of the quality measure NQF 2631?	The LTCH Quality Reporting Program adopted 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), in the FY 2015 IPPS/LTCH PPS Final Rule (79 FR 50291 through 50298). A cross-setting application of the quality measure, 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) was adopted in the FY 2016 IPPS/LTCH PPS Final Rule (80 FR 49739 through 49747). The item GG0130D, Wash upper body, is included in 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), and thus this item must be coded as part of the LTCH QRP requirements.
35	General	Would specialist appointments, performed outside the LTCH, be considered an interrupted stay?	Yes. For the purposes of the LTCH QRP, 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 record (planned or unplanned).

#	Section	Question	Answer
36	Section GG	Are the Discharge Performance items in Section GG required? Are they included in quality measures, NQF #2631 or NQF #2632?	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), requires admission and discharge functional status data for patients with complete stays. For patients with incomplete stays, the function items are not required at discharge. The Unplanned Discharge assessment is completed if the patient has an unplanned discharge, and the function items are not included on the Unplanned Discharge assessment Also, the Expired assessment is completed if the patient dies in the LTCH. The Expired assessment does not include the function items. The quality measures, Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632) and Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), require the collection and submission of all discharge items in Section GG for patients with complete stays. Patients with incomplete stays are excluded from the NQF #2632 quality measure calculation. As noted above, the function items are not included on the Unplanned Discharge and Expired assessments.
37	Section GG	For item GG0130A, Eating, would tube feedings or total parenteral nutrition (TPN) be considered code, 09, Not applicable?	If the patient eats by mouth, code the item GG130A - Eating, based on the type and amount of assistance required from a helper. The patient may be eating by mouth even though he/she has a G-tube. If the patient is unable to eat by mouth due to a medical condition, and relies solely on nutrition through a G-Tube or TPN, code Eating item GG130A as 88 - Not attempted due to medical condition or safety concerns.
38	Section GG	In Section GG, should the walking or wheelchair mobility items be left blank if they are skipped on the assessment or should we code 09, Not applicable? For instance, if a patient is walking on admission and not using a wheelchair, should items GG0170R & GG0170S be left blank?	Items GG0170H—Does the patient walk?—and GG0170Q—Does the patient use a wheelchair?—are gateway questions. If the patient does not walk and a walking goal is not clinically indicated (code 0), then the walking performance items are skipped and the computer application will not allow codes to be entered for the walking items. If the patient does not use a wheelchair or scooter (code 0), then the wheelchair items are skipped, and the computer application will not allow scores to be entered for the wheelchair items.

#	Section	Question	Answer
39	General	When will the video presentations from the November 2015 LTCH QRP Provider Training be posted for viewing?	Playlists of video presentations from Day 1 and Day 2 of the LTCH QRP Provider Training offered in Baltimore, Maryland on November 19 and 20, 2015, are available via the following URL on both the CMS YouTube channel and the CMS Web site: • **Day 1:** https://www.youtube.com/playlist?list=PLaV7m2-zFKph4TMS62MeXttvHL5AWfPGv. • **Day 2:** https://www.youtube.com/playlist?list=PLaV7m2-zFKpgikJeDWJ_YYokRgMMSqr-a.
40	Section M	Is this a true statement? A wound is considered worsened only if worsened numerically (by depth). In this scenario would any unstageable wound be considered a new pressure ulcer? Would a Stage 3 wound that becomes covered by slough be coded as unstageable and the Stage 3 wound would no longer be coded in M0300C?	The definition of worsened is a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a 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 as compared to the Admission assessment. So if a stage 3 pressure ulcer reported in M0300C that becomes covered by slough and/or eschar by discharge would be reported on M0300F, unstageable due to slough and/or eschar, on discharge and not in M0300C.
41	Section GG	How do I code Section GG Mobility items GG0170J, Walk 50 feet with two turns, and GG0170K, Walk 150 feet, if the patient can walk the distance but is unsafe to turn?	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. In the example given the patient's level of assistance to walk 50 feet with two turns may require more assistance than the activity walk 150 feet that does not include two turns. Each activity should be assessed by observing the amount of assistance required from the helper.

#	Section	Question	Answer
42	Section M	Can you clarify if device related pressure ulcers should be coded on the LTCH CARE Data Set? During the November LTCH QRP Provider Training, the answer was no. However, they are referenced in Section M, Skin Conditions, specifically item M0300E, Unstageable - Non-removable dressing/device.	The definition related to coding this item on page M-17 of the LTCH QRP Manual states that it includes a primary surgical dressing that cannot be removed, an orthopedic device, or a cast. It does not include endotracheal tubes, tracheostomy ties, elastic wraps, splints, oxygen tubing, CPAPs, and the like. Although we are not coding these on the LTCH CARE Data Set at this time, it is really important to ensure that you are ensuring the appropriate size medical device is being used, the skin is protected in high-risk areas like the bridge of the nose or over the ears, and keep an eye on these areas as frequently as allowable while these medical devices are in use.
43	General	When is it appropriate to use a skip pattern?	A skip pattern indicates that a specific item does not need to be completed, and 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, leave the item blank, and move to the next item as directed. For example, on the Admission assessment, if 0, No, is coded for M0210, Unhealed Pressure Ulcer(s) the system would skip to the next applicable question which in this example is Section O, item O0100, Special Treatments, Procedures, and Programs.
44	Section M	Our wound nurse assesses newly admitted patients on day two of the hospitalization. Is it acceptable to use this information to stage pressure ulcers on admission?	Clinical assessments performed on patients in the LTCH should be completed according to accepted clinical practice and comply with facility policy and State and Federal regulations. The general standard of practice for newly admitted patients is that patient clinical admission assessments are completed beginning as close to the actual time of admission as possible, and usually within 24 hours. So if your facility requires the wound nurse to complete that assessment within a timeframe that coincides with accepted clinical standards and as enumerated in your facility policy, then that is acceptable and the LTCH CARE Data Set would be coded based on that assessment. Information related to this question can be found on page M-5 of the LTCH QRP Manual.
45	Section O	For item O0250C, when would code 6 “inability to obtain influenza vaccine due to a declared shortage” be used? Who declares the shortage?	Code 6 should be used for item O0250C when the influenza vaccination was not administered to the patient due to a declared vaccine shortage. The vaccine shortage can be declared by the CDC and State Public Health Officers. We refer you to the following CDC Web page for information regarding shortages of the influenza vaccines: http://www.cdc.gov/vaccines/vac-gen/shortages/.

#	Section	Question	Answer
46	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 your example, the patient has been assessed and Item O0250A would be coded 0, No, because the patient did not receive the influenza vaccine during 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.
47	Section M	In the "Consolidated Responses to Questions from the LTCH QRP Provider Training" document posted on the LTCH QRP Web site, question #102: Are device-related pressure ulcers to be captured on LTCH CARE Data Set? Where has this been previously posted? I cannot find any reference to this not being included. Majority of our pressure ulcers that we have had to code as worsening or newly developed are due to devices such as nasal cannulas, CPAP or buck traction devices. So, to clarify, should we not include these pressure ulcers in the LTCH CARE Data Set when coding the discharge assessment?	The definition related to coding this item on page M-17 of the LTCH QRP Manual states that it includes a primary surgical dressing that cannot be removed, an orthopedic device, or a cast. It does not include endotracheal tubes, tracheostomy ties, elastic wraps, splints, oxygen tubing, CPAPs, and the like. Although we are not coding these on the LTCH CARE Data Set at this time, it is really important to ensure that you are ensuring the appropriate size medical device is being used, the skin is protected in high-risk areas like the bridge of the nose or over the ears, and keep an eye on these areas as frequently as allowable while these medical devices are in use.
48	Section O	What is the rationale for a "skipped" item?	The "skipped" answer is in reference to the skip pattern. A skip pattern indicates that a specific item does not need to be completed, and 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, leave the item blank, and move to the next item as directed. For example, if item O0250A is coded 0, no, then item O0250B does not need to be completed and should be skipped.
49	General	When do LTCHs begin using and submitting the LTCH CARE Data Set V 3.00? For patients admitted April 1? Or for patients discharged April 1?	The LTCH CARE Data Set V 3.00 goes into effect on April 1, 2016. The applicable LTCH CARE Data Set V 3.00 (Admission, Planned Discharge, Unplanned Discharge, and Expired) must be completed for eligible patients who have been admitted on or after 12 a.m. on April 1, 2016. For eligible patients who have been admitted prior to 12 a.m. on April 1, 2016, and have been discharged (or who die) on or after 12 a.m. on April 1, 2016, LTCH CARE Data Set V 2.01 Admission Assessment should be completed and the applicable LTCH CARE Data Set V 3.00 Discharge or Expired Assessment should be completed.

#	Section	Question	Answer
50	Section M	Are pressure ulcers that are identified during the admission Assessment Reference Date (ARD) considered to be hospital-acquired if identified during the initial assessment?	Pressure ulcers that are found during the timeframe of the admission assessment are considered as present on admission. However, if a pressure ulcer develops after that, they would be considered as not present on admission.
51	Section O	For a patient admitted in September who is assessed as not being in the facility during this year's influenza vaccination season but remains in the LTCH and is not discharged until November, do you have to document two assessments in this patient's chart? Or if not, how do we code the discharge assessment? The LTCH QRP Manual does not indicate that more than one assessment is required during the patient's stay. Please provide more guidance on this measure regarding patients that are admitted prior to the influenza vaccination season.	The influenza vaccination season (IVS) is defined as beginning October 1st or when the influenza vaccine becomes available, whichever comes first. The influenza vaccine is often available in September. If in this scenario, the vaccine were available, you should assess the patient on admission and complete the influenza items. If in this scenario, the vaccine was not yet available, you would not be required to assess and complete the influenza items on admission. You would be required to complete the influenza items on the discharge assessment because the patient was in the LTCH for one or more days during the IVS. Code the items according the instructions in the LTCH QRP Manual.
52	Section O	Is it appropriate to use a "-" for completing the influenza vaccination items if the patient's stay is completely outside of the influenza vaccination season (April 1 through September 30) and the hospital has not received the vaccine?	If a patient's stay is completely outside the IVS (April 1 through Sept. 30), LTCHs should answer the influenza vaccine items with a "-" and not leave the questions blank.
53	General	Can the LTCH CARE Data Set serve as the documentation of the patient assessment for the medical record or does the assessment need to be incorporated into the hospital's usual documentation forms?	As stated in the LTCH QRP Manual, Chapter 2 states: "The Centers for Medicare & Medicaid Services (CMS) recognizes that, in addition to items included in the LTCH CARE Data Set, a complete and ongoing patient assessment guided by clinical standards is essential for all LTCH patients. Therefore, completion of the LTCH CARE Data Set does not replace the assessment of each patient for the delivery of services in LTCHs. Further, completion of the LTCH CARE Data Set should never supersede or substitute sound clinical judgment. Similarly, completion of the LTCH CARE Data Set should not supersede applicable Federal, State, and local statutes and regulations."

#	Section	Question	Answer
54	Section B and C	How do you code Section B, item BB0800, and Section C for patients who are on a ventilator and are receiving sedation medication?	If a patient is diagnosed with a communication impairment or is using a ventilator, 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 is not only observational, but can also be found in the medical record, and/or from family or staff over the 3-day assessment period. Information that would be sought would indicate the patient's baseline or that the person is not at his/her baseline and has 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. 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.
55	Section O	How should the influenza vaccine items be coded on the Admission Assessment if unable to obtain the patient's history or there is no evidence that the patient was previously vaccinated?	To determine whether the patient has received the influenza vaccination in the LTCH for this year's influenza season, you should first review the patient's medical record. If the patient's influenza vaccination status is unknown, you should ask the patient if he or she received the vaccine outside of the facility for this year's influenza vaccination season. If the patient cannot answer, you should consult with the patient's responsible party, legal guardian, or primary care physician as to whether the patient received the influenza vaccination for this year's influenza vaccination season. If the vaccination status still cannot be determined, please refer to the standards of clinical practice to determine whether the patient should receive the influenza vaccination and proceed to code item O0250A.
56	General	Can you clarify that the term "skip" is not an actual selection on the LTCH CARE Data Set? By indicating "skip," do you mean that we should not complete this section?	A skip pattern indicates that specific item does not need to be completed, and 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, leave the item blank and move to the next item as directed. For example, if item O0250A is coded 0, no, then item O0250B does not need to be completed and should be skipped.