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

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON AUGUST 9–10, 2016

Current as of October 2016

Question #	Question	Section	Item #	Answer
1.	Can we get the slides with explanations to the practice scenarios and case studies? They would be very helpful for staff training.	General		Yes, the updated training materials, including answers to the coding scenarios and case studies, will be posted on the CMS LTCH QRP Training Web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html
2.	It is my understanding that the LTCH CARE Data Set forms are not to be part of the official medical record. As the information contained is reproducible and verifiable from the EMR, do they need to be kept/stored and if so for how long?	General		CMS does not require LTCH providers to store copies of the LTCH CARE Data Set (LCDS) as part of the medical record, although we highly recommend that LTCHs keep copies of each LCDS assessment that is submitted to CMS, whether in paper or electronic format. Such records may be useful in helping to prove compliance with LTCH QRP requirements should an LTCH receive a notice of noncompliance for a given fiscal year (FY) payment determination. CMS does not issue guidance regarding retention of records. LTCHs should consult their own hospital policies, as well as any State policies regarding the retention of such records. You can refer to the LTCH QRP Manual Version 3.0, Chapter 2, ~~available for download on the LTCH QRP Web site~~ for more information on LTCH CARE Data Set Requirements and Maintenance of Electronic LTCH CARE Data Set Records. The LTCH QRP Manual Version 3.0 is available on the CMS LTCH QRP Training Web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html

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3.	Do the actual paper CARE data set forms need to be completed/filled out, or can a facility create their own data collection form or use an EMR-generated report to gather the necessary information? The forms are long, take up a lot of storage space and resources, and are not very green.	General		LTCHs are not required to use paper forms to record the required LTCH CARE Data Set assessment data. Many LTCHs work with vendors to create electronic versions of the LTCH CARE Data Set. CMS offers free software (LASER), which allows LTCHs to collect and submit the required assessment data and ensures that the data are packaged in an acceptable format for submission. The free software is available for download on the following website: https://www.qtso.com/laser.html. Please note that LTCHs that choose to create their own electronic versions of the LTCH CARE Data Set must follow the data submission specifications, which outline all required coding conventions that must be used and that allow for submission of an appropriate data file that will be recognized and accepted by the CMS QIES ASAP system. The LTCH CARE Data Set data submission specifications are available for download on the CMS LTCH Quality Reporting Technical Information Web page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Technical-Information.html.
4.	If a patient is lethargic or has an altered mental status and is unable to give history, I'm putting unknown for prior level of function. What should I put in the prior device use (manual wheelchair, motorized wheelchair, hoyer lift) in the event that patient is not able to coherently state information and family is not available?	GG	GG0110	In the scenario that is presented, the LTCH should attempt to reference information provided by the previous medical setting prior to or during the patient's transition to the LTCH. If the patient is noncommunicative, and he/she has no family that is able to speak on their behalf, you would code Z, None of the above. In the absence of information, you would default to say no device.

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5.	If a patient is on PEG feeding, is it appropriate to put in Not Applicable for the feeding section?	GG	GG0130A	Eating is coded based on eating by mouth. If the patient does not eat by mouth and only gets food and liquid via the PEG tube, code 88, Not attempted due to medical or safety concerns or 09, Not applicable. If the patient did not eat by mouth prior to the current illness, injury, or exacerbation, code 09, Not applicable. If the use of the PEG tube is new with this episode of care, code 88, Not attempted due to medical or safety concerns.
6.	Can you use/code the discharge goals as their prior level of function?	GG	GG0130	Yes, if the patient is expected to return to his/her prior functioning, code the discharge goal based on the patient's prior level of function.
7.	Only one discharge goal is required in each section. Is there a benefit to selecting "dependent" as a D/C goal vs. using a dash, if the particular item assessed is not a major focus of the plan of care?	GG	GG0130; GG0170	To clarify, one goal is required for at least one of the self-care or mobility items on the LTCH CARE Data Set. If a patient is not expected to be able to perform an activity by discharge, code 1, Dependent, for the goal.
8.	If a patient has an inconsistent level of function (inconsistent meaning sometimes the patient feels that he/she wants to walk one day and on another day refuses to walk due to fatigue), what would be the appropriate functional level under GG on the discharge assessment?	GG	GG0170	For this patient, code the walking items based on the distance the patient walked and the amount of assistance the patient required when she/he walked each distance. The patient does not need to walk each day or multiple times to be coded on the walking items, but walking must occur at least once during the 3-day assessment period. If the patient walks 10 feet, but not more than then 20 feet due to endurance and fatigue problems, code item GG0170I, Walk 10 feet, based on the amount of assistance required by a helper. For this patient, items GG0170J, Walk 50 feet with 2 turns, and GG0170K, Walk 150 feet, would be coded as 88, Not attempted due to medical condition or safety concerns.
9.	If a patient falls outside the LTCH (i.e., at a STACH) and does not return to LTCH for >3 days, is this considered a fall during the initial admission at the LTCH?	J		No, this would not be recorded on the LTCH CARE Data Set, because the patient did not return to the LTCH within 3 days and would not be coded on the patient's unplanned discharge assessment.

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10.	Our patients are often admitted with a flexi-seal fecal management system. How would this category be coded?	H	H0400	H0400, Bowel Incontinence, would be coded 9, Not rated.
11.	When an unstageable ulcer is present on admission, but changes in classification between admission and discharge (e.g., unstageable due to nonremovable dressing to unstageable due to slough/eschar), it is counted as a "worsening" ulcer, even though that is usually not clinically accurate. Can you please explain the significance of the "worsening" designation?	M	M0300; M0800	The scenario presented in the inquiry would be coded as follows, using the included rationale: The status of the ulcer changed from unstageable due to dressing/device to unstageable due to slough/eschar from admission to discharge. Because M0800 captures the change in number and change in status of ulcers, this status change would be captured in M0800 as a new unstageable due to slough/eschar. It is not considered worsened, but M0800 captures both new and worsened. Coding on admission (If this was the only ulcer on admission): • M0300E1. Unstageable due to dressing/device – 1 Coding on discharge (If this was the only ulcer on discharge): • M0300E1 & 2. Unstageable due to dressing/device are not coded on discharge because status of the pressure ulcer changed to unstageable due to slough/eschar. • M0300F1. Unstageable due to slough/eschar – 1 • M0300F2. – 0 (Because the ulcer was not present as an unstageable due to slough/eschar on admission; it was unstageable due to dressing/device.) Coding on M0800 (If this was the only pressure ulcer on discharge): • M0800E. Unstageable due to slough/eschar – 1 (New status)