Centers for Medicare & Medicaid Services (CMS) Special Open Door Forum (SODF)

Patient Protection and Affordable Care Act (ACA) Section 3004: Quality Reporting Program for Long-Term Care Hospitals

Section M Update and Commonly Asked Questions

Thursday, August 30, 2012
2:00-3:30 pm EST

Presentation Overview

- This presentation will provide:
  - Updates to Section M: Skin Conditions
  - Review answers to select commonly asked questions for Section M
  - Review answers to select commonly asked questions for Section A and Section Z

Objectives

- Understand clarifications and changes made to Section M.
- Code Section M items correctly and accurately.
- Review answers to commonly asked questions.

Key Updates to Section M

- “72 hours” has been changed to “3 calendar days.”
- “Look-back period” has been changed to “assessment period.”
- Definitions of “numerical staging” and “unstageable” pressure ulcers have been clarified.
- Slough and eschar are both considered necrotic tissue. Therefore, “necrotic (eschar)” was changed to “eschar.”

Overview of Section M Items

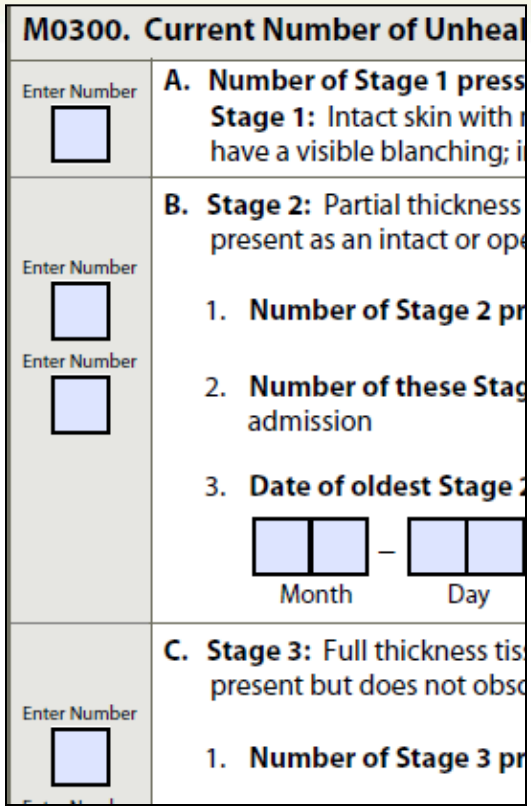
- M0210. Unhealed Pressure Ulcer(s)
- M0300. Current Number of Unhealed Pressure Ulcers at Each Stage
- M0610. Dimensions of Unhealed Pressure Ulcers
- M0700. Most Severe Tissue Type for Any Pressure Ulcer
- M0800. Worsening in Pressure Ulcer Status (Discharge Data Sets)

Item M0300

Current Number of Unhealed Pressure Ulcers at Each Stage

M0300 Current Number of Unhealed Pressure Ulcers at Each Stage

- This measure documents the current **number** of unhealed pressure ulcers for each stage.
- Numerical stages 2-4 and unstageable ulcers require the long-term care hospital (LTCH) to document ulcers that are present on admission (POA).



Steps for Completing M0300 A-G – Step 3: POA

- Two clarifying statements have been added:
  - The first refers to adhering to clinical standards of practice for clinical admission assessments.
  - The second refers to how the 3-day assessment period is reconciled with the POA definition.

M0300 Scenario

- Per facility policy, initial clinical admission skin assessment was completed on new patient Miss J. on day 1 of her stay. It was identified that Miss J. has one Stage 2 pressure ulcer.
- By day 3, the wound has worsened and is restaged as a Stage 3 pressure ulcer.
- How should Items M0300B1 and M0300B2 be coded on the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set Admission Assessment?

Scenario Coding

- Code M0300B1 Number of Stage 2 Pressure Ulcers as 1.
- Code M0300B2 as 1 Present on Admission.
  - Rationale: The Stage 2 pressure ulcer is the ulcer that was initially staged on the clinical admission skin assessment as POA.

Item M0700

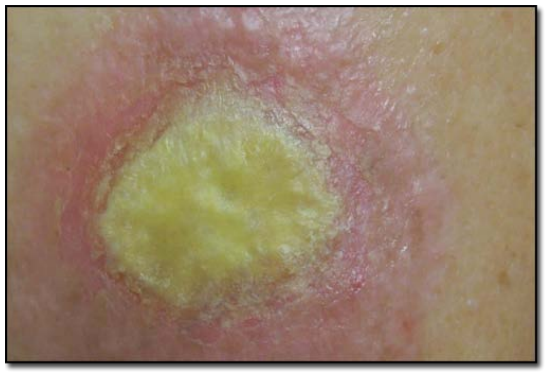
Most Severe Tissue Type for Any Pressure Ulcer

M0700 Most Severe Tissue Type for Any Pressure Ulcer

- This measure documents the most severe tissue type present in any pressure ulcer bed.
- Each tissue type refers to tissue that is visible in different stages as wounds evolve and heal.
- The list in M0700 is arranged from the healthiest types of tissues to the most devitalized.

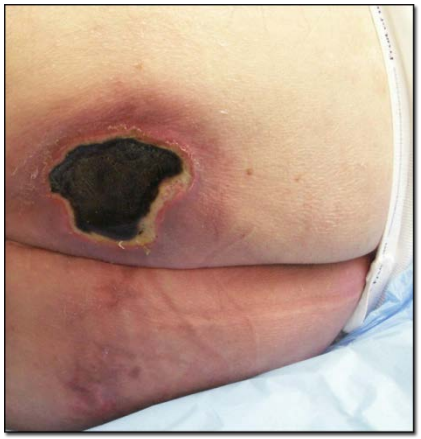
Necrotic Tissue

- There are two types of necrotic tissue:
  - Slough – which is nonviable yellow, tan, gray, green, or brown tissue. It is usually moist, and can be soft, stringy, mucinous with adherence to the base of the wound or present in clumps in the wound bed.



Necrotic Tissue (cont.)

- Eschar – which is dead or devitalized tissue; hard or soft in texture and is usually black, brown, or tan. It may appear scab-like and is usually firmly adherent to the base of the wound and often to the sides/edges of the wound.

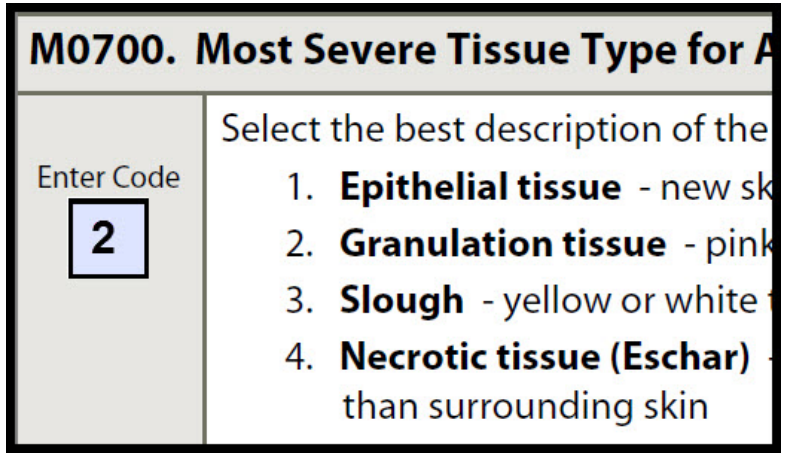


M0700 Scenario

- A patient has two pressure ulcers. One is a Stage 2 pressure ulcer on the right ischial tuberosity that is healing. It has epithelial tissue that has resurfaced 25% of the ulcer. The second is a Stage 3 pressure ulcer on the sacrum that is filled with 75% granulation tissue. How should item M0700 be coded?

Scenario Coding

- Code as 2. Granulation Tissue.
- Coding is based on the sacral ulcer, which has the most severe tissue type.
  - **Rationale:** Granulation tissue is the most severe tissue type present in the wound.



Item M0800

Worsening Pressure Ulcer Status (Discharge Data Sets)

M0800 Worsening Pressure Ulcer Status

- This measure documents, on the discharge assessment, the number of pressure ulcers that have worsened as compared to the prior assessment.
- The worsened definition includes
  - Number of **new** pressure ulcers

  AND/OR

  - Number of pressure ulcer(s) that have increased (**worsened**) in numerical stage.

M0800 Coding Guidelines

- Text was added to this item to further clarify coding for numerically staged POA pressure ulcers that become stageable, are debrided, and can be numerically staged.

M0800 Scenario

- A patient's admission assessment documented an unstageable pressure ulcer due to slough on the right ischial tuberosity.
- Five days into the LTCH stay, the patient's pressure ulcer was debrided and was numerically staged as a Stage 3.
- On discharge, it is noted that the pressure ulcer was reassessed and has increased in numerical stage (i.e., worsened) to a Stage 4.
- How should item M0800 be coded?

Scenario Coding

- Code M0800A, Worsening – Stage 2, as 0.
- Code M0800B, Worsening – Stage 3, as 0.
- Code M0800C, Worsening – Stage 4, as 1.
  - Rationale: The Stage 3 is not considered in the worsening item because it was the first time the pressure ulcer was numerically staged. Subsequently, the pressure ulcer increased in numerical stage and is therefore documented as worsened at M0800C Stage 4.

Section M - FAQs

Q. Why has CMS adapted National Pressure Ulcer Advisory Panel (NPUAP) guidelines related to blisters and Deep Tissue Injury (DTI)?

A. CMS consulted subject matter experts for clinical validation of pressure ulcer coding. At the time these items were finalized, it was determined that there was much that current science was unable to confirm regarding DTI. CMS opted for an holistic approach to pressure ulcer assessment that included characteristics of surrounding skin instead of a pure focus on what color fluid was visible inside of an intact blister.

Section M – FAQs (cont.)

Q. POA pressure ulcers are only allowed to be coded in acute hospitals when physicians or those with legal authority to make medical diagnoses have documented a POA pressure ulcer. So why is nursing documentation allowed in LTCH for coding POA pressure ulcers?

A. POA coding for short-stay acute hospitals focuses on billing codes specifically for purposes of Medicare payment under the Inpatient Prospective Payment System (IPPS). There are no CMS POA regulations related to Medicare payment in LTCHs at this time.

Section M – FAQs (cont.)

- Furthermore, State Nurse Practice Acts differ among states as to who can stage pressure ulcers.
- The American Nurses Association has confirmed that it is within the scope of the nurse to stage pressure ulcers.

Section M – FAQs (cont.)

Q. Why are pressure ulcers that have been repaired with grafting procedures considered surgical wounds and not coded as pressure ulcers?

A. Due to the surgical intervention tissue has been moved from the patient to close the pressure ulcer. Grafting provides the tissue to assist in that closure. Therefore, this is a surgical closure of the wound and no longer able to be staged or classified as a pressure ulcer if this surgical wound dehisced. Therefore, for purposes of coding the LTCH CARE Data assessments, a pressure ulcer that has been repaired by a grafting procedure is considered a surgical wound and is not coded on the LTCH CARE Data assessment as a pressure ulcer.

Section M – FAQs (cont.)

Q. How are Kennedy Ulcers to be documented in the LTCH CARE Data Set?

A. Kennedy Ulcers are considered pressure ulcers; therefore, they should be coded as pressure ulcers in the LTCH CARE Data Set, Section M, at the appropriate stage.

Section M – FAQs (cont.)

Q. If a patient had an identified Stage 2 pressure ulcer on the clinical admission assessment and on Day 2, the pressure ulcer was now a Stage 3, as I understand it, it is coded as Stage 3, not POA. Is that correct?

A. No, the LTCH CARE Data Set requires that the skin condition documented be from the skin assessment obtained as close to the time of admission as possible, so in this case, the Stage 2 is what would be coded on the Admission Assessment as POA.

If on the Discharge Assessment, this pressure ulcer is still a Stage 3, it would be coded as a Stage 3, worsened, and not POA.

Section M – FAQs (cont.)

Q. What do we do if a pressure ulcer worsens during the first 3 days of the patient's admission to the LTCH? How do we code the wound?

A. The patient assessment reflected in the Admission Assessment data set should coincide with the patient's Admission Assessment for the purposes of determining if a pressure ulcer was POA. A wound determined to be POA would specifically need to be "on admission." Thus, if a POA wound worsened during the 3 days, the admission assessment record should capture the wound's stage at admission and the stage to which it worsened. On the discharge record, the wound would be captured in the stage to which it worsened, if it had not healed. Still, the wound, because it worsened, would no longer be captured as POA.

Section M – FAQs (cont.)

Q. On Day 2 of the 3-day assessment period, a pressure ulcer was assessed as unstageable. On Day 5, the wound was debrided and staged as a Stage 3. On Day 24, the day of discharge, the wound was restaged as a Stage 4. How would this scenario be coded on the Admission and Discharge Assessments?

A. On the Admission Assessment, it would be coded as unstageable and POA. On the Discharge Assessment, it would be coded as a Stage 4, worsened, not POA. This is because the first time it was able to be numerically staged after debridement, it was staged as a Stage 3 then subsequently increased in numerical staging (worsened) to a Stage 4 prior to discharge.

General – FAQs

Q. I need clarification on the definition of “LTCH.” Are these long-term acute care hospitals or long-term care hospitals?

A. Long-term care hospitals (LTCHs) and long-term acute care hospitals are different names for the same type of hospital. Medicare uses the term long-term care hospitals. These hospitals are certified as acute care hospitals that treat patients requiring extended hospital-level care, typically following initial treatment at a general acute care hospital. If a hospital is classified as an LTCH for purposes of Medicare payments (as denoted by the last 4 digits of its 6-digit CMS Certification Number [CCN] in the range of 2000–2299), it is subject to the requirements of the LTCH Quality Reporting Program. If your critical access hospital (CAH) has **long-term care** beds that either provide skilled nursing facility-level or nursing facility-level care, it is not required to comply with a requirement that was mandated for LTCHs, which are hospitals.

General – FAQs (cont.)

Q. Where can I find the definitions for the LTCH quality measures?

A. For most current and up-to-date definitions for the three LTCH quality measures – catheter-associated urinary tract infection (CAUTI; NQF#0138), central line-associated bloodstream infection (CLABSI; NQF#0139), and pressure ulcer (#0678) – please refer to the LTCH Quality Reporting Program Manual available for download at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html.

We also invite you to visit this Web site for updates to measure specifications for each of these measures that may result from the National Quality Forum's review of these measures.

General – FAQs (cont.)

Q. Do we report patients with all payer sources for CAUTI, CLABSI, and pressure ulcers for LTCH or just patients admitted with Medicare payer source?

A. For the pressure ulcer measure, the LTCH CARE Data Set applies to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under the Medicare program. Data collection using the LTCH CARE Data Set applies regardless of patient's age, diagnosis, length of stay, or payment/payer source (Chapter 2, Section 2.1).

For the CLABSI and CAUTI measures, each LTCH must submit data for these measures on all patients from all inpatient locations, regardless of payer source (Chapter 5, Section 5.1).

General – FAQs (cont.)

Q. Are all demographic information items required?

Q: Are GG0160C (Functional Mobility: Lying to Sitting on Side of Bed); H0400 (Bowel Incontinence); I0900. (PVD/PAD [peripheral vascular disease/peripheral arterial disease]); I2900 (Diabetes); K0200A (Height); and K0200B (Weight; required only for admission assessments)?

A. Please refer to the LTCH Quality Reporting (QR) Program Manual, available for download at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html. Appendix E provides item-specific guidance on requirements for the completion of the LTCH CARE Data Set.

Section A – FAQs

Q. What is the definition for planned discharge?

A. A planned discharge is one in which the patient is nonemergently, medically released from care at the LTCH due to some reason arranged for in advance.

Section A – FAQs (cont.)

Q. What is the definition for unplanned discharge?

A: An unplanned discharge is:

- A transfer of the patient to be admitted to another hospital/facility that results in the patient's absence from the LTCH for longer than 3 days (including the date of transfer); or
- A transfer of the patient to an emergency department of another hospital in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation, resulting in the patient's absence from the LTCH for longer than 3 days; or
- When a patient unexpectedly leaves the LTCH against medical advice; or
- When a patient unexpectedly decides to go home or to another setting (e.g., due to the patient deciding to complete treatment in an alternate setting).

Unplanned discharges do not include planned transfers to acute-care inpatient hospitals for admission for planned interventions, treatments, or procedures, unless the patient does not return to the LTCH within 3 days.

Section A – FAQs (cont.)

Q. Can CMS please clarify whether there is a 72-hour rule or a 3-calendar-day rule in the following instances:
1. When a patient leaves an LTCH to go to another facility and then returns to the LTCH, for purposes of determining whether to submit a discharge assessment?
2. When a patient dies within 72 hours or 3 days after leaving an LTCH for another facility?

A. The 3-day interrupted stay is in accordance with the payment policies that have been established. If the policy states that day 1 of 3 begins on the day of transfer, then that day plus 2 would dictate the definition of the 3 days. If a patient dies during an interrupted stay, then the LTCH should submit an Expired data set. If the patient dies afterward, the LTCH should have submitted a Discharge item set because the patient did not return within 3 days.

Section A – FAQs (cont.)

Q. If patient's planned discharge is Friday, but the discharge is delayed until Sunday, what should the assessment reference date (ARD) be?

A. The ARD on discharge assessment will always be the patient's actual discharge date (Chapter 2). The LTCH has 5 days to complete the Discharge Assessment.

Q: If patient dies during the Assessment Period, should you fill out both Admission and Expired Assessments?

A: Yes, both admission and expired assessments should be completed. The ARD for Expired Assessment would be the date of death.

Section Z – FAQs

Q. Should the signature sections be filed and held at the hospital? If so, how long should they be kept?

Q: Do I have to retain Section Z?

A. CMS will not be receiving the signatures provided in Section Z, Z0400 and Z0500. We will receive the submission date. We strongly suggest that you retain what you submit to CMS, including Section Z, according to your facility and State regulations and requirements. Facilities should comply with their requirements pertaining to electronic signatures, if they require them.

Section Z – FAQs (cont.)

Q. Does the LTCH CARE Data Set require the signature of a registered nurse?

A. No. CMS has **removed** the language surrounding **and requirement** for a registered nurse's signature for the LTCH CARE Data Set's submission.

Q. Does the LTCH CARE Data Set require that the LTCH have an assessment coordinator on staff?

A. No. CMS has **removed** language pertaining to an assessment coordinator.

Materials from LTCH SODF

Presentation slides will be posted at the following site: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html

Transcript and audio file will be posted at the following site: http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODFSpecialODF.html

For SODF updates and call-in information, please refer to the following site: http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_SNFLTC.html

Please submit your questions regarding the LTCHQR Program to CMS at: LTCHQualityQuestions@cms.hhs.gov