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

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON NOVEMBER 19–20, 2015

Current as of January 2016

LTCH QRP Provider Training – Participant Questions From In-Person Training on November 19–20, 2015

#	Question Category	Question	Answer
1.	CDC	The VAE calculator is awesome. Do you have calculators for CLABSIs, CAUTIs and C. diff? It would be a great tool.	We are hoping to release a Worksheet Generator in the very near future. This tool will not be a "calculator" per se but will assist in outlining the Infection Window Period, Repeat Infection Timeperiod, and Secondary BSI attribution period based on the dates and data the user enters. This tool will be applicable for all NHSN events with the exception of VAE (http://www.cdc.gov/nhsn/vae-calculator/index.html) and MDRO/CDI event (http://www.cdc.gov/nhsn/labid-calculator/index.html), which have their own specific calculators.
2.	Data Submission	In what time frame did "5,279 LTCH CARE Records" yield ERROR 3900? (The dash warning)	The top 10 errors reported during the presentation were submitted between 01/01/2015 and 09/30/2015.
3.	Data Submission	Completed CARE 3.0 Assessments are certainly larger than the 0.8 to 1.3 MB of CARE Assessment 2.01 XML files. Since the current maximum .zip file size suitable for uploading to QIES is less than 10 MB, has QIES updated their data specifications to accommodate and reflect the increase in file size?	The maximum file size allowed by the QIES ASAP system remains at 5 MB.
4.	Data Submission	What areas if a dash is used will cause the fatal error?	A dash will result in a fatal error and cause the record to be rejected *if* the dash is submitted in an item but a dash is not a valid value for that item. A list of valid values for each item included in the XML file can be located in the LTCH Data Submission Specifications.
5.	Data Submission	What can be done if you can't locate a validation report?	If the ASAP system-generated final validation report cannot be located in the Validation Report or VR folder within 24 hours following submission of the zip file of LTCH CARE records, this indicates that there was a severe error with the zip file, there no XML records in the zip file or no records could be extracted from the zip file. The user that submitted the file to the ASAP system should request the LTCH Submitter Validation Report to identify the errors that were encountered. The report must be requested by submission ID. The submission ID can be found on the initial confirmation message printed from the LTCH Submission system following submission of the file. The submission ID can also be located on the 'My List of Submissions' page in the LTCH Submission System. The LTCH Submitter Validation report is available in the LTCH Provider report category in the CASPER reporting application. Refer to the CASPER Reporting User's Guide for step-by-step directions to request the Submitter Validation report.
6.	Data Submission	Is the purpose of the Resident Match criteria for the Accountable Care Act and looking at cost per Medicare beneficiary? I see no other purpose.	The purpose of the Resident Match criteria is to link assessments records from any of the five assessment collection systems to one patient record in the national repository.

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7.	Data Submission	If patients are matched in the national database based on state, how is it handled when patients have 2 states? There was an example of living in MN in summer and AZ in winter?	One patient could have a resident internal ID in more than one state. Referencing the example that was provided during the conference: if a patient resides in MN during part of the year and AZ for the rest of the year *and if* at least one assessment/HIS record was accepted for that patient in each state, the patient would have a resident internal ID for the state of MN and a different resident internal ID for the state of AZ.
8.	Data Submission	CASPER System - Is there a way to get a summary of all the assessments we have submitted during a period of time? For example, Once a month we provide a report by WARNING MESSAGE for each of our facilities? (see below table provided following this question)	Two new reports will be available to LTCH providers in the future. The first report, LTCH Submission Activity, will display a list of LTCH CARE records submitted during a user-specified time period. Later this year, a new report titled LTCH Assessments with Error Number XXXX, will be available in the CASPER Reporting application. This report will display a list of assessments that encountered the error messages selected by the user for the specified provider. The report can be requested by any of the LTCH errors contained in Section 5 - Error Messages of the LTCH Submission User's Guide.
9.	Data Submission	QIES Submission - Is it possible for a vendor to automatically submit to the QIES system on behalf of a client? The user takes an option in the software and the software calls the QIES - passes along correct data and the validation report is sent back to software - would really help out facilities that are not so tech savvy. Thank you!	If the question is addressing whether automated scripting, then the answer is No - automated scripting is not allowed.
10.	Data Submission	Once a resident identifier is assigned, how is/will the resident identifier be used? For example: Will you be able to use the resident identifier to a) compare risk adjusted outcomes across PAC settings? b) compare risk adjusted outcomes across episodes of care involving multiple PAC settings? Can you use the resident identifier to link PAC assessment data with the individual's Medicare costs in the PAC setting? Across episodes of care?	The resident identifier is used as a means of linking assessments from any of the five assessment collection systems (MDS, OASIS, IRF-PAI, LTCH CARE and HIS records) to a patient in the national repository.

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11.	Data Submission	In terms of marking residents info - are names case sensitive?	The data entry software used to format the LTCH CARE records into an XML file for submission to the ASAP system should ensure the letters in the patient's first and last name are submitted in uppercase. The patient's information is stored in the national repository in uppercase. If the patient's first and last name in the LTCH CARE record are submitted in lower or mixed case, the ASAP system will convert the letters to upper case before comparing to the patient information in the national repository.
12.	Data Submission	Can a user at the LTCH corporate office have access to all facility validation reports in the ASAP system?	A corporate user with authority to submit data on behalf of one or more LTCH providers can only have access to request or view validation reports for those same LTCH providers. Corporate users cannot view all validation reports for all providers.
13.	Data Submission	Can 3rd party vendors extract our validation reports?	Third-party bureau users can access final validation reports on the behalf of an LTCH provider, so long as the user has contracted with the LTCH provider for those services.
14.	Data Submission	Can 3rd party vendors submit our records?	Third-party bureau users can submit on the behalf of an LTCH provider, so long as the user has contracted with the LTCH provider for those services.
15.	Data Submission	If a record that was already submitted to the ASAP system: How would you inactivate the file?	The data entry software you use should contain functionality to allow you to inactivate a record that has already been accepted by the ASAP system. The inactivation record will have an A0050 Type of Record value = 3 (Inactivation). Once the inactivation record is created, it will be included in a zip file for submission to the ASAP system. If you need assistance to create/complete the inactivation record, contact the software vendor that created the data entry software that you are using.
16.	Data Submission	If you have completed an inactivated file, will that file replace the old file submitted to the ASAP system?	The purpose of the inactivation record is to move the erroneous record to an archive file in the QIES ASAP system. A new record containing the correct information for the patient will NOT automatically be saved into the national repository. If a new record is required, you must submit the new record following acceptance of the inactivation record by the ASAP system.

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17.	Data Submission	If a file was discovered an error and was already submitted to the ASAP system, do you correct it with modification and inactivation?	Use of a modification or inactivation record depends solely on the item that contained the erroneous information. If the error is in a key field used to identify the record or the patient, a modification record cannot be utilized. In this instance, an inactivation record is required. A list of key field items can be found on slide 67 of the Data Submission and Reporting slide presentation. The record and patient key fields can also be found in Chapter 4 of the LTCH QRP manual. If an error exists in a non-key field item, a modification record can be submitted to correct the error. If the state code or facility ID is in error, a special manual deletion request must be submitted to permanently remove the record from the QIES ASAP system. Following permanent deletion of the file, you would be required to submit a new record that contains the correct state code and facility ID.
18.	Data Submission	Is the LTCH provider participation sample report out now? What did it start?	The LTCH Provider Participation report is currently unavailable while additional enhancements are being applied to the report.
19.	General	The 915 warning message should be removed when it is a matter of a location change as 95% of LTCH patients come from another facility. Thank you.	Thank you for the suggestion. We will consider this suggestion for future enhancement for the LTCH ASAP system.
20.	General	Is there information on the CMS website on how to obtain facility and use ID and passwords for LTCH Care data set?	The QTSO website contains information about the registration process for the CMSNet User ID and the QIES User ID. Refer to the online training webinars referenced on slides 133-134. The training webinars outline the process to register for these user IDs.

#	Question Category	Question	Answer
21.	General	Are LTCHs in California required to submit quality data to CMS via the data sets?	The LTCH CARE Data Set must be completed on any patient admitted to and treated within your LTCH, as long as your LTCH meets the requirements as defined below: The LTCH CARE Data Set is applicable to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under the Medicare program. 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). The LTCH CARE Data Set is applicable to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under the Medicare program. 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). It is not applicable to patients receiving services in LTCH units that are not designated as LTCHs under the Medicare program. Data collection using the LTCH CARE Data Set is applicable regardless of patient's age, diagnosis, length of stay, or payment/payer source. Data collected must be submitted in the time frame, manner, and form established by CMS for the LTCH QRP. For more information regarding the requirements of the LTCH QRP, we refer you to the CMS LTCH QRP website, at: http://cms.hhs.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html.

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22.	General	Currently, we are not completing the data sets. When did the data set become mandated for California?	The LTCH QRP went into effect on October 1, 2012. Currently, it requires each LTCH to collect and submit data collection for the following quality measures: • National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138). • National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139). • Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678). • Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680). • Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431). • All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs (NQF #2512): This is a Medicare Fee-For-Service Claims-based readmissions quality measure adopted for the LTCH QRP. LTCHs do not need to submit data for this quality measure; claims data are used to calculate the risk-adjusted readmission rates. • 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). Starting January 1, 2016, the LTCH QRP requires data collection and submission for one additional measure: • National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure. Starting April 1, 2016, the LTCH QRP requires data collection and submission for four additional measures: • Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674). • 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 Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). • Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)

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23.	General	How soon should California facility start submitting LTCH Care Data sets?	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.
24.	General	Could a facility potentially get the 2% reduction twice? For example, a 2% monetary payment penalty for not being compliant with quality measure reporting AND a 2% payment penalty for not submitting IMPACT Act data correctly?	No. An LTCH can only receive a 2% reduction related to any applicable fiscal year (FY) Annual Payment Update (APU) for which they are determined to be out of compliance. The IMPACT Act requirements are an extension of the LTCH QRP requirements, and an LTCH cannot receive multiple 2% reductions to a specific FY APU.
25.	General	Does CMS have any plans for implementing any validation processes (for NHSN data or LTCH CARE Data Set)? There are a lot of reporting rules.	CMS is currently working to develop a data validation policy for the LTCH QRP. Any such policy will be proposed through notice-and-comment rulemaking.
26.	General	Do IPPS patients who are admitted to the LTCH who may or may not be Medicare or Medicaid need to be entered into the system? For example, IPPS patients who come to the LTCH that do not affect our 25 day LOS rule? These patients are expected to be at the LTCH less than 25 days.	Data collection using the LTCH CARE Data Set is applicable regardless of patient's age, diagnosis, length of stay, or payment/payer source.
27.	General	Our organization skips most questions on the current LTCH CARE Data Set (V 2.01). We only complete the items which are required. Will we have the same flexibility to skip questions in the LTCH CARE Data Set V 3.00?	The LTCH CARE Data Set V 3.00 will have data items that are required, as well as data items that voluntary. Please note that we have addressed this issue in Appendix D of the LTCH QRP Manual, which we have revised, in order to simplify the appendix and increase understanding and compliance. The revised Appendix D of the LTCH QRP Manual is now available in the LTCH QRP Manual V 3.0 zip file under the Downloads section of the CMS LTCH QRP Training website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.

#	Question Category	Question	Answer
28.	General	Will CMS Include an Appendix D in the LTCH QRP Manual V 3.0?	Yes. CMS has revised Appendix D of the LTCH QRP Manual in order to simplify the appendix and increase understanding and compliance. The revised version of Appendix D is now available in the LTCH QRP Manual V 3.0 zip file under the Downloads section of the CMS LTCH QRP Training website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
29.	General	What should be done if the person that submitted the LTCH CARE Data Set with errors is no longer working at facility?	If your LTCH discovers that incorrect data was submitted to CMS, you should take the necessary steps to correct that data. Whether your LTCH needs to file a modification request or an inactivation request to correct an error will depend upon which data items need to be corrected. Specific instructions regarding the correction of errors on the LTCH CARE Data Set is included in Chapter 4 of the LTCH QRP Manual V 3.0, which is available under the Downloads section of the CMS LTCH QRP Training website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
30.	General	Who is a "qualified/appropriate" staff member to complete the clinical assessment, complete the LTCH CARE Data Set, and submit it?	CMS is not prescriptive in our guidance related to whom it is that actually completes the LTCH CARE Data Set. Any data entered into these forms, however, must mirror patient data included in the medical record by appropriate clinical personnel. LTCHs should follow their own facility policy, as well as state regulations concerning which staff members are allowed to complete a formal patient assessment.
31.	General	Where can I find the LTCH QRP Manual V 3.0?	The LTCH QRP Manual Version 3.0 is available for download at the CMS LTCH QRP website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
32.	General	Do we need to complete an admission and discharge assessment if the patient was admitted and discharged from the LTCH within 3 days?	The LTCH would need to complete the LTCH CARE Data Set Admission assessment. Regarding the Discharge assessment, it would depend on whether, at the time of transfer to another hospital/facility, the patient was expected to return to the LTCH within 3-days (day of transfer + 2 calendar days). If, at the time of transfer, the patient was expected to return to the LTCH within 3-days, and does not return within 3 days, then, an Unplanned Discharge assessment needs to be completed for this patient. An Unplanned Discharge assessment would also be completed if the patient was transferred to another facility emergently. If the patient had a "planned transfer" to "another hospital/facility" that was going to result in the patient's absence from the LTCH for longer than 3 calendar days, then, the transfer is considered "planned" and a Planned Discharge assessment needs to be completed for this patient.

#	Question Category	Question	Answer
33.	General	Are LTCHs required to complete and submit the LTCH CARE Data Set for site neutral patients? For example, if a site neutral patient is admitted and subsequently discharged within two days, would we have to complete and submit the LTCH CARE Data set for that patient?	The LTCH CARE Data Set must be completed on any patient admitted to and treated within your LTCH, as long as your LTCH meets the requirements as defined below: The LTCH CARE Data Set is applicable to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under the Medicare program. 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 (LTCH QRP). It is not applicable to patients receiving services in LTCH units that are not designated as LTCHs under the Medicare program. Data collection using the LTCH CARE Data Set is applicable regardless of patient's age, diagnosis, length of stay, or payment/payer source. Data collected must be submitted in the time frame, manner, and form established by CMS for the LTCH QRP. For more information regarding the requirements of the LTCH QRP, we refer you to the CMS LTCH QRP website, at: http://cms.hhs.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html.
34.	General	Can someone who has not seen the patient complete the LTCH CARE Data Set based on interview with staff?	CMS is not prescriptive in our guidance related to whom it is that actually completes the LTCH CARE Data Set. Any data entered into the LTCH CARE Data Set, however, must mirror patient data included in the medical record by appropriate clinical personnel. LTCHs should follow their own facility policy, as well as state regulations concerning which staff members are allowed to complete a formal patient assessment.
35.	General	To clarify, does the day of admission count as Day 1 for the 3 day assessment period?	Yes, the first day of admission is considered the first day of the three day assessment period. More information regarding LTCH CARE Data Set requirements and timing of completing the assessments can be found in Chapter 2 of the LTCH QRP Manual, available in the Downloads section at the following link: http://cms.hhs.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
36.	General	Are all post-acute care providers, such as Inpatient Rehabilitation Facilities (IRFs) required to use the LTCH CARE Data Set?	LTCHs 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 QRP. As part of the LTCH QRP requirements, LTCHs must submit quality data to CMS via the LTCH CARE Data Set for CMS stewarded measures and also via the CDC's NHSN for CDC stewarded measures. Please visit the LTCH QRP Web site for more information: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Data-Submission-Deadlines.html. Inpatient Rehabilitation Facilities (IRFs) are not considered to be LTCHs and hence, IRFs are not required to collect and report through the LTCH QRP. Please email IRF.questions@cms.hhs.gov if you have questions regarding the IRF QRP.

#	Question Category	Question	Answer
37.	General	Will there be a FAQ available containing information for April 1, 2016 implementation of the LTCH CARE Data Set V 3.00?	Yes. CMS developed a FAQ, which is available on the LTCH QRP Training webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html
38.	General	Will updated training materials, including answers to the coding scenarios, be made available online?	Yes, the updated training materials including answers to the coding scenarios are posted on the CMS LTCH QRP Web site, here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html
39.	General	When is the training for SNF/PPS providers?	Training announcements related to the SNF QRP will be posted on the CMS SNF QRP website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting.html) in advance of any scheduled events. CMS also communicates with SNF providers via listserv email blasts. Please continue to check the CMS SNF QRP website for updates related to provider training.
40.	General	I understand this training was targeted to LTCH providers. But I also work with SNF, IRF providers. I wanted to know if/when CMS plans a similar training for SNF providers?	Training announcements related to the SNF QRP will be posted on the CMS SNF QRP website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting.html) in advance of any scheduled events. CMS also communicates with SNF providers via listserv email blasts. Please continue to check the CMS SNF QRP website for updates related to provider training.
41.	General	Will updated training materials, including answers to the coding scenarios, be made available online?	Yes, the updated training materials including answers to the coding scenarios are posted on the CMS LTCH QRP Web site, here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
42.	General	Will LTCHs be penalized if they do not complete the LTCH CARE Data Set past five days or submit the LTCH CARE Data Set past seven days, but submit all data well before the data submission deadline (135 days after the quarter closes)?	For the purpose of the LTCH QRP, submission of the LTCH CARE Data Set beyond the 5-day submission deadline will not affect CMS determination of the LTCH's compliance with the LTCH QRP as long as the data are submitted by the quarterly submission deadlines. The 5-day submission deadline/guidance is put into place to help ensure that LTCHs are submitting assessments as close to completion as possible on a routine basis.
43.	General	Regarding the LTCH CARE Data Set, can we code information based on observation or interview only? 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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44.	General	If you have to speak with staff to determine/clarify how to code an item, does this conversation have to be documented in the chart?	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.
45.	General	Do responses to interview questions need to be documented in the medical record? If yes, does the documentation need to be within the Assessment Reference Date (ARD)?	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. The 3-day assessment period 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 assessment sections that include patient assessment data should be consistent with the initial clinical assessment.
46.	General	If the discussions and interviews with nursing staff occur after the ARD but provide relevant information for coding activity during the ARD, can this information be used to code?	The 3-day assessment period 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 assessment sections that include patient assessment data should be consistent with the initial clinical assessment.

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47.	General	I have a question regarding a patient who was discharged from the LTCH and came back after 3 days (past the LTCH QRP interrupted stay policy). It is a new admission for the LTCH but, for payment purposes, the patient's original admission date to the LTCH is the same. What we are doing right now is we have a list of patients with a new LTCH admission date. Any thoughts?	CMS interprets this inquiry to state that the current interrupted stay policy for the LTCH QRP requires that an LTCH complete a Planned Discharge or Unplanned Discharge assessment on any patient whose temporary transfer to another facility that lasts greater than three calendar days. The policy also requires that the LTCH complete a new LTCH CARE Data Set Admission assessment when this patient returns to your LTCH (providing the interrupted stay is greater than three calendar days). The inquirer is making the point that, in this scenario, and for payment purposes, the patient's true admission date to their LTCH remains their original date of admission. By requiring LTCHs to complete a new admission assessment each time a patient returns to their LTCH from an interrupted stay that is greater than three calendar days, a patient may have multiple dates of admission, as recorded on the LTCH CARE Data Set assessments, while their true date of admission in their medical record, for payment purposes, remains their original date of admission for this episode of care, and this can get confusing or difficult to track. The purpose of the CMS LTCH QRP Interrupted Stay policy is to attribute the responsibility for patient care to the LTCH for any interrupted stay that lasts less than three calendar days. CMS believes that this is matter of care coordination, and that the LTCH from which the patient transfers, should remain responsible for any change in status related to the patients' health during those interrupted stays that last less than three calendar days, and that this is a reasonable expectation, which requires LTCHs to coordinate care and form relationships with those outside providers to whom they transfer patients. While this policy attributes the responsibility of the care of the patient to the LTCH for those interrupted stays that last less than three calendar days, it also protects the LTCH by attributing any change in patient health status to that facility to which a patient might be transferred to for an interrupted stay that lasts greater than three calendar days. Requiring an LTCH CARE Data Set admission assessment on patients which have interrupted stays lasting longer than three calendar days, allows LTCHs to record any changes in a patient's health status as present on admission, and thus attributes any changes in the patient's health status to the hospital to which the patient was transferred.
48.	MDRO	Specimens cultured for surveillance purposes are excluded from MDRO reporting. Since the intention of a provider when ordering a culture is usually only presumed, is there a definitive way to know that a positive culture is only "for surveillance"?	Active Surveillance Testing (AST) is a program conducted by a facility which includes a nasal, axillary or rectal swab taken upon admission to identify "colonization" rather than acute infection. The results may be used for process interventions, e.g. isolation, but are not used for treatment purposes and therefore, are not eligible for reporting as a LabID event.

#	Question Category	Question	Answer
49.	NHSN	Does NHSN have a reason for defining criteria for surveillance differently than other data aggregators?	NHSN uses surveillance definitions that were originally created as part of the National Nosocomial Infections Surveillance System (NNIS). The definitions have been modified over time. The definitions are used by thousands of people in thousands of facilities. They are also now used to collect data for many purposes, including assessing the effectiveness of infection prevention activities within healthcare facilities and to determine pay for performance for federally funded insurance programs. Because of this, they must be objective and feasibly collected by all involved. This limits the types of data that can be included in the definitions. Other data aggregators who have other purposes for data collection will use other factors to determine their definitions, and they may differ from the NHSN surveillance definitions. Data collected for different purposes may appropriately be collected by different methodologies.
50.	NHSN	Would routinely obtaining blood and urine cultures on day of admission reduce the likelihood of a facility being attributed as original source of device associated infections?	Medical care practices within healthcare facilities should be based on accepted standards of patient care that are developed by medical communities and organizations. One basic tenet of good patient care is to choose diagnostic testing based on the symptoms and presentation of the patient. Because a positive culture does not always indicate infection, diagnostic testing performed without suspicion of infection puts patients at risk of unnecessary treatment. This treatment can result in drug reactions, increased medical costs, the development of multidrug-resistant organisms, and *Clostridium difficile* infection. For these reasons, cultures of patient specimens should not be performed routinely to effect healthcare-associated infection data.
51.	NHSN	Are all these changes to definitions exactly the same for LTCH and Acute Care Hospitals?	Yes. Healthcare-associated infection surveillance for reporting to NHSN is performed using the same definitions and protocols in acute care hospitals and long-term acute care hospitals.
52.	NHSN	With interrupted stays, how does that affect these infection day spreads across two hospitals?	You will follow the location of attribution and transfer rules to make determinations of facility attribution assignment. Repeat Infection Timeframes (RIT) identified in one hospitalization do NOT continue into a subsequent hospitalization. Please note that if an event date occurs in the Transfer Rule period, then that event would be attributed back to the transferring or discharging location and therefore, any RIT will apply.
53.	NHSN	Question #1: What was the answer for the knowledge test, where patient on 8th day after admission (1/23/15) had fever and urine culture res. >100,000 true or false? What is the rationale?	The correct answer is “True”. The rationale is that the patient did not meet the UTI criteria in an infection window period (IWP), using the January 15 urine culture as the diagnostic test. This is because there were no symptoms or matching positive blood culture during the IWP. Therefore no UTI repeat infection timeframe was set based on the January 15 urine culture. The patient then had a positive urine culture and fever on the same day, and therefore met the Symptomatic UTI criterion on January 23. The PowerPoint files with answers for all of the case studies will be posted on the CMS website.

#	Question Category	Question	Answer
54.	NHSN	NHSN asks if a client has been "discharged" from my facility. Given the various names in use to label a client's absence from a facility wouldn't a more quantitatively precise, objective term be more useful? I don't think accounting for the absences of the past four weeks would be more burdensome than determining if a "discharge" occurred.	The question asking if a client has been 'discharged' from your facility within the past 4 weeks is specific to inpatient admission, i.e. doesn't include ED or observation visits. Therefore, the verbiage "discharged" is appropriate for the question asked.
55.	NHSN	Re: HCP Influenza Vaccinations: Does CMS or NHSN require facilities to keep records to corroborate summarized data submitted at the end of the immunization season? If so, for how long?	There is no NHSN requirement for facilities to retain records that corroborate the HCP influenza vaccination summary data reported to NHSN. Facilities may wish to keep these records for their own purposes, but this is not a requirement for NHSN reporting.
56.	NHSN	Please explain rationale for not including fever as a symptom in patients >65 for CAUTI? Nobody in our group or adjacent tables understands the reason.	In the elderly, non-catheterized patient who has a fever but no other localizing signs for UTI, there is a cause other than UTI in 90% of the cases. Therefore one of the other symptoms of UTI must be present to meet the NHSN UTI criteria in this patient population to avoid over-calling UTIs.
57.	NHSN	For VAE: Are we only counting location ICU or are we also counting ward? Do we enter separate locations?	Per Long-Term Care Hospital Quality Reporting (LTCHQR) Program Healthcare Facility HAI Reporting Requirements to CMS via NHSN, beginning in January 2016 VAE surveillance is to be conducted in Adult LTAC ICUs & Wards.
58.	NHSN	Is VAC data entered real time or after patient discharges?	VAE events can be reported as identified. From an NHSN standpoint, upon identification of a VAC you will need ample time for determination of whether the IVAC or PVAP definition can be met. Once final determination is made the event can be reported to NHSN. Remember you report all VAE events (not just VACs) at the highest level met within the VAE algorithm. Also remember each VAE establishes a 14 day VAE event period where date of event is day 1. No new VAEs are reported or upgraded within the VAE event period. Please refer to CMS for reporting deadlines requirements.
59.	Section A	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?	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).

#	Question Category	Question	Answer
60.	Section A	If a patient was transferred out of the LTCH and does not return by Day 3 and instead returns on Day 4, will I need to complete an LTCH CARE Data Set Unplanned Discharge assessment and mark the interruption dates?	This is not considered an interrupted stay because the patient transferred out of the LTCH and did not return by day 3. You will need to complete an LTCH CARE Data Set Unplanned Discharge assessment for this patient but you should not mark the interruption dates of this transfer.
61.	Section A	If a patient is transferred to a short-term acute care (STAC) hospital for a planned procedure with the expectation of returning to the LTCH, but the patient does not return within three days, would this be a planned or unplanned discharge?	The LTCH would complete the LTCH CARE Data Set Unplanned Discharge assessment as the patient did not return to the LTCH within the three day period.
62.	Section A	If a patient was transferred out from the LTCH but returned on Day 2, do I complete the interrupted stay items on the discharge assessment when the patient is discharged from the LTCH?	Yes, on the patient's discharge assessment, you should indicate that there was a program interruption.
63.	Section A	If a patient is at another facility for only few hours but it crosses midnight before she returns to the LTCH, is this considered an interrupted stay?	Yes, on the patient's discharge assessment, you should indicate that there was a program interruption. Because the patient returned to the LTCH after midnight, you would enter the start date (date in which the patient transferred to another facility) and the end date (date in which the patient returned to the LTCH).
64.	Section A	Regarding program interruptions, is there a minimum amount of time required to be considered an interrupted stay or does this apply only to overnight stays? Is it still considered an "interruption" if the referenced absence is due to reasons other than "for services unavailable at LTCH" such as absence without leave, a scheduled visit to their doctor, or trial home visit?	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).
65.	Section A	Interrupted stays are 3 days or less on the discharge assessment. Financially, interrupted stays are 9 days are less. Has this changed? This affects reimbursement.	The policy has not changed. 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).

#	Question Category	Question	Answer
66.	Section B	Regarding Section B: Aside from a comatose or vegetative state, what type of documentation needs to be present to support the clinician's coding of the assessment items? Would this be considered a subjective assessment?	LTCH CARE Data Set coding should be based upon information gathered from the patient's medical record, direct observation, interviews with staff member, patient family members, or a combination of information from these sources to code the items. Facilities should have medical record documentation that matches coding data entered into the LTCH CARE data set to verify the rationale used for assessment coding. Each clinician coding the LTCH CARE Data Assessment should have undergone training in coding the LTCH CARE Data Set. The professional judgement of the clinician who is completing the LTCH CARE Data Set is to evaluate the information gathered to objectively determine appropriate and accurate coding of the LTCH CARE Data Set.
67.	Section B	Section B and other sections in the LTCH CARE Data Set recommend the use of a variety of sources to gather information used to code quality reporting program items. When documentation by other staff members contradicts other source information, how should the item be coded?	LTCH CARE Data Set coding should be based upon information gathered from the patient's medical record, direct observation, interviews with staff member, patient family members or a combination of information from these sources to code the items. Facilities should have medical record documentation that matches coding data entered into the LTCH CARE data set to verify the rationale used for assessment coding. Each clinician coding the LTCH CARE Data Assessment should have undergone training in coding the LTCH CARE Data Set. The professional judgement of the clinician who is completing the LTCH CARE Data Set is to evaluate the information gathered to objectively determine appropriate and accurate coding of the LTCH CARE Data Set. In the example provided, the coding clinician may need to observe further patient activity to determine coding or interview staff further to probe for more detailed information. 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.
68.	Section B	Will the data collected in Section B, Hearing, Speech, and Vision be risk adjusted?	These items 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, LTCH Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632).

#	Question Category	Question	Answer
69.	Section C	How would we code Section C. item C1610A and C1610B for the following patient: The patient has suffered from a traumatic brain injury (TBI). The patient's behaviors *after* the TBI includes an acute change in cognitive abilities, behavior fluctuations during the day due to fatigue or over-stimulation. Would these be signs and symptoms of delirium?	Based upon the information provided, C1610A would be coded as 0. No. The rationale is based upon the description provided, the patient has suffered a TBI and the abnormal behaviors of inattention, disorganized thinking, and altered level of consciousness have not acutely changed since the TBI. While you are assessing the patient within the assessment period you would gather information from the family, patient medical records, and discharging facility (if applicable), as well as staff observation and interview. However, if there had been acute changes in this patient's behaviors from the patient's baseline (after sustaining a TBI) and this occurred during the assessment period, then you should answer C1610A as 1. Yes. Regarding C1610B. Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity? If the patient's baseline in exhibiting fluctuating abnormal behavior per staff and family has not increased or decreased in severity then code this item as 0. No, the (abnormal) behavior does not fluctuate during the day, the fluctuations remain consistent with the patient's baseline since the TBI. However, if the patient's baseline in exhibiting fluctuating abnormal behavior per staff and family has in fact increased or decreased in severity from the patient's baseline then code this item as 1. Yes, the (abnormal) behavior fluctuates during the day.
70.	Section C	For the items in Section C, how should the LTCH code this section if the patient's discharge is unplanned? There is no specific documentation for the last three days of the patient's stay about the patient's behaviors for use in completing section C coding.	Although the patient had an unplanned discharge, the clinical staff who cared for the patient prior to the patient's discharge can be interviewed about the patient's behavior before the patient's unplanned discharge. The information gathered from these staff members can be used to code this item. Facilities should have medical record documentation that matches coding data entered into the LTCH CARE data set to verify the rationale used for assessment coding. In the event that there is no information or recorded in the medical records concerning the patient's behavior related to this item then a "-" (dash) would be the appropriate response for the assessment item. CMS realizes there are instances when it is appropriate to use a dash; however, it is expected that these instances are rare.
71.	Section C	For Section C, item C1610A, is there evidence of an acute change in mental status from the patient's baseline? How is the patient's baseline defined? Does assessing the acute change in the patient's mental status only include observation of the 3-day assessment period, or does it include the patient's baseline status prior to admission considered? Our LTCH treats patients with TBI and so should we consider their cognitive patterns prior to the TBI as their baseline mental status?	Using your patient diagnosis example of a patient with a TBI, the baseline is the cognitive status of the patient after the TBI occurred. The clinician should consider what the patient's baseline was and compare it to the abnormal behaviors occurring. If the patient has been transferred to the LTCH from another facility, the previous facility would have the patient's status in the medical records from which to compare the patient's present status and/or the patient's family or caregiver may provide information on the patient's previous baseline.

#	Question Category	Question	Answer
72.	Section C	In Section C, please consider adding a question about documentation of encephalopathy. Medicare recognizes taking care of a confused patient costs more and will reimburse the hospital more. However, the only way for the facility to receive this reimbursement is for the physician to document encephalopathy. Delirium/confusion is not recognized in coding world as a "Major Complication and Comorbid Condition (MCC)".	Thank you for your suggestion and comment.
73.	Section C	Do Section C items (e.g. disorganized thinking, inattention) take into consideration communication impairments? How would a clinician code Section C items for a patient with a diagnosis of comatose?	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. For example, for item C1610A, if after observation, reviewing information in the medical record, and talking to family and/or staff, 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. Yes. In a scenario where the patient has a severe communication impairment (e.g. severe dysarthria due to stroke and unable to use alternative communication) and the clinician is not able to assess item: C1610D. Disorganized Thinking - Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? The provider who is absolutely unable to assess this information, would use a dash: however, it is expected that these instances are rare. 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
74.	Section C	Section C: When a patient is admitted from an acute care hospital and has already sustained the acute cognitive status and behavioral changes resulting from a brain injury (e.g. acute altered cognition and impulsivity), how would the clinician code C1610 A? Upon admission to the LTCH is the patient's baseline established then or do we consider the patient's behavior status prior to being admitted to the LTCH as the patient's baseline? How would the coding differ if the patient's behavior changed after admission and during the assessment?	The assessment item C1610A is coded during a snapshot of time; upon admission or discharge. An acute change in behavior can take place within the assessment time period or outside of the assessment time period. An acute change for someone with a brain injury would be based upon their baseline function, reflecting their present diagnosis of brain injury. If the patient has been transferred to the LTCH from another facility, the previous facility would have documented the patient's status in the medical record in order to compare the patient's present status and or the patient's family or caregiver may provide information on the patient's previous baseline. The baseline is established after the brain injury occurred which is prior to the present behavior being assessed. If there was not an acute change C1610A in the patient's behavior since observing the patient's baseline then C1610A would be coded 0. No. The rationale is that the patient's behavior has not acutely changed since entering the facility and the patient's family states that the patient's behavior is consistent with his behavior since his brain injury. If there was an acute change in abnormal behaviors then C1610A would be coded 1. Yes.
75.	Section C	Item C1601E uses the term "Alert" for coding C1601E1. Please provide a definition of "Alert".	The assessment asks for the clinician to determine if the patient is alert versus vigilant, lethargic, in a stupor or coma. Alert means awake and responsive as well as not showing any of the signs described in C1610E2.
76.	Section C and Section B	Section C: How do you code a patient who cannot be assessed such as with sedation and/or ventilator?	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 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. 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.
77.	Section H	For Section H item H0350, 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.

#	Question Category	Question	Answer
78.	Section H	For Section H item H0350, please confirm that response 2 ("incontinent less than daily") or response 3 ("incontinent daily") is not used if the relevant episodes are stress incontinence?	That is correct. Stress Incontinence is coded as a "1" only.
79.	Section H	If the patient has rectal tube should we code a dash ('-') or code 9, not rated?	Please code 9, not rated, if the patient uses a rectal tube.
80.	Section H	If a patient lies on his side and is allowed to pass the stool via manual stimulation into a disposable pad, is this still considered continent of bowel even though he is not on the toilet, commode, or bedpan? This is in reference to H0400. Bowel Continence.	Patients who require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories, or enema) would be considered bowel continent as long as the result of releasing the stool was in a commode, toilet, or bedpan. H0400 would be coded as 1, 2, or 3 because the patient passed the stool into a disposable pad.
81.	Section I	What is the definition of "severe" cancer? This refers to Section 1 item I0101. Severe and Metastatic Cancers.	A patient has an acute diagnosis of severe or metastatic cancer if they have metastatic cancer, and acute leukemia, lung cancer, multiple melanoma, and lymphoma.
82.	Section I	On the LTCH CARE Data Set V 3.00 Admission assessment is I1501, Chronic Kidney Disease, Stage 5 equivalent to end stage renal disease? Also, is CMS only interested in patients who have Chronic Kidney Disease, Stage 5, but are not on dialysis? For I1502, Acute Renal Failure, would you check this if patients are on dialysis or when they are not? Dialysis is a separate question.	Chronic Kidney Disease, Stage 5, is equivalent to end stage renal disease (ESRD). CMS is interested in all patients that have ESRD regardless of whether or not they are on dialysis. If the patient has Chronic Kidney Disease, Stage 5, you would check I1501 in the Genitourinary section of the Comorbidities and Co-existing Conditions. If this is also the patient's primary medical condition you would enter code 5 in I0050 and indicate the ICD code for ESRD in I0050A. If the patient has acute renal failure you would check I1502 in the Genitourinary section of the Comorbidities and Co-existing Conditions. If this is also the patient's primary medical condition you would enter code 5 in I0050 and indicate the ICD code for acute renal failure in I0050. Check O0100J, Dialysis, in Section O of the LTCH CARE Data Set if dialysis is part of the patient's treatment plan. You would select this item if the patient undergoes peritoneal or renal dialysis as part of the treatment plan. You would select this item if the patient is receiving treatments of hemofiltration (Intermittent or continuous), Slow Continuous Ultrafiltration (SCUF), hemodialysis, and Continuous Ambulatory Peritoneal Dialysis (CAPD). This item may be checked if the patient performs his or her own dialysis.

#	Question Category	Question	Answer
83.	Section I	For Section I, there are several comorbidities and co-existing conditions listed and we need to check all that apply. If the patient's medical condition includes one of those listed in Section I, for example amyotrophic lateral sclerosis (ALS) or peripheral vascular disease (PVD), how do we code the first item I0050?	You would indicate the patient's primary medical condition category in I0050. The patient's primary medical condition is one of the four categories (1. Acute onset respiratory condition, 2. Chronic respiratory condition, 3. Acute onset and chronic respiratory conditions, 4. Chronic cardiac condition) or code as 5. Other medical condition and indicate the ICD code. For example, if the condition is ALS, then code 5. Other medical condition, enter the ICD code for ALS, and check I5450. Amyotrophic Lateral Sclerosis in the comorbidities and co-existing conditions
84.	Section I	How are malnutrition (I5601) and at risk for malnutrition (I5602) defined? Especially "at risk".	In general, undernutrition 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 at risk for malnutrition based on their clinical status. For the purposes of coding in 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.
85.	Section J	To clarify the definition of an "unintentional" fall, if a therapist is walking a weak patient and she makes the decision to lower the patient to floor, is this considered a fall?	If the therapist believed the patient would have fallen if not intercepted (lowered to the floor by the therapist) then this is considered a fall.
86.	Section J	Regarding the major injury definition in Section J, item J1900C, the list appears to be finite. Other major injuries, such as quadriplegia or death, could occur but since they are not listed are they not considered major injuries?	The "major injury" inclusion items are not finite. Death or spinal cord injury resulting from a fall would be considered "major injury".
87.	Section J	I have a question about one of the examples of J1800 and an "intercepted fall" provided at the LTCH QRP Provider Training. In this example, the patient did not come to rest on the ground, floor, or onto the next lower surface so how does this meet the fall definition?	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.
88.	Section J	Are witnessed or patient observed intercepted falls expected to be documented? How can staff determine if the patient would have/would not have fallen?	Yes, if the patient or other reports/describes an intercepted fall, it should be documented.

#	Question Category	Question	Answer
89.	Section K	Regarding weight, one of the slides presented at the LTCH QRP Provider Training stated to use first weight if patient is weighed multiple times during ARD. Another slide, however, said use the most recent weight. Please clarify if it is the first weight or most recent weight?	We apologize for the confusion. When coding K0200B, Weight, if the patient has been weighed multiple times during the assessment period, use the first weight.
90.	Section M	Mr. R is an 83 year old with primary medical history of hypothyroidism, encephalopathy, HTN, and seizures. Admitted to STACH with signs and symptoms of sepsis. Admitted to the LTACH for vent weaning and continuation of antibiotic therapy. Patient has NO pressure ulcers on admission to the LTACH. Patient is started on weaning trials but doesn't progress well due to atelectasis. Three weeks following admission to the LTACH patient develops closed areas of non-blanching redness to each heel. Patient is on a low air-loss mattress and off-loading pressure from the heels is ordered. The following week, the patient's medical condition continues to deteriorate. The patient is started on vasopressor medication. Five days later, the areas of the patient's heels are noted as having progressed to DTIs. Four days later the patient expires. Should these wounds be considered Kennedy Terminal Ulcers? (Patient's ulcers developed within 6 weeks of death - Chapter M). NOTE: the physician's documentation in the discharge summary includes "…the patient's condition worsened significantly as patient was experiencing very poor peripheral perfusion contributing to skin breakdown secondary to decrease global perfusion, evident by use of pressors and continued low blood pressure and mottled skin..."	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
91.	Section M	If a patient admits with multiple pressure ulcers (e.g. 5) -- three of these heal -- a new one develops. Is it adm 5, d/c 3, present on admission 2?	Yes
92.	Section M	If the RN assesses and documents a "wound" on day 1 but the WOCN "re" classifies same area as a pressure ulcer on day 2 or 3, can it be reported present on admit?	This would first depend on your facility policy regarding who has been identified as the appropriate person to stage and document pressure ulcers, and secondly which of the clinical assessments by the identified clinician is closest to the time of admission as possible. In this example, if it is the WOCN, then the Stage 3 would be documented. If there is no policy, any discrepancies would need to be resolved by the facility prior to coding on the LTCH CARE Data Set, and the status of the pressure ulcer as close to the time of admission as possible would be coded.
93.	Section M	Scenario: Admission nurse completes skin assessment on day 1 and stages a wound as stage 1. The wound specialist completes a skin assessment on day 3 (within ARD) and, based upon supporting evidence to include pictures from both assessments, determines that the wound was mis-staged and is actually a stage 4. Can the data from the second assessment be used to complete the CARE data set?	The LTCH CARE Data Set needs to be completed with correct assessment data. If the data entered on the LTCH CARE DATA Set is incorrect, then it must be modified to reflect the status of the patient in the LTCH either on admission or discharge. (FYI - This situation is different than the example above because there isn't the qualifier that the stage was "mis-staged," just that two different people came up with two different stages.)
94.	Section M	Will we get copies of the slides with the scenario answers and rationale?	The training materials will be posted on CMS' website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html
95.	Section M	M0800 - Worsening in Pressure Ulcer Status since Admission: Does this apply to admission assessment? Or only for Planned and Unplanned Assessment only? Thank you.	Please see the LTCH Quality Reporting Program Manual, Chapter 3: Section M, pg. M-27, Steps for Assessment: "This item refers back to the pressure ulcer coding on the Admission assessment. Complete only if A0250 = 10 Planned Discharge or A0250 = 11 Unplanned Discharge."
96.	Section M	Is Section M exempt from the 3-day assessment? For the example used the Stage 2 was identified on day 3. Could that be stated it was present on admission?	If this question refers to the Admission assessment, the rationale for the first M0300 coding example suffices. If this question refers to the Discharge assessment, and the Stage 2 is still present on Discharge, it is not considered as present on admission because the patient entered the LTCH with no pressure ulcer identified by the initial skin assessment that was completed as close to the time of admission as possible.
97.	Section M	How are M0300 rows completed at Unplanned discharge?	The same way they are completed for the Planned Discharge with information about the status of the ulcer as close to the time of discharge as possible.

#	Question Category	Question	Answer
98.	Section M	How can I obtain a copy of NPUAP staging definitions?	www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/
99.	Section M	Clarify Kennedy Ulcers: 2nd paragraph, Chapter 3, Section M - contradictory information. Pg. M-3: "skin ulcers that develop in patients who have terminal illness or are at the end of life should be assessed and STAGED AS PRESSURE ULCERS even if it is determined that the ulcer is part of the dying process (also known as Kennedy Ulcers)." When an ulcer has been determined to be a Kennedy Ulcer, it should NOT be CODED as a PRESSURE ULCER."	Same response as Row 48. There is no other clarification that can be made.
100.	Section M	Pg. M-2, Clarify 2nd paragraph. If CMS has adopted NPUAP guidelines, why do the definitions NOT correlate with each stage?	CMS did not "adopt" NPUAP guidelines, we "adapted" NPUAP guidelines. The current items on the LTCH CARE Data Set were taken from the MDS 3.0 which was developed before the 2009 pressure ulcer definitions were updated by NPUAP. CMS decided to remain with the 2007 staging definitions, because the difference between the two versions was not significant. Over several years, CMS has collaborated with NPUAP as well as several clinical subject matter experts to ensure that the current LTCH CARE Data Set provides the most up to date staging information and best guidance related to the current state of science related to pressure ulcers. The items are also tied to quality measure specifications that were already developed and advanced to the National Quality Forum.
101.	Section M	Upon discharge when asking for total # of pressure ulcers at each stage, can you restate the question to make it clearer? i.e. Presently - "Number of these stage 3 pressure ulcers present on admission", change to - "Number of these stage 3 pressure ulcers present on admission as a stage 3 pressure ulcer"	This is already how it appears in the manual. Providers need to read the manual, not just rely on the item sets for guidance.
102.	Section M	Are device-related pressure ulcers to be captured on CARE data set?	No, not at this time.

#	Question Category	Question	Answer
103.	Section O	The guidelines state that the patient was assessed for influenza while in the hospital. If we assess on admission and either it was in September, and patient was not in the LTCH during the flu season, or the patient was not eligible, such as a medical contraindication, are we to document Code 5 "not offered" or Code 9 "--" which can result in a 2% penalty? At discharge, we don't have another assessment documented in the medical record so are we supposed to be doing an assessment on admission and discharge? If so, how can we do this on unplanned discharge and expired patients? If we are assessing on admission and not on discharge, are we still in compliance and not subject to the 2% penalty? Please provide a clearer definition in the manual.	Per the LTCH QRP manual, the influenza vaccination season is defined as beginning October 1, 2015, or when the influenza vaccine becomes available (whichever comes first) through March 31, 2016. If the vaccine is available in September when the patient was admitted, your facility should assess the patient for the influenza vaccine and complete the influenza items on the LTCH CARE Data Set. If the vaccine was not yet available when the patient was admitted in September, and the patient was discharged on or after October 1, facilities should assess on discharge. The influenza items are also included on the discharge and expired assessments.
104.	Section O	If a patient receives the influenza vaccine, is then discharged to an acute care facility, and then returns to the LTCH 10 days later, do you record the date it was given in the LTCH facility during the previous stay?	Because the patient was discharged from the LTCH and did not return to the LTCH within 3 calendar days, you would complete the LTCH CARE Data Set Unplanned Discharge assessment for this patient. If the patient received the influenza vaccine in the LTCH during this year's influenza vaccination season you would code 1, Yes for O0250A, Did the patient receive the influenza vaccine in this facility. You then continue to O0250B, Date Influenza Vaccine Received and enter the appropriate date.
105.	Section O	What is the rationale for adding O0250, Influenza Vaccine, to the expired patient's assessment?	The expectation is that the influenza vaccine be administered to all eligible patients, regardless of whether their stay ended in death. The influenza items on the LTCH CARE Data Set are to be completed on the Expired assessment if not on the Admission assessment. Expired patients are not excluded from this measure. Inclusion of expired patients in the quality measure is new for LTCHs in order for the measure to be harmonized with the other settings (i.e., NH and IRF).

#	Question Category	Question	Answer
106.	Section O	Regarding item O0250, Influenza Vaccine, can you clarify when to code 6, "inability to obtain influenza vaccine due to a declared shortage"? Who declares this?	We refer you to the following CDC webpage for information regarding shortages of the influenza vaccines: http://www.cdc.gov/vaccines/vac-gen/shortages/. For example: Mr. L was admitted to the LTCH comatose after an intracerebral bleed. His family requests that he receive an influenza vaccine during his hospitalization. The nurse explains that there is currently a declared shortage of influenza vaccine and that Mr. L will receive a dose when the facility obtains more vaccine. Coding: O0250A would be coded 0, No; O0250B would be skipped; and O0250C would be coded 6, Inability to obtain vaccine due to a declared shortage. Rationale: Mr. L did not receive the influenza vaccine because there was no influenza vaccine available at this time. Mr. L will receive the vaccine once the facility receives more vaccine.
107.	Section O	Regarding item O0250. Influenza Vaccine, can the flu season start prior to October 1 if, for example, the flu vaccine arrives in September or the facility starts administering in September? Is the intent instead to address "post-October 1" arrivals of the flu vaccine? Please clarify.	Per the LTCH QRP Manual Version 3.0, the 2015-2016 influenza vaccination season is defined as beginning October 1, 2015, or when the influenza vaccine becomes available (whichever comes first) through March 31, 2016. Thus, the intent is NOT to address post-October 1 arrivals of the vaccine. If the vaccine is available in September, or even earlier, your facility should begin assessing patients for the influenza vaccine and administering the vaccine, as well as completing the influenza items on the LTCH CARE Data Set.
108.	Section O	Regarding item O0250. Influenza Vaccine, why do the data submission specifications include choices that are not listed on LTCH CARE Data Set paper form? For example "No information/Not assessed"? Why isn't this on the paper form?	Dashes (-) are used to indicate that an item was not assessed or the information was not available. Dashes are allowed on most, but not all, items. When a dash is allowed for an item, it is listed in the "Item Values" table in the data submission specifications. A dash must not be submitted for items where the "Item Value" table does not list it as an allowable value; submitting a dash for such an item results in a fatal error. When a dash is allowed for "not assessed", a single dash should be submitted for the item regardless of the item's normal length. For more information please review the LTCH CARE Data Submission Specifications V 2.00.0 and associated errata documents available for download here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-Data-Submission-Specs-FINAL-v2000-August-2015-%E2%80%93-Implementation-on-April-1-2016.zip.
109.	VAE	What is the acceptable national benchmark on the following: NQF#0678, NQF#0680, NQF#0138, NQF#0139, NQF#1716, NQF#1717, NQF#0431, VAE?	The following Measures pertain to NHSN: NQF#0138 (CAUTI), NQF#0139 (CLABSI), NQF#1716 (MRSA), NQF#1717 (CDI), NQF#0431 (HCP Flu Vacc). The national pooled mean baseline rates for CAUTI and CLABSI SIRs, for LTCHs, have been published in the NHSN 2013 Data Summary, available from: http://www.cdc.gov/nhsn/datastat/index.html. The MRSA and CDI LabID baselines, as well as the VAE baselines, have not yet been developed for LTCHs.